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THE MEDICAID EVOLUTION:

The Political Economy of Medicaid Federalism

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THE MEDICAID EVOLUTION:

The Political Economy of Medicaid Federalism

by

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Dissertation

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In Memory of

my grandmother, Lilia de Medici, the matriarch;

my sister, Myra Monika, the pathbreaker; and

my mother, Ileana Spagna, my very dear friend

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THE MEDICAID EVOLUTION:

The Political Economy of Medicaid Federalism

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The Medicaid Evolution: The Political Economy of Medicaid Federalism is a policy analysis of the largest health financing initiative in the United States, as well as the largest federal grant program to the states. Concentrating on the bargains that shaped Medicaid federalism over its more than 40-year history, the evaluation extends back to the New Deal Era and the institutional roots of the Social Security Act. Public Policy is bargaining. And no area of Public Policy is shaped more by conflict resolution than Federalism. The publication concentrates on particular "moments in time" or "punctuations" when Medicaid financing and its administrative structure were prioritized on the national agenda. It then "unpacks" these negotiations. This Medicaid review is inevitably intertwined with the most profound attempts at national health reform in our country's history.

The writing is comprised of four parts: ***Part I: Policy and Federalism Theory***; ***Part II: Medicaid in Retrospective***; ***Part III: The Modern Era***; and ***Part IV: Summary and Conclusions***. In its two chapters, the first part establishes, first, the theoretic framework of Institutional Economics and a compilation of political science theories, and, second, a meta-analysis of federalism theory. Part II, Chapters 3 to 6, moves through the Pre-Medicaid Enactment Era, the LBJ Rights Era, the Watershed Era of President Nixon's Administration, and the Budget Era of the Reagan years. Part III

focuses on "The Modern Era," defined as 1992 through 2007. Chapters 7 through 11 are informed by dozens of interviews with the most prolific experts and pivotal decision makers in Medicaid. Part III reviews President Clinton's Waiver Presidency and the pre-eminence of The Administration State during the G.W. Bush Administration. Part IV, Chapter 12, provides Summary and Conclusions.

In addition to the interviews, the primary research includes archival review of several collections at ***The Lyndon Baines Johnson Presidential Library***, ***The Center for Legislative Archives (NARA)*** in Washington, D.C., and extensive research at the ***Law Library of The Library of Congress*** and the ***National Library of Medicine***. It builds on substantial periodical and newspaper review, including forty years of Congressional history. Hundreds of secondary sources also inform this work.

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THE MEDICAID EVOLUTION:

The Political Economy of Medicaid Federalism

ACRONYMS

American Welfare State and Tax Programs

AFDC	Aid for Families with Dependent Children
EITC	Earned Income Tax Credit
MAA	Medical Aged Assistance
OAA	Grants to the States for Old Age Assistance for the Aged
OASDI	Federal Old-Age, Survivors, and Disability Insurance Benefits (Social Security)
SCHIP	State Children's Health Insurance Program
SSI	Supplemental Security Income Program
TANF	Temporary Aid for Needy Families
TITLE XX	Block Grants to the States for Social Services

Legislation and Budget Terms

ADA	Americans with Disabilities Act of 1990
BBA	Balanced Budget Act of 1997
BEA	Budget Enforcement Act of 1990
DRA	Deficit Reduction Act of 2005
ERISA	Employee Retirement Income Security Act
GRH	The Gramm-Rudman-Hollings Act, officially the Balanced Budget and Emergency Deficit Control Act of 1985
OBRA	Omnibus Budget Reconciliation Act
PAYGO	Pay-As-You-Go
SSA	Social Security Act of 1935

Government Agencies and Administrations

ACIR	Advisory Commission on Intergovernmental Relations
BOB	Bureau of the Budget
CMS	Centers for Medicare and Medicaid Services
HCFA	Health Care Financing Administration
HEW	Department of Health, Education, and Welfare
HHS	Department of Health and Human Services
OIG	Office of the Investigator General
OMB	Office of Management and Budget
SSA	Social Security Administration

Associations

AARP	American Association of Retired Persons
AHA	American Hospital Association
AHSA	American Human Services Association
AMA	American Medical Association
NASMD	National Association of State Medicaid Directors, a member of the (AHSA) American Human Services Association
NCSL	National Center for State Legislatures
NGA	National Governors Association
NHLP	National Health Law Program

Health and Medicaid Subsystem

DSH	Disproportionate Share Hospital Payments
FPL	Federal Poverty Level
FMAP	Federal Medical Assistance Percentage
GPPPs	Group Practice Prepayment Plans
HSAs	Health System Agencies
IGT	Intergovernmental Transfer
MCO	Managed Care Organization
UPL	Upper Payment Limit

Political Theory and Policy Bargaining Terms

ACF	Advocacy Coalition Framework
BPM	Bureaucratic Politics Model
BATNA	Best Alternative to a Negotiated Agreement
MPP	Macro Public Policy Framework

Manuscript Collections

LBJ PL	Lyndon Baines Johnson Presidential Library, Austin, Texas
CLA/NA	Center for Legislative Archives at the National Archives, Washington, D.C.

INTRODUCTION

...[E]ntitlements are a product of history,
not logic -- of evolution, not design. Wildavsky

INTRODUCTION

Medicaid is arguably the most complex program in American social policy. It represents multiple paradoxes in that it is both a federal and a state program; it overlaps both welfare and health politics; it funds acute and long-term care; it assists the middle-class but continues as a critical part of the safety net; it is a public program that is financially important for many private industries – particularly nursing homes; and it maintains federal minimum requirements for state governments but states retain the ability to "waiver" federal requirements through petitions.

This work addresses an area that is understudied, the federal decision making apparatus and its policy decision making that shapes the Medicaid program. While texts review certain aspects of Medicaid federalism or review the different versions of state Medicaid programs, this text focuses on how the institutional arrangements in the federal government and policy bargains shape the program. It concentrates particularly on debates related to Medicaid's grant structure, but also considers waiver authority and decision making regarding which state financing schemes will be allowed. Past work on social policy federalism work concentrating on American governance has excluded Medicaid, claiming it is a "lower-profile social policy issue related to federalism."[1]

[1] See Footnote #8 in Daniel Béland and François Vergniolle de Chantal,"Fighting 'Big Government': Frames, Federalism, and Social Policy Reform in the United States," in the *Canadian Journal of Sociology* 29(2) 2004: 237-264.

Medicaid provides health care to 55 million Americans and costs $350 billion dollars annually, second only to Social Security in entitlement spending. It is, by far, the largest grant the American government provides for the states, comprising the largest portion of many state budgets. How Medicaid qualifies as "lower profile" in American federalism defies imagination. Due to these types of miscalculations, Medicaid and the decision making apparatus that shapes the structure of its federal-state relationship is understudied.

BROAD TRENDS

This project concentrates on the primary moments in time when the Medicaid financing and administrative structure was prioritized on the national agenda. Stated broadly, the project studies the Political Economy of Medicaid federalism. In doing so, it focuses on those times when the institutional grant structure was debated and challenged on the national stage. Figure 1 provides an overview of the major punctuations in the Political Economy of Medicaid Federalism.

Pre-Development and Enactment Years

In the pre-developmental and enactment years, the "moments" chosen for review are key periods before, during, and shortly after Medicaid enactment that include the two big bangs in American social policy – The New Deal and The Great Society – as well as two fertile periods of rights activism – Franklin Delano Roosevelt's Economic and Social Bill of Rights and the Civil Rights Movement. This development era is distinguished by rights based rhetoric as an undercurrent of domestic policy debate. The Warren Court and its progressive Supreme Court decisions supported this policy stream. Also the involvement of institutional economists trained in the old institutionalist tradition that embraced historicity contributed to this trend.

During this era, President Nixon, the Republican ironically known for his New Federalism initiative, effectuated the federalization of three public assistance programs into the Supplemental Security Income (SSI) program and also proposed the

federalization of the fourth cash welfare program enacted during the New Deal, Aid to Families With Dependent Children (AFDC). AFDC was not federalized, but at that point remained an open-matching grant, and a program historically linked to Medicaid.

The Major SeaChange and Reasons for the Policy Crater in 1974 and 1981

Policy bargaining in national domestic, particularly social, politics changed substantially after the mid-1970s. This was a tipping point in the way that Medicaid's structure as a national agenda item was bargained. Part of the explanation for this shift is the 1974 Budget Act that introduced a new institutional structure for the United States Congress to address the country's budget.[2] In 1981, the process was first used as a vehicle for entitlement reform. Although there are a myriad of additional reasons for this shift in macro domestic policy that will be discussed, the new uses of budget bargaining provided a new vehicle for entitlement politics. The first major proposed Medicaid reform in the Omnibus Budget Reconciliation Act (OBRA) process was in 1982. With vastly different rules than typical Congressional debate, Democrats and Republicans both used it for strategic reasons. While not necessarily benefiting one side, it shifted power, decision points, committee involvement, and the terms of Congressional debate.

Also, the role of the Office of Management and Budget (OMB), a White House based office, in this budget process changed fundamentally in 1981 when Reagan's OMB Director, David Stockman, introduced "campaign tactics" to the process.[3] Similar to those used in both political and military campaigns, the OMBs role was much more prominent and the scope of interaction broadened in the budget process after 1981.

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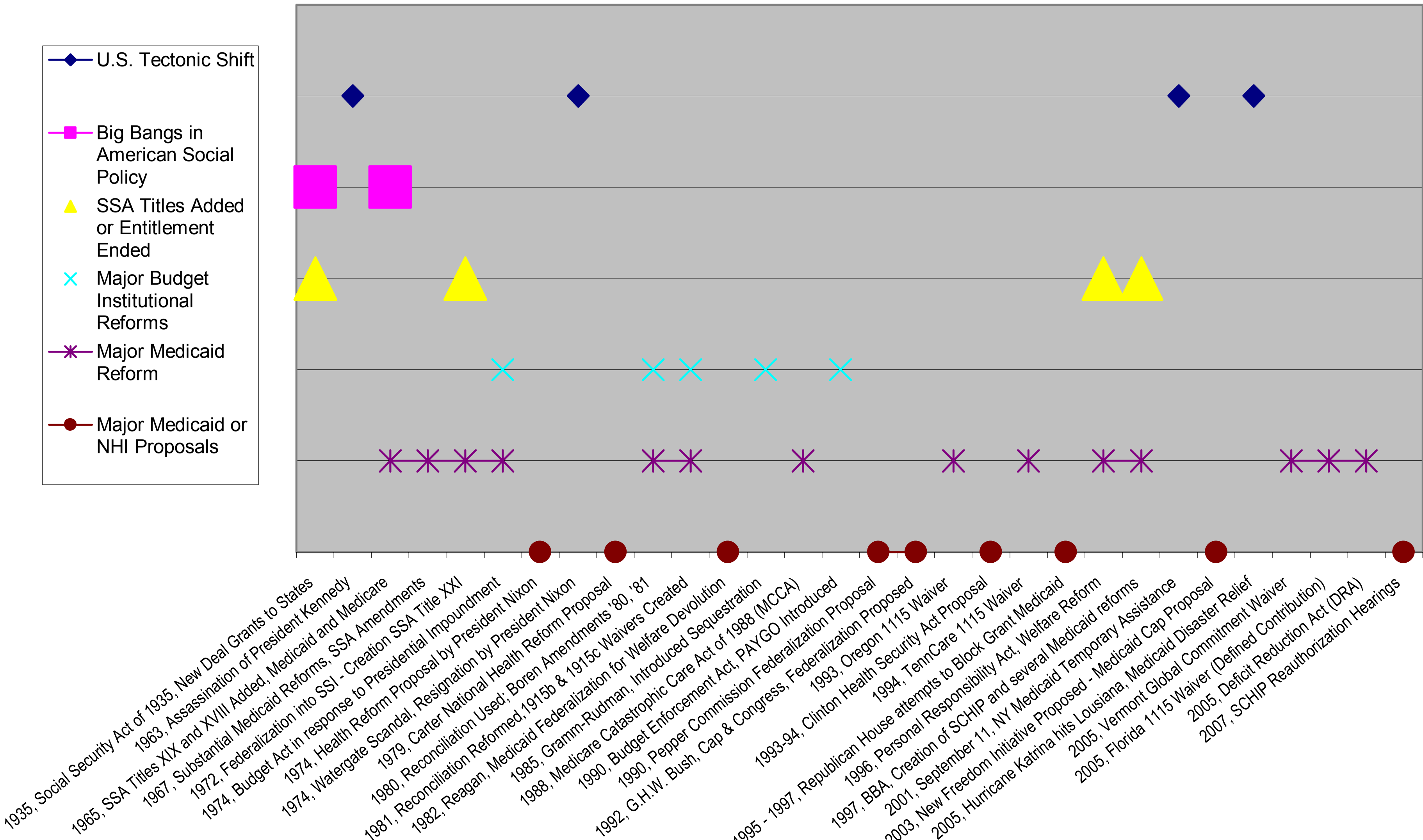
[2] In fact, the enactment of the Congressional Budget and Impoundment Control Act was to protect Congressional intent from Presidential power. Nixon had used Impoundment in so many ways to subvert Congressional intent that this Act was passed.

[3] David G. Smith referred to this as "Campaign Mode" in his book, *Entitlement Politics: Medicare and Medicaid 1995 – 2001* (New York: Walter de Gruyter, 2002).

Figure 1: PRIMARY MEDICAID EVOLUTION "MOMENTS"



What theorist Theodore Lowi referred to as the Second Republic was ebbing to a close. The Second Republic according to Lowi was "an eagerness to establish and maintain a national government presence in all aspects of social and economic life."[1] If President Ford's Administration began the Second Republic's descent, then President Reagan slammed the door. Adding to these trends, the Warren Court had ended. Extensions of civil rights based arguments to disability, women, poverty, and health entered a new era with the Burger Court.

Another reason for the shift in the mid-1970s that is particular to Social Security Act legislation – of which Medicaid is the 19th Title -- is that many of the core group of economists who served as Presidential advisors, Agency Secretaries and key staff, and indeed drafted a great deal of the Social Security Act legislation for Congress going back to The New Deal, either retired or became less active from these hands-on roles in government life. The group held different ideals, marked by a belief –for lack of a better descriptor—as communitarianism. A part of this faith was in what today is called the old institutional economics. Cohen, Witte, Altmeyer and others had either directly trained or been influenced by the Johns Commons tradition at The University of Wisconsin. The Commons brand of economics emphasized its historical, institutional, and dynamic components.[2] Also, some key players in government generally, including J.K. Galbraith, were trained as agricultural economists who considered a wide range of factors in addition to the generally highly mathematical modeling of neoclassicism.[3] This general

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[1] Theodore J. Lowi, *The End of Liberalism: The Second Republic of the United States*, 2nd ed. (New York: W.W. Norton & Company, 1979), 274.

[2] In a 1931 *American Economic Review* article, John Commons outlined some thoughts on institutional economics. He writes, "The difficulty in defining a field for the so-called institutional economics is the uncertainty of meaning of an institution…If we endeavor to find a universal circumstance, common to all behavior known as institutional, we may define an institution as collective action in control, liberation and expansion of individual action. Collective action ranges all the way from unorganized custom to the many organized going concerns, such as the family, the corporation, the trade association, the trade union, the reserve system, the state. The principle common to all of them is greater or less control, liberation and expansion of individual action by collective action." See John R. Commons, "Institutional Economics," *American Economic Review*, 21 (1931), 648 - 657.

[3] Thorstein Veblen's work was the bedrock for the institutional paradigm. His *Theories of the Leisure Class: An Economic Study in the Evolution of Institutions*, originally published as (NewYork: Macmillon, 1899) and more recently (Mineola, NY: Dover, 1994) is required reading for social scientists. In general, he postulates that human behavior at the socio-economic level requires explanation in evolutionary terms. Ethical ideas shape institutions and social institutions are shaped by human habits and behavior. A famous

trend shifted, while many institutionalists were no longer the ones brokering Social Security Act deals.

The new economists negotiating Medicaid and other social policy legislation, beginning roughly from the Nixon/Ford era, more often than not could be lumped into a large group termed neoclassical theorists – a sharply different paradigm. While sociologists, political scientists, policy specialists, and others were part of these processes, an increasing faith was placed in the predominance of neoclassicism in economic thinking. In social sciences other than economics, many adapted economic rational choice thinking to their own disciplines as well. The old institutionalism of Commons, Ayers, and others faded from the language of the select public intellectuals who had developed and applied it so effectively and the neoclassical tradition took center-stage.

In particular, this trend also emphasizes the importance that a few select individuals can have on national policy. Wilbur Cohen's influence on the Social Security Act was so substantial that his move back into academia alone and his reduced role in policy brokering after the LBJ era in and of itself marks a turn in Social Security Act negotiations. Certainly an institutionalist, Cohen was a master policy bargainer who had expressed plans for Medicaid to be federalized. The questions asked by the institutionalists are wholly different than those asked by the neoclassical economist.

Questions asked by institutionalists include the nature of the desired policy outcomes and the original intent of the program, while the questions asked in The Budget Era framed policy decisions in terms of aggregate budget totals. Post-Vietnam, and in the midst of the Watergate scandal, the 1974 Budget Act was enacted to restrict Presidential power in impoundment of federal funds. Also, the 1981 Reconciliation changes were enacted shortly after the assassination attempt on Reagan, a time during which he was politically popular. All of these factors contributed to a larger sea change, which profoundly affected Medicaid policy bargaining along with American governance more generally.

Veblen quote likens the hedonistic conception of man to be that of a "lightning calculator of pleasures and pains."

The Modern Era

Significant events in Statewide 1115 waivers occurred in 1993 and 1994 when the Oregon and Tennessee waivers changed the Medicaid landscape forever in the Clinton Administration. Known as the Waiver President, Bill Clinton's states as laboratories beliefs -- honed as Governor of Arkansas -- were evident in the Administration's approach to all social policy and not only Medicaid. Block grant politics defined the mid-1990s with eager Republican House freshman working to permanently cap the program and remove the individual entitlement. President Clinton's principled stand against the Reconciliation package defined Medicaid for the rest of his Administration. The Administration's own per capita cap proposal -- only suggested as a counter to Republican block grant plans during the negotiation -- was revisited in the next couple of years. So were several other themes generated from the National Health Reform discussion in 1993 - 1994. Many of these negotiated and re-negotiated terms were finally implemented in the 1997 Balanced Budget Act (BBA).

During the G.W. Bush era, a rise in the Administrative state is a primary trend. Waivers are utilized to negotiate Medicaid with states in new ways, passing a great deal of responsibility -- as well as decision making flexibility -- onto individual state governments. Passing the buck politics via waivers has resulted in many unintended consequences, including states like Massachusetts turning to universal coverage due to the hardball tactics of the Center for Medicare and Medicaid Services (CMS). Waiver pluralism has gone wild, negating the original Medicaid principles of statewideness, beneficiary freedom of choice of provider, and comparability of benefits. There is now a much greater emphasis on non-transparent, non-public dispute resolution processes between federal and state governments than in the past. This was formalized in the DRA of 2005 where many Medicaid requirements previously requiring a waiver application now only require a "State Plan Amendment" (SPA) change.

TRENDS IN MEDICAID POLITICAL ECONOMY

So far, a dialectic has been established for this work. On one side of this dialectic is the pre-mid 1970s culture where rights-based rhetoric permeated Medicaid discussions stemming back to FDR's Social and Economic Bill of Rights to the Civil Rights era and extending through the Nixon era. On the other side, particularly gaining force with OBRA 1981 and the Reagan Presidency, is the use of a newly instituted budget based institutional structure for framing discussion on which level of government is best to handle various Medicaid program functions. Like most dialectics, this requires a number of caveats and refinements and, of course, is not by any means absolute.

Rights arguments did not abruptly end in 1974, nor was there no consideration of budget politics before 1974. In fact, this was not true at all. Wilbur Mills, the influential Chairman of the Ways and Means Committee that brokered the Medicaid/Medicare package was obsessed with ensuring future financial solvency of the programs. Also, every civil rights victory since 1974 disproves the notion that there was an abrupt drop-off. What changed was the nature of the policy streams, the strength of the moral imperative behind ensuring Equal Opportunity, the emotional link between justice and federal enforcement powers as opposed to then prejudicial state politics, and the institutional rules of the budget process. In short, the streams behind rights based rhetoric and budget politics has proceeded throughout Medicaid policy history, but the strength and direction of those streams has changed significantly.

Many of the major rights based legislative achievements in The Modern Era, including the 1990 Americans With Disabilities Act, were based on the 1964 Civil Rights model. In this and a multitude of other ways, that achievement lives on. The distrust of state governments, so prevalent of progressives during the Civil Rights Era, has given way to questions of the degree to which federalism is now progressive via the use of Medicaid waivers to provide universal coverage for the uninsured in some states. In a few states, social and economics rights were set in state constitutions since the notion was abandoned at the national level in the early 1970s. The pre-dominance of these trends –

or the strength and direction of these policy streams– has changed. The changes are effectuated in the day-to day-policy choices that accumulate over time.

The timing and sequence of events during enactment were particularly important. First, the Civil Rights Bill was enacted in 1964. Medicaid was then enacted the next year in 1965. The structure of Civil Rights framed in many ways the principles behind Medicaid. The original Medicaid statute talked of Equal Opportunity, ensuring access to the same institutions and providers that people with other payers had access to, and instructing states to work towards providing comprehensive care for eligibles. Because the mandates were federal, there was a certain floor level of standardization across the country, and, with regard to these ideals, all states would comply. The federal government was seen as an arm of the State that worked toward justice, as opposed to Southern state governments.

At the same time, the political bargaining that resulted in both Medicaid and Medicare was highly influenced by participating private interest groups. Coalition politics and interest-based politics were important in the early bargaining in the program. Many more concessions were made to private interests to get them on board than would be made by an institutional designer rationally planning a program in the absence of the constructs of this type of a policy negotiation. These interests bargained for considerable latitude in payment methodologies for institutional providers and physicians during enactment but also in discussions with Administrative agency staff in the year following enactment. The Administrative staff of the Health, Education, and Welfare (HEW) Department "gave away the farm" so to speak. The fragmentation of the American system requires subsidization of private industry in order to incorporate them into the fabric of social and health security. This is the American way; it is required by our health system's fundamental institutional design. Once this is fully realized and embraced, we will stop comparing our health expenditure figures to that of European countries because the metric is different. We spend so much more on health care because we are subsidizing, including, embracing private industry.

During these early policy bargains, very little was required in the way of cost containment. An emphasis on rights and an interest-based bargaining environment that resulted in little cost containment were co-evolutionary policy forces. Two streams that fed into the same tributary, so to speak. Also, due to leeway initially given to states in the Medicaid program, the programs first enacted by state legislatures were significantly larger than had been anticipated by federal actors. In fact, New York State's Medicaid program alone cost more than had been projected for the entire country's Medicaid program. Federalism itself was also inflationary. This meant that Medicaid would first incur the added costs of policy bargaining and getting private interests on board, as well as the added costs that federalism incurs. In cost escalation terms, in addition to the escalation in health costs due to technology improvements and other factors generally, the Medicaid program faced a double and triple effect.

MEDICAID FEDERALISM AND PURPOSE OF THIS WORK

Medicaid federalism as a concept implies more than the structural changes in Medicaid's grant structure to states. It also includes waiver processes where states experiment in various ways to provide different models than stipulated by the federal government. It includes various strategies that states have used over the years, including the Disproportionate Share Hospital (DSH) payments, provider donations and taxes, and other mechanism to maximize federal matching dollars without paying the requisite state matching amount. These strategies attempt to substitute federal dollars for state dollars in Medicaid funding through gaming the system whereby federal dollars "match" state dollars spent on the program. Medicaid federalism also includes a plethora of mandates by the federal government – some funded, some not – that affect states' ability to administer and fund their share of the program. When Medicaid federalism is considered more broadly, it includes the myriad of decisions that states make regarding their Medicaid programs that may alter in turn the national agenda. This work considers all of these factors in its review of the evolution of this vital program.

In many ways, this work is about institutional design –what affects it and how to shape it. The point of the project is to investigate the evolution of these concepts in the way that they really happen – in evolutionary, dynamic, and interactive ways that are profoundly shaped both by institutional design and coalition transformation. The idea is that studying Medicaid this way will teach us about the real levers of reform. Where do we take action if we truly require change? If we need to understand public policy, how it unfolds and how things become what they are, we can simply footnote the phenomenon as spontaneous order or we can learn the rules of how these things transpire. For some, nothing short of a prediction of the future is adequate. Here, the lessons are more about maturation in our understanding of the policy process so that we hone our judgment and discernment as policy professionals.

A good part of this process understands the things we can change –and its attendant degree of difficulty-- and the things we cannot change. We may never hold the moment of complete certainty when making many policy decisions, but we hone our understanding, our judgment, our discernment, free a relatively clear view of how things really evolve so that we make the best possible choice – even from a selection of sub-optimal ones. Finally, we are learning that if we ask certain questions, we are going to get certain answers. Improving the public good means knowing the questions to ask and having the strength as a nation to face the real hard-felt effects that those decisions have on policy losers – those left out of the favored circle by everyday policy choices.

Lessons include such factors as the profound effect that single actors can have on the policy subsystem, the importance of life-changing events -- such as the assassination of JFK, 9-11, Watergate, and the assassination attempt on Reagan -- the typical behavioral patterns between federal and state governments, the effects of various grant models, the importance of rights debates and how all sides invoke the moral weight of rights arguments, intricacies of the budget process and the profound effect of these institutional rules on Medicaid, agenda setting patterns in national policy, the tug and pull between the power of the Executive and the Legislative branches, and the importance of Administrative Agency and private business negotiation after a bill is through Congress.

PRIMARY RESEARCH QUESTIONS

This work serves as a review of the evolution of the Medicaid program, a unique analysis of the federal role in policy decision making for the largest grant-in-aid program to the American states. The project is meant for a number of audiences including those interested in policy theory, in institutional economics, in American social policy, in health system management, in American federalism, and policy history.

While the areas of policy inquiry are broad, this work addresses three primary research questions:

1. What conflict resolution and political bargaining processes have resulted in key choices in Medicaid federalism? Who were the primary actors?
2. What are the paradigm shifts, tipping points, veto points, shifts of policy bargaining venues, critical junctures, the results of asset specificity (investing in a policy to the point of supporting it more intensely in the future), and co-evolutionary trends? In other words, what is the common decision calculus for Medicaid policymakers?
3. What legislation, court decisions, and executive actions have resulted in the greatest shifts in Medicaid federalism?

METHODOLOGY OF THIS WORK

The Methodology is organized according to methodologies utilized for Part II, for Part III, and those used jointly for both Parts II and III of the Dissertation. Part II, the "Medicaid in Retrospective" section of the Dissertation relied on several methodologies. Extensive archival research was conducted at the ***LBJ Presidential Library***, including review of the Personal Papers of Wilbur J. Cohen, dozens of Oral Histories, dozens of Presidential Telephone Conversations, dozens of boxes of material from the White House Central Files (WHCF), the Personal Papers of John Gardner, the Office Files of Harry

McPherson, the Office Files of S. Douglass Cater, and the Administrative History Collection. In addition, archival research was conducted spanning several years of Congressional papers and hearings at ***The Center for Legislative Archives at the National Archives*** in Washington, D.C.

For Part III, "The Modern Era," 25 interviews were conducted with the nation's most prolific decision makers and policy bargainers in the modern era (1992 - 2007). The interviews averaged two hours in length, ranging from 50 minutes to three hours and 30 minutes. The interviews were digitally recorded and anonymity was only requested in two cases. The interviewees were chosen from a list of individuals who were known to have participated in the most important Medicaid policy bargains during the 1992 - 2007 time period or to be among the nation's most important thought leaders in the scholarly areas covered in the research. Ten of the interviewees have played major roles in state level Medicaid politics, representing state interests in the macro Medicaid policy bargaining arena. These include a Governor, State Secretaries of Health, State Medicaid Directors, and individuals who represent state interests at the national level for a state lobbying organization. Ten of the interviewees played substantial roles negotiating Medicaid policy for the United States Congress. Only Congressional staff who were "at the table" during these negotiations were interviewed, representing the Authorizing, Budget, and Appropriations Committees. Eight of the interviewees have served at some point in their careers in the White House or at the highest level of Federal Agency decision making. Four of the country's leading Medicaid law and/or welfare rights experts were also interviewed. Also represented in the interviews are the current President's Medicaid Commission, by two interviews, and the National Governors Association Medicaid Task Force, by a Governor on the Task Force.

For Part III, a compilation of dozens of newspapers were searched using the ***Lexis*** search engine for relevant articles during The Modern Era. Examples of newspapers where the search generated articles that were quoted in the dissertation include *The New York Times*, *The Washington Post*, *The Houston Chronicle*, *The Dallas Morning News*, *The Times - Picayune (New Orleans, LA)*, and *The National Journal*.

Methodologies overlapping both Parts II and III include the research of more than twenty-five Congressional hearings from ***The Law Library of the Library of Congress*** and the ***Center for Legislative Archives***. Several collections from the ***Library of Congress*** were accessed, including the *Public Papers of the Presidents of the United States*. Several periodicals were reviewed in a systematic way, including --but not limited to -- *The Congressional Quarterly Almanac* from 1960 - 2004, *Congress and The Nation* from 1992 - 2004, and *CQ Weekly* from 1992 - 2000. Primary research was also conducted at the ***National Library of Medicine*** in Bethesda, Maryland. Several literature searches generated secondary sources. The search engines used to conduct these searches included, but were not limited to, ***EconoLit***, ***JSTOR***, and ***PubMed***. Hundreds of secondary sources were reviewed for this work.

ORGANIZATION OF THE TEXT

This work is organized in four parts: Policy and Federalism Theory; Medicaid In Retrospective; The Modern Era; and Summary and Conclusions. Part One is dedicated to policy and federalism theory. Part II considers the Medicaid program prior to 1992 from a historical perspective. Uncoiling the negotiations from the New Deal's First Big Bang that established the cash welfare model until the George H.W. Bush era in four chapters, Part II focuses particularly on the policy history of the program. This begins with early welfare program development in 1935, continuing to Medicaid enactment in 1965, and in aftershock reforms in 1967. This era continues through Richard Nixon's Presidency where he proposed a national health plan that would be supported by a federalized Medicaid program. Reagan's budget revolution is the focus of the final chapter in Part II. During the 1980s and early 1990s, the budget reconciliation process was used successfully to expand the program several times by Congressional Democrats and select moderate Republicans.

Part III is comprised of five concise chapters concentrating on particular policy bargains in The Modern Era. The first chapter, entitled "Prelude to a National

Discussion: The Medicaid and State Federalism Environment Before the Near Big Bang," introduces the national debate that informed health politics over the next several years. The second chapter considers state federalism and waiver politics prior to the 1993-1994 national health reform discussion, while the third focuses on the effects on Medicaid of that discussion. The next to last chapter reviews the 1995 - 1996 Medicaid block grant attempts, AFDC reform, and the 1997 BBA. The G.W. Bush era is considered in "Medicaid Transformed," the final chapter of Part III. Of particular importance is the Deficit Reduction Act of 2005 and its reworking of the federal uniformity in benefits between categories of Medicaid eligibles. Part IV is comprised of the Summary and Conclusions of this work.

1. CONCEPTUAL FRAMEWORK FOR *THE MEDICAID EVOLUTION*

INTRODUCTION

In many ways, *The Medicaid Evolution: The Political Economy of Medicaid Federalism* can be seen within the context of both economic history and political science. It traces economic history from the demand side of poverty -- of a financing program bent on addressing the demand side of poverty. This work identifies the highlights of Medicaid federalism over a long span of time and then investigates the policy bargaining of coalitions and actors in greater detail at each of these moments in time. The theory behind this work is not purely political science. Medicaid is a financing program and the unfolding of events over time is linked to both the history of economics and historicity of political institutions. From the first of these traditions, Douglass C. North writes, "History matters. It matters not just because we can learn from the past, but because the present and the future are connected to the past by the continuity of a society's institutions. Today's and tomorrow's choices are shaped by the past. And the past can only be made intelligible as a story of institutional evolution. Integrating institutions into economic theory and economic history is an essential step in improving that theory and history."[1] It is in this tradition that the Medicaid program was investigated, era by era.

A wealth of literature informs the theoretic structure of *The Medicaid Evolution: The Political Economy of Medicaid Federalism*, particularly Institutional Economics on

[1] Douglass C. North*, Institutions, Institutional Change and Economic Performance*, Political Economy of Institutions and Decisions Series, (Cambridge, UK: Cambridge University Press, 1990; repr. 2004) Preface, vii.

the economics side and a group of political science theories on the political science side including the central themes from Historical Institutionalism and Punctuated Equilibrium, the Advocacy Coalition Framework (ACF), Incrementalism and Gradualism, and the Bureaucratic Politics Model (BPM). Since one political science tradition did not address all of the aspects utilized for this work, these were combined in a framework called The Macro Public Policy Framework (MPP).

A major precept of this work -- the Conceptual Framework that drives it -- is that by studying policy (institutional) development using a marriage of Institutional Economics on one side and the Macro Public Policy Framework on the political science side as a theoretic lens, it is possible to identify paradigm shifts, tipping points, veto points, shifts of policy bargaining venues, critical junctures, the results of asset specificity (investing in a policy to the point of supporting it more intensely in the future), and co-evolutionary trends. In other words, it is possible to learn the common decision calculus for Medicaid policymakers. The importance of institutional economics is discussed throughout this work but particularly in greater detail in the Introduction and in Chapter 5, "The Watershed Years, New Federalism, and Proposals for a New Federal Role in Medicaid." The remainder of this chapter will consider the component parts of the MPP Framework.

Historical Institutionalism and Punctuated Equilibrium

Historical Institutionalism has, for some time, acknowledged that "institutional change typically involves a dynamic of 'punctuated equilibrium'" -- periods of institutional creation followed by periods of stasis.[2] Over time, there are heightened, more active periods of institutional change. These punctuations were identified over the course of the history of the Medicaid program. The benefit of approaching the analysis in this way is that it lends itself to macro, big-picture analysis, allowing the work to consider macro trends in the evolution of Medicaid. Part II, Chapters 3 to 6, concentrates

[2] Paul Pierson, *Politics in Time: History, Institutions, and Social Analysis* (Princeton, NJ: Princeton University Press, 2004), 134-135.

on “Medicaid in Retrospective,” and in particular, attempts to consider the periods in between the major moments of Medicaid policy bargaining as possibly containing important data on policy development. The lack of consideration of these times of stasis has been a criticism of historical institutionalist accounts in the past.

Historical institutionalism is particularly concerned with how institutions and policies evolve over time. Institutions are defined as “the rules of the game in a society, or, more formally, …the humanly devised constraints that shape human interaction.”[3] Institutions may represent rules of the game for formal entities such as the U.S. Congress, the Supreme Court, federal agencies, and state governments. Institutions are also the informal rules, culture, and mores that govern policy decision making. Policies are types of institutions in that they are rules that structure how the game unfolds – particularly who wins and who loses. In Medicaid policy, institutions structure who receives benefits, what benefits they receive, what providers are paid, standards of quality, and innumerable other factors.

Historical institutionalism generally considers long-periods of policy evolution in order to understand broader, macro-level policy change. Studies usually require long periods of inquiry in order to understand how institutional and policy change unfolds. It is this long-range macro bird’s eye view that is its strength. Timing, sequence of events, and positive feedback are all critical considerations. The timing of when a reform occurs will change its effect on the policy, as will the order in which events occur, and self-reinforcing dynamics.[4] Historical Institutionalism recognizes that there is a “stickiness of inherited social arrangements.”[5] Path dependence results in “self-reinforcing processes.” Later on, there is no longer a clean slate per se but a “bricolage” effect – “where key

[3] Paul Pierson, *Politics In Time: History, Institutions, and Social Analysis* (Princeton, Princeton University Press: 2004), 27.
[4] Paul Pierson identifies policy feedback as self-reinforcing dynamics in *Politics In Time*, a must read text on the tangencies of historical institutionalism and rational choice.
[5] Pierson, *Politics In Time* (2004), 8.

actors are not building from scratch but rather reworking the institutional materials at hand."[6]

The biological concept of punctuated equilibrium is also used as a policy construct. Critical junctures, or "moments" where Medicaid is prioritized on the national agenda are studied longitudinally. The overall project concentrates on particular punctuations -- or key events -- in the Medicaid timeline. The Punctuated Equilibrium Framework holds that:

> In policymaking, new ways of thinking about public problems, rapid mobilizations of new constituencies, chances in institutional structures, and self-reinforcing effects of these trends occasionally combine to create dramatic and unpredictable policy changes in an issue-area. Such punctuations are an important part of policymaking even if most policies most of the times are subject to no such dramatic events. Rather than making moderate adaptive adjustments to an ever-changing environment, political decision making is characterized sometimes by stasis, when existing decision designs are routinely employed, and sometimes by punctuations, when a slowly growing condition suddenly bursts onto the agendas of a new set of policymakers or when existing decision makers shift attention to new attributes or dimensions of an existing situation.[7]

Punctuated Equilibrium was originally a biological construct developed by Stephen Jay Gould and Niles Eldredge that is now applied to policy constructs.[8] It recognizes incrementalism by saying that punctuations interrupt normal incremental political interchange.

Incrementalism and Gradualism of American Social Policy

In any study of American social policy, it is necessary to recognize that American social policy is characterized by incrementalism and gradualism as opposed to wholesale

[6] Kathleen Thelen, "How Institutions Evolve: Insights from Comparative Historical Analysis," In J. Mahoney and D. Rueschemeyer (eds.), *Comparative Historical Analysis in the Social Sciences*, (Cambridge, Cambridge University Press: 2003), 227.
[7] Bryan D. Jones, Frank R. Baumgartner, and James L. True, "Policy Punctuations: U.S. Budget Authority, 1947 – 1995, *The Journal of Politics* 60, no. 1 (Feb., 1998): 1 – 33.
[8] Stephen Jay Gould and Niles Eldredge, "Punctuated Equilibria: An Alternative to Phyletic Gradualism," in Thomas J.M. Schopf (ed.), *Models in Paleobiology* (San Francisco: Freeman Cooper, 1972).

change. During the formation of the Social Security Act in the years preceding 1935 and the Great Society in the years preceding 1965, a group of institutional economists played the major role in designing, advising the different Presidents and Congress regarding, and finally implementing the major pieces of social policy over 30 years. Arthur Altmeyer, Edwin Witte, Elizabeth Wickenden, Wilbur Cohen, I.S. Falk, Robert Ball, and several others, many from the Wisconsin school of thought, used a philosophy of incrementalism to guide the development of American social policy. This philosophy of incrementalism holds true today. Wilbur Cohen describes this philosophy in an oral history:

> I think this has been a typically incremental American way of going at a problem, not with some kind of overall plan that Congress really had, but a more or less ad hoc, incremental, adaptive plan arising out of the felt needs of people and the adjustment of various institutions to fill a role that had not existed. It may not be the most efficient way, it may not be the way that limits overutilization, but it is typically American in that it has evolved piecemeal in a way that is more or less acceptable to the American people. Whether, after all the parts of this jigsaw are in place, someone will try to rationalize it in a much more efficient way, that remains to be seen.[9]

Incrementalism, also known as "Muddling Through," was developed in the 1950s by Charles E. Lindblom in a number of classic articles in the *Public Administration Review* and numerous books.[10] Lindblom observed that it was not necessary for actors to align their preferences, but instead to come to some agreement on a policy issue. He held that "for the method of successive limited comparisons, the test is agreement on policy itself, which remains possible even when agreement on values is not." The process of mutual adjustment between actors is a signal of society's preferences and comparisons to

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[9] Transcript. Wilbur Cohen Oral History, August 6 & 7, 1979, by Lewis E. Weeks, "Wilbur J. Cohen: In First Person: An Oral History," Lewis E. Weeks (Ed.), Hospital Administration Oral History Collection, Lewis E. Weeks Series, 17 and 18. Retrieved from the LBJ Presidential Library.

[10] Select works by Lindblom on incrementalism include "The Market as Prison," *The Journal of Politics* 44, no. 2, (May 1982): 324-336; *Democracy and Market System* (London: Norwegian University Press, 1988); *The Intelligence of Democracy: Decision Making Through Mutual Adjustment* (The Free Press: New York, 1965); "The Science of 'Muddling Through'," *Public Administration Review* 19, no. 2 (Spring 1959): 78-88; "Still Muddling, Not Yet Through," *Public Administration Review* 7 (April 1967): 211-222; "Policy Analysis," *American Economic Review* 48 (June 1958): 298-312; "The Market as Prison," *The Journal of Politics* 44, no. 2 (May 1982): 324-336.

past events provides the only data to indicate how society's preferences change over time. Our policy reality today is based on successive policy choices made up to the present.

The Advocacy Coalition Framework (ACF)

Conceptualized in 1981 by Paul Sabatier, the ACF borrows from organizational management and the natural sciences in its structuring of policy "subsystems."[11] The ACF includes two sets of factors that influence coalition actors. The first set are fixed factors, described as "Relatively Stable Parameters," that are difficult to change, influence coalition behavior, and endure stresses that might be placed on them by coalition strategies. The second set, "External System Events" are dynamic and variable. With respect to belief systems and public policies, the framework distinguishes "core" from "secondary" elements. Coalitions are assumed to organize around common core beliefs, such as the proper scope of governmental versus market activity and the proper distribution of authority among levels of government. Since these core beliefs are hypothesized to be relatively stable over periods of a decade or more, so too is coalition composition.[12] The concepts of Relatively Stable Parameters and External System Events and some of the hypotheses around coalition change and timeframes are the most relevant as applied to the MPP theoretic framework for the Dissertation.

The Bureaucratic Politics Model (BPM)

A focus of the MPP, bargaining between actors, resembles that described by Graham Allison in the Bureaucratic Politics Model (BPM) applied to the Cuban Missile

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[11] Paul A. Sabatier and Hank C. Jenkins-Smith, "An Advocacy Coalition Framework: An Assessment," Chapter 6 in Paul A. Sabatier (ed.), *Theories of the Policy Process* (Boulder, CO: Westview Press, 1999), 117. Also see Paul A. Sabatier and Hank C. Jenkins-Smith, *Policy Change and Learning: An Advocacy Coalition Approach* (Boulder, CO: Westview Press, 1993).

[12] Paul A. Sabatier. "Toward Better Theories of the Policy Process." *Political Science and Politics*, Vol. 24, No. 2 (June 1991), 147 – 156.

Crisis in *The Essence of Decision*.[13] Allison writes, "Happenings in foreign affairs are understood, according to the bureaucratic politics model, neither as choices nor as outputs. Instead, what happens is categorized as outcomes of various overlapping bargaining games among players arranged hierarchically in the national government."[14] While much of the work using the BPM was applied to foreign affairs, some basic concepts are applied here to the Macro Public Policy Framework. The MPP operates roughly on Allison's idea, "[i]mportant government decisions or actions emerge as collages composed of individual acts, outcomes of minor and major games, and foul-ups. Outcomes that could never have been chosen by an actor and would never have emerged from bargaining in a single game over the issue are fabricated piece by piece. Understanding of the outcome requires that it be disaggregated."

THE MACRO PUBLIC POLICY FRAMEWORK

The Macro Public Policy Framework (MPP) accounts for bargaining not just between levels of government but also between actors in the public policy sphere. It recognizes stable societal factors and external events that change over time. In addition, it explicitly addresses the punctuations and incremental reform that occur over time. Figure 3 is a chart to help visualize the Macro Public Policy Framework. It has a dynamic component of interactions between policy actors, including all levels of government. So the U.S. Congress, the President, and U.S. Supreme Court are matched at the state level by the state legislatures, the Governors, and the state Supreme Courts. Similar local government actors -- including city councils, mayors, and local courts -- are also involved.

While the executive and legislative branches are within the bargaining arena, the courts are held outside of the bargaining zone, but their decisions affect these interactions. While scholars have commented on the Supreme Court's agenda setting,

[13] Graham Allison and Philip Zelikow, *Essence of Decision: Explaining the Cuban Missile Crisis*, Second Edition (New York, Addison-Wesley Educational Publishers, 1999).
[14] Allison, Graham T. "Conceptual Models and the Cuban Missile Crisis." *The American Political Science Review*, Vol. 63, No. 3 (Sep., 1969), 689 – 718.

negotiating, and political bargaining activities within its Chambers,[15] the focus here will be on the Federal Courts' decisions and their effects on the public policy bargaining arena. The Courts' area is called The Judicial Wing.

The remaining policy actors are split into two camps. They are represented in the diagram as Non and Quasi- Governmental Policy Subsystem Actors (NQG) and Other Actors. The NQG are mostly non-government actors. This is complicated by one exception. Organizations such as the Administration on Aging play a type of dual role, particularly in nursing home oversight. The ombudsman program and Area Agencies on Aging are both patient advocates and wings of the government. These mostly non-governmental actors are part of the negotiations and play a considerable role in political bargaining in the U.S. system. Representatives of business interests play a particularly large role in these negotiations.

A group of "Other Actors" are placed outside of the negotiating sphere including the media, policy researchers, and analysts. It is recognized that the causal relationship between those negotiating and this group goes both ways – they influence each other – but that these actors are not themselves typically the negotiators. Therefore, they are removed from the bargaining zone.

The MPP Framework also adheres to the theory that there are relatively stable parameters and external events that affect the environment surrounding the policy bargaining process and the policy subsystem(s), as does the Advocacy Coalition Framework (ACF). The MPP includes a few additional parameters and external events other than the ACF. The relatively stable parameters include:

- History and traditional role of federal, state, and local governments, as well as private institutions in the area;
- Institutional structures, norms, and history;
- Fundamental sociocultural values and social structure;
- Attributes of the problem area;
- Method of distribution and level of resources; and
- Basic constitutional structure and rules.

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[15] See H.W. Perry, *Deciding to Decide* (Cambridge, Mass: Harvard University Press, 1991).

External events include:

- Demographic shifts in a society;
- World events that change focus or direction of the nation;
- Socioeconomic condition shifts on the international and domestic levels;
- Public opinion shifts;
- Systemic governing coalition transitions; and
- Policy decisions and impacts from other subsystems.

The Bargaining Arena in the Macro Public Policy Theory (MPP)

Policy actors interact and bargain policy within a policy subsystem. Policy subsystems are particular areas of public policy inquiry. Subsystems tend to overlap with others, particularly if they are defined as subsets of larger areas. For example, in this case, we recognize that there is a Medicaid subsystem, but also that it is subsumed within two others: (1) the Health Care for Low Income Americans Policy Subsystem and (2) the Welfare Policy Subsystem. Also, it overlaps with two other subsystems: (1) The Disability Initiatives Policy Subsystem and (2) the Retirement and Pension Initiatives Policy Subsystem. These subsystems are depicted in Figure 2.

Figure 2: Inclusive and Overlapping Subsystems

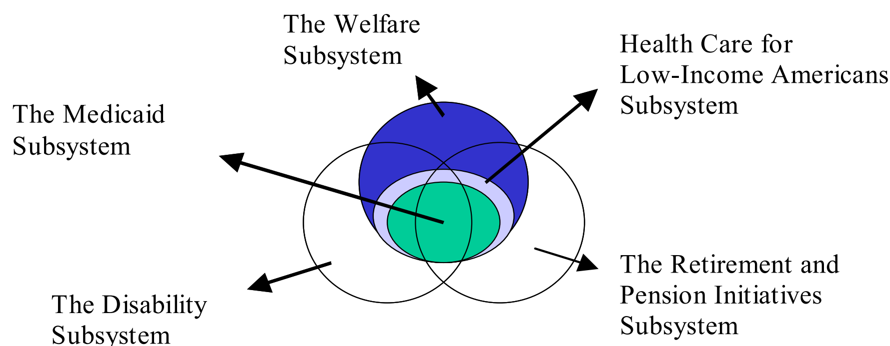
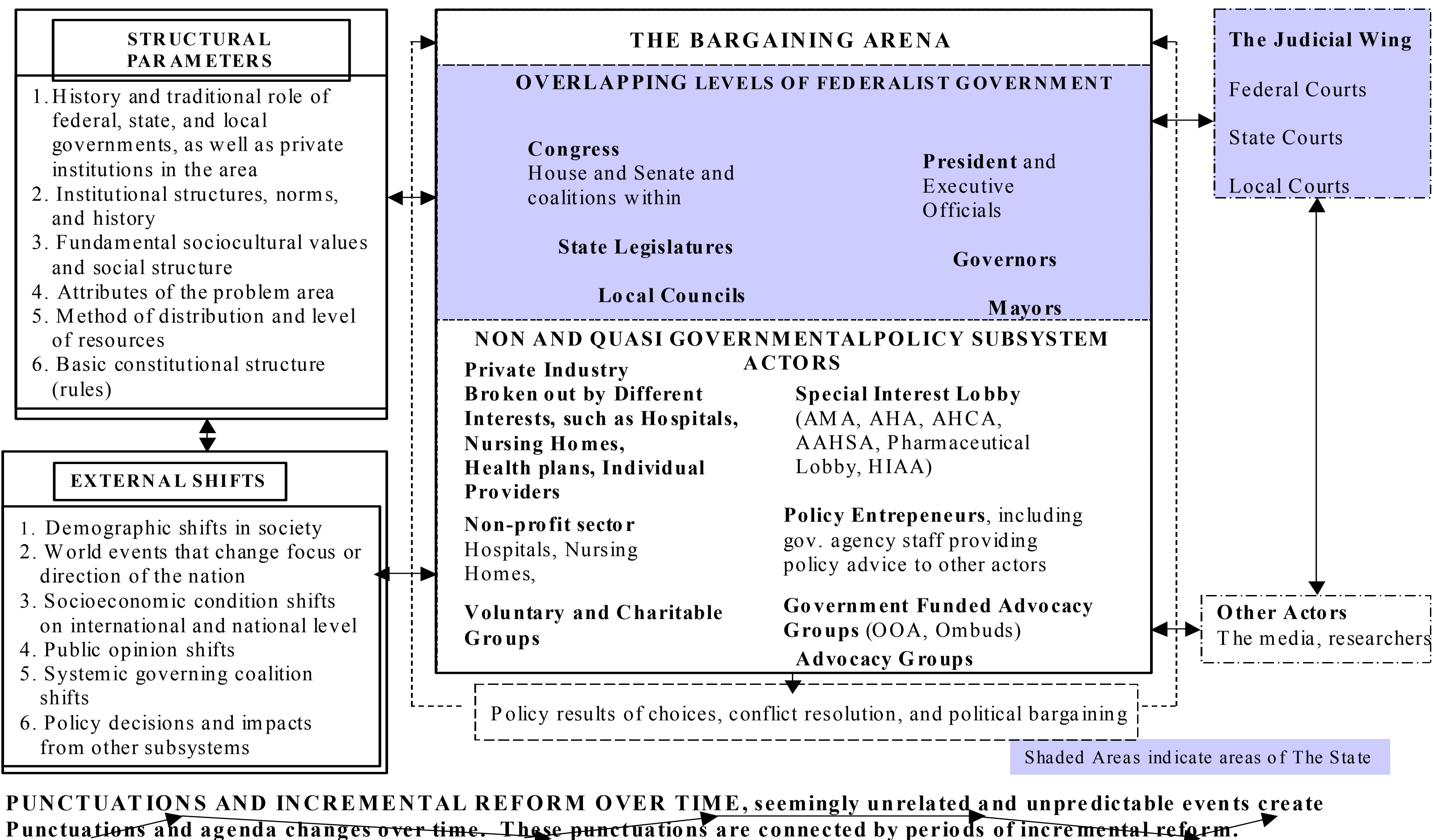


Figure 3: THE MACRO PUBLIC POLICY FRAMEWORK



There are times when bargaining between actors takes place on several different topics at one time. For example, Congressional members, the President, and the Supreme Court may make a single decision that affects a wide range of topics. Likewise, elected officials may make bargains that trade issues in completely different arenas. At the same time, the Medicaid debate includes actors that are specific to that topic area. Even though certain actors are particular to the Medicaid debate, it is important to recognize external influences and trades with other policy issue areas.

The Macro Public Policy (MPP) Framework assumes that policy bargaining results in very different outcomes than any of the players rationally planned at the onset of the process. It suggests that often times, in sorting out the winners and losers from a conflict and consensus process in public policy, there is the recognition that no one got what they wanted but instead got the negotiated conclusion -- the end result.

Consequently, the democratic process does not guarantee that actors will maximize their take, but that a result works "well enough" for enactment. Choices that are made during the process are resultants that were not necessarily planned by any of the participants, but instead the result of an intentionally checked government of limited powers. As Charles Lindblom writes in *Democracy and Market System*, the only way to claim that bargaining is not useful is to claim that government is not useful, for in the U.S. governing is bargaining.

CONCLUSION

The conceptual framework for this work targets Political Economy -- Institutional Economics on one side and a group of political science theories, particularly well-suited for the research questions of this work, called the Macro Public Policy Framework (MPP). The meeting of these two traditions addresses the need for the best of both economic and political considerations in the unpacking of Medicaid policy bargains over a long-span of time. This conceptual framework emphasizes policy bargaining and is particularly well applied to studies of federalism since federalism necessitates bargaining

between governments. Particular punctuations or "points in time" are chosen for study across the Medicaid timeline, emphasizing those policy bargains that affected the federal and state relationship in the program the most. Examples of primary policy bargains in Medicaid federalism are listed in Figures in the Introduction and in the Summary and Conclusions Chapter.

2. MEDICAID FEDERALISM AS DIALECTICAL DEBATE:

ARE THERE NATURAL INSTITUTIONAL STRENGTHS OF DIFFERENT LEVELS OF GOVERNMENT IN MEDICAID?

INTRODUCTION

The primary purpose of this chapter is to provide a grounding of the federalism theoretic scholarship for the entire investigation in *The Medicaid Evolution* on Medicaid federalism. This second chapter in Part I, "Medicaid Federalism As Dialectical Debate" is intended to work with the first theory chapter, "Conceptual Framework for *The Medicaid Evolution*," to set the theory in place for Parts II and Part III, dynamic investigations of actual policy bargains in Medicaid federalism. Part I sets the stage by outlining the policy and federalism theory behind *The Medicaid Evolution*. Parts II and III roll the tape.

This chapter reviews the material as a dialectical debate, the pros and cons provided in a full range of academic scholarship for the federal government versus state governments controlling the financing, administration, and policymaking in Medicaid. The work of constitutional scholars, public finance and fiscal federalism experts, political federalism theorists and a whole range of material is encapsulated in this chapter. It provides a footing for understanding the federalism -- and the policy bargaining that

shapes this constitutional compact -- behind the most impressive example of this institution in American social policy -- the Medicaid program.

PRAGMATIC FEDERALISM AND VALUES

Over time an impressive number of definitions of Federalism have emerged: Competitive, Cooperative, Dual, Creative, New, and, of course, Constitutional. The enduring American institution evolves over time and also has pluralistic applications. While federalism itself is enshrined in the United States Constitution, the nature of the relationships between the Federal and State governments takes on different characteristics with the actors involved, the policy at hand, and the era of government. During the evolution of Medicaid, Pragmatic Federalism has been a particularly relevant model. Pragmatic Federalism refers to the instrumental nature of the institution when actors use federalism in order to attain more closely cherished values. For example, an actor may really want to minimize the role of government altogether but will advocate for devolution of a program to state or local governments because it is believed this will reduce its reach. At the same time, there may be cases where federalization of a program is desired in order to weaken a program. In a Pragmatic Federalism tradition, switching between governments is done strategically in order to accomplish other goals and less so due to a belief that a particular level of government is fundamentally the right government to address an initiative

If there were a clear answer regarding which level of government, and which grant structure, best organized the Medicaid program, then the matter would not be such a contested policy issue. It is left to the policy bargaining arena precisely because groups have such divergent views about its solution. There is not a set formula that dictates what level of government would best perform the various functions of Medicaid, whether financial, administrative, policy decision making, or enforcement. As in all areas of policy, coalitions espouse different values regarding entitlements, rights, the role of the budget process, and federalism itself. These differences are in part a reflection of

divergence on core distributive justice values such as equity, equality, need, and allocative and technical efficiency. It also reflects differences with regard to beliefs on the role of redistribution and regulation in social and health security, the proper role of the state, and on how vital tenets of democracy are achieved. Between two people who demand that individual freedom is mandatory for democracy, one may insist that the federal government only support basic infrastructure needs and a national defense while another demands the federal government ensure a basic minimum safety net because a life in abject poverty --or without access to proper health care -- is not freedom at all.

Pragmatic federalism is the reason that Ronald Reagan, the anti-government President, used the federal power to protect business interests and why Advocates sought decentralization to state courts of the controversial same-sex marriage legality issue. Actors are using federalism instrumentally to place political and policy debates in the arena where they believe they have the best chance of either winning, improving their policy position, or mitigating losses.

INSTITUTIONAL STRENGTHS OF DIFFERENT LEVELS OF GOVERNMENT AND GRANT MODELS

Having established an argument for Pragmatic Federalism, there are particular institutional strengths of grant models and arguments for greater involvement by one level of government in Medicaid or the other. The results of a meta-analysis, conducted by the author, on the key arguments in favor of state generated reform and control, as well as in favor of federal reform are considered here. Also, a meta-analysis that considers the benefits and drawbacks of the current open matching grant structure and an alternative, aggregate block granting, is presented. The idea is to utilize the strength of dozens of studies in order to understand if there are institutional strengths of different levels of government performing functions in Medicaid or of particular grant models in structuring the Medicaid program.

The strength of meta-analyses is that it is possible to gather the power behind the work of dozens of researchers who conducted individual studies or their own meta-

analyses into a unified set of findings. This meta-analysis is structured in this chapter as a dialectical policy debate. Policy dialectics are often presented in reviews of policy debates, even if they are not so called. Oftentimes, academic journals will let an expert from one perspective present an article on an issue and publish this side-by-side with the opinion of an expert from a very different worldview. The point is to generate conflict by presenting two different perspectives. Each pole is defined in terms of how it differs from the other and the debate is simplified to a one versus the other perspective instead of allowing for the multitude of worldviews –and all the contingent policy variations -- that are possible. Think-tanks, newspapers, the television media – all use policy dialectics to investigate thorny policy issues, particularly where widely divergent core values translate into wide differences of opinion on future policy paths for specific programs, as with Medicaid. Originating with the philosopher Hegel, dialectics as applied to policy science means that the original plan, the thesis, and an alternate plan, the anti-thesis, can potentially be combined through negotiation into a policy synthesis.[1] The meta-analyses presented here are structured in a policy dialectic framework to compare and contrast opposing worldviews.

A few caveats, to the degree that cash welfare examples are provided, it should be noted that the health arena involves many private interests, provider networks, and insurers that make it fundamentally different. Health also differs fundamentally from other policy subsystems such as Education. Finally, it should be noted that many of these findings are pro-federal or pro-state in aggregate, whereas Medicaid program functions can be parsed. For example, a possibility is "federalizing" long-term care, or at least removing it from state budgets. Also, it is possible to change the current federal/state financing and administrative framework by having the federal government finance Medicaid completely but the state contracted for administration.[2] Who performs which functions, then, can be parsed.

[1] For Hegel see *Phenomenology of Mind*, 2nd Edn Transl. by J.B. Baillie, (London: George Allen and Unwin, 1964). For a very interesting consideration of policy dialectics in social science, see Ian I. Mitroff and Richard O. Mason, *Creating A Dialectical Social Science* (Boston: D. Reidel Publishing Company, 1981).

[2] A final possibility is re-designing Medicare to finance long-term care.

Key Arguments in Favor of Federal Reform and Control

Equality and Justice Arguments

The history of the Civil Rights era left a painful memory of the injustice that left a distrust of state governments and courts. Federal rights of action in federal courts are important for Medicaid beneficiaries and providers so that there is a higher power to rule in the case of allegations of unjust eligibility determinations, service denials, or low payments. This argument supports a role for the federal government judicially, legislatively, and administratively in the Medicaid program. Answering the claim that this is a concern of the past and not the present, Paul Peterson writes "States have never been known for their ability to protect the interests of the disadvantaged. For all of the modernization of state politics that has supposedly occurred, state legislatures still seem to deserve this reputation."[3]

Equality arguments -- particularly those in favor of equalizing benefits and services for beneficiaries and payment schemes for providers -- are exceptionally strong in favor of federal organization of Medicaid. Justice as fairness, a Rawlsian concept, can be applied here in a public policy context.[4] If we made public policy choices without knowing what standing or place we had in life – our income, our health status, the state or locality in which we resided, family details -- then we may be apt to desire a more uniform eligibility and benefit structure than currently exist in the Medicaid program. A more uniform program would mean less state variation, higher minimum eligibility or benefit standards, removal of requirements that eligibles fit into particular categories or have particular health conditions in order to qualify, or even federalization of financing

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[3] Paul Peterson, *The Price of Federalism* (Washington, D.C.: The Brookings Institution, 1995), 146.
[4] John Rawls, *A Theory of Justice*, Revised Edition (Cambridge, Mass.: Harvard University Press, 1999). Original Copyright in 1971 and sixth printing in 2003.

and administration of the program altogether. Perhaps a Medicare-type structure could be adopted, for example.[5]

In these examples, horizontal equity in policy choice – state action creating similar situations between like situated people – is more fully achieved by the federal level of government than by state governments. After all, federalism is inequality.[6] Taxpayers are also prone to Medicaid horizontal inequalities. If people are paying higher taxes for either the same or a lower level of Medicaid program between states, there is horizontal inequality between taxpayers, as well.[7]

State fiscal capacity variations also disadvantages poor states in Medicaid, regardless of attempts by the federal government to equalize its match. The Federal Medical Assistance Program (FMAP) matching formula provides a higher match to states the lower their per capita income. Matching rates vary from 50% to 83%. This is an example of the federal government attempting to create vertical equity, meaning it is attempting to equalize a policy situation by treating states unequally. Since some states are poorer than others, an unequal match to disadvantaged states is intended to equalize the policy scenario.

In Medicaid, poorer states have to pay more per capita to cover a proportionately larger Medicaid population. Since the state is poorer, more people qualify for Medicaid, and since the state is poorer, they have less tax revenues with which to dedicate to the Medicaid program. This means that they generate less financial help from the federal government because they can afford to dedicate less of their own state funds. State funds are dedicated first and there is no cap. The federal government, then, matches this amount. So, state funds drive how much federal money is invested in their own state Medicaid program. People living in poorer states, then, are working with less for their

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[5] See Marilyn Moon, "Making Medicaid A National Program: Medicare As A Model," in *Federalism & Health Policy*, eds. John Holahan, Alan Weil, and Joshua M. Wiener (Washington, D.C.: The Urban Institute Press, 2003), 325 - 360.

[6] This refers to the conclusion by Aaron Wildavsky that "federalism means inequality" Further, "uniformity is antithetical to federalism." In Robertson and Judd (1989), 378.

[7] See Thomas W. Grannemann and Mark V. Pauly for a discussion of this phenomenon in Medicaid horizontal inequality, *Controlling Medicaid Costs: Federalism, Competition, and Choice* (Washington, D.C., American Enterprise Institute for Public Policy Research, 1982).

Medicaid programs even though their states are investing, percentage-wise, as much or more than other states. Even with the current matching formula calibrated to provide a greater match to states with less per capita income, state fiscal capacity differences are still pronounced than and inequity still exists. Federalizing the financial component of the program removes the inequality created by differences in state fiscal and tax capacity.

Federal Policy Decision Making Recognizes Medicaid's Distributional Importance to a Vital National Economy

Medicaid is as much a distributional as a redistributional program. Private business interest is high, particularly by the nursing home industry but also by some physicians – who made the program a cottage industry directly after enactment – and managed care companies in the modern era. The health sector provides a major subsidy to private business, whether or not interests are satisfied with payment levels. This is a reason why comparisons to other countries' health costs, which have been used to support a hypothesis that the U.S. system is prohibitively expensive, compares apples to oranges. Government financed health expenditure in the U.S., including Medicaid, supports private business and is a contributor to a healthy, vibrant economic sector.

While covering populations, the U.S. welfare state interweaves with private industry so that the money spent in the public sector supports, subsidizes, and invests in business. The policy bargaining allows for a great deal of leeway in investment – some would call them "give aways" -- to private industry. It is difficult to get private industry to sign on for particular public initiatives without "sweeteners" in the bargaining process. Therefore, some portion of costs spent on healthcare, and on Medicaid, is due to the distributional importance of the program.

Given that many health industries are national in scope, and cross state boundaries effortlessly and continuously, national level regulation simplifies rules for business.[8] A reason to further federalize political and policy decision making is that distributional

[8] A similar argument is made in Peterson, *Price*, 128.

decisions made at the federal level are part of a healthy, vibrant national economic system that recognizes the health sector as serving plural interests.[9]

The Federal Government Handles the Re-distributional and Administrative Aspects of Medicaid Better Than Decentralized Governments

The federal government is best to organize redistributional programs.[10] Redistribution is best handled by the federal government because it can develop strategies for addressing differences in state fiscal capacity; for addressing price variations in local health markets; or for dealing with potentially necessary differentials for groups of people or individuals. Higher level governments, since they incorporate the smaller level ones, are capable of correcting for various differentials between players and so can at least try to mitigate these differences. In the case of Medicaid, although the match does not remove state fiscal capacity differences, it does mitigate them.

Organizing redistributive programs at the federal level also helps prevent problems with mobility, meaning flight of wealthy taxpayers out of regions where poor people reside. Tiebout, Oates, and many others have produced important empirical work showing the effects of this "race to the bottom," when taxes for decentralized social programs are organized at the local – or subsidiary government – level.[11] To the degree that local governments fund social programs, wealthy individuals may flee from the area – that political unit – in order to escape paying taxes on services they will never use. If taxed at the federal level with the federal government feeding that funding back into the

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[9] The textbook public finance view also supports distributional decision making at the federal, as opposed to decentralized, levels of government. See, for example, Richard W. Tresch, *Public Finance: A Normative Theory*, 2nd Edition (San Diego, Academic Press, 2002), 835 and 841. "Public sector economists have provided a variety of answers to this, none entirely satisfactory (Why not let the national government do everything?) In considering them, keep in mind that each answer attempts to justify a role for lower level governments only with respect to the standard allocational or efficiency questions. Almost everyone concedes the distributional question to the national government. Social welfare issues are largely absent in lower level, or local, government decision making in the federalism literature." On 841, "The literature on the optimal structure of a federalist system of governments is virtually unanimous in assigning decisions on income distribution to the national government."

[10] Wallace Oates, "An Essay on Fiscal Federalism," *Journal of Economic Literature* Vol. XXXVII (September 1999): 1121.

[11] Charles M. Tiebout, "A Pure Theory of Local Expenditures," *The Journal of Political Economy* 64, no. 5 (Oct. 1956): 416 - 424; and Oates, "An Essay," 1120 - 1149.

re-distributive program, this incentive to move is removed. Organizing financing of programs at the state level does not mitigate the race to the bottom to the same extent as federal redistribution.

Due to the strength of the federal government in redistributional matters, Alice Rivlin in *Reviving the American Dream* suggested that states contribute to the federal government for certain initiatives so that the federal government could then use its redistributional strengths in administration. In this case, the administrative strength of the federal government is funded by states helping to finance the programs by upward financial contributions. Rivlin's work did not specify Medicaid per se, but it recognized the power of the federal government in yet another area – Administration.

Federal Taxation More Progressive Than State Taxation

Federal taxation is more progressive than state taxation and so the federal government funding the program is preferable. As further evidence of the strength of the federal government in redistributive efforts, what state would prefer to finance Medicaid wholly independently? The financial issue, then, is not whether the federal government should finance a large part of the Medicaid program in its current structure -- this is settled.

The Federal Government is More Administratively Cost-Effective and "Rationalized" Than 50 Separate State Governments

As Fishman writes in *Running In Place*, "It is not particularly likely that 50 state programs would result in less bureaucracy than one national one."[12] Administrative costs are lower with fewer governments involved. The number of associations, and therefore

[12] Eliot Fishman, *Running in Place: How the Medicaid Model Falls Short, and What to Do about It*, A Century Foundation Report in The Devolution Revolution Series (New York, NY: The Century Foundation Press, 2002), 46.

transaction costs, are lower with one level of government involved than with 50 plus the national government.[13]

In addition to administrative cost-effectiveness, Medicaid would be more rationalized if federalized. A Committee on Federalism and National Purpose advocated a "greater separation of responsibilities" among governments. According to the Committee's proposals, health and welfare would be federalized while other functions would be more fully decentralized.[14] According to this view, Medicaid would be more fully federalized and other programs more fully decentralized because this line-drawing creates clearer boundaries and responsibilities. This mitigates confusion regarding enrollment and benefit eligibility. Medicaid's rules are so multitudinous and overlap so many jurisdicitons that potential eligibles and state caseworkers often cannot begin to determine who is eligible. An argument in favor of federalization of the Medicaid program is rationalization, simplification, and administrative cost-effectiveness and efficiency. Also, many federal programs tend to be inflation-adjusted over time, providing beneficiaries the same level of benefits from year to year, whereas state programs tend not to be, leaving beneficiaries with diminishing benefits.

Effects of Lack of Health Coverage Crosses Geographic Boundaries

State and local governments are not well suited to deal with externalities in many types of social policy.[15] Lack of access to Medicaid – and lack of access to health insurance generally -- contributes to lack of disease prevention, delays in diagnosis and treatment, and bloated costs from more complex conditions due to delays in diagnosis and treatment. These problems cross geographic boundaries and are national problems. Disease spreads across state lines. To the degree that health providers and insurers are

[13] Similar to argument made in Cashin, Sheryll D., "Federalism, Welfare Reform, and the Minority Poor: Accounting for the Tyranny of State Majorities," *The Columbia Law Review* 99 (April 1999): 596.
[14] Peterson, *Price*, 186.
[15] See generally Ronald C. Fisher, *State and Local Public Finance* (Chicago: Irwin); and Tresch, *Public Finance*.

part of larger companies that cross state lines, the explosive costs that result from not diagnosing and treating health conditions early is shifted across state boundaries.

Also, the Institute of Medicine (IOM) found that uninsurance is the sixth leading cause of death.[16] If uninsurance leads to death in some groups more prominently than others, first, this is immoral and wrong. Next, it is to be assumed that this group of people's productive power is lost, their potential energy extinguished, their potential contributions to the political system gone. Externalities – bad effects from the system – cross state boundaries. Organizing administration and policy decision making at the federal level captures these externalities and addresses them as a nation.

Federal Political Structures Are More Amenable To Fair Deliberation of Medicaid Issues

Health policy affects federal more than state elections. Voters take health policy more into account when electing federal than state government officials. Since this is the case, organizing Medicaid at the federal level means that elected officials will be held more closely accountable for policy choices than if the program is organized at a level where voters do not consider health policy to the same degree in voting.

According to many, federal politics is more likely to protect the poor, and to cover the poor across the country in a more similar, fair way, than state politics.[17] Placing redistributive decision making at the level of state majoritarian politics will work in the middle-income voters favor over the poor when they vie for scarce public dollars. Although Medicaid serves both the middle-class and the poor, federal involvement introduces fairer institutional structures for the poor. They are less politically hamstrung at the very beginning, by the institutional rules that govern decision making. Also, to the

[16] Institute of Medicine (IOM), *Care Without Coverage: Too Little, Too Late* (Washington, D.C.: IOM, May 2002). Consider Marwick's findings, as well. For example, uninsured patients with breast cancer have a 30% to 50% greater chance of dying than patients with private insurance coverage. Uninsured patients with colon cancer have a 50% to 60% higher mortality rate than those with private insurance. Finally, there is a 37% higher mortality rate among uninsured accident victims than among those who were privately insured. See C. Marwick, "For the Uninsured, Health Problems Are More Serious," *Journal of the National Cancer Institute*, July 3, 2002.

[17] Peterson, *Price*, 146. A variant of this argument is presented in Cashin, "Federalism, Welfare Reform."

degree that a state is represented more by rural than urban voters, state organized programs adversely affect city-dwellers.[18] This same argument can be applied to many groups and minority interests. Greater aggregation means that plural interests are considered more effectively in policy choices, which is particularly important for people with low-incomes.

Finally, state and local governments, research has found, are more susceptible to interest group capture,[19] meaning that major policy decision making at that level is more susceptible to non-democratic influence and power monied interest politics. This is highly unlikely to benefit the poor. In a related argument, business leaders while displaying an ability to work towards community financial improvement have not displayed as much tenacity in effectively addressing tangled issues of indigence and medical necessity on a broad scale.[20]

The Federal, Not State Governments, Encourage Localism and Closeness to The People

Federalism may not encourage and in fact discourages decentralization to local government.[21] The Federal Government contributes more to localism than state governments despite the prevalent belief that decentralization to states brings programs closer to the people and matches needs better to resources expended. Local needs, then, are better addressed in cooperation between the federal and local governments then between state and local governments. Also, many citizens are more attuned to federal than state politics.

Frank Cross's "The Folly of Federalism" reviews several pathologies in common understanding of federalism that describes states as the level of government closest to the people. He argues, "True decentralization does not involve decision making at the level of state governments…The most populous states are very large in size and tantamount to

[18] Many authors including Cashin refer to the "Tyranny of the Suburban Voters."
[19] Cashin, "Federalism, Welfare Reform," 577.
[20] Peterson, *Price*, 36.
[21] Frank B. Cross, "The Folly of Federalism," *Cardozo Law Review* 24 (November 2002): 1.

central governments. Their decision making largely sacrifices the benefits of decentralization, because these states are seeking to govern a diverse population that will have very heterogeneous preferences…The real virtues of decentralization are attributable to local, not state, governance."[22]

Localism is not federalism, and state governments are not the closest governments to the people. According to Rubin and Feeley in "Federalism: Some Notes on a National Neurosis": "There is simply no reason why an immediate political unit would be more favorable to local units than the nation's central authority."[23] Cross concludes, "Indeed, both theory and experience suggest that states will be less amenable to decentralized localism, with all of its benefits."[24]

Key Arguments in Favor of State-Generated Reform

Experimentation After Federal Involvement Fails

One reason in favor of devolving a program to state governments is because the federal government has not done a good job during its tenure running a program. At one point in the AFDC block granting debate, for example, Governor Tommy Thompson of Wisconsin delivered a compelling argument to fellow Governors at the National Governors Association that with no proven solutions, the best possible tact was to leave the difficult reform questions to the states. In other words, in the absence of knowing the effective policy solution, the default he argued was with state governments, who at the time were enjoying some victories in the cash income support area.[25] In an important book on Medicaid structural questions, Grannemann and Pauly reiterate this argument regarding Medicaid cost containment in the early 1980s:

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[22] Cross, "Folly," 34-35.
[23] Edward L. Rubin and Malcolm Feeley, "Federalism: Some Notes on a National Neurosis," *UCLA L. Rev* 41 (1994): 916, according to the original source Cross, "Folly," in Footnote #191 and #5.
[24] Cross, "Folly," 33.
[25] David Ellwood, "Discussion," in John Kincaid, "The Devolution Tortoise and the Centralization Hare," *New England Economic Review* (May/June 1998): 44-45.

> At the moment, therefore, there is no basis for trying to direct states to trim their Medicaid programs in any particular way. With the prevailing uncertainty about what is best, giving states the flexibility to experiment and adapt their cost controlling efforts to local circumstances, and to develop incentives for physicians and patients to control costs, may be the most sensible policy. [26]

This is an argument, based not on theory but on humility, as James Q. Wilson articulated: "In a recent article Wilson argued that we know so little about the tangle of pathologies that produce welfare dependency that we may as well turn welfare over to the state and local governments. We do not know what to do at the federal level, so we may as well turn it over to the states and see if they can do better than we have to date."[27] Grannemann and Pauly's work suggests that the signals may, at least be clearer and reactions quicker, for states in the face of this uncertainty.[28] The greater the uncertainty of what level of government finances or administers Medicaid more effectively, the more costly it is to insist on national uniformity.[29]

Governments Closer to the People Identify Needs Better and Match Resources to Those Needs Better

Localities can target needs better than central governments and so provide more efficient amounts, types, and combinations of services.[30] Meeting heterogenous preferences enhances welfare.[31] Paul Peterson in the *Price of Federalism* described this phenomenon is a slightly different way, "… economic signals to the national government indicating the relative efficiency of its policies are not as clear or as rapidly conveyed as

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[26] Thomas W. Grannemann and Mark V. Pauly, *Controlling Medicaid Costs: Federalism, Competition, and Choice* (Washington, D.C., American Enterprise Institute for Public Policy Research, 1982), 18 - 19.
[27] David Beam, "Discussion," in John Kincaid. "The Devolution Tortoise and the Centralization Hare," *New England Economic Review* (May/June 1998): 43.
[28] Grannemann, *Controlling Medicaid Costs*, 34 - 35.
[29] See Cashin, "Federalism, Welfare Reform," in Footnote #112, "The greater the uncertainty about what works and what doesn't, and the greater the ability and willingness of states to share information, the more valuable are state-level policy innovations and the more costly is any requirement of national uniformity."
[30] For an argument along these lines, see the section "The economic case for decentralized government," in Wallace Oates, *Fiscal Federalism* (New York: Harcourt Brace Jovanovich, 1972), 11 - 13.
[31] Cross,"Folly," (November 2002): 51.

signals available to local governments…As a result, the national government receives less information from the marketplace about the effectiveness of its policy choices."

State Governments Are More Apt At Taking Into Account Market Differentials

Health delivery is a decidedly local enterprise. The U.S. medical system has differing local medical prices, structures of local delivery systems, maturation and penetration of managed care, and other variants depending on market and geographic areas. Given this, a mechanism for taking these into account is wise. A completely federalized program may be less apt at this than one that involves states.[32]

State Involvement in Medicaid Encourages Competitive Federalism

Competitive Federalism provides "market solutions." This argument was developed by Thomas Dye in *American Federalism: Competition Among Governments* in his conceptualization that efficiency, maximization of personal objectives, and societal progress result from competition.[33] Innovation, then, is encouraged by decentralization. This is also expressed in the idea of states as laboratories, where states test ideas that can either be implemented by the national government or other states. Vice versa, there are also examples of national policies that are borrowed and implemented by the states.

States Involved To The Degree Medicaid Is A Local Public Good

To the degree that Medicaid is considered a local public good, instead of a national public good, individuals are not going to be as willing to pay taxes for someone in another area or political unit who requires Medicaid.[34] In theory, people would prefer to move to an area with a lower tax burden. To the degree that Medicaid is considered a

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[32] Grannemann, *Controlling Medicaid Costs*, 95.
[33] Thomas R. Dye, *American Federalism: Competition Among Governments* (Lexington, Massachusetts: Lexington Books, 1990), 14.
[34] A variant of this idea is expressed in Grannemann, 36 - 37.

local public good, or to the extent people are willing to help neighbors in their own community but not every Medicaid recipient across the country, taxpayers may consider a national financing system unfair. The "general understanding" will be that fairness to taxpayers is abrogated by having to pay taxes to support it on a national level. Also, to the extent that the public good has localized effects, public finance theory favors decentralized provision on grounds of economic efficiency. Finally, to the degree that the local public good is highly price inelastic, there are potential welfare gains from decentralized finance. [35]

Political Participation and Democracy Strengthened By State Involvement

Civic political participation and influence increases as level of government decreases.[36] In the Supreme Court's *Garcia* decision[37] Justice Powell writes that state and local governments are more efficient because they are more accessible and democratically responsive than the federal level.[38]

State Involvement Better Protects Basic Liberties and Freedoms

Involving decentralized governments in Medicaid helps to protect basic liberties and freedoms. The additional points of access to community, local, and state political participation allows citizens to work within the democratic political system towards change in the Medicaid program more effectively than if the program were wholly federal.[39] This works to protect basic liberties and freedoms of individuals.

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[35] Oates, "An Essay," 1122 - 1123.
[36] Oates, "An Essay," 1138.
[37] See *Garcia* v. *San Antonio Metropolitan Transit Authority*, 469 U.S. 528, 105 S.Ct. 1005, 83 L.Ed.2d 1016 (1985).
[38] Cashin, "Federalism, Welfare Reform," (1999): Footnote #98, see *Garcia* v. *San Antonio Metro Transit Auth.*, 469 U.S. 528, 576-77 (1985) (Powell, J., dissenting).
[39] See Robert P. Inman and Daniel L. Rubinfeld, "Rethinking Federalism," *The Journal of Economic Perspectives*, Vol. 11, No. 4 (Autumn, 1997): 43 – 64, particularly 44 and 54.

INTERGOVERNMENTAL GRANTS: THE FINANCING INSTRUMENT THAT BRIDGES GOVERNMENTS

Just as federalism is a negotiation between governments, intergovernmental grants are a means to achieve this bargain. The benefits of federal and state rule can be combined in one program using intergovernmental grants as a bridge.[40] The power of the possibilities of negotiation between governments using grants has evolved over time, but part of this evolution was overcoming questions of their constitutionality.[41]

The unique feature of intergovernmental grants is their ability to juxtapose so many of the positives described in the last section from every level of government into one program. Political bargainers rely on these instruments in order to broker deals by trading interests through the structure of the grant. Richard Nathan writes: "A grant-in-aid is the product of a political bargaining process, not just in Washington where the grant is created, but also at the state and local levels where it is executed. One way to think about this process is that there is a horizontal policy bargaining process, which consists of decision-making about policy goals and instruments for the country as a whole, and a vertical dimension, involving the way in which a particular grant is defined and executed by individual recipient jurisdictions."[42]

Intergovernmental grants, then, make it possible to combine interests on both sides of the federalism debate. It is possible for the federal government to redistribute and for local governments to match needs to services, all within the same program. Intergovernmental grants create a bridge where the dialectical debate is resolved through

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[40] "Much of the devolution literature misses what is now the central challenge in social policy, that is, that we as a society want both the advantages of federal rule and some of the advantages of state rule." See David Ellwood, "Discussion," in John Kincaid, "The Devolution Tortoise and the Centralization Hare," *New England Economic Review* (May/June 1998): 45.

[41] The Constitutional challenge to intergovernmental grants was addressed in 1923. During *Massachusetts* v. *Mellon*, "a unanimous Court turned aside Massachusetts's challenge to the Sheppard-Towner Act, which gave conditional grants to the states for maternal and infant health. Massachusetts claimed that the law induced states to yield sovereign rights reserved to them. The Court held that the states' choice to accept the grants was voluntary and that there was no deprivation of a right that fell within judicial cognizance." See Martha Derthick, *Keeping the Compound Republic: Essays on American Federalism* (Washington, D.C.: The Brookings Institution, 2001), 129.

[42] Richard P. Nathan, "State and Local Governments under Federal Grants: Toward a Predictive Theory," *Political Science Quarterly* (Spring 1983): 48.

combining Medicaid functions among different levels of government. In general, intergovernmental grants are purported to internalize spillover benefits of other jurisdictions, encourage fiscal equalization across jurisdictions, and contribute to an improved overall tax system. In fact, the veil hypothesis holds that intergovernmental grants are a "veil" for a federal tax cut.[43] These fiscal benefits are matched by the ability of federal and state politicians to share responsibility for lawmaking and for federal and state administrators to share in policy setting, implementation, and enforcement.

Past Medicaid federalism debates concentrated on the current grant structure, open matching grants, and the Medicaid reform proposal of block grants. Block grants became the social policy reform model of choice for Reagan, Gingrich, and George W. Bush. President Ford proposed block granting Medicaid but this proposal did not garner serious action. The conversion of the income support program Aid to Families with Dependent Children (AFDC), which was financed through an open-matching grant, to the block-granted Temporary Assistance for Needy Families (TANF) in 1996 was a fundamental shift in American income support policy. Continuing liberalization of Medicaid waivers and the addition of new waivers, for example HIFA waivers, to states has given state and local governments greater and greater discretion in decision making in the Medicaid program. The strengths and weaknesses of block grants and a brief review of the reasons for staying with the status quo of open-matching grants are considered here.

These strengths and weaknesses are necessarily generalizations, but a caveat is offered that not all block grants are the same. In a review of block grant politics, Timothy Conlan lists a number of items debated when past policymakers considered block grants including "the division of money and authority among different levels of government, the total level of funding to be authorized, the extent and character of federal oversight, the range of eligible activities to be permitted, the specific programs to be consolidated, and the factors to be included in the allocation formula."[44] For example,

[43] Oates, "An Essay," 1129.
[44] Timothy Conlan, "The Politics of Federal Block Grants: From Nixon to Reagan," *Political Science Quarterly* (Summer 1984): 258.

one 1995 proposal created several block grants from the Medicaid program, splitting it into several separate initiatives.

Open - Matching Grants

One of the primary benefits of open matching grants is that they stimulate state spending in a program. States contribute more to Medicaid than they would without this structure because with every dollar spent, they receive federal funds in return. The more states spend, the more federal money they receive. And, there is no limit. This reduces the price of Medicaid for states. Also, since it is targeted to Medicaid specifically, it is theoretically supposed to "lower the unit cost or price of the supported services and limit the opportunities for the funds to leak into state or local tax relief."[45] In truth, the Medicaid program has had instances where states have used the Disproportionate Hospital Payment system or provider tax schemes to maximize federal funding and those funds were used for other state purposes. According to theory, though, the magnitude of the stimulative effects of open matching grants is "quite large, much larger than the effect of unconditional grants on state and local spending."[46]

One reason for the dramatic expansion in Medicaid in the late 1980s was a series of mandates to expand coverage to include more low-income families. Based on U.S. Census of Government's data on total welfare spending, Baicker has argued that states' fiscal response to these mandates was to cut back on other welfare spending by an amount almost exactly equal to the extra cost of the mandates. This result, if correct, suggests that the national government is highly constrained in its ability to incentivize states to expand coverage and increase spending on the needy.[47]

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[45] Wallace E. Oates, "The New Federalism: An Economist's View." Chapter 7 in *Studies in Fiscal Federalism* (Aldershot England: Edward Elgar, 1991), 100. Originally published as "The New Federalism: An Economist's View," *Cato Journal* 2, no. 2 (Fall 1982): 482.
[46] Wallace E. Oates, "The New Federalism: An Economist's View." Chapter 7 in *Studies in Fiscal Federalism* (Aldershot England: Edward Elgar, 1991), 100. Originally published as "The New Federalism: An Economist's View," *Cato Journal* 2, no. 2 (Fall 1982): 482.
[47] Howard Chernick, "Federal Grants and Social Welfare Spending: Do State Responses Matter?" *National Tax Journal* LIII, no. 1: 148.

Aggregate Block Grants

Aggregate block granting Medicaid would convert the open matching grant structure to a lump-sum payment to states. Block grants tend to shift more responsibility for programs to states and localities, and they tend to result in the federal government cutting its contribution to the block granted program. Block grants are non-stimulative in terms of public budgets in that states are not induced to spend more on Medicaid. Block grants offer much more flexibility to states to spend the funds according to their own priorities, in theory, than open matching grants. Also, block grants are by definition capped so that there is a fixed amount given to states, which may help in planning for the federal government as well as with deficit reduction, budget balancing, and entitlement spending as a percentage of total national budget control. In the past two and a half decades, deficit pressure has bolstered calls for block granting generally. Paul Posner has researched this phenomenon in relation to unfunded mandates. He writes, "From a budgetary perspective, block grants have distinct advantages as a tool of cutback management….especially if states come to believe that cuts are inevitable, block grants offer the advantage of increased flexibility to manage the reductions."[48]

Interestingly, critics of block grants are numerous and their backgrounds varied. First, block grants are seen as "buck passing" when applied to programs without clear rationalized reasons for being block granted. In the event of a block grant, many more of Medicaid's challenges would be passed to states. Federal elected and appointed officials, then, would not be responsible for these policy choices. Some fiscal conservatives have claimed that this buck passing is a "prescription for fiscal irresponsibility." In short, the pain of taxing is separated from the joy of spending "in a thinly disguised revenue sharing program."[49]

A strong argument in favor of block grants is that it removes the possibility of states using strategic games to maximize federal Medicaid funding, as it has done under

[48] Paul L. Posner and Margaret Wrightson, "A Perennial but Unstable Tool of Government," *Publius: The Journal of Federalism* 26, no. 3 (Summer 1996): 92

[49] Posner, "A Perennial," 94.

the open matching grant formula.[50] At the same time though, the stimulative incentives of open matching grants are lost. In other words, not only will the federal government reduce its contribution and cap spending on the Medicaid program, but, in the absence of the incentives of a matching grant, states will reduce their spending on Medicaid, as well. The marginal price of the Medicaid program will go up for states because the federal government is no longer giving the states funds for every dollar the states invest.[51]

A counter to this argument exists, as well. It is not proven that all states have maintained their level of effort in the Medicaid program. Some states who do not agree with federal goals for the Medicaid program may be substituting federal dollars for money they would have used on the program anyway. Therefore, this represents a substitution of federal dollars for money that states would have spent on the program without federal involvement.[52] Block grants (sometimes referred to as revenue sharing or power equalizing) are sometimes thought as a panacea for all that is wrong with the federal system. The advantages, however, of national equity can be combined with those of state and local efficiency. [53]

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[50] Several interviewees and experts expressed this view that block granting Medicaid was the only way to stop state maximization of the federal open match via provider taxes and donations, Disproportionate Share Hospital Payments (DSH), Upper Payment Limits (UPLs), Intergovernmental Transfers (IGTs), and a whole host of state techniques. In economic theoretic terms, Singh and Thomas (2001) convey the conceptual idea this way, "The shift towards block grants is seen to increase efficiency through the elimination of the dead weight loss resulting from selective input subsidies, or attempts to convert contingent funds to an income supplement." See Nirvikar Singh and Ravi Thomas, "Matching Grants versus Block Grants With Imperfect Information," *National Tax Journal* XLII, no. 2 (2001): 191

[51] A similar phenomenon was hypothesized in welfare reform. Howard Chernick writes in 1998, "While the discussion of devolution and welfare reform in the U.S. has emphasized regulatory decentralization, paradoxically, the predicted fiscal effect of the block grants will be to further centralize re-distributional finance, as states reduce their own effort in response to the increase in the marginal price of redistribution." See Howard Chernick "Fiscal Effects of Block Grants for the Needy: An Interpretation of the Evidence," *International Tax and Public Finance* 5 (1998): 228.

[52] As Hanson (1984) writes: This finding is consistent with Jennings (1982) conclusions about the mixed effects of fiscal incentives on state policymakers' behavior. It cannot be presumed that fiscal incentives – like the progressive reimbursements that give poor states "more bang for their bucks" – will stimulate more liberal policies. Some states will simply use these incentives to add to their own efforts, while others will use them to substitute for their own action. Hence, equalizing resources will not equalize policies, unless the willingness of policymakers to use those resources for federally intended purposes is the same." See Hanson, Russell L., "Medicaid and The Politics of Redistribution," *American Journal of Political Science* 28, no. 2 (May 1984): 328.

[53] Peterson, *Price*, 23.

An expected substantial reduction in Medicaid spending, meaning cuts in eligibility and services, is a strong argument against a block grant structure. In short, in the past expansions have been encouraged by the institutional structure of the matching grant. Without this structure, reductions in coverage and eligibility are very likely. Howard Chernick's public finance research has supported this empirically, "In contrast to the results on cash assistance, estimates from the Medicaid literature suggest a strong price response to federal matching subsidies. The implication is that efforts to cap Medicaid, or convert it to a block grant, would lead to very large reductions in Medicaid spending. Mandates to expand coverage under Medicaid, coupled with the price subsidy through federal matching, appear to have been effective at achieving their purpose."[54] An implicit lump-sum grant is transferred from the federal government to states through the current institutional design is the DSH program.

Although the rules have been tightened in recent years, the use of provider taxes and donations and the DSH schemes to maximize federal funding can be seen as a lump sum payment to subsidize federal mandates. Since the federal government has allowed this strategic maximization to continue, with some important reforms, it results in the federal government contributing more to state Medicaid programs than intended from its matching grant institutional design. Instead Medicaid is really an open matching grant program with added on lump-sum grants to states who strategically maximize these tax, donation, and DSH systems to generate additional federal dollars.

Again, though, the question of how close state governments truly are to the people arises. While it seems settled that the federal government is the right government to collect money to fund the Medicaid program, the question of what level of government makes political and policy decisions and administers the program is still in question. If revenue sharing utilizes the strength of federal progressive taxation but then transfers the funds to state governments for their decision making and prioritization to set the framework for Medicaid, is this actually moving Medicaid away from – and not toward the people? If localities and private carriers are involved through waivers or mandates by

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[54] Chernick, "Federal Grants," 150.

the federal government in Medicaid currently, would this improve with a block grant – or will many of the local entities currently involved be cut out of the program? The arguments for decentralization that include bolstering civic and community participation and democratic ideals may in fact be hurt – not helped – by decentralization. As Sheryll Cashin writes, "replacing entitlements that enable beneficiaries to act for themselves with block grants actually moves away from the people and toward state government."[55]

The individual entitlement to Medicaid will end by shifting to an aggregate block grant structure, even if the state entitlement remains. Federal rights of action will be severely restricted – if not eliminated – for beneficiaries and providers. Block grants substantially alter Medicaid not just because of federal versus state considerations but because individuals will be much more dependent on states and their legal and policy decisions. If there is a dispute, federal governments will be severely restricted in their ability to intercede given that the individual entitlement no longer exists at the federal level. This, in fact, harms federalism since a main tenet of federalism is that different levels of government are involved precisely in order to protect individual rights and liberties.

Block grants also do not address the concern that out-of-state voters have for people who do not reside in their own states.[56] One of the reasons that programs are organized on the federal level is because there is something gained by taxpayers all over the country from contributing to the care of people in need. This may be called community responsibility or caring, beneficence, belief in the common good – but the main point is that someone who contributes to funding a program through federal taxation may want the federal government to ensure that this tax money is helping people. If a federal taxpayer in Ohio disagrees with Florida's Medicaid eligibility determinations, block grants create a situation where taxpayers contribute to funding the program but are not able to voice objections to its institutional structure because they reside in a different state.

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[55] Cashin, "Federalism, Welfare Reform," 13.

[56] A related argument is made in Grannemann, *Controlling Medicaid Costs*, in Chapter 4 "Goals for a Reformed Medicaid Program," 30 - 41.

Finally, A Medicaid block grant will be disproportionately tough on poor states. Current differentials in states' eligibility, benefits, and provider payment – already representing an uncomfortably large horizontal inequality – will become even more pronounced.[57] Poor states will be less able to bridge the gap and make up for reduced federal funds due to their lower state fiscal capacity than wealthy states.

CONCLUSION

In the particular policy dialectic described in this chapter the "Key Arguments in Favor of Federal Reform and Control" are pitted against the "Key Arguments in Favor of State-Generated Reform." Scholars of many disciplines contributed to the defense of dozens of reasons why one level of government or another is better suited for controlling Medicaid decision making. Pragmatic federalism means policy decision makers pick the argument that best defends the deeper values they are driven to achieve.

Even in light of this, there are particular institutional strengths of different levels of government. Governments that are inclusive of others, such as the federal government, tend to be better for redistribution and particularly adept at enforcing certain types of equality. Governments closer to the people tend to match resources to needs more effectively and to encourage competition.

This chapter provided a meta-analysis, pitting one view of federalism against another in a policy dialectic: Reasons for Federalizing Medicaid versus Reasons for Decentralizing Medicaid's functions. It also provided a meta-analysis of open-matching and block grant structures. At the end of the day, the Medicaid program is truly a paradox. It fills so many roles. It builds on the strengths of its use, through an open-matching grant structure, of federal, state, and local governments. The following lists a few of the paradoxical twists of Medicaid federalism. Medicaid is:

[57] Howard Chernick stipulates, for the economic reader, "So long as the price elasticity of AFDC [in this case Medicaid] is greater than zero, block granting should in the long run increase benefit differentials." See Chernick, "Fiscal Effects," 224.

- Not only a federal or state program, per se, but both;
- Not simply a health program but historically lumped with cash income programs;
- Not only acute or hospital based, but important for physicians, the long-term care industry, the mental health infrastructure, the dental profession, school based health, the aging network, and every aspect of the broader social milieu;
- Vital as a health financier not only for those with low-incomes, but increasingly for the middle-class;
- Not only a public program, but integral to many private business interests; it is also connected to America's business competitiveness world-wide by its financial effects on heath system costs as a whole;
- Not only a program for children and pregnant women but for the adult disabled and the elderly; and
- A program where advocates for federalization often base their argument on individual rights and advocates of block granting or greater state flexibility also base their arguments on a different set of individual rights.

In this paradox, arguments around Medicaid tend to be "Rights" versus "Rights" arguments; it's just that the opposing factions are choosing to espouse different rights as integral to their own set of personal values. Medicaid serves many distinct populations and is asked to do it all well. To quote a scholarly paper, there's just something about Medicaid.58

The program's federal and state relationship has resulted from innumerable policy bargains over its four plus decades. The next two sections concentrate on some of the major "moments" or most influential policy bargains for Medicaid federalism. The next part, Part II which includes Chapters 3 through 6 considers "Medicaid in Retrospective." It is more historical in nature and progresses from the New Deal through the George H. W. Bush era. Part III, comprised of Chapters 7 through 11, considers "The Modern Era." Part III tends to focus in more intently on specific policy bargains, benefiting from

[58] Alan Weil, "There's Something About Medicaid," *Health Affairs* 22, no. 1 (Jan./Feb. 2003), 13 - 30.

interviews with the major players in Medicaid federalism policy bargaining from 1992 through 2007.

Now, after Chapters 1 and 2, the theoretical cement is set. We can now roll the tape and learn how the policy bargaining in Medicaid federalism actually plays out in the real world. In Part II we have the benefit of the historical record and in Part III we have the benefit of extensive interviews with the most involved, dynamic, and thoughtful policy makers in Medicaid today.

CHAPTER OUTLINE FOR PART II

THE MEDICAID EVOLUTION

Medicaid In Retrospective

INTRODUCTION TO PART II

3. THE FIRST BIG BANG, 1935:
LEADING TO MEDICAID ENACTMENT -- POLICY BARGAINS FROM THE NEW DEAL TO KERR MILLS

4. THE SECOND BIG BANG, 1965:
THE LBJ RIGHTS ERA

5. THE WATERSHED YEARS, NEW FEDERALISM, AND PROPOSALS FOR A NEW FEDERAL ROLE IN MEDICAID

6. REAGAN'S BUDGET REVOLUTION, SECOND WAVE OF NEW FEDERALISM, AND THE MEDICAID EXPLOSION

INTRODUCTION TO PART II

Policy history provides a unique opportunity to study a particular phenomenon in a real life scenario. While it is not possible to know precisely how a Medicaid policy bargain will unfold in the future, it is possible to understand trends, traps, and patterns from previous Medicaid federalism joists. It is possible to understand a great deal about public policy deal making, the institution of federalism, and the evolution of the Medicaid program in the process. Not all the trends, traps, and patterns will be helpful in the next policy bargain, but after studying enough bargains over enough eras, a great deal is learned about the coalitions involved and how the public policy in this area transpires.

Part II considers "Medicaid in Retrospective." The experts who know Medicaid best made it very clear during interviews that understanding Medicaid in 2007 is not possible without understanding the eras leading up to it. This section is comprised of four chapters. Chapter Three, "The First Big Bang" covers the thirty years prior to the enactment of Medicaid in 1965 in order to understand how the evolution of the Social Security Act, the Economic Bill of Rights, and the national health debates shaped Medicaid federalism. There is no Medicaid without this history. It sets up the following chapter on the LBJ Rights Era.

While Medicaid tends not to be a policy area of major interest to Presidents, Lyndon Baines Johnson made his Medicare/Medicaid bill the first and foremost legislative priority after winning the Presidential election in 1964. Possibly it was said best in his own words on a recorded phone conversation from the LBJ Presidential archives, "-- "but I'd just say this that there is not anything that has happened in my six months or that will happen in my whole term in my judgment that will mean more to us as a party or me or you as individuals than this piece of legislation [Medicaid/Medicare]."[1] The prioritization by the President was paramount to its passage

[1] Telephone Conversation between Lyndon B. Johnson and Wilbur Mills, June 9, 1964, Tape WH6406.03, Program No. 12, Citation No. 3642, Tapes and Transcripts of Telephone Conversations and Meetings, LBJ PL.

-- and after forty years of benefiting from that Presidential choice, the victories of these programs are two of many pillars to his legacy.

Chapter 5 covers the "Watershed Years" of the 1970s. A profound era, the Nixon/Ford national health proposals were never embraced by Congressional Democrats, even though in today's terms the Nixon offer appears in many ways comparable to President Clinton's 1993-94 proposal. The Medicaid program is forever tied to national health reform proposals. There is no escaping that a proposal for national health reform is a proposal for Medicaid reform. During the Nixon era, the FAP proposals also resulted in the creation of the Supplemental Security Income (SSI) program, a very important eligibility category for Medicaid. In general though, this watershed era was marked by multiple profound changes. The effects of the Congressional Budget Act would remain latent for some years. In fact, though, this Nixon era reform -- put in play to curb his power -- revolutionized Medicaid and entitlement policy bargaining.

Chapter 6, the final chapter of Part II, covers the 1980s and early 1990s. Medicaid federalism's twists and turns in this era were marked by state financing mechanisms where states attempted to maximize their federal match. In many ways, the federal response to, in their view, "these games," was the strongest support for block granting Medicaid. First proposed by President Ford, capping Medicaid expenditures was a staple of the Reagan OMB machine. Another method of control, also proposed, was federalization. Once federalized, the program could be shaped by the Administration as it saw fit. With the benefit of hindsight, Chapter 6 in fact covers "The Budget Era" -- a time when reining in entitlement spending, restructuring the budget rules in favor of the party in power, and rewinding The Great Society were priorities. Medicaid, in the face of it all, expanded.

One of the most endearing qualities of Medicaid is its ability to survive in the toughest conditions and thrive when asked to do so much for so many different types of extremely complex medical predicaments. This all comes at a price though. And Part II sets up the history which leads to "The Modern Era" (1992 - 2007). The largest health program in the country, today Medicaid spends more than $350 billion a year, serving

well over 50 million people. The program that was referred to as "an afterthought" during the LBJ era still in 2007 operates under most Congressional staff's radar screens. Part II reviews its policy history and the federal and state struggles up until The Modern Era.

3. THE FIRST BIG BANG, 1935:

LEADING TO MEDICAID ENACTMENT -- POLICY BARGAINS FROM THE NEW DEAL TO KERR MILLS

INTRODUCTION

This chapter begins at Medicaid's enactment in 1965 in order to connect this event backwards to FDR's New Deal. The first and second big bangs in American social policy, there was never again such institutional fire branding as first with the creation of the Social Security Act in the mid 1930s and then the addition of the health programs, Medicaid and Medicare, in 1965. Connecting the two Administrations there was an adherence to creative federalism. Both Democratic Presidents and their Administrations believed in the power of all levels of government to work with private industry in the hope of achieving great outcomes. Many of the dedicated and talented staff that worked on the New Deal played key roles in the Great Society. The institutional economists of the New Deal and the Great Society were simpatico. It was not until after the New Deal, that the American welfare state lent its ear more forcefully to the neoclassicists.

The FDR Administration thus forged cash income programs on a shared federal-state model that Medicaid, in the LBJ era, would be modeled upon. The importance of the time period leading up to the enactment of the predecessor programs to Medicaid, particularly Kerr Mills in the early 1960s, cannot be overstated. This chapter also examines policy bargains through Truman's, Eisenhower's, as well as President John F. Kennedy's Administrations. It illustrates the importance of national health reform

debates in the eventual development of the 1950 medical vendor payment programs, Kerr-Mills, and, finally, Medicaid.

The first couple of sections of this chapter begin with the enactment of Medicaid and then link back to FDR and the initiation of the Social Security Act (SSA). Eventually, Medicaid would be Title XIX of the SSA. This chapter is intended to review Medicaid's precursor debates, and the policy bargains that shaped them. Not a program that was developed suddenly. The history behind how Medicaid evolved into being is important in explaining where we stand in 2007. This chapter tells that story and introduces the next chapter which focuses on enactment.

CONNECTING BACKWARDS: HOW CREATIVE FEDERALISM AND MEDICAID POLICY BARGAINING STEM FROM FDR'S FIRST BIG BANG

Any study in political negotiation – and in this case a study of policy bargaining—certainly does well to begin with the Johnson Presidency.[1] A giant in legislative bargaining, President Johnson urged his intended audience in a speech on the Federal Government's Relations With State and Local Government And The Private Sector, "Perhaps you can help. Don't just complain. Develop better doctrine. Tell my successor how it should be done. Urge the universities to study these relationships systematically. Get beyond rhetoric and examine the machinery by which the relationships are mediated."[2] As President Johnson intimates, the entire policy system is mediated and the enactment of Medicaid is no different.

The enactment of Medicaid in 1965 is often reported in texts focusing on the enactment of Medicare. Tied together in the first bill of the new Congress, it was a three-pronged approach combining means-tested coverage for all age groups in Medicaid, social insurance for hospital care for those over 65 in what would eventually become

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[1] A multitude of texts chronicle President Johnson's legendary legislative bargaining acumen. For recent texts, see Robert A. Caro, *The Years of Lyndon Johnson: Master of The Senate* (New York: Knopf, 2002) and also Randall B. Woods, *LBJ Architect of American Ambition* (New York: Free Press, 2006).

[2] Notes for Speech, "Notes for Speech on the Federal Government's Relations With State and Local Government and the Private Sector," no date provided, Office Files of Harry McPherson: Creative Federalism, Box 55, Office Files of the White House Aides (hereafter OFWHA), LBJ Presidential Library (hereafter, LBJ PL), 8.

known as Medicare Part A, and voluntary supplemental coverage for those over 65 in Medicare Part B. Many enactment accounts describe the linking of three different Medicare financing approaches into one final bill in March 1965 as a surprise. The idea is often described as a work of legislative genius on the part of Wilbur Mills, but the record shows that combinations of legislation had been proposed before. Possibly not, however, with the breadth of scope and coverage of the final enactment legislation.

Medicaid is often described as a sleeper program. It was not widely debated, as Medicare had been, viciously at times, since Truman scaled back his national health insurance proposals to limited coverage of only the elderly in 1952. In fact, the vast majority of hearings and discussion prior to enactment targeted Medicare. Medicaid was considered an expansion of Kerr-Mills or of cash welfare and comprised little of the pre-enactment debate. The link with cash welfare stemmed from the nominal payments to individuals for medical services that, in fact, were linked with income maintenance payments since the New Deal. The Kerr-Mills program, enacted only five years earlier in 1960, was a means-tested program for the elderly, with select care for the disabled and blind added in 1962. Thus, in the White House papers at the time, Medicaid was referred to repeatedly as the "Kerr-Mills Extension" and is not systematically referred to by its own name until post-enactment.

CREATIVE FEDERALISM

Creative Federalism – the Johnson era brand of federalism—espoused a combination of cooperative federalism among not just the various levels of government, but also with the private sector. Much of the Administration directed legislation linked the national government directly with local governments, including the Economic Opportunity Act, the Model Cities Act, and the Elementary and Secondary Education Act.[3] As Johnson believed, "the hope of the future lies in the creative interplay between

[3] Notes for Speech, "Notes for Speech on the Federal Government's Relations With State and Local Government and the Private Sector," no date provided, Office Files of Harry McPherson: Creative Federalism, Box 55, OFWHA, LBJ PL, 6.

the Federal Government, State and local governments and the private sector- an interplay that preserves the autonomy of the non-federal elements. We are faced with problems of great complexity and magnitude. The resources of talent and energy and institutional strength to cope with those problems is widely dispersed throughout the various segments of our society. When the nation is in need it is unthinkable that we would not find ways in which all segments could collaborate to move us toward a better future."[4]

In this way, creative federalism insisted that not to use all forms of decentralization, including privatization, meant squandering scarce resources. All points of influence – and thus all points of decision making—were utilized to affect goals. To not use these resources was to let go of bottled energy. As one Administration document explained, "A foreigner once described the United States as the greatest outburst of human energy the world had ever seen. It is true that our kind of society is a great releaser of energy, and chiefly for two reasons, the driving effort to unshackle human potential and the tradition of dispersing power and initiative."[5]

Creative federalism was infused with an ethic of community and of individual participation. Johnson encouraged listeners, "…this is a self-governing society, and you too must be preoccupied with statecraft. It should be exhilarating to you to know that our system is still evolving and that you can insure the healthy course of its evolution."[6] Citizens were called to be active participants in creative federalism. Also, creative federalism was not talked about in simple dichotomies of decentralization versus centralization or cooperation versus competition, instead it was a fusion of these concepts. The Congressional Record records Senator Muskie on March 25, 1966: "Creative Federalism, as I see it, involves both cooperation and competition of ideas and performance between all levels of government, between Government and private

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[4] Notes for Speech, "Notes for Speech on the Federal Government's Relations With State and Local Government and the Private Sector," no date provided, Office Files of Harry McPherson: Creative Federalism, Box 55, OFWHA, LBJ PL, 8.
[5] Draft Speech, "The Choices Before Us," 10/2/67, Office Files of Harry McPherson: Creative Federalism, Box 55, OFWHA, LBJ PL, 26.
[6] Notes for Speech, "Notes for Speech on the Federal Government's Relations With State and Local Government and the Private Sector," no date provided, Office Files of Harry McPherson, Box 55, OFWHA, LBJ PL, 8.

organizations, and between individuals…Its primary reliance is on joint effort, joint planning, and joint programs with State and local jurisdictions, rather than on direct federal action. This is symbolized most vividly by the expansion of the grant-in-aid device in Great Society programs."[7] Creative Federalism was shown particularly through use of grant-in-aid mechanisms that transferred funds from the federal to decentralized governments. Medicaid, according to this reading then, was an expression of Creative Federalism, although it was modeled on the AFDC cash welfare model to which it had such close ties.

Wilbur Cohen did not label Creative Federalism as a solely 1960s phenomenon that occurred in tandem with the Civil Rights and Great Society era alone. According to Cohen,

> The great believer in creative federalism was Franklin D. Roosevelt, because Franklin D. Roosevelt in 1933 could have federalized or nationalized anything he wanted. There's no question that at the bottom of the depression if Franklin D. Roosevelt wanted to create all national banks, have a single national financial system, had wanted to have a national system of Social Security and health insurance, he could have gotten it. I don't say it would be Constitutional, but the country was in such broken-down condition and the States and localities were so unable to do anything that the man who should get credit for creating federalism is Franklin D. Roosevelt. Because by building upon federal grants and aid for Social Security, he opened the door to the whole federal-state relationship which is now so diverse and so embedded. We would have a different political system today in my opinion if Franklin D. Roosevelt had made the decision to consider the states as sub-sovereignties of the federal government. But having been governor of New York, he was sensitive to the use of the states; and although many of the people who opposed him politically in 1936 and 1940 thought of him as a great radical, both in his use of the federal-state system and his use of Social Security, he was the great conservator of creative federalism and the private economy and the role of the states in our political system.[8]

Indeed, it was President Roosevelt's New Deal that constructed a dichotomous American social policy system constructing a cash welfare system via the grant-in-aid mechanism on the one hand juxtaposed against a federal social insurance system for

[7] Congressional Record -- Senate (p 6500), "The Challenge of Creative Federalism, I. Intergovernmental Relations: What It Is About," March 25, 1966, FG 604 Advisory Commission on Intergovernmental Relations (2 of 2), Box 369, EX FG 600/Task Force/Urban Problems, WHCF, LBJ PL.
[8] Transcript, Wilbur J. Cohen Oral History Interview, December 8, 1968, by David G. McComb, Tape #1, Oral History Collection, LBJ PL, 22 - 23.

retirement, commonly referred to as Social Security. The remainder of this chapter will connect the first big bang in American Social Policy, FDR's New Deal, to the Great Society that birthed Medicaid.

HEALTH INSTITUTIONS AND THEIR FORMATION: FDR, WORLD WAR II, AND THE NEW DEAL

In 1934 The Committee on Economic Security suggested that a study be conducted on the practicability of national health insurance. According to the Committee's staff director, Edwin Witte, "that little line was responsible for so many telegrams to the members of Congress that the entire Social Security program seemed endangered."[9] A comprehensive health financing measure was not included in the Social Security Act.

Although not discussed as a major provision of the New Deal, there were nominal health payments for medical care made through the public assistance programs of the Social Security Act. While there was no provision for Federal matching of costs of medical care as such, "such costs could be included in the maintenance payments to an individual or family."[10] If the cost of needed medical care was included in a recipient's payment, the amount was matchable from Federal funds in the same way as costs for food and shelter. The individual's total payment was subject to State and Federal matching maximums per month per recipient.[11] From the enactment of the Social Security Act, health related payments were a Federal-State joint endeavor. Also, medical payments were not independent and separate as a social need. Instead, they were subsidiary and enveloped within cash welfare. The federal cost sharing for these nominal

[9] Newsarticle, Folder: "Printed Material;" Box Number 4, Personal Papers of Wilbur J. Cohen, LBJ PL. Originally cited as Richard Harris, "Annals of Legislation, Medicare, 1 ~ All Very Hegelian," *The New Yorker*, July 2, 1966, 31.
[10] U.S. Department of Health, Education, and Welfare, "History and Evolution of Medicaid," Chap. 1 in *Medicaid Lessons for National Health Insurance*, Allen D. Spiegel and Simon Podair (eds.) (Rockville, Maryland: Aspens Systems, 1975), 5.
[11] U.S. Department of Health, Education, and Welfare, "History and Evolution of Medicaid," Chap. 1 in *Medicaid Lessons for National Health Insurance*, Allen D. Spiegel and Simon Podair (eds.) (Rockville, Maryland: Aspens Systems, 1975), 5.

payments were increased in 1939, 1946, and 1948, but remained limited and, of course, the care varied widely in nature and scope from state to state.[12]

In 1935, President Roosevelt appointed an Interdepartmental Committee to Coordinate Health and Welfare Activities, and in 1938, its report entitled "A National Health Program," was presented to a Presidential sponsored National Health Conference. The report recommended federal health insurance, and, "over the animated opposition to the AMA's representative at the meeting, it was endorsed by the conferees."[13] On February 28, 1939, Senator Robert F. Wagner, Sr. of North Carolina introduced the first of what would be many bills translating the conference's report into a National Health Bill.[14]

The Senate trio Wagner-Murray-Dingell proposed many versions of the national health provision bills over several years. The 1939 version was organized around state-operated health and welfare services, whereas a 1943 version relied much more heavily on the federal government.[15] Monte Poen, who chronicled Medicare's Truman years, argues that the experience of the second World War solidified the increased acceptance of federal initiative in social and health programs. Connecting the war effort with these initiatives Senator Wagner quipped in 1944, "We could not win this war with 48 state commanders; we cannot win the peace with 48 separate economic programs."[16] World War II, while separate from the social policy penumbra, combined with The Great Depression to change the acceptability of federal government involvement in domestic affairs. Labor in some cases came to support the federalization trend, while it is not clear whether this was an additional cause of or an effect of increased federal involvement. At the same time, they utilized collective bargaining increasingly to attain benefits for

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[12] Advisory Commission on Intergovernmental Relations (ACIR), "Intergovernmental Problems in Medicaid," Commission Report A-33, (Washington, D.C.: ACIR, September 1968), 4.
[13] Newsarticle, Folder: "Printed Material;" Box Number 4, Personal Papers of Wilbur J. Cohen, LBJ PL. Originally cited as Richard Harris, "Annals of Legislation, Medicare, 1 ~ All Very Hegelian," *The New Yorker*, July 2, 1966, 38.
[14] Newsarticle, Folder: "Printed Material;" Box Number 4, Personal Papers of Wilbur J. Cohen, LBJ PL. Originally cited as Richard Harris, "Annals of Legislation, Medicare, 1 ~ All Very Hegelian," *The New Yorker*, July 2, 1966, 38.
[15] Monte M. Poen, *Harry S. Truman Versus the Medical Lobby: The Genesis of Medicare*. (Columbia, Missouri: University of Missouri, 32. (Hereafter Poen, *Harry S. Truman*).
[16] Poen, *Harry S. Truman,* 33.

workers and their families. Also, post-1937 Supreme Court decisions supported the federalization trend, as well.[17]

There is, however, an altogether different reading of the effect of World War II on the health financing area. This reading suggests that social insurance as a method of financing full health coverage was successfully linked by opponents of social insurance to Germany during this time period. Since Bismarck adopted social insurance to finance health in the late 1800s, social insurance as a financing mechanism for health insurance was – these opponents maintained—German. While the overall trend during this time period was toward greater federal involvement, specifics about this involvement – from financing mechanisms to potential populations to be covered—were being successfully manipulated in the public opinion arena. The term "socialized medicine" was coined by opponents of broad coverage solutions and repeatedly used to entrap proponents of comprehensive rights-based health coverage. The "socialized medicine" trap was set particularly to ensnare proposals where the federal government – as opposed to state and local governments – had a greater role in either financing or administration.

The federalism debate, then, became infused with a fear of loss of control. Federalism questions are not often fought along the lines of "What is the best level of government to finance or run the program?" but instead about "What level of government and which group of people will control the program?" In the end, in many policy areas there is evidence supporting each level of government's claim (or lack of a claim, as the case may be) for organizing various components or functions on that level. So, the policy evidence, if needed, can be produced to support the claims of all sides of the policy debate. The issue, then, becomes how the policy evolution unfolds. If states, or alternatively localities, take responsibility for the program, this primarily means that their own strengths, weaknesses, values, beliefs, customs, mores, and web of power relationships will come into play during major program related decisions. Whether or not this is a good thing, depends on what one believes about a state's or locality's values, beliefs, and web of relationships. There will be winners and losers in the program

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[17] Poen, *Harry S. Truman,* 32.

decisions. Depending on one's place, you may prefer that the federal, state, or local government make the choices that you are going to live with.

NATIONAL HEALTH INSURANCE, MEDICAL VENDOR PAYMENTS, AND THEIR INTERACTION WITH CIVIL RIGHTS DURING TRUMAN'S PRESIDENCY

During Truman's Presidency, entrenched interests were committed to ensuring some level of control over any future health program. At this time, the American Dental Association, the American Pharmaceutical Association, Blue Cross-Blue Shield commissions, the U.S. Chamber of Commerce, the American Legion, the Farm Bureau Federation, the National Grange, the Health Insurance Council, and the Health and Accident Underwriters Conference joined the AMA against an overarching government framework in health.[18] Some of these interests believed that they would be better able to influence the program at more decentralized levels of government. A policy dialectic in health policy reform re-appeared. The Wagner-Murray-Dingell bills were pitted consistently against an altogether different paradigm for addressing health care financing. In 1947 --again in 1949 -- the Taft proposals[19] stood as alternatives to the Wagner-Murray-Dingell approach. In 1947 Taft joined with other Republicans for their own National Health Bill.[20] It "offered a medical welfare system for the nation's indigent that would be financed through federal grants and administered entirely by the participating states."[21] A primary argument against the Taft model of national health reform was voiced by Senator Wagner: "Adequate medical services on the basis of need, not ability to pay, is the birthright of every American… It is a matter of right, not charity."[22] The policy dialectic was set: Rights-Based Wagner Democrats versus Indigent-Only Charity Taft Republicans.

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[18] Margaret Greenfield, *Health Insurance for the Aged: The 1965 Program for Medicare, Its History and a Summary of Other Provisions of P.L. 89-97* (University of California, Berkeley: Institute of Governmental Studies, January 1966), 110.
[19] The Taft Bills are often referred to as the earliest precursors of what eventually would be the Medicaid program.
[20] S. 545, 80th Congress, 1rst Session.
[21] Poen, *Harry S. Truman*, 96.
[22] Poen, *Harry S. Truman,* 97.

Leading up to the 1948 re-election campaign the Truman administration considered compromise, in the form of a catastrophic health plan, in order to bring conservative Southern Democrats on-board for the re-election bid.[23] The hard-line on comprehensive, rights-based health insurance was unpopular with this segment of the party. The Civil Rights debate proved more divisive. A parallel policy issue, in the sense that its progression was co-evolving along with health reform, their two separate tracks criss-crossed and coalitions against Civil Rights greatly resembled the coalitions against national health reform. The "anti-union, anti-urban, voting element" that "lined up almost to a man with the Republicans to block floor action on the Wagner-Murray-Dingell bills,"[24] also opposed civil rights advances. After Truman narrowly won re-election, the Congress returned bitterly divided. In 1949, even though several health reform plans were presented, only one was enacted, an expansion of the Hill-Burton Act of 1946.[25] Given the AMA's derision of federal intervention in medicine, it is ironic that thousands of physicians benefited from the infusion of federal dollars into the construction and expansion of hospitals nation-wide through Hill-Burton and its subsequent expansions.[26]

The next year in 1950, the first major revision of the Social Security Act since 1939 unfolded, after a year and a half of Congressional compromise and debate. Old age and survivor's insurance coverage was expanded to include about 10 million additional workers, and OASI payments were increased by an average of 80 percent.[27] A provision to expand OASI to include individuals who were disabled was defeated, in part due to concerted efforts by the American Medical Association which claimed that "to initiate a

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[23] Poen, *Harry S. Truman*, 227.
[24] Poen, *Harry S. Truman*, 225.
[25] The Hill-Burton Act of 1946. Grants were added for research on hospital utilization in 1949; for construction of nursing homes, diagnostic and treatment centers, rehabilitation and chronic disease facilities (1954); to give hospitals the option of accepting a long-term loan instead of a grant (1958); for constructing out-of-hospital community health facilities (1961); for hospital modernization; and for urban services developed through regional, metropolitan, or local area plans (1964). For more information see Rosemary Stevens, *American Medicine and The Public Interest* (Berkeley, California: University of California Press, 1998), 510. (Hereafter Stevens, *American Medicine*.)
[26] Newsarticle, Folder: "Printed Material;" Box Number 4, Personal Papers of Wilbur J. Cohen, LBJ PL. Originally cited as Richard Harris, "Annals of Legislation, Medicare III ~ We Do Not Compromise," *The New Yorker*, July 16, 1966, 68.
[27] Poen, *Harry S. Truman*, 185.

Federal disability program would represent another step toward wholesale nationalization of medical care and the socialization of the practice of medicine."[28]

In terms of the future Medicaid program, the particularly vital reform from the 1950 SSA Amendments was the creation of a medical vendor payment program for public assistance recipients that had federal financial support. A State could submit a plan for making vendor payments on behalf of recipients of assistance under one or more of the Federal-State public assistance programs for a content of care defined by the State.[29] This action foretold the future Medicaid program which would be a vendor payment program. The issue of whether to make payments directly to needy individuals or only to providers would, in the future, be another contested policy issue with significant ramifications.

While the particulars of these OASI and medical vendor payment provisions were being solidified, the national health financing debate co-evolved. President Truman was unable to mobilize on national health reform as the conflict in Korea erupted. Again, as it had after World War II, the pressures of war contributed to the downsizing of efforts to enact health reform. In the policy prioritization scheme of a President, war always trumps health care institutional structural reform. This did not stop the President from using failure of national health insurance in the election politics of the 1950 Congressional races.[30] In doing so, he, possibly inadvertently, sacrificed the policy itself in the hopes of political gain. By using the inability to attain health reform to accuse Republicans politically, the policy issue itself diminished further. The emphasis on its failure made it less likely to become policy reality. More directly, the Democratic party suffered losses in candidates who had emphasized health reform during the 1950 campaign. The Party distanced itself from the comprehensive version of the Truman

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[28] Poen, *Harry S. Truman*, 185. Poen attributes the quote to Arthur Altmeyer's *The Formative Years of Social Security*, 179 – 189.
[29] U.S. Department of Health, Education, and Welfare, "History and Evolution of Medicaid," Chap. 1 in *Medicaid Lessons for National Health Insurance*, Allen D. Spiegel and Simon Podair (eds.), (Rockville, Maryland: Aspens Systems, 1975), 5.
[30] Newsarticle, Folder: "Printed Material;" Box Number 4, Personal Papers of Wilbur J. Cohen, LBJ PL. Originally cited as Richard Harris, "Annals of Legislation, Medicare II ~ More Than A Lot of Statistics," *The New Yorker*, July 9, 1966.

health plan after these results.[31] The AMA sharply reduced its lobbying budget to fight Truman's health insurance initiatives given the dimming light of comprehensive reform.[32]

By 1952, with another Presidential election politics again in play, Truman batted along party lines by establishing a Commission to Study the health reform issue. While the Commission helped clarify the policy issue, as well, interim reports were produced that the Administration hoped would cast Republicans in poor light.[33] The U.S. President's Commission on the Health Needs of the Nation in 1952, also known as The Magnuson Commission, concurred with the President that there was a need for greater federal government involvement in health. The proposed solution differed, however, from Truman's insistence on national health insurance. Instead the Commission "called for a cooperative federal-state program wherein each state would establish its own health insurance plan (subject to the approval of a federal agency) with federal matching funds providing the payments for those who could not afford the premiums."[34]

This proposal was seen as clearly between the Wagner and Taft proposals. Once again, when the country looked for a consensus on the macro national health policy debate, a dialectic formed and the solution was somewhere in the middle of the two opposing proposals. Shortly before Truman left office, he accepted the compromise position put forth by the Commission. Acceptance of this compromise strategy was a vital point in the evolution of the federal role in American Medicine. With the election results settled, this action was important on many levels. It is a notable event when a President, having held so tightly to a policy position of federally funded comprehensive coverage as a matter of right, finally formally accepts a compromise solution. It is symbolic in that there is a realization that the ideal will not – or cannot – be achieved in the current political climate. The Commander in Chief sends the official signal that a

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[31] James L. Sundquist, *Politics and Policy: The Eisenhower, Kennedy and Johnson Years* (Washington, D.C.: The Brookings Institution, 1968), 290. (Hereafter Sundquist, *Politics and Policy*)
[32] Poen, *Harry S. Truman*, 187. Poen reports that the AMA cut back lobbying expenditures by $2 million to $500,000 from the previous year.
[33] Poen, *Harry S. Truman*, 195.
[34] Poen, *Harry S. Truman*, 208.

lesser option is acceptable. Also, given that a primary premise behind Truman's original position was that health care was a right, any compromise seemed to lessen what had been presented as a principle, or truth, that could not be subdivided into lots and traded as bargaining chips. If health care is a right, then how can a right be compromised?

Looking back, shortly before FDR's death, he enunciated the Economic Bill of Rights demanding a basic health package for all Americans. President Truman had accepted the mantle and was a leader of the national health insurance effort. Now, post-election on January 9, he compromised – not in a re-election ploy, as in 1948, but with the election settled and just the future role of a citizen ahead. In his last health-related transmittal to Congress he " conceded that its proposal to give federal grants-in-aid to establish private, state-sponsored plans was probably the best solution to the nation's health needs."[35] The future would tell if this compromise was a beneficial recalibration or a deleterious concession.

THE EISENHOWER ERA: KERR-MILLS, CATASTROPHIC CARE PROPOSALS, FAITH IN STATES, AND HEALTH PROVISION AND THE PRICE OF FREEDOM

During the 1952 Presidential campaign, future President Eisenhower had maintained that government should provide only "indigent medical care."[36] In many respects the AMA enjoyed entrée to the White House during this time period. In 1956, against the AMA's strident resistance, the Democratic-controlled Congress added disability for those 50 and older to Social Security. This was the first contact of a semi-medically related area with social insurance in any significant way.[37] In 1956, 1958, and again in 1960 the federal payments in the state-run medical vendor system were expanded. At this time, the interests that benefited from publicly sponsored care began to assert themselves separately from those interest groups that did better in a privately sponsored model. For example, in 1955 an American Hospital Association Commission

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[35] Poen, *Harry S. Truman,* 208 – 209.
[36] Poen, *Harry S. Truman*, 204.
[37] Transcript, Robert Ball Oral History Interview, November 5, 1968, by David G. McComb, Tape #1, Oral History Collection, LBJ PL, 31.

determined, "It does not seem likely that voluntary prepayment can on any broad scale cover such groups as the nonworking aged, the unemployed, or the low income groups without assistance from government." Another interest, the American Nurses Association, in 1958 supported a Medicare-type model.

President Eisenhower's Administration continued to look for ways that the federal government could assist private enterprise in the health area. The Administration believed that privately financed care was the optimal solution to the nation's health needs. The federalism question was posed in terms of "What is the role of the federal government in assisting private insurance companies to expand coverage?" Previously, legislation was proposed for the federal government to purchase private health insurance for citizens. In 1949, this had been a leading source of debate and counter debate.[38] In 1954, Eisenhower proposed a reinsurance plan to protect private health insurance companies "from abnormal losses, thereby enabling them to broaden their benefits and coverage."[39] Two years later the Administration "devised a plan for relaxation of the antitrust laws to permit insurance companies to pool their resources and efforts in order to extend coverage."[40] Both proposals were easily defeated.

In response to the reinsurance plan's defeat, Eisenhower was prophetic, "There is nothing to be gained by shutting our eyes to the fact that all of our people are not getting the kind of medical care to which they are entitled. I do not believe there is any use in shutting our eyes to the fact that the American people are going to get that medical care in some form or other."[41] Interestingly, Eisenhower invoked the concept of entitlement, even though his preferences were towards privately sponsored care for the majority and state-sponsored care only for the indigent, preferably with a key role for states.

The insurance industry had been noncommittal to the 1954 reinsurance proposal and the AMA flatly opposed it. Even this measure was dubbed to be "the opening wedge

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[38] Stevens, *American Medicine* , 426.
[39] Poen, *Harry S. Truman*, 211.
[40] Sundquist, *Politics and Policy*, 292.
[41] Sundquist, *Politics and Policy*, 292.

to…socialized medicine."[42] By taking such a scorched earth stance on this relatively mild provision, organized medicine drew a line in the sand that later became untenable.

The Emergence of Aging As Its Own Distinct Policy Force

While it may well be described as a paradigm shift, the importance of the issue of aging at this time may also be described as a resurgence. During the Ham and Eggs era several social movements including the Bonus Marchers, the Townsend Movement, and the Epic Campaign advocated pension and other types of reforms.[43] National attention was focused on this aging demographic as a political force. In the middle of the Eisenhower area, the evolution of aging as its own distinct area of interdisciplinary and interrelated concerns was well established. Eisenhower established the Federal Council on Aging in 1956. In the health area, there was a surfacing of discussions for an only over 65 health plan that had taken place in the Federal Security Agency since at least 1950. AFL-CIO prioritized health insurance for retired persons that year as their primary objective.[44]

The momentum behind some federal action in the health area – particularly for those over 65-- pushed into the 1960 Presidential election campaign, but there was still a void to be filled. No iterative measures had been accepted by organized medicine; no fence had yet been constructed. The Democrats, also, had not yet struck any deals and so, the future of American health financing reform, was still wide open.

Election Politics and The Kerr Mills Compromise

With a void needing to be filled regarding the federal role in health provision and the AFL-CIO on a mission to design an over 65 health care package, the bill that eventually led to Medicare was first prepared. Wilbur Cohen and Isidore Falk wrote the

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[42] Sundquist, *Politics and Policy,* 291.
[43] For more see Daniel J.B. Mitchell, *Pensions Politics and the Elderly: Historic Social Movements and Their Lessons for Our Aging Society* (Armonk, New York: M.E. Sharpe, 2000).
[44] Sundquist, *Politics and Policy*, 294 – 299.

bill, the AFL-CIO sponsored it, and Ways and Means committee member Aime Forand of Rhode Island was convinced to sponsor what would become known as the Forand bill.

The American Dental Association, the American Hospital Association, and the American Nursing Homes Association joined with the AMA in a highly publicized series of arguments against the measure. Particularly involved were state and county medical societies, which arranged debates and panel discussions, in what became an orchestrated version of participatory democracy – the special interest sponsored variety. To call this participatory democracy, though, may be a stretch. Reports of intimidation, threats, and propaganda surfaced, resulting in embarrassment and sometimes anger when members of Congress were apprised.[45]

The strategy though resulted in a few difficult policy lessons. First, encouraging participation by citizens may result in them deciding that they are "for" a proposal that the events were designed to make them "against." Sometimes people do not think or do as they are told – especially in the face of coercion. Finally, once a debate is put into play, the originator cannot always control where the path of the reform ends up. Congressman Forand commented, "I want to pay tribute to the AMA for the great assistance they have given me in publicizing this bill of mine….They have done more than I ever could have done."[46]

As the 1960 Presidential election neared, health politics was once again a determining factor. The missile gap, Castro, and the Cuban people were more dramatic election issues, but once Democratic Candidate John F. Kennedy gave a fiery speech at the State Fair Grounds in Detroit embracing the Forand proposal in March, the Medicare die was cast.[47] Edward T. Chase wrote, "The determination of our next President may be

[45] Newsarticle, Folder: "Printed Material;" Box Number 4, Personal Papers of Wilbur J. Cohen, LBJ PL. Originally cited as Richard Harris, "Annals of Legislation, Medicare II ~ More Than A Lot of Statistics," *The New Yorker*, July 9, 1966, 64.
[46] Sundquist, *Politics and Policy*, 298 - 299.
[47] Later, it was revealed that Kennedy aides had been working with Wilbur Cohen on Medicare as an election issue since at least 1958. Cohen helped Kennedy with a cadre of issues including aid to dependent children and unemployment insurance reforms. For more, see Sheri I. David, *With Dignity: The Search for Medicare and Medicaid* (Westport, Conn.: Greenwood Press, 1985), 20.

profoundly affected by the debate."[48] On March 31, the Ways and Means Committee voted 17-8 against the Forand proposal. The bill's momentum was not stopped by this set-back.

After a series of pleadings from the Republican candidate Richard Nixon, the Eisenhower Administration finally proposed a counter bill. In many ways more comprehensive than Forand, the Administration proposal was based on matching grants from federal and state governments "to be used to subsidize insurance policies for the elderly poor that would actually be written by commercial carriers."[49] Large deductibles and copayments would be required.

The New Yorker reported that the bill had few supporters, "Governor Rockefeller said that it was fiscally irresponsible and cumbersome to administer; the A.F.L – C.I.O. said that it was hopeless on every score; the A.M.A. denounced it as government interference; Senator Goldwater called it socialized medicine; and Vice President Nixon declined to comment on it at all. The President, on the other hand, stood up for the measure." Eisenhower had to defend his proposal because it was more expensive: "I am against compulsory medicine and that is exactly what I am against, and I don't care if that does cost the Treasury a little bit more money there…But after all, the price of freedom is not always measured just in dollars."[50]

In this argument, President Eisenhower, invokes a liberty argument in support of a joint federal-state program. While Democrats entitlement based arguments supported a greater federal role and the use of social insurance, the Republican President equated freedom, justice, rights, entitlement to both federal and state governments enabling the private sector. Government directed care was to be used as a back-stop measure for the indigent. Also, the Republican measure was more comprehensive and more costly, both

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[48] Newsarticle, Folder: "Printed Material;" Box Number 4, Personal Papers of Wilbur J. Cohen, LBJ PL. Originally cited as Richard Harris, "Annals of Legislation, Medicare II ~ More Than A Lot of Statistics," *The New Yorker*, July 9, 1966, 65.
[49] Newsarticle, Folder: "Printed Material;" Box Number 4, Personal Papers of Wilbur J. Cohen, LBJ PL. Originally cited as Richard Harris, "Annals of Legislation, Medicare II ~ More Than A Lot of Statistics," *The New Yorker*, July 9, 1966, 69.
[50] Newsarticle, Folder: "Printed Material;" Box Number 4, Personal Papers of Wilbur J. Cohen, LBJ PL. Originally cited as Richard Harris, "Annals of Legislation, Medicare II ~ More Than A Lot of Statistics," *The New Yorker*, July 9, 1966, 69.

in contrast to traditional notions of fiscal conservatism. Another striking product of this Republican proposal was that the Party went on record with a federal health plan. A principled stand against all federal plans was no longer viable given that they were now on the record in support of one. In terms of bargaining, this moved the Republicans further into a viable range of compromise with the Democrats. Long poles apart on this issue, the Eisenhower plan moved their minimum acceptable point of negotiation much closer to that of the Democrat's minimum negotiable point. A resolution to years of debate on the topic seemed much more likely.

On June 3, the Ways and Means Committee again rejected the Forand proposal, 17-8. Chairman Mills, with his own Arkansas re-election politics and powerful state medical lobby in mind, then proposed another measure to extend the Old Age Assistance program so that the federal government could make unlimited matching grants to states for medical care specifically targeted at the elderly poor. The proposal maintained a great deal of state flexibility. The Mills Bill passed the Ways and Means Committee and easily received full House approval three weeks later.[51] On the Senate side, Senator Kerr of Oklahoma called Wilbur Cohen at The University of Michigan. While Cohen had helped design the Forand proposal, he had not written the Mills bill. Senator Kerr invited Cohen to design a counter to the Mills plan. This proposition apparently presented no conflict of interest in the Social Security expert's mind. He later told an interviewer,

> …Then during that time Senator Kerr called upon me to help him with the formulation of the Kerr-Mills Bill. While I was doing that, I would go around and see Sorenson [John F. Kennedy's aide] and tell him that while I was working with Kerr, that was only one aspect to my interest --- I was equally concerned about Medicare. Now at that time most people felt the Kerr-Mills was the substitute for Medicare. It was my position that you ought to have both of them. And I was the only one who believed that. I finally sold both Kennedy and Kerr that position.[52]

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[51] Newsarticle, Folder: "Printed Material;" Box Number 4, Personal Papers of Wilbur J. Cohen, LBJ PL. Originally cited as Richard Harris, "Annals of Legislation, Medicare II ~ More Than A Lot of Statistics," *The New Yorker*, July 9, 1966, 70.
[52] Transcript, Wilbur J. Cohen Oral History Interview, December 8, 1968, by David G. McComb, Tape #1, Oral History Collection, LBJ PL, 34.

Senator Kerr's final plan was designed with his own re-election campaign in mind. According to a Kerr biographer, his health reform alternative to Presidential Candidate Kennedy was intended to distance himself from the Democratic Catholic since Kerr was running in a state of Baptist and Methodist voters.[53] He also asked Cohen to defer to his state of Oklahoma during the drafting of the bill. The end result was, in fact, very favorable to both Oklahoma and Mill's beloved Arkansas.

During the progression of the eventual compromise in the form of Kerr-Mills, several additional plans were put forward. In addition to the Forand and the Administration's bill, which was sometimes referred to as the Flemming Plan, ten other essentially similar bills were introduced; more notable proposals included the Kennedy-Anderson bill, The McNamara bill, and the Javits bill (a modification of the Administration's bill to subsidize private insurance policies).[54] The threat of a Social Security based health care bill apparently became real enough to opponents that the AMA placed a full-page add in several city papers urging the Senate to pass the Mills bill.[55] This was ironic given that Kerr met with AMA officials only weeks before and they were still citing reports that there was no need for federal involvement in health care for the aged. On August 23, the Kennedy-Anderson bill failed after a notable effort by Vice President Nixon to gather votes so that its passage and subsequent Eisenhower veto would not be a major campaign issue. Kerr's bill passed the Senate easily, 91 – 2.[56] Two days later the conference committee accepted the Kerr bill almost intact. In mid-September, President Eisenhower signed Kerr-Mills into law. For the time being, the

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[53] For more on this and Senator Kerr's career in general, see Anne Hodges Morgan, *Robert S. Kerr: The Senate Years* (University of Oklahoma Press, 1977), 194.
[54] Margaret Greenfield. *Health Insurance for the Aged: The 1965 Program for Medicare, Its History and a Summary of Other Provisions of P.L. 89-97* (University of California, Berkeley: Institute of Governmental Studies, January 1966). Also see Newsarticle, Folder: "Printed Material;" Box Number 4, Personal Papers of Wilbur J. Cohen, LBJ PL. Originally cited as Richard Harris, "Annals of Legislation, Medicare II ~ More Than A Lot of Statistics," *The New Yorker*, July 9, 1966, 74.
[55] Newsarticle, Folder: "Printed Material;" Box Number 4, Personal Papers of Wilbur J. Cohen, LBJ PL. Originally cited as Richard Harris, "Annals of Legislation, Medicare II ~ More Than A Lot of Statistics," *The New Yorker*, July 9, 1966, 74.
[56] The only votes against the Kerr bill in the Senate were by Senators Goldwater and Strom Thurmond from South Carolina.

social insurance method of financing health was trumped by a matching grant program. Kerr-Mills was the precursor to Medicaid and Medicare. The future programs would each share characteristics of Kerr-Mills.

Kerr-Mills Enactment and The Policy Choice of an Open Matching Grant

In the Kerr-Mills enactment, the choice of a matching grant financing method was a very important policy choice and one rooted in political, not just policy, maneuvering. On the policy issue, there was a measure of genuine concern by both Mills and Kerr regarding the financial soundness in the long-term of social insurance financing for health. At that time, the health program was considered an add-on to Social Security and the financing structure would be achieved through an increase of the Social Security tax. Arguably, the decision for a matching grant form of financing for Kerr-Mills was largely political. The federal-state relationship and matching grant format was established due to four primary factors:

1) **Political Expediency** – Senator Kerr and Congressman Mills could get it through Congress and still win re-election in their home states. Grant-in-aid programs are generally politically popular because federal funds are transferred to the states.
2) **Potential for state wind falls** -- A grant-in-aid program provides at least the possibility that previously state-only costs can now, in part, be transferred to the federal government. Also Kerr and Mills had the legislation designed in a way that was favorable to Oklahoma and Arkansas;
3) **Powerful interests were pacified** -- Powerful interests were pacified by the prospect of a federal – state arrangement due to their ability to influence state and local decision makers more so than national ones. In many respects, this desire for state control stemmed from fears that restrictive payment systems would be designed by the federal government; and
4) **History and precedence** – Kerr-Mills was an expansion of the public assistance medical vendor payment programs. These were an expansion of nominal medical

payments through the federal-state public assistance programs, an arrangement introduced in the New-Deal.

These factors combined with the fact that Kerr-Mills was in many ways an expansion of the medical vendor payment system and not a new reform, so that Kerr-Mills easily passed Congress. Wilbur Cohen, who was the architect of this legislation, was very well aware of the federal-state role in public assistance programs and how nominal medical payments were first provided through these programs in 1936. Having played a role in social policy development since the New Deal, the 1950 creation of the medical vendor payment system through the public assistance programs was intimately familiar to him. Medical vendor payments were expanded in 1956 and 1958. Cohen's philosophy in social policy development was in his own words one of gradualism, taking what you can get, adding on a piece at a time. In short, *Time* magazine called him the "salami slicer."[57] Cohen commented, in a biography of his life, that this reflected his view of the "evolution of social legislation; to take a bit and a time and digest it."[58]

While some accounts of Kerr-Mills enactment highlighted the positive aspects of the potential of the program, other news accounts report that no one was truly happy with it. In a classic review of the politics leading up to Medicaid's enactment, Robert and Rosemary Stevens concluded that the federal role in the program benefited many players: "Kerr-Mills was perhaps less a means of increasing aid to the elderly than it was a means for shifting the burden of that aid from others to the federal government. The many counties in the United States subsidizing medical relief could look upon Kerr-Mills as a golden egg of additional state support; hospitals and doctors could view it as a means of reducing their own private charitable contributions to medical care to the indigent by its

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[57] *Time*, "The Salami Slicer," April 5, 1968.

[58] See Edward D. Berkowitz, *Mr. Social Security: The Life of Wilbur J. Cohen* (University Press of Kansas, 1955), 270; Martha Derthick, *Policymaking for Social Security* (Washington, D.C.: The Brookings Institution, 1979), 26l; Sheri I. David, *With Dignity: The Search for Medicare and Medicaid* (Westport, Conn.: Greenwood Press, 1985), 38 - 40 (hereafter, David, *With Dignity*); Transcript, Wilbur J. Cohen Oral History Interview, December 8, 1968, by David G. McComb, Tape #1, Oral History Collection, LBJ PL; Transcript, Wilbur J. Cohen Oral History Interview, May 10, 1969, by David G. McComb, Tape #5, Oral History Collection, LBJ PL; Columbia University Oral History Series by Peter Corning, Tape #2, LBJ PL.

introduction of more realistic fees for welfare patients who were elderly; and the states had the pleasant prospect of expanded federal funding."[59] *The New York Times* reported a critic's observation that it would do more to relieve the county hospitals of their charity cases then to help the elderly.[60]

On the other hand, the *Wall Street Journal* quoted a government official, "Congress couldn't reconcile its conflicting viewpoints, so it passed the buck to the states."[61] From one perspective, the ability to transfer costs to the federal government appeared to benefit the states, but from another, responsibility was dumped onto the states. The back and forth of Medicaid federalism was taking its first steps.

Kerr Mills State Directed Implementation

For all the back and forth regarding who won and who lost from Kerr-Mills, all players were remarkably drab about its implementation. By the time Eisenhower left office, only five states had programs in operation.[62] The specifics about the program, however, strongly foreshadowed the eventual Medicaid program. Of particular importance, was the creation of the Medical Aged Assistance (MAA) category. The MAA classification established a concept of "medical indigence" that allowed for medical assistance eligibility if an elderly person's medical bills were sufficiently high in view of their income. The MAA provision was new, created by Cohen and Kerr for this legislation. In existence before the 1960 legislation, the OAA medical vendor payment program's federal share was increased by the Kerr-Mill's legislation.[63]

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[59] Robert Stevens and Rosemary Stevens, *Welfare Medicine in America: A Case Study of Medicaid* (New Brunswick: Transaction Publishers, 30). (Hereafter Stevens, *Welfare Medicine*)
[60] David, *With Dignity,* 43. David cites *New York Times*, September 8, 1960, 17.
[61] Newsarticle, Folder: "Printed Material;" Box Number 4, Personal Papers of Wilbur J. Cohen, LBJ PL. Originally cited as Richard Harris, "Annals of Legislation, Medicare III ~ We Do Not Compromise," *The New Yorker*, July 16, 1966, 36.
[62] David, *With Dignity,* 44.
[63] Kerr-Mills authorized Federal matching for an additional $12 per recipient of OAA for expenditures in the form of vendor payments for medical care. See Spiegel and Podair, *History*, 6.

The MAA matching rate was more generous to states than that of OAA, and states transferred many of their aged to the MAA category.[64] Even in this early version of the program, the joint federal-state structure translated into gaming, cost shifting, and fiscal substitution by states. In 1962, MAA was expanded to the over aged 21 blind and disabled persons whose medical bills were prohibitively high and whose incomes could not support these high medical payments.[65] The MAA program created the "medically needy" grouping. While the MAA was comprised of individuals not eligible for public assistance, it was run by state welfare agencies[66] and, at the federal administrative level, Kerr-Mills was administered by the Bureau of Public Assistance, the federal welfare agency. The signals from federal and state government was that this was a welfare program, through and through.

The federal requirements on the states were sparse, and during implementation states made the majority of the decisions. The first decision completely up to the states was whether or not to participate at all. By the end of 1962, 28 states had MAA programs.[67] One claim was that the wealthy states were shifting costs they were already paying onto the Federal Government. During Ways and Means Hearings Congressman

[64] Stevens, *Welfare Medicine*, 32 – 33. The authors report that "Massachusetts… began its Kerr-Mills program in October 1960 by transferring 14,000 persons – recipients needing and receiving long-term nursing home care – from other public assistance programs; these person represented 89 percent of the initial recipients under MAA. A study of MAA in Connecticut found that in its first month of operation (April 1962) 3,887 of the total 3,929 individuals on MAA were already receiving assistance through the OAA; and the transfers continued. Altogether, it was estimated that nearly 100,000 persons then on other welfare programs in the states were moved to the new program. There was nothing illegal about such transfers; indeed, from the state point of view, they were perfectly reasonable measures to protect their taxpayers against greater costs. But, at the same time, the transfers frustrated the alleged intention of the Kerr-Mills legislation to provide a major new source of services to the elderly and to serve an entirely new group of recipients. Indeed, one report in 1963 estimated that nationwide the combined percentage of old people who were covered for medical care under OAA and MAA had actually declined after the adoption of the new program, from 14 to 13 percent."

[65] Spiegel and Podair, *History*, 6. In 1962 the per-recipient vendor payment addition was increased to $15 per recipient for OAA, and the increase was extended to the blind and disabled for those states electing to use the combined program – Aid to the Aged, Blind, or Disabled, Title XVI of the Social Security Act.

[66] Newsarticle, "The 'Medicare' Controversy In The Current Congress, Pro & Con," *Congressional Digest*, March 1965, Folder: CQFact Sheet on Medicare, Box 381(23) Office Files of Frederick Panzer, OFWHA, LBJ PL.

[67] Stevens, *American Medicine,* 437.

Burke stated that seven states comprised 90% of federal funds.[68] Another source claimed that as few as three states – New York, California, and Michigan -- were receiving 90% of the federal funds.[69] While the exact data differ, the take-away point is that a majority of federal Kerr-Mills funds were generated by very few states' investment.

Poor states could not afford to participate, even with a generous federal match. While Georgia in 1961 and Mississippi in 1964 authorized programs, state money was never appropriated to operationalize the program. Even with a match of as much as 80%, this did not change the fact that states had to ante their own funds in order to receive any federal money at all. It was not a federal give away. Many states found it difficult to generate federal support because they had to first contribute themselves. In House Ways and Means Committee Hearings, Governor Edmund Brown from a wealthy state, California, commented that extending MAA into a comprehensive program "would bankrupt the State and county governments."[70] This evidence provided mixed evidence about the degree to which Kerr-Mills was "buck passing" by the feds or an opportunity for cost shifting by the states.

The states were far from happy with the arrangement. Prior to enactment, at a Governors conference, 30-11 had voted for the social insurance financing method over a

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[68] U.S. House of Representatives, Box No. Y6493, RG 287, Publication of the Federal Government (Congress: Committees of Congress) House. Hearings before the Committee on Ways and Means, Eighty-Eighth Congress, First and Second Sessions on H.R. 3920, November 19, 1963, Center for Legislative Archives, National Archives, Washington, D.C. (hereafter CLA/NA).

[69] Newsarticle, Folder: "Printed Material;" Box Number 4, Personal Papers of Wilbur J. Cohen, LBJ PL. Originally cited as Richard Harris, "Annals of Legislation, Medicare III ~ We Do Not Compromise," *The New Yorker*, July 16, 1966, 59. Still a third source, Stevens, *Welfare Medicine*, 33, claimed that five states – New York, California, Massachusetts, Minnesota, and Pennsylvania – with 31 percent of the country's aged, received 62% of federal MAA monies. The source for this figure is Testimony of Wilbur Cohen, Senate, U.S. Congress, Social Security, Hearings before the Senate Committee on Finance on H.R. 6675, 89th Congress, 1rst Session, 1965, 166 from the CLA/NA, Washington, D.C.. A fourth source from the House of Representatives, Box No. Y6493, RG 287, Publication of the Federal Government (Congress: Committees of Congress) House Hearings before the Committee on Ways and Means, Eighty-Eighth Congress, First and Second Sessions on H.R. 3920, November 19, 1963, CLA/NA. Testimony by HEW Secretary Celebrezze "For example, 73 percent of the funds expended in September 1963 under MAA went to just five States – five of the industrialized, financially better off States –which have within their borders only 33 percent of the Nation's aged population."

[70] House of Representatives, U.S. Congress, Committee on Ways and Means, Medical Care for the Aged, Hearings, 88th Congress, 1rst and 2nd Session, 1963 – 64, p. 31, CLA/NA. Also, Stevens, *Welfare Medicine*, 34.

grant-in-aid program.[71] Many states implemented programs very slowly, if at all. In the final analysis, Kerr-Mills differentially affected states primarily depending on a state's fiscal capacity. States did not necessarily consider themselves winners from the Kerr-Mills arrangement. Also, Republicans did not consider Kerr-Mills an achievement. Nixon thought it "most inadequate."[72]

THE KING-ANDERSON PROPOSAL, NOW DEFINED IN TERMS OF KERR-MILLS

In 1961, President Kennedy continued to pursue King-Anderson, a social insurance approach to addressing the health needs of the aged. In the meantime, in cash welfare developments, the Public Welfare Amendments of 1962 authorized waivers of federal requirements for public assistance experiment or demonstration projects. According to an overview by Cohen and Ball,

> Congress recognized the need for the development of new methods and for experimentation to better meet the complex and social and economic problems in the public assistance programs. Accordingly, it authorized the Secretary to waive any of the requirements from State plans in States that desire to carry on an experimental, pilot, or demonstration project likely to assist in promoting the objectives of the programs.[73]

A monumental development that received little fanfare, waivers of federal requirements in the future Medicaid program would later provide a major wrinkle to Medicaid federalism. With regard to policy bargaining, in the continuing King-Anderson debates on Capitol Hill, instead of the void that existed during the Truman and Eisenhower era national health debates, the void was filled with Kerr-Mills. Instead of

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[71] Sundquist, *Politics and Policy*, 305.

[72] Eugene Feingold, *Medicare: Policy and Politics* (San Francisco, CA: Chandler, 1966), 113. (Hereafter, Feingold, *Medicare*)

[73] Bulletin, Wilbur J. Cohen and Robert M. Ball, "Public Welfare Amendments of 1962," Oct. 1962, Folder Title: "Volume I, Part XVII, Social and Rehabilitation Service (1 of 2), Box No. 9, Administrative History Collection, LBJ PL. From section, "Waiver of State Plan Requirements for Demonstration Projects," 13. Reprinted from the Social Security Bulletin, October 1962, U.S. Department of Health, Education, and Welfare, Social Security Administration, 3 - 16.

King-Anderson being debated as a program absent any other, it was debated in comparison to Kerr-Mills. In November 1963 the questioning in a House Ways and Means Committee Hearing between HEW Under-Secretary Nestingen and Congressman Collier eventually turned to Kerr-Mills:

> **Mr. Collier:** I realize there is a basic limitation in the expenditure of tax funds, be it at the city, county, State, or Federal level, but here we are dealing with a problem that we regard as a priority problem. Therefore, if it is a priority problem and I am prepared to say that it is in many cases, then it would seem to me that the fund problem should be treated on the basis of the priority that it demands.
>
> **Nestingen:** I might say, Mr. Collier, inherent in the problem of helping to assure adequate coverage for health costs of the aged through the Kerr-Mills legislation is some thing you have touched on inferentially that merits comment…There is priority on this particular problem in varying degrees in varying parts of the country. In some States they say, "We don't need Kerr-Mills. We will handle it through the vendor payments of OAA." In other States they say they will take care of it by MAA on a more limited basis as compared to other States. In addition to that you have **the problem of biennial sessions of the legislature** and competing pressures for use of funds each time a legislature meets…You find a varying composition of the legislative bodies at succeeding sessions. As you find these varying circumstances arising through 50 different jurisdictions, you are finding 50 different answers being given and those answers varying from one legislative session to another as a good possibility…If we are to have an answer to this problem on a national basis, as we believe must be the case, the King-Anderson bill provides the best mechanism for an answer on a national basis.[74]

During Kennedy's New Frontier, the King-Anderson Bill was presented as "a program of prepayment for health costs with absolute freedom of choice guaranteed.

[74] U.S. House of Representatives, Box No. Y6493, RG 287, Publication of the Federal Government (Congress: Committees of Congress) House. Hearings before the Committee on Ways and Means, Eighty-Eighth Congress, First and Second Sessions on H.R. 3920, November 19, 1963, CLA/NA.

Every person will choose his own doctor and hospital."[75] The stage was set for beneficiary rights to be established from the beginning – at least for the social insurance component. Equality of opportunity would be institutionalized in the new program through the freedom to choose doctors and hospitals. This, at least, was the path that President Kennedy intended. With a policy agenda including domestic issues as vital as Civil Rights and on the international front as perilous as The Cuban Missile Crisis, President Kennedy was still engaged on health care. He had a history as a United States Senator working for national health reform. When Kennedy was assassinated in November 1963, there was a fundamental shift in American public policy. In terms of progressive policy, the second big bang in American social policy was about to take place. Creative Federalism, if begun under FDR, was finalized by LBJ.

CONCLUSION: FROM THE NEW DEAL FEDERAL-STATE NOMINAL HEALTH PAYMENTS TO KERR-MILLS

President Roosevelt and the New Deal established institutional frameworks for every facet of American life. While a national health reform was not enacted, the Social Security Act provided the institutional design for any future reform. Creative federalism, also an FDR concept, would be the driving force behind the design of many future programs, including Medicaid. Presidents Eisenhower and Truman also left their stamp on the progression of national health reform. Looking back at events that changed the landscape of social policy, FDR's Economic Bill of Rights resounded a courageous message -- health care is a right.

At this point, the importance of the United States Congress and Ways and Means Committee Chairman Wilbur Mill's power was paramount in shaping the Social Security Act through frequent SSA Amendments that altered American social policy regularly. Also, the work of so many dedicated government administrators like Wilbur Cohen who fashioned the framework for Kerr-Mills, the predecessor to the Medicaid program, was a

[75] Theodore R. Marmor, *The Politics of Medicare*, 2nd ed. (Hawthorne, New York: Aldine de Gruyter, 2000), 31.

policy shaping force of the era. Only now, no one could foresee a presidential assassination that would stop the world. The Great Society and the LBJ era, the topic of the next chapter, were at hand.

4. THE SECOND BIG BANG, 1965: THE LBJ RIGHTS ERA

INTRODUCTION

Medicaid, as part of the agreement that also established both Medicare's Hospital Insurance, Part A, and Supplemental Medical Insurance, Part B, in 1965, was hardly debated prior to enactment. What today is a larger program than Medicare, both in terms of number of people served and cost of the program,[1] Medicaid received consideration in a very small number of Congressional hearings prior to enactment. According to the *New York Times*, a total of five Congressional hearings were held on the program prior to enactment. A primary review by the author of the Legislative files of that era in the National Archives did not even turn up that much Congressional debate and discussion.[2]

On the national level, Presidential prioritization in late 1963 was given to the Civil Rights legislation and in the House Ways and Means Committee to the Tax Bill. The prioritization of Civil Rights was in part a response to Civil Rights protest and unrest

[1] The most recent estimates state that Medicaid serves 47 million recipients at a combined cost to federal and state governments of $350 billion. Medicare, on the other hand, serves 45 million beneficiaries at a cost of $300 billion. Recent estimates of the astronomical cost of the 2004 Medicare prescription drug benefit, nearly three times the original projection, may once again place Medicare as the second most costly American social policy program behind Social Security (OASDI). Until then, Medicaid holds that spot.

[2] According to *The New York Times*, "Ironically, the sweeping program was largely ignored by legislators, and the public as it was being developed. Four legislative hearings on it were held last year and one Senate hearing on it was held last March 23." Newsarticle, "Broadened Program of Medical Aid for Needy Flares as Major Political Issue Upstate," *New York Times,* 6/28/66, Folder: Medicare, Box 379, Panzer, OFWHA, LBJ PL. The author reviewed the files at the Center for Legislative Archives, National Archives.

in the spring and summer of 1963. Setting the stage, the Truman and Kennedy Administrations had taken key stands at critical points. Public opinion in parts of the country was turning sour as racial violence was increasingly televised. In terms of Medicaid politics, the Civil Rights struggle was hugely influential in several aspects. Several other co-evolutionary political, economic, and policy-related areas played a major role in the enactment of Medicaid and in the language that comprised the statute.

This chapter concentrates on the 1965 enactment of Medicaid and its intertwining fraternal twin, Medicare, along with the all-important Medicaid revisions in the 1967 Amendments. Medicaid was not the same program after 1967. Only two years after becoming Title XIX of the Social Security Act, it was re-drawn in profound ways. Also, after the 1967 SSA Amendments, an upsurge in hostilities in Vietnam further constrained funding for social policy initiatives. Medicaid, then, had a tumultuous beginning with its original and program design principles almost immediately questioned and re-designed. Possibly the most important reform in Medicaid until the DRA of 2005, the SSA Amendments in 1967 were driven by the expenses of just a couple of states in the first year of the program's implementation. As a final note introducing the LBJ chapter, this was an era where opportunity, entitlement, and civil rights were prioritized. This chapter sets up the crater of the Nixon era. While the next chapter considers just what happened in the 1970s, here we focus on Great Society liberalism -- and how Medicaid began. LBJ reigned over The Rights Era.

CIVIL RIGHTS, FEDERALISM, AND HEALTH REFORM

There is a link between the legacy of racism in the South and desire of state governments to control decision making in social programs. Opposition by southern interests made it very difficult to get a comprehensive health financing approach through Congress due to the power of Southern Congressmen, particularly as Committee Chairmen. There was a history linking health policy reform and racial politics. For example, during Truman's Presidency, those opposed to his defense of civil rights voted

in a block against him on national health insurance bills, known as the Wagner-Murray-Dingell bills.[3] Later, during the Kerr-Mills debate – a predecessor program of Medicaid and Medicare-- it was reported that two Southern Senators did not approve of bypassing the Senate Finance Committee because "it provided a precedent for bypassing the Judiciary Committee on Civil Rights legislation."[4] Finally, during the Kennedy Administration, in the summer and fall of 1963 a backlog of legislation was not acted on. Among the many reasons purported was that this was a bargaining strategy by Southern Democrats. They were backlogging legislation, even appropriations, so that Civil Rights proponents would have more pressure when choosing between a long-filibuster on Civil Rights and various important legislation.[5]

When the Civil Rights Act was passed in 1964, as expected there was a fundamental shift in how the Civil Rights issue affected the health reform debate. Prior to this time, opponents' strategies revolved around how to prevent – or at least stonewall – the actual legislative reform. Concurrently, the Warren Court was acting to enforce Civil Rights principles and also established a template for rights that many groups co-opted for themselves. Disability rights were in part established using this template.[6] Likewise, the Warren Court began to lean towards a newfound stance in Public Assistance law where property rights were linked with public assistance benefits.[7] After Medicaid was enacted, this extension of rights-based notions of public assistance extended to that program.[8]

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[3] Poen, *Harry S. Truman*, 225.

[4] This concern was attributed to Richard Russell of Georgia and Lister Hall of Alabama. See Feingold, *Medicare*, 124.

[5] Feingold, *Medicare* 128.

[6] Consequently, in 1990 the Americans With Disabilities Act (ADA) was modeled on the Civil Rights Act of 1964.

[7] See Charles A. Reich, "The New Property," *The Yale Law Journal* 73, no. 5 (April 1964): 733 - 787; and Charles A. Reich, "Individual Rights and Social Welfare: The Emerging Legal Issues," *The Yale Law Journal* 74, no. 7 (June 1965): 1245 - 1257; Frank I. Michelman, "The Supreme Court 1968 Term, Foreword: On Protecting the Poor Through the Fourteenth Amendment," *Harvard Law Review* 83 (1969): 7 - 59; and Frank I. Michelman, "In Pursuit of Constitutional Welfare Rights: One View of Rawls' Theory of Justice," *University of Pennsylvania Law Review* 121 (1972 - 1973): 962 - 1019.

[8] Timothy Stolzfus Jost, "The Tenuous Nature of the Medicaid Entitlement; Federal Rights Remain Under Threat and Must Be Strengthened," *Health Affairs* 22, no. 1 (January - February 2003); and T. Jost, *Disentitlement?: The Threats Facing Our Public Health Programs and a Rights-Based Response* (New York: Oxford University Press, 2003). (Hereafter, Jost, *Disentitlement*)

The fear of federal power was proven warranted after Medicaid and Medicare's enactment in 1965. The federal government insisted on desegregation of hospitals where federal funding was being spent. In fact, federal officials did follow-through on its desegregation rules. These rules proved important for desegregating Southern hospitals, as well as hospitals in some Northern cities and metropolitan areas that had adopted separatist policies. Medicaid is particularly responsible for providing health coverage to many people who did not previously have access to the health care system, but this legislation is also responsible for desegregation in health facilities nationwide.[9]

As Wilbur Cohen reminisced ten years after enactment: "…there is one point that doesn't come out very much. The Medicare and Medicaid programs, on July 1, 1966, resulted in tearing down all the signs 'White' and 'Colored' throughout the South. In one day, twenty-four hours, in the nursing homes and in the hospitals, the offices of private physicians, in the cafeterias, at the drinking fountains, 'White' and 'Colored' signs were taken down. Now I am not saying that that was the beginning of the end of all discrimination, but few people realize that that was done without any visible or notable ideological opposition in the South. It came instantaneously and was accepted. And while Senators would argue with me when I was Secretary about education, not a single Southern Senator that I know of ever raised a question with me about the implementation of desegregation in connection with Medicare or Medicaid. And I think that notable and important contribution is extremely important and is an overlooked accomplishment of the Great Society."[10]

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[9] Wilbur Cohen, "From Medicare to National Health Insurance," Chapter 8 in David C. Warner (ed.), *Toward New Human Rights: The Social Policies of the Kennedy and Johnson Administrations* (Austin, Texas: The LBJ School of Public Affairs, 1977), 150.

[10] Wilbur J. Cohen Statements in "Part V: Education and Health." In Jordan, Barbara and Rostow, Elspeth (eds.), *The Great Society: A Twenty Year Critique* (Austin, Texas: The Lyndon Baines Johnson School of Public Affairs and The Lyndon Baines Johnson Library 1986), 104 –5.

LEGISLATIVE BARGAINING ACUMEN WITHIN THE WHITE HOUSE AND EXECUTIVE RANKS

Other than setting the Presidential Agenda, LBJ contributed to the eventual passage of the Medicaid and Medicare package by his remarkable legislative bargaining acumen. Having presided so mightily over the Senate and from years of Congressional Service, he was indeed a pre-eminent legislative bargainer. LBJ needed no time from when he took office to establish ties, form relationships and bonds, build up his knowledge on Congressional procedures and processes, and learn the ways things work on the other side of Pennsylvania Avenue. In fact, he had re-written many of those rules himself. In one example, he suggests that Medicare proponents take an extreme position in order to end up in the middle with a compromise they can live with. Prior to the 1964 election, in a conversation with Larry O'Brien, his legislative affairs lead, he references the Ribicoff proposal, which would have allowed for a choice by beneficiaries of either cash or health care:

> LBJ: My feeling is without having touched any of the bases very strongly…
> … they ought to have Anderson really go to bat, slug it out, all the way with all the chips in…stack …move in on King-Anderson… go to conference and then be willing to be reasonable…and I would say if we can put that on in this bill…I'd be prepared to have nothing rather than not have Medicare….but ah…If we can put it on in the Senate with King-Anderson and then I'd go to conference. I'd let Wilbur scare the living hell out of the doctors and everybody else….and then he could come up with a compromise and say, "well you can make your choice between getting this extra money and having health insurance," and I think you can establish the first health insurance that way if you can get it over.
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> O'Brien: Now I feel… I haven't walked in yet… but I feel that if I get a strong view that will be…. Clint Anderson and the leadership that we could move with the Ribicoff proposal and go into conference with that.

LBJ: Well if you move that and you get a take out you'll have nothing to trade off. If you move in with King-Anderson you can trade for Ribicoff.

O'Brien: Well, that's the pitch I'll make… [portion of tape not able to decipher]

LBJ: I'll tell you this…Wilbur Mills will take your pants off unless you have something to trade for…and you haven't have the guts on that side to do it. Anderson won't be on the conference. You'll have a man against it; it will be Bird; it will be Smathers; it will be Russell Long. But, if they could go in there with King-Anderson to support and then come back with Ribicoff, that's what I would try to do. But you be your own judge…

O'Brien: I'll play it that way and see…

LBJ understood other politician's electoral political realities. When a politician takes a policy position, they have to be careful if, when, and how they switch to another one. Wilbur Mills, for example, openly discussed with the President the fact that since, early on in the negotiations, he and others had taken a stance against King-Anderson, they would not be able to vote for King-Anderson unless it was re-designed as an alternative.[11] In several conversations, Congressmen discussed similar concerns with the President as if he were one of their own – an inside member – as opposed to resenting the imposition from the Executive Branch on such matters. In addition, many of the President's staff had 30 years of experience in bargaining Social Security reform. At times, they were helping write legislation, as Congressional insiders and at other times they played the traditional Agency Administrator or Presidential Advisor role. They too were on the inside, often asked to help draft legislation or offer alternatives to members of Congress, as opposed to being thought of as outsiders.

[11] Telephone Conversation between Lyndon B. Johnson and Wilbur Mills, June 11, 1964, Tape WH6406.06, Program No. 2, Citation No. 3686, Tapes and Transcripts of Telephone Conversations and Meetings, LBJ PL.

Health Financing and Election Cycle Politics

Prior to the election in 1964, the Senate passed Medicare – the first time in either House of Congress. Even with this success though, there was Democratic insecurity about the ability to see a provision through the full Congress. The health care provision was included in a broader Social Security package. There was concern by the Democrats that passing Social Security provisions including an increase in the Social Security payroll tax would, "give them [Republicans] what they want which is something to bar health care."[12] The fear was that without a health reform attached, "if the [Social Security] increase becomes operative Medical Care is lost for all time."[13] Since at that time, Medicare was to be financed by the Social Security payroll tax, it was feared that an increase in that tax without Medicare would inch it closer to an invisible ceiling on that tax of 10%.[14] This had long been considered the practical upper bound of the payroll tax. Also, the inability to pass Medicare was increasingly viewed by Democrats as an election issue that would help them with the Presidential and Congressional races. As it had been used so many times in Presidential elections in the past, the failure of national health reform once again was suggested as a way to beat the opposition. As Senator George Smathers advised the President:

> Goldwater is against this Social Security thing… you're for it… now, if it's held up, it's blocked, and defeated in the Senate by Williams at the last minute in an effort to get out by John Williams and Dirkson and a couple of fellas…why you're off the hook… and I'll tell you this, it's a lot better issue….I campaigned on this in'62 and when they find out what they're not going to get… under this Social Security and they're not going to get free teeth and they're not going to get free…They're not

[12] Telephone Conversation between Lyndon B. Johnson and Senator Clinton Anderson, September 24, 1964, Tape: WH6409.15, Program No. 12, Citation No. 5688, Tapes and Transcripts of Telephone Conversations and Meetings, LBJ PL.
[13]Memo, Mike Manatos to Larry O'Brien, August 14, 1964, Folder: LE/IS1 2/21/64 - 9/10/64, Box 75, WHCF LE, LBJ PL. Stapled to a Memo from Larry O' Brien to the President, August 14, 1964.
[14] See Sundquist, *Politics and Policy*, 317.

going to get free hospitals and they're not going to get free hospitalization… and they're not going to get $90 to start with every time, and boy, when you tell them that… they think that somebody has taken them to the cleaners…..and I really think it's a helluva lot better issue… Labor has had to repeal the Taft-Hartley bill as an issue for years, and it's a helluva better issue [if not passed, for election gains]… than it is a fact on the books… and I think we oughta keep it that way because I don't think that you're going to come out with it anyway this time. What I'm trying to suggest to Mansfield just discretely is that why don't you blame the Republicans that you don't pass a Social Security Bill.[15]

Also as a Presidential Aide Bill Moyers memo relayed with regard to Goldwater's vote against the health care plan, "I don't think you should be kicking Goldwater, but this is a great opportunity for us to beat him to death among these older people if we just play it right."[16] Senator Albert Gore, Sr. also relayed his beliefs that the election results would provide a mandate from the people on the health care bill.[17] The results of the election were resounding. The 89th Congress would be the most heavily Democratic Congress since Franklin Roosevelt's 1936 sweep.[18]

The 1964 election success for the Democrats proved instrumental in ushering in The Great Society. Wilbur Cohen would later recount when asked the reason LBJ was able to get through so many proposals that President Kennedy could not, "I think it was primarily because Barry Goldwater ran against Johnson. In other words, it was the election."[19] Barry Goldwater's legislative history included being one of only two Senators to vote against the passage of Kerr-Mills. *The New York Times* in 1966 agreed,

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[15] Telephone Conversation between Lyndon B. Johnson and Senator George Smathers, August 1, 1964, Tape WH6408.01, Program No. 4, Citation No. 4604, Tapes and Transcripts of Telephone Conversations and Meetings, LBJ PL.
[16] Memo, Bill Moyers to the President, September 2, 1964, Folder LE/IS1 2/21/64 – 9/10/64, WHCF, Box 75, LBJ PL.
[17] Telephone Conversation between Lyndon B. Johnson and Albert Gore, Sr., October 2, 1964, Tape WH6410.01, Program No. 4; Citation No. 5804, Tapes and Transcripts of Telephone Conversations and Meetings, LBJ PL.
[18] Feingold, *Medicare*, 137.
[19] Transcript, Wilbur J. Cohen Oral History Interview, March 2, 1969, by David G. McComb, Tape #3, Oral History Collection, LBJ PL, 26.

"The Presidential election of 1964, giving the voters a clear ideological choice, produced the greatest popular landslide of this century, which weakened the conservatives, strengthened the liberals, broke the power of the conservative Republican-Southern Democrat coalition in the House of Representatives, and created a majority for social and economic measures that had been blocked for a generation. In short, quite an 'echo.'"[20]

TOBACCO VOTE TRADING

Early in 1964, the politics of another health issue intersected with health reform bargaining. Just as other issues, such as war, macroeconomic policy, and civil rights intersected with this policy debate and affected agenda setting, the politics of big tobacco involved the same national legislators and many of the same lobbyists and state officials. As reported by *The New Yorker*, the Surgeon General released a report in January 1964 that attributed various forms of cancer to cigarette smoking. The next month, a 10 million dollar contribution was made by the six leading cigarette manufacturers to the AMA to establish a tobacco-research institute to study the health consequences of smoking. After this arrangement, there were charges that "The A.M.A. has made a deal with the tobacco industry…to get tobacco- state congressmen to vote against Medicare." The AMA opposed a Federal Trade Commission order that cigarette packages and cigarette advertisements carry a warning about the hazards of smoking. According to the AMA, "More than 90 million persons in the United States use tobacco in some form…Long-standing social customs and practices are established in the use of tobacco; the economic lives of tobacco growers, processors, merchants are entwined in the industry; and local, state, and the federal governments are the recipients of and dependent upon many millions of dollars of tax revenue." The claim was that tobacco state

[20]Newsarticle, by James Reston, "Washington: The Goldwater Congress," *New York Times*, October 19, 1966, Folder: LE/IS1 3/1/65 – 5/31/65, Box No. 75, WHCF LE, LBJ PL. The article goes on to say, "This change was not produced by a massive switch in the Democratic majority. The Democrats made a net gain of only 38 seats in the House. The decisive difference was that so many of the Republican conservatives, closely identified with Goldwater's philosophy, were replaced by Democratic liberals who then furnished the margin to put over the social legislation that had been blocked for a quarter of a century."

legislators were being courted for an alliance against the social insurance --or federal government focused-- health reform plan.

In the past opponents to federal involvement in health financing often used the "socialized medicine" claim and later in the debate shifted their strategy to claims that the proposed federal social insurance system was not comprehensive enough. In fact, since Eisenhower --albeit in a charity model -- the joint federal-state plans, while more limited in terms of the scope of people eligible, did provide a more comprehensive scope of benefits. At some point in the debate though, the argument appeared that states and local governments had historically been responsible for taking care of people who could not afford health care. It should continue this way because this was how things had been done in the past.

Oddly, in the 1990s it would be state Medicaid programs which would be reimbursed for tobacco's effects and it would be Medicaid that was supported in the upcoming 1965 debate by the AMA. From any direction one looks at the issue, there is at least the cause for suspicion that votes were traded. One has to wonder, though, if tobacco state Congressmen would have voted against federally sponsored health financing plans regardless. In the summer of 1964, Representative Watts from a district in western Kentucky, took back a proxy he had originally intended to be used in support of a Medicare plan. With that proxy, Chairman Mills on the Ways and Means Committee could have passed a House version of Medicare in 1964. *The New York Post* reported that "The alliance between the tobacco industry and the American Medical Association caused the defeat of the Medicare program in the House Ways and Means Committee."

MANAGED CARE

As part of the debate, the Kaiser Foundation Health Plan, Inc. appeared before the Ways and Means Committee in February 1965 in order to advocate for a place for a managed care model plan in the new legislation. They argued that this "could assist in holding down hospital utilization, and hence costs…. And to avoid adversely affecting

plans of our type and their members."[21] According to a subsequent letter, "As we understand it from the Chairman the major problem is the Department's continuing insistence that it does not know how the proposal can be administered. It seems to us that this is a solvable problem, and we plan to pursue it further with HEW."[22] While Kaiser did not broker a clear role for managed care at that time, the future would prove much different.

When the details of provider payment were being negotiated after enactment, HEW bargainers defended choice of minimizing the role of managed care by arguing that it interfered with the rights of other interests involved. As Judy Feder writes with regard to Medicare politics at the time, "In contrast to the hospitals, whose satisfaction Medicare officials found essential, GPPPs [Group Practice Prepayment Plans] were a small number of providers whose cooperation with the program was relatively inconsequential. Medicare did not need them; they needed Medicare. To administrators developing a reimbursement system for all sorts of medical care institutions, GPPPs appeared one more interest group seeking all they could get. Unlike the nation's hospitals, the GPPPs lacked the support of the medical establishment…Their demands would interfere with the 'rights' of that establishment."[23]

The Group Health Association of America in 1968 reported that 20 states had "serious restrictions in their laws with reference to group practice," particularly prepaid group practice. In 1968, the ACIR recommended that "In order to broaden the health service options available to Title 19 beneficiaries and possibly to reduce the cost of this program, the States should strike the Constitutional and Legislative shackles that impede

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[21] Letter, From Edgar F. Kaiser, Kaiser Foundation Health Plan, Inc. to The Honorable Wilbur D. Mills, March 5, 1965, Folder: LE/IS1 3/1/65 – 5/31/65 (2 of 2), Box 75, WHCF LE, LBJ PL.

[22] Letter, From Lloyd N. Cutler (Wilmer, Cutler & Pickering) to Douglass Cater, March 6, 1965, Folder: LE/IS1 3/1/65 – 5/31/65 (2 of 2), Box 75, WHCF LE, LBJ PL.

[23] According to the HIBAC Minutes…"We do not believe that it is possible under the law to adopt administrative procedures or that it would be desirable to amend the law to allow the adoption of administrative procedures, that would dilute these rights of beneficiaries, physicians, and providers." In Judith M. Feder, *Medicare: The Politics of Federal Hospital Insurance* (Lexington, Massachusetts: Lexington Books, 1977), 86 – 87. (Hereafter, Feder, *Medicare: The Politics*)

the organization and expansion of group practice."[24] States had established their own blocks to managed care infiltration. Since HEW did not explicitly embrace managed care at the time of enactment, ACIR was suggesting it as a possible panacea to the cost problem.

MEDICAID ENACTMENT – THE SLEEPER PROGRAM

The eventual proposal to combine three separate legislative proposals into one in March 1965 is described by some sources as a show-stopping moment – a flash of brilliance. Wilbur Cohen is reported to have said "Like everyone else in the room, I was stunned by Mill's strategy. It was the most brilliant legislative move I'd seen in thirty years."[25] The plan combined the Democrat's King Anderson bill, the AMA's Eldercare proposal – which was basically a revision of Kerr-Mills, and the Republican Byrnes Bill. These three proposals were the eventual Medicare Part A, Medicaid, and Medicare Part B. In a memo for the President, Wilbur Cohen described the three measures as:

> 1. The basic provisions of the Administration's King-Anderson bill to be financed through social security,
> 2. A supplemental and expanded Kerr-Mills program along the lines of the Administration's Child Health and Medical Assistance Act, and
> 3. A voluntary supplementary system of health benefits which would be subsidized in part from general revenues and in part from voluntary deductions from the individual's social security benefits.[26]

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[24] Advisory Commission on Intergovernmental Relations (ACIR), "Intergovernmental Problems in Medicaid," Commission Report A-33, (Washington, D.C.:ACIR, September 1968), 72.

[25] Newsarticle, Folder: "Printed Material;" Box Number 4, Personal Papers of Wilbur J. Cohen, LBJ PL. Originally cited as Richard Harris, "Annals of Legislation, Medicare IV~A Sacred Trust," *The New Yorker*, July 23, 1966, 40.

[26] Memo, From Wilbur J. Cohen, Assistant Secretary of HEW to the President, March 2, 1965, Subject: "Hospital Insurance for the Aged Through Social Security: Developments Today at the Executive Session of the House Ways and Means Committee," Folder: LE/IS1 3/1/65 – 5/31/65, Box 75, WHCF LE, LBJ PL.

In the memo Cohen continued, "The effect of this ingenious plan is, as Mr. Mills told me, to make it almost certain that nobody will vote against the bill when it comes on the floor of the House." In another source, Cohen explained, "The doctors couldn't complain, because they had been carping about Medicare's shortcomings and about its being compulsory. And the Republicans couldn't complain, because it was their own idea. In effect, Mills had taken the A.M.A.'s ammunition, put it in the Republican's gun, and blown both of them off the map."[27]

For all the reported adulation regarding the plan, it was not the first time that proposals were made to combine at least two of the proposals into one legislative bill. Possibly, part of the success of the combination of the three legislative proposals into one was the timing. Also, a weakness of all measures up to that point was that they all seemed in some major way insufficient. From the Senate side, around the same time Wilbur Mills was presenting his three-pronged approach, Senator Abe Ribicoff was penning a letter to the President about his concerns on the Administration's proposal. He wrote, "Medicare in its present form is going to disillusion millions of the nation's elderly. Too many believe all of their medical bills will be paid, not just the hospital and related charges actually covered up to prescribed limits. Details are not easily explained to the public. When elderly people find that they still have to pay for doctors, drugs, and long-term convalescent care, they are going to be disappointed at what was not done, rather than pleased with what was done." He continued, "The full effect of this disillusionment will be felt in the two years preceding the 1968 election." And later, "As a general approach, I suggest that some package of benefits be added on top of the King-Anderson package. The supplemental package could provide doctors' services, drugs and extensive hospital care. It could be offered on a voluntary basis to those who want it. It could be financed partly by the beneficiary, partly be general revenues, and partly by the states."[28]

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[27] Newsarticle, Folder: "Printed Material;" Box Number 4, Personal Papers of Wilbur J. Cohen, LBJ PL. Originally cited as Richard Harris, "Annals of Legislation, Medicare IV~A Sacred Trust," *The New Yorker*, July 23, 1966, 40.
[28] Letter, From Abe Ribicoff (United States Senate Committee on Finance) to the President, March 3, 1965, Folder: LE/IS1 3/1/65 – 5/31/65, Box 75, WHCF LE, LBJ PL.

Cohen made clear that "The great limitation of the Kerr-Mills approach is the inability of the States to put up their share of the funds. This point is completely concurred in by the Republican leaders who have endorsed the Byrnes bill which does not involve State financial participation."[29]

The change in the composition of the Committee, which was more heavily Democrat and so more sympathetic to King-Anderson may have played a role in the difference in perception to a proposal for multi-layering of existing bills. Also, it is not clear why it would be assumed that a proposal to combine three different plans was void of the possibility of criticism or retreat on the part of all parties. In fact, Republicans and Democrats supported the proposal, but a major interest in the debate, the AMA, opposed the three-pronged approach.[30] In any event, the passage of Medicaid was very much seen as an extension of the Kerr-Mills program and was far overshadowed by the debates regarding the other two prongs in the three-pronged plan.

The brilliance of the maneuver was attributed to its bridging of two polar strategies of dealing with the same program – providing health coverage to the elderly. As Kermit Gordon, Director of the Bureau of the Budget,[31] would later conclude: "It was, as you remember, a kind of series of compromises, mainly in the House and Means Committee, and a last minute shotgun marriage of a Democratic plan and a Republican plan."[32] Instead of forcing a choice between the values incorporated in both plans, Chairman Mills agreed to utilize them both, thus bringing both sides of this policy debate into the "winners" group. He sought a win/win solution. Medicaid was added on as the bottom layer – support for those near indigence -- of what some at the time referred to as

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[29] Memo, From Wilbur J. Cohen, Assistant Secretary of HEW to the Honorable Jack Valenti, "Subject: Letter from Senator Ribicoff, March 4, 1965, Folder: LE/IS1 3/1/65 – 5/31/65, Box 75, WHCF LE, LBJ PL.

[30] As Wilbur Cohen wrote Douglass Cater on March 10, 1965, "Obviously, the AMA is shocked and opposed to the tentative action of Chairman Mills with the overwhelming support of both Republicans and Democrats on the Ways and Means Committee to approve the President's social security financed proposal plus a voluntary insurance plan for covering physicians services." Memo, From Wilbur J. Cohen, Assistant Secretary of HEW for Honorable Douglass Cater, "Subject: Health Insurance and Social Security Bill," March 10, 1965, Folder: LE/IS1 3/1/65 – 5/31/65, Box 75, WHCF LE, LBJ PL.

[31] Today the then Bureau of the Budget is named the Office of Management and Budget (OMB).

[32] Transcript, Kermit Gordon Oral History Interview, April 8, 1969 by David McComb, Tape #1 of 1, Oral History Collection, LBJ PL.

the "three-layer cake." Interestingly, it is the one measure that was accepted and supported by the AMA. A massive public relations and advertising campaign was waged against the other provisions and in favor of the Kerr-Mills-esque provision. Called Eldercare, it emphasized state administrative predominance and so left much of the important decision making at the level that state medical societies had their greatest influence.

As the *Congressional Quarterly* reported in 1965,

> In its last-ditch stand against Medicare legislation the AMA switched its major argument against the program, in previous years anti-Medicare advertising had stressed that the plan would 'lead the country down the road to socialized medicine.' In 1965 the AMA apparently decided that its most effective argument against the bill was not that it would go too far, but that it would accomplish too little…..Building on the idea of more comprehensive coverage, the AMA in January mobilized an intensive campaign of newspaper and television advertising attacking the Administration bill and proposing a new, alternative 'eldercare' plan.
>
> The eldercare plan was introduced Jan. 27 in the House (HR 3727, 3728) by Ways and Means Committee members Thomas B. Curtis (R Mo.) and Sydney Herlong Jr. (D Fla.) and Jan. 28 in the Senate (S 820) by John G. Tower (R Texas). It called for a voluntary medical insurance program which would be available to persons over 65 only if their state government signed up for the program. The coverage would vary, since it would depend upon the private insurance policy contracted for by each state, but it would include hospital, doctor and drug costs.[33]

After the enactment of the final package an AMA representative was reported to have said, "I never thought we'd end up spending several million dollars in advertising to expand the bill."[34] In the strategy to argue for a more comprehensive bill, the AMA had hoped to bolster the argument that their federal-state initiative provided a more comprehensive package. In supporting the language of expansion and comprehensiveness, however, the AMA inadvertently proved their case all too well. Instead of moving the debate in favor of Eldercare, they bolstered the case for enacting both the Administration's Bill and the Republican's Byrnes Bill. As Wilbur Cohen wrote

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[33] 1965 *Congressional Quarterly Almanac*, 248 – 249. (Hereafter *CQ Almanac*)

[34] Newsarticle, Folder: "Printed Material;" Box Number 4, Personal Papers of Wilbur J. Cohen, LBJ PL. Originally cited as Richard Harris, "Annals of Legislation, Medicare IV~A Sacred Trust," *The New Yorker*, July 23, 1966, 40.

to Douglass Cater at the time, "As Chairman Mills has said to me the Committee action is in large part due to the attack the AMA has made on the limitations of the Administration proposal."[35] By many accounts, the AMA's principled hard-edged stand and faulty tactics hastened and broadened the legislation.[36] The fence that was put around the program would be self-imposed by Chairman Mills.

The only part of the three-pronged approach that may have still been questioned was the expansion of Kerr-Mills – the AMA plan. One argument for the enactment of Medicaid as a third piece to this legislative tour-de-force was that Chairman Mills wanted to "build a fence" around the social insurance aspects of the plan. By creating Medicaid which included provisions to provide some care to populations in all age groups, Mills hoped to keep social insurance fenced in for the 65 and over population only. If an indigent health care plan existed for those of all age groups, it would be more difficult to claim that there was a stark need for expanding social insurance to additional age groups.[37]

Prioritization of the Issue on the Presidential Agenda

It was rumored that House Ways and Means Chairman Mills was considering bypassing passage of health reform in favor of a Kerr-Mills expansion in late Spring 1964.[38] Some Presidential staff wondered out loud if Chairman Mills was in cohorts with the American Medical Association (AMA) and that an expansion of Kerr-Mills would

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[35] Memo, Wilbur J. Cohen to Honorable Douglass Cater, March 10, 1965, Folder: LE/IS1 3/1/65 – 5/31/65, WHCF LE, Box 75, LBJ PL.

[36] For example: "'After nearly two decades of struggle and controversy, million-dollar advertising drives, rallies, and political-action campaigns, the A.M.A.'s crusade failed,'" the *Medical World News* observed in June. "'And in the opinion of many knowledgeable people in Washington, the A.M.A.'s own strategy of uncompromising resistance contributed to the dimensions of the defeat.'" This was reported in LBJ Presidential Library, Personal Papers of Wilbur J. Cohen, Box Number 4, Folder: Printed Material; Harris, Richard. Annals of Legislation, Harris, "Medicare IV~A Sacred Trust," *The New Yorker*, July 23, 1966, 56.

[37] This argument was made in the classic text documenting the enactment of Medicare by Marmor, *The Politics of Medicare*, 2nd ed.

[38] Telephone Conversation between Lyndon B. Johnson and Larry O' Brien, May 18, 1964, Tape WH6405.08, Program No. 1, Citation No. 3472, Tapes and Transcripts of Telephone Conversations and Meetings, LBJ PL.

make him a hero to that interest group at the expense of an Administration backed proposal.[39] The States though demanded reform. Reportedly, "The states could not bear the monetary burden that Kerr-Mills required." They pressured their Congressman to find an alternative.[40]

After the Tax bill business was complete in the House Ways and Means Committee, health reform stepped into the place of first priority for that committee. In two conversations with Chairman Mills, President Johnson reiterated the importance of health reform several times:

--"but I'll tell you this… the most important.. the single most popular thing is the bill you're working on…no question in may mind about it…"[41]

-- "but I'd just say this that there is not anything that has happened in my six months or that will happen in my whole term in my judgment that will mean more to us as a party or me or you as individuals than this piece of legislation…"[42]

-- "If you do that will do more for us this year than any other single thing that we'll do…Except your tax bill… and that's already behind us… But ahhh…It will be the most positive, affirmative, future thing that we'll have…"[43]

-- "I'd rank it Number One."[44]

-- "my judgment is that is by far the most popular thing that we have ever touched… and will do us more good than all the other put together…and I'd put Taxes and

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[39] Telephone Conversation between Lyndon B. Johnson and Larry O' Brien, June 22, 1964, Tape WH6406.12, Program No. 7, Citation No. 3804, Tapes and Transcripts of Telephone Conversations and Meetings, LBJ PL.
[40] David, *With Dignity*, 47.
[41] Telephone Conversation between Lyndon B. Johnson and Wilbur Mills, June 9, 1964, Tape WH6406.03, Program No. 12, Citation No. 3642, Tapes and Transcripts of Telephone Conversations and Meetings, LBJ PL.
[42] Telephone Conversation between Lyndon B. Johnson and Wilbur Mills, June 9, 1964, Tape WH6406.03, Program No. 12, Citation No. 3642, Tapes and Transcripts of Telephone Conversations and Meetings, LBJ PL.
[43] Telephone Conversation between Lyndon B. Johnson and Wilbur Mills, June 11, 1964, Tape WH6406.06, Program No. 2, Citation No. 3686, Tapes and Transcripts of Telephone Conversations and Meetings, LBJ PL.
[44] Telephone Conversation between Lyndon B. Johnson and Wilbur Mills, June 11, 1964, Tape: WH6406.06, Program No. 2, Citation No. 3686, Tapes and Transcripts of Telephone Conversations and Meetings, LBJ PL.

Civil Rights and Poverty and Education bills…all of which we will have passed… I don't think there… this one is comparison…"[45]

--"and if you get.. you get this moderate thing that you're talking about…we'll go to town and we'll improve as the years go on…but it'll be the biggest day you ever had and you ever did for your country…I can tell you that… and all these other things are important but that's the important one."[46]

Procedurally, there were questions about how Title VI of the Civil Rights Act would apply.[47] The federal reach of Title VI was threatening to those who opposed this reform, and some states fought for greater autonomy in order to continue as they had in the pre-1964 past. This stance during the Civil Rights era linked "states rights" in many people's minds to morally corrupt, prejudicial, and small thinking. In terms of the health reform debate, open consideration of the effects of the Act on any future health reform's reach were reportedly intentionally suppressed by the Administration.[48] If the Civil Rights opposition did not question how a federal health program would incorporate Title VI of the Civil Rights Act, then the Administration was not going to bring it to their attention.

MEDICAID'S BASIC PROVISIONS AT ENACTMENT

Federalism in the Medicaid program was a key feature from the start. Even though the program was jointly administered, states were responsible for part of the

[45] Telephone Conversation between Lyndon B. Johnson and Wilbur Mills, June 11, 1964, Tape: WH6406.06, Program No. 2, Citation No. 3686, Tapes and Transcripts of Telephone Conversations and Meetings, LBJ PL.
[46] Telephone Conversation between Lyndon B. Johnson and Wilbur Mills, June 11, 1964, Tape WH6406.06, Program No. 3, Citation No. 3687, Tapes and Transcripts of Telephone Conversations and Meetings, LBJ PL. Telephone Conversation continues the conversation from Program No. 2 from the same tape number.
[47] Title VI of the Civil Rights Act of 1964 provides that "No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance." Report, U.S. Department of Health, Education, and Welfare, Social Security Administration, "Putting Medicare Into Effect," June 1966, Folder: IS1 3/24/66 - 6/16/66, Box 1, WHCF INSURANCE EX IS, LBJ PL.
[48] David, *With Dignity*, 198.

financing and for carrying out the day-to-day on-the-ground administrative duties. Deciding the framework of the program was first a federal responsibility, in that the statute dictated certain requirements. Filling in the stipulations within the broad framework was the purview of the states.

The Federal Government Sets Framework for Links Between States and Localities

With regard to financing, local governments could be involved by states but only in the manner that the federal government said they could be. The final provisions decided that local governments, under certain conditions, could share with the state government in providing the non-federal matching funds.[49] Originally, the states were required to pay at least 40% of the non-federal share.

The plan was that within 5 years, the state government would be required to pay the full non-federal share, except in the case of a federally acceptable tax equalization plan. The Advisory Commission on Intergovernmental Relations (ACIR) performed an extensive review of Medicaid's enactment. In surveying state officials opinions they found that at least one state Governor expressed his view that this provision infringed on states' rights. Several state legislative leaders expressed this same sentiment in a number of different ways:

- "This is unwarranted meddling by the Federal Government in a matter which is and should continue to be a purely state and local matter."
- "Transferring non-federal share entirely to state will not guarantee funds being available."
- "The Federal Government dangles too many carrots. We in [ ] cannot match all these Federal matching fund projects."

[49] 1965 *CQ Almanac*, 267.

- "Counties will exercise higher degree of surveillance if they share financially."[50]

On the administrative side, certain state arrangements were restricted by the federal government. For example, any state agency could be designated to administer the new program as long as the eligibility requirements were established by the agency administering the old-age assistance program.[51] As long as eligibility was determined by welfare departments and the program relied on means testing, it was considered a welfare program.

The relationship between the states and local governments changed in many respects during the transition from Kerr-Mills to Medicaid. As Robert and Rosemary Stevens write, "Once again, therefore, these provisions encouraged the notion of state rather than local responsibility. Responsibility for welfare medicine was moving upward, from the county to the state."[52] For example, in Ohio, before Medicaid was enacted, programs for all but the aged were county run and varied considerably between counties in scope. Afterwards, Ohio extended the full scope of services to all public assistance categories.[53] So, the enactment of Medicaid represented centralization – only it was centralization to the state, instead of the federal, level.

Medicaid had many inequalities including large variabilities in eligibility and benefits between states (geographical inequality), the income notch effect (inequality between taxpayer and recipient), and categorical requirements (competition between groups of needy for Medicaid coverage). But it also removed at least one type of inequality. By consolidating five separate types of medical vendor payment programs, Medicaid provided uniformity in matching funds from the federal government between these five initiatives. Also, even though overall costs skyrocketed, it should not be

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[50] Advisory Commission on Intergovernmental Relations (ACIR), "Intergovernmental Problems in Medicaid," Commission Report A-33, (Washington, D.C.: ACIR, September 1968), 39 - 40. (Hereafter ACIR, *Medicaid*)
[51] 1965 *CQ Almanac*, 267.
[52] Stevens, *Welfare Medicine*, 60.
[53] Report, Tax Foundation, Inc., "Medicaid: State Programs After Two Years," June 1968, Folder: Medicaid (Title XIX) Book 2 [Removed from binder – Folder (of 2)], Box 64, Personal Papers of Wilbur J. Cohen, LBJ PL, 19. (Hereafter Tax Foundation, *Medicaid*)

assumed that all states recorded increases in recipients upon Medicaid's enactment. In fact, during post enactment decision making, some states actually reduced the number of eligibles for the program.[54]

The enactment of Medicaid also changed the nature of the MAA program, which became voluntary for states and also could be extended beyond the elderly to other categorical groups. Initially, at least 12 states elected to establish only the basic Medicaid program, excluding the previous MAA group.[55] Medicaid was on the one hand a reform that fundamentally changed the rules established before in Kerr-Mills, while at the same time it was a consolidation of five previous programs into one. In relation to localities, more than half of the reporting states indicated that the state had assumed a larger share of non-federal medical assistance costs than before Title 19.[56]

Link with Medicare's Provider Payment

Oddly, though, just as Medicaid's evolution connected it to state welfare departments and the cash income program, Medicaid's co-evolution with Medicare would link it intrinsically to this social insurance initiative, as well. Because the Medicaid program was enacted in the three-part legislative coup that also created Medicare, the payment mechanisms between Medicaid were directly related to Medicare. This was particularly noteworthy from a policy bargaining perspective. When the Medicare package was bargained, a primary reason for excluding physician payment from the social insurance financed part of the package was because of extreme opposition on the part of the AMA. Also, the AMA was hotly opposed to any pre-payment, capitation payment methodology. In order to avoid this battle altogether, the King-

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[54] From ACIR, *Medicaid*, 30 "The Tax Foundation's State survey in the Fall of 1967 found that in the first year of implementation, Title 19 had a wide range of effects on the number of people receiving public assistance medical care. Estimates of changes in coverage ranged all the way from declines in four states (Maine, Oregon, Utah, and West Virginia) to a more than doubling in five (Conn., Delaware, Michigan, Montana, and OK)." Also see Tax Foundation, *Medicaid*.
[55] Tax Foundation, *Medicaid*, 23.
[56] Tax Foundation, *Medicaid*, 59.

Anderson versions presented during the maneuvering in early 1965 did not include physician's services at all.

This, in turn, spurned concerns on the part of many players including Chairman Mills on the House side and Senator Ribicoff on the Senate side that the enactment of a King-Anderson type measure could actually be used against the Democrats in future elections given that the benefits were so limited. In a conversation with the President after the three-way approach was devised, Wilbur Cohen answered LBJ on this point:

> LBJ: Now how do we know…does he [the doctor] charge what he wants to?
>
> Cohen: No, he can't quite charge what he wants to because this has been put in a separate… separate fund. And what the Secretary of HEW would have to do is make some kind of agreement with somebody like Blue Shield… let's say. It would be their responsibility—under the way the Chairman has provided the bill—that they would regulate the fees in effect of the doctor. Because what he tried to do is to be sure that the government wasn't regulating the fees directly. They shouldn't deal with the individual doctor. And the bill provides that the doctor could only charge only the reasonable charge but this intermediary… the Blue Shield… would have to do all the policing so that the government wouldn't have it's long hand…
>
> LBJ: Alright that's good… [57]

Physician's payments were not removed from the social insurance component from the program because this was the optimum policy arrangement; it was removed in order to make the whole package viable for passage.[58] This mattered for Medicaid

[57] Telephone Conversation between Lyndon B. Johnson, Wilbur Cohen, John McCormack, Wilbur Mills, and Carl Albert, March 23, 1965, Tape: WH6503.11, Program No. 9, Citation No.:7141, Tapes and Transcripts of Telephone Conversations and Meetings, LBJ PL.

[58] As Lawrence R. Jacobs observed in *The Health of Nations*, 153: "They fully anticipated that the great majority of physicians would oppose any Medicare bill, no matter how carefully designed. Accordingly, they narrowed Medicare's scope in order to blunt the AMA's potential appeal to the public; as a high ranking HEW administrator explained, 'avoiding payments to physicians…makes the AMA opposition less

because this arrangement –bartered through this series of events -- extended to Medicaid by adoption of many of Medicare's payment mechanisms. Instead of creating different Medicaid provider payment mechanisms, many of these were co-opted from Medicare.

If Kerr-Mills had been extended or Medicaid enacted without the concurrent creation of Medicare, the payment mechanisms may have been completely different. As they were, Inpatient Hospital Care was to be reimbursed on a "reasonable cost" basis – not on a statewide fee schedule.[59] The language for service providers other than hospitals was that they were to "provide such safeguards as may be necessary to assume that…such care and services will be provided in a manner consistent with simplicity of administration and the best interests of the recipients." With regard to physician payment, by 1967, 15 states paid physicians according to their "usual and customary fees." This was the Medicare language for physician payment that had been co-opted for the Medicaid program. Medical assistance programs' physician payments increased five-fold between 1965 and 1969.[60] Medicaid did not require that nursing homes be reimbursed on a reasonable cost basis. Still, nursing home construction quickened after Medicaid passage. Also, quality standards were more stringent on the federal level than they had been under Kerr-Mills in many states. Expenditures on publicly financed nursing home care more than doubled between Fiscal Years 1966 and 1968.[61] The link between Medicaid and Medicare, particularly in hospital payment policy, was seen as

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relevant.'" "To make interest group criticism 'less relevant,' Medicare's coverage was limited to focus on hospital costs and exclude doctor services." And later on p. 234, "In the fragmented American state, though, politicians and policy experts compromised Medicare's organizational integrity in order to circumvent the public's enduring suspicion of the state; introducing a massive and visible change in the state's organizational capacity was inconceivable. Lacking the administrative competence possessed by their British counterparts, American policymakers built a major new state program without the presence of a major state; indeed, they willingly ceded control over Medicare's cost and administration to non-state bodies." Lawrence R. Jacobs, *The Health of Nations: Public Opinion and the Making of American and British Health Policy* (Ithaca, New York: Cornell University Press, 1993). (Hereafter, Jacobs, *Health of Nations*)

[59] Rosemary Stevens and Robert Stevens, "Medicaid: Anatomy of a Dilemma," *Law and Contemporary Problems* 35 (1970), 381. (Hereafter, Stevens, *Medicaid: Anatomy*)

[60] Stevens, *Medicaid: Anatomy*, 382, 384, 385.

[61] Stevens, *Medicaid: Anatomy*, 383.

deleterious and extremely prohibitive cost-wise by many states.[62] This federal requirement was funded, in part, by state dollars.

It seems as though states' dissatisfaction would have been offset somewhat by the lifting of many people off of state Kerr-Mills program roles by Medicare and enabling states that had not fully adopted Kerr-Mills initiatives to embrace Medicaid.[63] The enactment of Medicare would seem to provide fiscal relief to states in this regard, but the cost escalation proved so severe that this was hardly mentioned by states in the aftermath of Medicaid's enactment. Another aspect of this is that the Medicaid program paid the Medicare deductibles and co-insurance for many people who were eligible for both Medicaid and Medicare.[64]

As one scholar reviewing the Medicare enactment wrote,

> In effect, congressional and administration officials decided to sign a check to cover specified services for the elderly but declined to 'interfere with the practice of medicine' in order to control the amount on the check and the quality of care it purchased. All reasonable changes would be covered and oversight would be left to private bodies sympathetic to providers. The decision, then, by Mills, Johnson, and other policymakers in favor of a weak hierarchy and specialization continued the American states' tradition of weak administrative capacity.[65]

In addition – in another effect of the simultaneous enactment -- it was accepted that just as Medicare would embrace private intermediaries in coordinating provider payment, so Medicaid would allow for the use of private carriers for the same purpose in that program. In the aftermath of the cost escalation of the program in the first couple of

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[62] ACIR, *Medicaid*, 50 - 52.
[63] HEW Secretary Celebrezze had expressed this hope in a November 1963 hearing, "With a basic program of hospital insurance under social security, many additional States, relieved of what would otherwise be a very heavy burden on their general revenues, would be able to afford an MAA program as a supplement to social security, and the States which now have inadequate medical programs will be able improve them." House of Representatives, November 18, 1963, RG 287, Publications of the Federal Government, (Congress: Committees of Congress) House. Ways and Means Committee, 1884 – Beginning: Y4 .W36 M46/3/pt1, Ending: Y4. W36: pt M46/11, Box No. Y6493. Hearings before the Committee on Ways and Means House of Representatives, Eighty-Eighth Congress, First and Second Sessions on H.R. 3920, CLA/NA.
[64]Tax Foundation, *Medicaid*, Footnote #7, 23.
[65] Lawrence Jacobs, *The Health of Nations*, 153.

years, the California legislature considered limiting the reach of private carriers in the Medicaid program in order to establish some modicum of control over costs.[66] Other states considered adding fiscal intermediaries in order to quicken and streamline billing processes.

HEW did explain the link between Medicaid and Medicare reimbursement, " By July 1967 the Medicare program already had been in operation for a year and a half and payment for hospital care was being made on the basis of the reimbursement formula which had been developed by the Bureau of Health Insurance of Social Security Administration. The proposal to adopt the Social Security Administration method was supported by a desire for uniformity among programs operated within the Department of Health, Education, and Welfare. Even those hospitals which opposed the use of the Social Security method felt that it would be burdensome for them to employ still another method for a different program within its institution. Approximately, 6,700 hospitals of the 7,000 hospitals in the United States are participating in Title 18."[67]

Hospitals

As early as 1962 during the Kennedy Administration, the American Hospital Association (AHA) was able to bargain for the utilization of private organizations such as Blue Cross in administering benefits for the Medicare program.[68] In terms of Medicaid directly, hospitals benefited because previously state and local government hospitals now received infusions of some federal monies for those now covered by the Medicaid – and Medicare – programs. Some people who previously were served "free" were now insured through one of these government programs. Also, through Medicaid, the federal government shared in costs for tuberculosis and mental care in approved hospitals.[69]

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[66] Tax Foundation, *Medicaid*, 36.
[67] ACIR, *Medicaid*, 74.
[68] Sundquist, *Politics and Policy*, 312.
[69] Tax Foundation, *Medicaid*, 27 - 28.

After Medicaid was enacted, the inflation in hospital costs became a substantial problem, as well.[70]

Medicaid Equal Opportunity

Reflecting the values fostered by The Warren Court Era and The Great Society, the 1965 version of Medicaid aspired towards Equal Opportunity. Medicaid recipients were to receive care from the same physicians, in the same hospitals, under the same conditions and payment policies as people with other sources as payers. There was no second-class. One of the most important provisions in this regard was the Comprehensiveness Provision, Section 1903(e). It stated:

> The Secretary shall not make payments under the preceding provisions of this section to any State unless the State makes a satisfactory showing that it is making efforts in the direction of broadening the scope of the care and services made available under the plan and in the direction of liberalizing the eligibility requirements for medical assistance, with a view toward furnishing by July 1, 1975, comprehensive care and services to substantially all individuals would meet the plan's eligibility standards with respect to income and resources, including services to enable such individuals to attain or retain independence or self-care.[71]

On one level this is an effort, in the long-term, to remove the categorical requirements in the Medicaid program. All individuals below the income and resource requirements were to receive care. On another level, benefits were supposed to be expanded to a comprehensive level. In a third dimension, the services are not those restricted to health care, but included supportive services. Section 1903(e) was repealed a few years later, but its intent haunts the current Medicaid program. When Medicaid was first drawn, it had high ideals.

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[70] Tax Foundation, *Medicaid*, 27 - 28.
[71] Stevens, *Medicaid: Anatomy*, 365.

One of the early principles of the program was the Free choice principle, meaning that Medicaid recipients had a right to choose an individual physician, a physician from a group practice, or a physician from a prepaid group practice medical care program.[72] They found that in comparison to pre-19 medical assistance programs, the real reform was not in the scope of medical services offered to those receiving the most generous aid, "but in the extension of comparable services to other groups, who in some instances had received only minimum medical assistance." Another aspect of the federal-state structure of Medicaid was that it was so confusing to both recipients, citizens, and providers that very few people really understood who was eligible, in what state, and under what conditions.

HIGH COSTS AND FRAUD LEAD TO MEDICAID RECALIBRATION THROUGH THE 1967 SOCIAL SECURITY AMENDMENTS

After Medicaid was enacted, the primary story in the aftermath was of very high costs. Oddly, while cutting back the Medicaid program in many ways, the Social Security Amendments of 1967 also provided for the largest benefit increase for the retirement program in Social Security history.[73] Between 1965 and 1967, state expenditures for medical assistance payments ranged from an increase of 371 percent in Delaware to a decrease of 15% in West Virginia. New York had to increase payments for medical bills by $487,238,000 during the period, while West Virginia decreased payments by $1,751,000.[74] As the *Congressional Quarterly Almanac* reported: "Since the states themselves could define the medically needy, there arose differences in income specifications among the states. New York, for example, initially defined as medically

[72] ACIR, *Medicaid*, 14. "Beginning July 1, 1969, states must allow Medicaid recipients free choice among qualified practitioners, medical facilities, and community pharmacies. The free choice principle includes the right to choose a qualified group of physicians organized in group practice, as well as to choose a qualified physician. Group practice covers not only a voluntary association of three or more physicians working as a team, but also a consumer-sponsored, prepaid, group practice medical care program."
[73] Memo, Wilbur J. Cohen, Under Secretary of HEW for the President, "Social Security Bill Developments," November 4, 1967, Folder: LE/WE6 9/1/67, Box 164, WHCF Legislation EX (LE/WE), LBJ PL.
[74] 1969 *CQ Almanac*, 201.

needy and eligible for Medicaid a family of four with an annual net income of $6,850. The figure later was lowered to $6,000 and still later to $5,300, but still remained one of the highest of any state. Median -- $3,500 for a family of four."[75] In 1967 the Social Security Amendments took several steps to limit the ability of the states to define the medically needy, in addition to many other types of amendments.

The Wall Street summed up the sentiment in an August 8, 1967 article, "How do you begin the broadest and perhaps one of the most expensive government medical programs in the nation's history? Start with a total lack of preparedness, move quickly into Chaos, add a little apathy and then stir up some fights with the doctors, dentists, and pharmacists. Much of the trouble with Medicaid, say both its administrators and critics, stems from the fact that almost from its inception it has been a spur of the moment program with few of those involved realizing its vastness."

As the Tax Foundation concluded, "In a period of less than two years after Medicaid became effective, the rate of medical assistance payments in all states approximately doubled from their 1965 level. The bulk of the rise was in the 35 states that were operating Title 19 programs by September 1967; these states dispensed nine-tenths of all public assistance medical payments. It is clear that Medicaid programs, as expected, increased these costs far more rapidly than they would have risen otherwise. In the Title 19 states, the expansion over pre-Medicaid experience was nearly five times as great as in the other states (105 percent as compared to 23 percent)." When overall costs increased, variability between states increased as well.[76]

The cost increase was particularly striking in two states: New York and California. The decisions made by New York's legislature in enacting that state's Medicaid program were so generous that the federal share was more than had been projected by the federal government for the entire country. Due to their wealth, New York and California could afford a state share that was more substantial than many other states. The disparities and inequality that this introduced between states was pronounced.

[75] 1969 *CQ Almanac*, 201.
[76] The States ranked in the top four in increased costs between 1965 and 1967 were 1) NY; 2) CA; 3) Mass.; and 4) OK. Tax Foundation, *Medicaid*, 33.

Even with a slightly more generous federal match for poorer states than Kerr-Mills, the re-distributive formula did not close the gap between wealthy and poor states. Another factor for federal-state programs is that since, in general, state taxes are more regressive than the federal income tax, the state share is derived from a relatively regressive tax structure. State funding then is more heavily placed on the poor in order to fund a program that is for a selective group of the poor. There are in fact people who cannot afford health insurance paying taxes to support the Medicaid program.

In California, Medi-Cal was launched on March 1, 1966, to provide a comprehensive range of services to an estimated 13 percent of the state's population.[77] The California Governor at the time was Ronald Reagan. The same Governor who in 1962 had advocated against proposed Medicare proposals saying, "one of the traditional methods of imposing statism or Socialism on a people has been by way of medicine."[78] In 1967 the *U.S. News and World Report* stated that the country was waiting to see the outcome of Reagan's stand against the burgeoning Medi-Cal program since this was the first cutback attempted.[79] Governor Reagan sponsored a conference for the states on Medicaid cost increases. At least from the LBJ Administration's perspective the conference was judged a "failure." Cohen wrote in a memo at the time, "the general consensus was that California's troubles grew out of their own administration of the program, not from the basic nature of the program itself."[80] According to Cohen, some state representatives at the meeting identified a primary problem with Medicaid: "the present program forgets the person who is too old for dependent child care, too young for old age support, insufficiently disabled to qualify for the program, and able to see." In the light of these drawbacks some state representatives considered ways of providing and

[77] This was a reported 2.5 million people. Tax Foundation, *Medicaid*, 35.
[78] Newsarticle, Folder: "Printed Material," Box Number 4, Personal Papers of Wilbur J. Cohen, LBJ PL. Originally cited as Richard Harris. "Annals of Legislation, Medicare III ~ We Do Not Compromise," *The New Yorker*, July 16, 1966, 54.
[79] Newsarticle, "Medicaid in the Billions – Getting Out of Hand?," *U.S. News &World Report*, October 16, 1967, Folder: "Medicare," Box 380 (22), Office Files of Frederick Panzer, OFWHA, LBJ PL.
[80] Memo, Wilbur Cohen, UnderSecretary of HEW, to Charles H. Shreve, Regional Director, San Francisco Regional Office, "Governor Reagan's Interstate Conference on Medic-Aid," September 26, 1967, Folder: "IS1 7/1/67," Box 2, WHCF Insurance EX IS1, LBJ PL.

paying for health care. In this case, some states wanted flexibility in order to experiment for providing a more inclusive program instead of a more restricted one.[81]

Herein lied another dilemma in Medicaid federalism – the dilemma provoked by the differences in what states would do with additional flexibility. Some states use flexibility to provide fuller coverage, to experiment in progressive directions, to do more with less – while at the same time, other states, if given this same flexibility, struggle to maintain the minimum standards that the federal government sets. In California's case, the state legislature acted and the result was large increases in eligibility that the state could apparently not maintain. Governor Reagan, in a move as the top executive official in the state, ordered drastic curtailment of services.

In 1968 the California state legislation considered several proposals for reducing costs, including:

(1) contracting physician's services out on a capitated basis;
(2) providing local tax relief by state assumption of costs of the program;
(3) trying a cost-sharing arrangement with recipients;
(4) controlling utilization of medical procedures;
(5) increasing fraud control; and
(6) replacing Medi-Cal private financial intermediaries with states paying providers.[82]

In New York, expectations regarding the Medicaid program cost-wise were not realized. New York's state legislature expected that the federal Medicaid share would increase by $114 million and decrease the state and local share by $78 million. The actual outcome was quite different, and costs increased sharply for all three levels of government.[83] What was possibly the most remarkable part of New York's response was that the Governor recommended to the 1968 legislature that a payroll-tax funded

[81] Memo, Wilbur Cohen, UnderSecretary of HEW, to Charles H. Shreve, Regional Director, San Francisco Regional Office, "Governor Reagan's Interstate Conference on Medic-Aid," September 26, 1967, Folder: "IS1 7/1/67," Box 2, WHCF Insurance EX IS1, LBJ PL.
[82] Tax Foundation, *Medicaid*, 36.
[83] Tax Foundation, *Medicaid*, 37.

compulsory health insurance plan be enacted. It did not receive approval.[84] In the face of over-budget Medicaid costs, one of the best alternatives appeared to be a comprehensive solution to health care for the state. Once again, questions of Medicaid resulted in a comprehensive plan solution – at least by some key decision-makers. Part of the turn to a comprehensive solution, at least on the Governor's part, was the scope of New York's Medicaid program. Initially, about one third of the state's population was eligible.[85] Another source had the number eligible as high as 45% of the population, some 8 million people.[86]

Another option, also supported by the Governor, was federal financing of welfare programs. For Medicaid, that meant suggesting that the federal government find an alternative for providing health care, and, at the same time, saving states from increasingly poor budget situations.[87] This would prove true for Medicaid repeatedly in the future. States that struggled to support Medicaid would respond by becoming supporters of federal – not state – solutions. Also, Medicaid reform proposals sometimes took the form of suggestions for comprehensive national reform, comprehensive coordinated health planning efforts among communities, or other reforms that fundamentally changed the health financing system altogether – as opposed to just changing Medicaid.

In light of the staggering reach of Medicaid after the New York legislature acted, local medical societies were rebuffed. The Erie County Medical Society demanded repeal. The Suffolk County Medical Society labeled Medicaid "socialized medicine, designed to deprive physicians of their constitutional rights to practice medicine in a free society."[88] Once again, the Socialized Medicine claim was used when physicians disagreed with the extent of the program's reach, the comprehensiveness of its scope, or the payment arrangement particulars. This time, though, the claim was levied not during

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[84] Tax Foundation, *Medicaid*, 37.
[85] Tax Foundation, *Medicaid*, 51.
[86] Stevens, *Medicaid: Anatomy*, 366.
[87] Stevens, *American Medicine*, 492.
[88] Stevens, *Medicaid: Anatomy*, Footnote #73, 367. Stevens further cited *NY Times*, June 4, 1966, col. 2; id. June 5, 1966, at 66, col. 3.

enactment bargaining, but after both federal and state legislatures had acted. The Socialized Medicine claim was used to roll back legislative actions during subsequent implementation and enforcement stages, as well in future re-thinking of statutes by legislatures.

In New York, there was a reported effect on municipalities' taxes of the Medicaid legislation. Around 28 municipalities raised their sales tax and practically all 62 counties raised their property tax – citing Medicaid as a reason. At this point, it is unclear if Medicaid was scapegoated as the reason for tax increases. Given the increases in eligibility, though, it is reasonable to assume that the local governments were truly suffering in New York due to the increased cost pressing on a relatively regressive tax structure. The clash between taxpayer and beneficiary rights in New York State was very real. In many cases, additional taxes were paid by lower-income people who themselves did not have adequate medical care but did not qualify for Medicaid for one reason or another. The extent to which this rights holder clash -- taxpayer versus beneficiary -- extended to other states is unclear, although one source reports that one out of every three states was forced to raise taxes in part because of Medicaid.[89]

The cost situation in Medicaid was caused by the interaction of two factors. For one, the federal-state relationship made it difficult to accurately project costs. Secondly, private entities were able to bargain for concessions in order to get the Medicaid/Medicare package through that provided few cost control mechanisms and, in fact, encouraged cost escalation. While states did not attribute state tax increases totally to the Medicaid cost increase, some indicated that it may have played a factor.[90] Local tax increases in New York were attributed to an expansive Medicaid program that covered additional populations not matched by the federal government. The Tax Foundation reported that "According to press reports, 29 of the states in 62 counties in

[89] Stevens, *Medicaid: Anatomy*, 385 – 387.
[90] "None of the 27 states (all operating Medicaid programs) reported that new or higher state-level taxes had been imposed to date solely in support of the Medicaid program, but several indicated that recent tax increases were linked in part to the Medicaid programs." Tax Foundation, *Medicaid*, 40.

the past year or so have enacted local sales taxes or raised property taxes, primarily to meet the cost of Medicaid."[91]

Another area where Medicare and Medicaid hospital payments overlapped was in the post-enactment negotiations of reimbursement for hospital's capital costs. As Somers and Somers wrote at the time, "Most observers of the long reimbursement negotiations agree that the hospitals' drive to increase funds for capital formation colored and complicated every major dispute on payment. It intruded upon consideration of items, where it seemed relevant and where it did not, and proved to be the hospitals' most effective weapon in obtaining various liberalizations."[92] Basically, the provisions regarding adjustment of hospital payment to account for depreciation was extended from Medicare to Medicaid, and the allowance of this on the part of Medicare was a post-enactment bargain between HEW bureaucrats and private interests.

In a review of the bureaucratic policy bargaining with the hospitals, Judy Feder writes in *Medicare: The Politics of Federal Hospital Insurance*: "Their [the Hospitals] primary objective was to obtain additional revenue in two areas: (1) the definition of Medicare payments for depreciation on buildings and equipment; and (2) the inclusion of a return on equity as an allowable cost."[93] The policy bargaining about this issue had expansive consequences, and the tack of placating business interests was later questioned. Did the government negotiators give away too much? In analyzing this, one can ask if this strategy of turning potential enemies into allies was worth the trade-off in cost escalation that resulted not just for the program bargained for – Medicare – but also for the program that copied so many of its provisions – Medicaid.

[91] "In New York, coverage extends to medically indigent persons between 21 and 65 years of age, for whom there is no federal sharing in costs; thus the federal share of the entire program, instead of being 50%, is only 36%, and the state and local governments share equally in the remainder of the costs. According to press reports, 29 of the states 62 counties in the past year or so have enacted local sales taxes or raised property taxes, primarily to meet the cost of Medicaid." Tax Foundation, *Medicaid*, 40.
[92] Herman M. Somers and Anne R. Somers, *Medicare and the Hospitals: Issues and Prospects* (Washington, D.C.: The Brookings Institution, 1967), 161.
[93] Feder, *Medicare: The Politics*, 58.

The end result was that the two areas were lumped together, as Feder writes, "as the justification for a 'plus factor' in reimbursement, that is, the addition to each hospital's Medicare reimbursement of 2% of its identified allowable cost."[94]
Feder continues:

> Their feeling, according to a senior SSA official, was that the hospitals would have to go along with whatever the department promulgated. "But there's a real difference in launching a program with the help of the hospitals as opposed to against them. To an administrator, that difference makes all the difference in the world." A BHI official expressed a similar point of view: The hospitals were not "our adversaries; we were all in the same lifeboat together."[95]

Those who negotiated the terms of the arrangement with the hospitals were reportedly confident that re-negotiations would minimize or even negate these initial give-aways. As history showed though, the compromises proved to be much more resilient. Gradualism did not move in the direction of correcting for past transgressions towards cost-push inflation in Medicaid hospital payment. The bargain stuck and Medicaid's evolution of hospital payment was not progressive – from the point of view of someone who believed that greater federal control meant greater cost control. Feder argues that the Social Security Administration's continuing concern with political balance actually led to these policies entrenchment,[96] and not a gradual progression towards the government negotiators most-preferred policy solution.

This example is just one that shows the difficulties of policy bargaining for government negotiators. If a compromise is reached, they may be giving away more than they want and will not be able to "make-up" for the sweetener. If they do not compromise, they may alienate key interests and create hostile relationships. Given that federal administrators in the health field will have multiple successive interactions with these interests, poor relationships are costly in and of themselves. This dilemma, The Compromise Trap, is one of the key traps in American social policy.

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[94] Feder, *Medicare: The Politics*, 66.
[95] Feder, *Medicare: The Politics*, 66 – 67.
[96] Feder, *Medicare: The Politics*, 70.

The Compromise Trap is when a deal is brokered by government negotiators through a deal that in the long-run hems in progressive reform efforts. Federal negotiators give too much in a give and take conflict resolution, thinking that their compromising is the best negotiating style for that particular situation. Sometimes "giving away the farm" due to lack of thought about strategy or negotiating skill, sometimes trying too hard to please the people on the other side of the negotiating table whom they will work with in the future, sometimes wanting a resolution to an issue very much or negotiation fatigue. Regardless of the reason, The Compromise Trap is one policy bargaining phenomenon to watch for in social policy negotiations.

In *Social Insecurity*, one aspect of this phenomenon is considered. After a new program, like Medicaid, is enacted, the Federal agency staff develops relationships with private interests and state administrators that result in accommodation in many instances. In other words, if people in the federal agency work with the same people in state agencies or private business day in and day out, they develop associations and a type of civic community with those individuals that may transcend other relationships or interests – even interests of beneficiaries. With regard to the close relationships between federal and state administrators, the term "vertical functional autocracies" was dubbed to describe how even state Governors lose power in the face of strong relationships between civil servants at different levels of government.[97]

Another explanation is that compromises during times of genuine policy reform are more intransigent – and stick more – than the policy entrepreneurs of The New Deal and The Great Society realized. In fact, policy negotiators today still make bargains where they give up more than most beneficiaries would like using the defense that they can gain back some of the losses after ensuring enactment. At a 2004 LBJ School of

[97] The Kestenbaum Commission, a Commission on Intergovernmental Relations in 1955, reported, "In the absence of [supervision and review by the state government and legislature], there is a tendency for groups of professional administrators in a single, specialized field, working at National, State, and Local levels, to become more or less independent governments of their own, organized vertically and substantially independent of other State agencies." Commission on Intergovernmental Relations, *A Report to the President for Transmittal to the Congress* (Washington, June 1955), 44. The Author obtained this quote from Derthick, *Keeping the Compound Republic* (Washington, D.C.: The Brookings Institution, 2001), Chapter 6, "Up-to-Date in Kansas City," Footnote #12, 175.

Public Affairs Conference, "Big Choices: The Future of Health Insurance for Older Americans," David Certner the Director of Federal Affairs for AARP spoke of AARP's acceptance of the proposed Medicare Prescription Drug Benefit even though they did not agree with some of the features, particularly the overly advantageous arrangements with drug plans. The reasoning was that after so many years and rounds of negotiations on a Medicare prescription drug benefit, they wanted to get something in place and work to improve that, instead of starting from scratch and having to start "rolling the boulder up the hill again."[98] The U.S. system of government encourages this because its extensive system of checks and balances makes it exceedingly difficult to get any major legislation through, on any terms.

In terms of negotiations after enactment, then, there are a few rules with regard to bureaucratic behavior. In negotiating the details of programs, agencies may (1) attempt to preserve a status quo[99] or (2) attempt to preserve positive relationships regardless of costs. The further implementation of these policy agreements by states, by fiscal intermediaries and carriers, and by providers themselves involves yet another level of policy bargaining.

1967 Amendments

In a historical link between medical indigence and cash welfare payment levels in the states, the 1967 Social Security Amendments established a number of Medicaid cutbacks in waves. By July 1, 1968, the Federal Government would only provide

[98] The conference was held at the Lyndon Baines Johnson Library and Museum on April 22 - 13, 2004 by the Center for Health and Social Policy (CHASP), a LBJ School of Public Affairs research center.

[99] Thought attributed to Feder, *Medicare: The Politics*. Also, Feder quotes Anthony Downs *Inside Bureaucracy* (1967), which is re-copied here for further support (153-154 from Feder): Like most large organizations, bureaus have a powerful tendency to continue doing today whatever they did yesterday. The main reason for this inertia is that established processes represent an enormous previous investment in time, effort, and money. This investment constitutes a "sunk cost" of tremendous proportions. Years of effort, thousands of decisions (including mistakes), and a wide variety of experiences underlie the behavior patterns a bureau now uses. Moreover, it took a significant investment to get the bureau's many members and clients to accept and become habituated to its behaviors. If the bureau adopts new behavior patterns, it must incur at least some of these costs all over again. Therefore, it can rationally adopt new patterns only if their benefits exceed both the benefits derived from existing behavior and the costs of shifting to the new patterns.

matching funds to a state up to a ceiling where a medically indigent person earned 150% of the state's AFDC income standard. By July 1, 1969, this ceiling would be lowered to 140%, and by January 1, 1970, it would be lowered even more to 133 1/3%.[100] Interestingly, while the 1967 Amendments were an embodiment of Congressional limitation on the states, the ceiling was tied to states' own AFDC levels. As is typically the case with shared federal-state programs, states could self-fund anything above and beyond the federal limits, and, of course, states could chose to raise their AFDC levels.

The result was that eight states (CA, DE, KY, MD, NY, OK, PA, and RI) reduced eligibility to the 150% level. In effect, Pennsylvania avoided the cutback by raising its maximum AFDC payment levels. Two other states (CT and IL) imposed cutbacks by January 1969 and a third (IA) imposed a cutback to reach the 133 1/3% level by July 1968.[101] Other important revisions from the 1967 Amendments included:

- Authorization to the Secretary of HEW to approve new reimbursement methods proposed by the states that had promise to increase efficiency without reducing quality.[102]
- Allowed a state to establish different income levels for eligibility under Medicaid based on variations in the cost of housing in urban and rural parts of a state.[103]
- Stipulated that only nursing homes meeting certain specifications could be used for public assistance recipients under Medicaid. Permitted federal matching for Medicaid beneficiaries in ICFs.[104] The newly-invented category of intermediate care facilities was expected to remove part of nursing home expenditures from Medicaid.[105]

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[100] 1967 *CQ Almanac*, 895.
[101] ACIR, *Medicaid*, 33 – 34 and Stevens, *Medicaid: Anatomy*, 377.
[102] ACIR, *Medicaid*, 14 – 15.
[103] 1967 *CQ Almanac*, 895
[104] 1967 *CQ Almanac,* 895
[105] Stevens, *Medicaid: Anatomy*, 378.

- Required states to make sure that unnecessary services were not provided under Medicaid – and to assure that payments did not exceed "reasonable charges," including payments for drugs.[106]
- Authorized the Secretary of HEW to approve experiments with new ways of reimbursement that promise more efficient methods of providing medical care and services without adversely affecting their quality.[107]

The waiver authority, beginning in 1962 with the general Social Security Act authority targeted Medicaid reimbursement specifically in 1967. In many ways, 1967 set the rules for Medicaid. The enactment in 1965 had established a very strong foundation for national health insurance. The 1967 amendments began to unravel a few of those original commitments. Those original commitments have continued to unravel ever since.

MEDICAID IMPLEMENTATION AND CIVIL RIGHTS

One of the truly remarkable things about the enactment of Medicaid was the civil rights implications in health care nationwide. As Wilbur Cohen remarked at a LBJ School of Public Affairs conference in 1976, "But there is one other very important contribution of Medicare and Medicaid which has not received public notice -- the virtual dismantling of segregation in hospitals, physicians' offices, waterfountains, restrooms, and lunchrooms in hospitals which said "For White Only" came tumbling down overnight. There was very little resistance. There was no legal opposition. A major and monumental change in the way health care was administered to black men, women, and children was implemented without a serious challenge. If Medicare and Medicaid had

[106] 1967 *CQ Almanac, 895.*
[107] ACIR, *Medicaid*, 14 - 15.

not made another single contribution, this result would be sufficient to enshrine it as one of the most significant social reforms of the decade."[108]

The record shows that the transition was more arduous, in at least some Southern hospitals, and not quite as overnight as this last quote implies. In a June 25, 1966 White House memo it is suggested that military hospitals be used in communities with Civil Rights Act Title VI problems. The compliance percentages of those communities with low compliance with Title VI are listed in Chart 1.

Chart 1: States With Title VI Hospital Compliance Problems

Alabama – Mobile (less than 20%); Birmingham (40%); Montgomery (21%);
Florida – Jacksonville (44%);
Georgia – Atlanta (20%); and Columbus (less than 50%);
Louisiana – Baton Rouge (less than 50%); and Shreveport (less than 50%);
Mississippi – Jackson (30%); and Meridian (less than 20%);
North Carolina – Charlotte (55%); and Greensborough (less than 50%);
South Carolina – Columbia (less than 50%);
Tennessee – Knoxville (less than 20%).[109]

Even with these initial compliance problems, though, the Administrator in charge of administering Medicare at the time remembered, "In fact one of the really bright chapters in the Medicare story is that literally hundreds and hundreds of hospitals throughout the South in a period of a few months, for the first time in their history made medical care in their hospitals available to blacks on the same basis as to whites. They added Negro doctors to their staffs and desegregated generally."[110]

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[108] Wilbur Cohen, "From Medicare to National Health Insurance," Chapter 8 in David C. Warner (ed.), *Toward New Human Rights: The Social Policies of the Kennedy and Johnson Administrations* (Austin, Texas: The LBJ School of Public Affairs, 1977), 150.
[109] Memo, Philip R. Lee, M.D., Assistant Secretary for Health and Scientific Affairs for the Honorable Douglass Cater, Subject: "Contingency Use of Federal Hospitals by Medicare Patients," June 25, 1966, Folder: "HEW Health - Medicare," Box 19, Personal Papers of John Gardner, LBJ PL.
[110] Transcript, Robert Ball Oral History Interview, November 5, 1968, by David G. McComb, Tape #1, Oral History Collection, LBJ PL, 40.

Later in the Medicaid payment debate, physicians attempted to change the rules so that they received payment directly from patients instead of through the Medicaid program. As Douglass Cater wrote to the President, "Neither Secretary Gardner nor Wilbur Cohen believe this is justified. The point out that it will contribute to medical cost inflation. It would also permit racial discrimination since Title VI is not enforceable when the patient is billed directly." Administration officials had a vital reason to keep patients out of the payment cycle – enforcement of Title VI.[111]

THE LBJ RIGHTS ERA SUNSET: ESCALATION OF VIETNAM, KIDDICARE

During LBJ's Presidency, the escalation of hostilities in Vietnam made action on domestic issues increasingly difficult. In an oral history, former HEW Secretary Wilbur Cohen was asked about "increasing difficulty due to the Viet Nam situation?" He responded, "Yes, I found it so, not so much in the legislative aspect, but in the getting of appropriations to implement it." Later in the interview, the interviewer asked, "Did the President express any regret about this in regard to his domestic program?" Cohen's response, "Yes. In my discussions with him particularly during November and December and January of 1968 - 69, when I was proposing getting so much greater appropriations requests, he expressed the deep regret that he couldn't do it."[112]

In late 1965, staff countered questions regarding the effects of the war. For example, Harry C. McPherson, Jr. said "Charlie Schultze is cool to the idea of a traveling circus of senior officials explaining the new programs across the country. His reasons are: a) this has the inevitable consequence of stimulating interesting programs we cannot adequately finance; b) raising hopes and then crushing them because of budgetary limitations is worse than leaving the public in the dark about the new programs. These are persuasive considerations. The only counter-argument I can make is that we are not

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[111] Memo, From Douglass Cater for the President, April 7, 1967, 10:10 AM, Folder Title: "Cater, Douglass: April, 1967," Box 16, Office Files of S. Douglass Cater, OFWHA, LBJ PL.
[112] Transcript, Wilbur J. Cohen Oral History Interview, May 10, 1969, by David G. McComb, Tape #4, Oral History Collection, LBJ PL, 34.

closing the door on the Great Society; we are just muting our welcome to it because of Vietnam."[113]

The post-Medicaid cutback 1968 Advisory Commission on Intergovernmental Relations report mentioned Vietnam several times in justifying Medicaid cutbacks. The report states, "We recognize and understand the fiscal conditions that led Congress and the Administration in 1967 to impose a cutback on Federal participation in the care of the medically needy and thus move away from the goal set by Section 1903(e)….Yet we believe that this action as the result of concern over the unanticipated escalation of the Title 19 budget… and the unrelenting fiscal pressure from other public demands, particularly military requirements."[114] In some sense, fiscal capacity limitations is often mentioned as a reason to keep social programs financed at the federal level, but, as Vietnam demonstrated, this does not protect social programs financially from the costs that war impose on federal budgets. Placing social programs firmly at the federal level of financing does not protect them from the primary concern of the Federal Executive and Legislative Wings: Protecting the country and its interests in war.

In 1968, HEW Secretary Cohen proposed a social insurance financed health program for children to President Johnson. Called Kiddy Care, Cohen explained that it was just too big of a bite to take on the remainder of one hundred and eighty additional people. However, "Kiddy Care represents to me not only an establishment of a new system of priorities by directing our attention now to children in the new generation as against the aged, but at the same time it helps you to swing into an evolutionary process where over a course of time you could end up with a more comprehensive program than you have today."[115]

The Bureau of the Budget was opposed to the measure. They wrote to the President, "About 4 million births would be covered each year. But only about 1 million

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[113] Letter, From Harry C. McPherson, Jr. for Bill Moyers, December 13, 1965, Folder: "Office Files of McPherson: Legislative Programs (1965 thru 1968), Box 11 (1411) (1412), Office Files of Harry McPherson, OFWHA, LBJ PL.
[114] ACIR, *Medicaid*, 60.
[115] Transcript, Wilbur J. Cohen Oral History, December 8, 1968, by David G. McComb, Tape #2, Oral History Collection, LBJ PL, 11.

of the 4 million are not now adequately covered by private medical insurance, group practice, or their own resources. In other words, under the proposed program, we would be spending \$3 on those who don't need the help to get \$1 to those who do. You are aware of how difficult it is to get higher taxes. And this will soon apply to payroll taxes as well – since they are already scheduled to rise steeply over the next decade. Why burden the tax system with \$4 worth of hard-to-get taxes in order to get \$1 of medical care where it is really needed?"[116] The argument used by the Bureau of the Budget was the same as was repetitively argued and continues to be in the modern era. The primary question in American social policy has been whether to broadly cover entire populations with social insurance financing versus whether to target particular populations, means-test, and only provide services to those who can find care in no other way.

The problem faced here has continued to plague health financing expansions into the modern era. When new reforms to cover people without health insurance incurs cost shifting to the government for populations that already have some form of health financing, it generally stops the reform. The only way to overcome this hurdle would be to "eat" the additional cost of covering people who already have access to health financing who also make the eligibility cutoffs in order to cover everyone else who does not have access to health financing.

In another repeating policy debate in health care, that of rights versus costs, the Bureau of the Budget questioned the expense of Kiddicare. They wrote to the President, "Medical costs are already rising at 9-10% per year. Putting this additional load on the system will accelerate this problem – which can become a major national issue. On the other hand, a carefully targeted program, aimed at the much smaller group in real need of it, could much more easily be handled by the system."[117] In conclusion, they suggested to finance this effort through Medicaid and to "liberalize Medicaid to increase the federal

[116] Memo, Charles L. Schultze, Director Bureau of the Budget, for the President, Subject: "Insured Medical Care for Mothers and Children ("Kiddicare"), January 3, 1968, Folder: LE/WE6 9/1/67, Box 164, WHCF Legislation EX (LE/WE), LBJ PL.
[117] Memo, Charles L. Schultze, Director Bureau of the Budget, for the President, Subject: "Insured Medical Care for Mothers and Children ("Kiddicare"), January 3, 1968, Folder: LE/WE6 9/1/67, Box 164, WHCF Legislation EX (LE/WE), LBJ PL.

contribution for maternal and child health costs."[118] Almost as soon as Medicaid was enacted, a trend began to allocate – even push off – responsibilities to the Medicaid program that were too costly, too complex, too difficult for any other possible health financing solution. Medicaid became a catch-all net that was asked to meet multiple, incredibly challenging social problems – including health and supportive services. The Bureau of the Budget may not have realized it at the time, but Medicaid would take on this role for the next 40 years. It was asked to do multiple different tasks and to do them well. The states, of course, were partly caught in the whirlwind, for they were asked to finance, in part, this program. Another outcome, though, social insurance was not expanded from the elderly to kids. Wilbur Cohen's attempt to add populations to the social insurance financed group did not materialize.

The Rights Versus Costs Dilemma

Since the beginning of the Medicaid program costs have tempered rights. The Medicaid program began with a provision requiring "comprehensive care and services to substantially all individuals who were financially eligible for services" by July 1, 1975. Section 1903(e) of Title XIX (Medicaid) restricted HEW from making Medicaid payments to states unless states showed "efforts in the direction of broadening the scope of care and services" and "in the direction of liberalizing the eligibility requirements for medical assistance, with a view toward furnishing by July 1, 1975, comprehensive care and services to substantially all individuals who meet the plan's eligibility standards with respect to income and resources, including services to enable such individuals to attain or retain independence or self-care."[119] By 1967, New York state's projected federal share for that state's Medicaid program superseded the amount projected for the entire country. This spearheaded several restrictive changes in the program by the U.S. Congress

[118] Memo, Charles L. Schultze, Director Bureau of the Budget, for the President, Subject: "Insured Medical Care for Mothers and Children ("Kiddicare"), January 3, 1968, Folder: LE/WE6 9/1/67, Box 164, WHCF Legislation EX (LE/WE), LBJ PL.
[119] Stevens, *Medicaid: Anatomy*, 365.

including a direct eligibility link to cash welfare, then called Aid to Families with Dependent Children (AFDC).

The original idea behind Medicaid, which was enacted in 1965, was towards expansion and full coverage regardless of categorical distinctions – or as the section read "with a view toward furnishing by July 1, 1975 comprehensive care and services to substantially all individuals" who were financially eligible for services. Instead, however, expansion gave way to cost concerns. Wilbur Cohen recounted: "We know it wasn't possible in 1965 to put cost controls in it. It would have never passed Congress. That would have been federal control, which was the whole political issue at the time."[120] So cost controls were not introduced in order to assure passage of the initial legislation. Even with a financing arrangement structured around federalism, with the federal government sharing the costs with the states of the original principle of Comprehensive Care in Medicaid, the provision did not survive. In 1969, the comprehensive services provision was postponed from 1975 until 1977.[121] In 1970, the 1977 deadline for comprehensive services was deleted altogether.[122] This path to the "right to healthcare" via the Medicaid program was not preserved, even with the benefit of federalism, with costs being dispersed between governments.

In March 1968 President Johnson sent to Congress a message on health in which he relayed that health care costs of the country would double and costs for an average American family would double in seven years. Action was needed. He asked Congress for authority to change the hospital reimbursement systems – a cost and cost-plus system at the time. He was denied.[123] Cost savings would have to be generated from other retractions.

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[120] Wilbur J. Cohen, Discussion in "Part V: Education and Health." In Barbara Jordan and Elspeth Rostow (eds.), *The Great Society: A Twenty Year Critique* (Austin, Texas: The Lyndon Baines Johnson School of Public Affairs and The Lyndon Baines Johnson Library 1986), 114.

[121] Stevens, *Welfare Medicine*, 215.

[122] Stevens, *Welfare Medicine*, 337.

[123] Joseph A., Califano, Jr., Statement in "Part V: Education and Health." In Barbara Jordan and Elspeth Rostow (eds.), *The Great Society: A Twenty Year Critique* (Austin, Texas: The Lyndon Baines Johnson School of Public Affairs and The Lyndon Baines Johnson Library 1986), 99 - 100.

There were other paths to a right to healthcare via the Medicaid program. The Medicaid program, however, then exposed subtleties – or perhaps not so subtle characteristics – of its entitlement. The entitlement was subject to the country's financial status of the time. Therefore, rights were variable. These were not the rights of the 14th Amendment, per se, where the federal government placed protections from discriminations of different types as above most cost benefit analysis. There would be no discrimination regarding particular protected groups. The Warren Court made this clear. Medicaid – and more generally Welfare – Rights at one point in the Warren Court era were made stronger by decisions that identified poverty as a suspect classification or fundamental interest under the 14th Amendment's Equal Protection and Due Process clauses.

This trend was not continued in the Burger Court era. Without Constitutional backing, courts tended to defer to legislative policy decisions in specialized areas of social policy where administrative expertise was often considered necessary to spend limited resources. Medicaid thus was subject to the will of the majority and health provision left as the provision of a "generous legislature" instead of a basic minimum right. Minimum health provision was subjected to cost constraints and thereby – even though an entitlement – not one with revered Constitutional status or even the consensus that health protection was a natural right.

This decision, in part, was based on the fact that determining minimum health package for all American was – and remains – a daunting task. The expenses could be astronomical. In fact the expenditure of GNP could surpass 100% and even continue from there in an upward direction. The definition of this minimum would mean the federal government was rationing – not just health services – but life itself. These decisions seemed best to leave to Adam Smith's invisible hand in the market and to the political bargaining that is politics version of the invisible hand. This line of thinking was described by the legal scholar Cass Sunstein: Regulatory legislation of the 1960s and 1970s has often been indifferent to cost, on the theory that no price tag should be put on life and health, which are "inalienable rights." He continues, "No sensible regulatory

program, however, can be indifferent to cost. Regulatory expenditures, if sufficiently high, will endanger the economy, increase unemployment and poverty, and eventually risk both life and health as a result."[124]

As the Stevens recounts in the classic *Welfare Medicine*, which was first written in the early 1970s, "Medicaid would rise and fall according to fiscal rather than humanitarian objectives." The Medicaid entitlement to individuals was weak,[125] so weak that it was balanced against costs as a matter of course. In fact, costs often cause retractions or restriction in the entitlement. It was not the entitlement of strict scrutiny or a fundamental interest of the 14th Amendment. It was also not the entitlement of social insurance programs – earned and paid for. Finally, it was not the entitlement of strictly federal means-tested programs (SSI, Food Stamps) which clearly involved the federal courts in disputes with agencies. The interaction of federalism, means-testing, and categorical distinctions in the Medicaid program created a very weak individual entitlement indeed.

CONCLUSION

The enactment of Medicaid -- and Medicare -- was the great shock wave in American health policy. The year 1965 is the year America got its version of a national health effort. Business and distributional interests would play a key role in bargaining the institutional structure of Medicaid and Medicare. For in the U.S., the private business infrastructure buoys the government health programs -- and in time, this arrangement has become reciprocal.

It is no accident that creative federalism was at the heart of the Medicaid compact. This was FDR's federalism, and it was LBJ's brand of federalism too. A big believer in

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[124] Cass Sunstein, *After the Rights Revolution* (Cambridge, Massachusetts: Harvard University Press, 1990), 90.

[125] See Timothy Jost, "The Tenuous Nature of the Medicaid Entitlement; Federal Rights Remain Under Threat and Must Be Strengthened," *Health Affairs* 22, no. 1, (January - February 2003); and Timothy Jost, *Disentitlement?: The Threats Facing Our Public Health Programs and a Rights-Based Response* (New York: Oxford University Press, 2003).

gradualism, Wilbur Cohen fashioned Medicaid to be a possible basis for national health reform. Wilbur Mills, the powerful Ways and Means Committee Chairman, would later comment that the Medicaid open matching structure was not a policy reform he agreed with in retrospect. He was leery of its inflationary propensity. Nonetheless, a monumental shock wave for Medicaid was the 1967 Social Security Amendments. Severely restructuring the original Medicaid compact, one of the country's foremost Medicaid experts called these 1967 amendments "the deal with the devil."[126] After New York and California structured programs that would spend as much for their states as was projected for funding the entire Medicaid program, the Medicaid rules were re-written.

This was the beginning of the re-structuring of the original principles of the Medicaid program. States indigent care populations far outstripped the newly constructed Medicaid boundaries after the 1967 re-working.[127] The momentum tipped toward an eventual reneging on the promise for states to try to cover all their indigent populations, first postponing the Comprehensiveness Provision in 1969 and then dismissing it altogether in 1970.

And now, in the flanks awaited a whole new team of policy professionals -- waiting to re-fashion the American welfare state in their own way. President Nixon was both progressive and conservative. An anomaly and a fascinating study of the American welfare state are his Administration's negotiations around its agenda for reform. This is the topic of the next chapter. Medicaid was caught in the maelstrom and, at times, was addressed specifically by an Administration that had impressive plans for the American welfare state. The next chapter investigates the Nixon, Ford, and Carter Administration eras in terms of Medicaid federalism, the policy bargaining that shaped it, and all of the macro forces that pressured its development.

[126] Interview with Author, October 31, 2006.
[127] Interview with Author, October 31, 2006.

5. THE WATERSHED YEARS, NEW FEDERALISM, AND PROPOSALS FOR A NEW FEDERAL ROLE IN MEDICAID

INTRODUCTION

The Nixon years are among the most intriguing in American social policy history. Nixon's domestic agenda included proposals for a federal minimum income, national health insurance, and a renewed role for the federal government towards the Medicaid population. These policy positions, with no information regarding the specifics, point to a seemingly progressive, even liberal, social policy agenda. Nevertheless, President Nixon espoused a New Federalism and a social policy agenda claiming to be antithetical to LBJ's War on Poverty. His use of the federal government in social policy supported the development of localized private entities, particularly prepaid capitated arrangements such as health maintenance organizations, and worked towards uniform standards linked with personal responsibility. He often turned to the rhetoric of equal opportunity in collaboration with his numerous federal cost and price control measures. By the end of his term, he had proposed and fought for major structural Medicaid, national health, and social policy reform.

The Nixon era is instrumental in Medicaid policy history for a number of reasons. First, the Medicaid law in 1965 was written relatively quickly with very little debate, meaning that it was intended that regulation -- or future statutory action -- would further define the main precepts behind the program. The original major precepts were expansionary, embraced equal opportunity for those with low incomes in the broader health care marketplace, and tied provider payment --particularly for Medicaid hospital

care -- to Medicare payment rates. Instead of further defining Medicaid in expansionary terms, the succeeding amendments had limited the program. During the Nixon era, many of the original precepts were abrogated themselves and incremental reform leaned towards greater experimentation by states, use of prepaid capitated care, and reductions in provider payment for Medicaid services.

Nixon started his Presidency claiming in his first inaugural address " I ask you to share with me today the majesty of the moment"[1] and ended his Presidency claiming "I am not a crook." In between was one of the greatest pushes for a new federal role in Medicaid, social policy, and national health reform in the country's history. In particular, the possibilities for national health reform would not be as imminent again until President Clinton's national health reform proposal in 1993-94. Nixon, as Clinton also would claim later, presented the most striking welfare state renewal since the New Deal. The epic nature of his national health proposal -- including the parallel federal Medicaid reform -- combined with the seriousness with which it was considered lends this effort a "near big bang" status in American social policy. This chapter reviews the major policy bargains, policy environmental factors, and co-evolutionary policy streams that structured this watershed era.

NIXON POLICY -- AND HIS SOCIAL WELFARE AGENDA

Nixon policy positions were greatly affected by intense medical price inflation. Medicaid costs increased three times more than the number of people served between 1968 and 1970.[2] Also, by 1970, the number of people who received Federally aided medical assistance doubled from 1965.[3] President Nixon's messages regarding health

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[1] Richard Nixon, "Inaugural Address," January 20, 1969, Item #1, *Public Papers of the Presidents of the United States, 1969* (Washington D.C.: U.S. Government Printing Office, 1971), 1.
[2] 1970 *CQ Almanac*, 578.
[3] U.S. Senate Committee on Finance, *Social Security Amendments of 1970 Hearing on H.R. 17550*, "Statement of Hon. Elliot L. Richardson," July 14, 1970, Committees of Congress Senate Committee on Finance, Beginning: Y.F49 So1/8/958 - Ending: Y .F49: So1/8/970/3, 4-1377, Box No. 4-1377, RG 287, Ninety-First Congress, Second Session, Part I, Legislative Archives, National Archives -- Washington D.C., 66 - 69. (Hereafter U.S. Sen. Comm. on Finance, *SS Amendments of 1970 Hearing*)

embraced both the language of cost control and of equal opportunity. He supported the inclusion of medical prices in the Economic Stabilization program[4] and spoke eloquently of the need for equal opportunity regarding financial access in health care.[5] Even while seemingly identifying victories on equal opportunity from the 1960s as models of what he wanted to accomplish in the health area, he was largely critical of many Great Society initiatives.[6] Regarding the 1965 enactment of Medicare and Medicaid, he repeatedly blamed the architects for ignoring the laws of supply and demand. Repeatedly throughout his Presidency he derided the social planners of the Great Society for the medical inflation that far outpaced other prices. "It does little good…to increase the demand for care unless we also increase the supply….This axiom was ignored when Medicaid and Medicare were created -- and the nation paid a high price for that error."[7]

The President's policy positions and priorities have been described as ironic, contradictory, even schizophrenic. At the very least, President Nixon's policy views cannot be cleanly pinpointed on the ideological spectrum. In biographies attempting to grasp Nixon's Presidency, it is offered that Nixon's "compassionate conservatism" was never communicated effectively to the public and also that welfare matters "absorbed more of his interest than any other domestic issue."[8] Perhaps, the message is clearest in his own memoirs: "I wanted to be an activist President in domestic policy, but I wanted

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[4] Richard Nixon, "Special Message to the Congress on Health Care," March 2, 1972, Item #74, *Public Papers of the Presidents of the United States1972* (Washington D.C.: U.S. GPO, 1974), 385 - 386. "Several months ago, the Price Commission ruled that increases in physician fees must be kept to within 2 1/2 percent. Rules also were issued to hold down runaway price increases among hospitals, nursing homes and other health care institutions."

[5] "Just as our National Government has moved to provide equal opportunity in areas such as education, employment and voting, so we must now work to expand the opportunity for all citizens to obtain a decent standard of medical care. We must do all we can to remove any racial, economic, social or geographic barriers which now prevent any of our citizens from obtaining adequate health protection. For without good health, no man can fully utilize his other opportunities." From President Nixon's Feb. 18, 1971 message to Congress on health insurance. Source: Richard Nixon quoted in 1971 *CQ Almanac*, 34 - A.

[6] His policy decisions reportedly attempted to eventually dismantle the Office of Economic Development (OED) and de-fund the legal services network that had won so many federal legal battles in welfare rights.

[7] Nixon, Richard, *1971 CQ Almanac*, 34-A (from President Nixon's Feb. 18, 1971 message to Congress on health insurance.)

[8] See Joan Hoff's *Nixon Reconsidered* (New York, NY: Basic Books, 1994), 118 - 119. Quote on welfare matters is attributed to Patrick Moynihan. Certainly, from a particular point, he repeatedly reminded Congress that the Family Assistance Plan (FAP) was his first priority. His Medicaid reform plans stemmed directly from FAP -- and so the link between cash welfare and welfare medicine placed Medicaid atop the President's Domestic Agenda.

to be certain that the things we did had a chance of working." Nixon's Federal Assistance Plan (FAP) for cash welfare families failed but the debates around the initiative introduced language and thought on minimum income proposals and use of the federal government to standardize benefits across states. After the Nixon Presidency, the tally card read victories scored in creating a minimum income for the blind, elderly and disabled via the new Supplemental Security Income (SSI) program and a revolutionized Food Stamp program. Unintended spin-offs included the Earned Income Tax Credit, which was neatly hidden in a massive tax bill by Senator Long after Nixon had already left office[9] and a monumental change in the institutional rules governing the budget, instigated by Nixon's impoundment of federal funds.

THE WATERSHED ERA

Shortly after winning a razor-close election, Nixon quipped: it's time "to get down to the nut-cutting."[10] The 1970s mark a watershed era in American policy.[11] If one year was pinpointed as the turnaround, when the cover was closed on a previous era and the book opened on the new age, it was 1974. In entitlement bargaining, including for Medicaid, the apex of the turnaround is marked by enactment of the Congressional Budget and Impoundment Control Act (P.L. 93-344). Importantly, 1974 marks the resignation of President Nixon following the culmination of the Watergate Scandal. The Budget Revolution was also instigated by the President's decisions "to impound billions of federal dollars appropriated by Congress."[12]

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[9] Christopher Howard,, *The Hidden Welfare State: Tax Expenditures and Social Policy in the United States* (Princeton, New Jersey: Princeton University Press, 1997), 70 - 73.
[10] Bruce J. Shulman, *The Seventies: The Great Shift in American Culture, Society, and Politics* (Cambridge, Massachusetts: Da Capo Press, 2001), 23.
[11] See particularly Edward D. Berkowitz, "The 1970s as Policy Watershed," Draft paper for the 2005 Meetings of the American Political Science Association. (Hereafter, Berkowitz, "The 1970s as Policy Watershed")
[12] National Archives and Records Administration, The Senate Committee on the Budget, "A Brief History of the Committee." See http://archives.gov/records_of_congress/committee_resource_guies/senate/budget/budget.html (accessed April 22, 2005).

Via the Budget Act, the institutional rules that shaped social policy bargaining were re-written, the Congressional Budget Office created, and Congressional Committee responsibilities surrounding the budget re-designed. Pre-1974, many social legislation initiatives were part of amendments to the Social Security Act. After the rule changes in 1974-- not fully effectuated until 1980 and 1981 when Reconciliation was further defined-- social policy legislation was more often than not enacted in Omnibus Budget Reconciliation (OBRA) bills. This institutional rule change -- as mundane the details may seem -- marks the most fundamental shift in how American social policy is negotiated in history.

Other major shifts of the era include the ideological trajectory of the Supreme Court moving substantially to the right with four new Nixon appointees. New Constitutional welfare rights were no longer a viable possibility.[13] Second, in addition to Congress imposing deep limits on Executive power with the enactment of the aforementioned Congressional Budget Act of 1974, it also began providing guidance and earmarks to federal agencies with greater intensity. The early 1970s also marks a transformation in the rules of the United States Congress, discussed in more detail later in this section. Medicaid's pre-eminent House Ways and Means Committee was stripped of a great deal of deference via numerous rule changes, which culminated with Wilbur Mill's resignation. Hence, the exit in 1975 of the man who sponsored Kerr-Mills, the predecessor to Medicaid, and who had included Medicaid in the three-pronged 1965 enactment. Medicaid's jurisdiction was transferred in 1975 to the House Energy and Commerce Committee, thus separating it from Medicare Part A, which remained under the jurisdiction of Ways and Means.

Numerous retirements of institutional economists and administrators who had institutional knowledge back to the New Deal added to the tectonic shift of the mid-1970s. Finally, inflation and the economic trajectory began to undermine social policy initiatives, until finally President Ford in 1975 decided to carefully watch any costly new federal commitments. As if this all was not enough, there was a paradigm shift of major

[13] In particular the 1970 *Dandridge* v. *Williams* and the 1973 *San Antonio Independent School District* v. *Rodriguez* were sea-changing Supreme Court decisions.

proportions in macro-economic thought around the 1974-75 recession, discussed in the next part. On the Revenue side, tax policy also was going through a metamorphosis, with negotiations emphasizing efficiency moreso than redistribution or economic justice.[14] More generally, citizen faith in the State to solve social problems was tarnished by the Watergate scandal. In aggregate, American political economy was never the same. A neoliberalism was gaining ground on social democracy in many advanced democracies. The ground was fertile for a new wave of thinking, for the "Me Generation," out of which would sprout Reagan-Thatcherism.[15] Federalism would be used instrumentally in wholly new ways in this new era -- shaped by the institutional rule changes of the Nixon era. Medicaid, far from being part of the block granting efforts of Nixon's New Federalism, instead was part of the social welfare state deemed in need of federal intervention, standardization, and equal opportunity.

Changes in Macro-Economics and Changing of the Guard in Administration

As Walt Rostow observed, the economy in the early 1970s "experienced a turning point…a break as sharp as those of the 1790s, 1840s, 1890s, and 1930s."[16] From the post-war boom of the 1940s until the late 1960s, the economy had surged, only to begin a descent in the 1970s. The 1974-75 recession included inflation and stagnation -- stagflation. "Instead of inflation or recession, as conventional theory, including neoclassical Keynesianism the 1970s thus brought inflation with recession."[17] This created an environment of tectonic shift in macroeconomic theorizing. As Rosenof

[14] Julian E. Zelizer, *Taxing America: Wilbur D. Mills, Congress, and the State, 1945 - 1975* (Cambridge, UK: Cambridge University Press, 1998), 166. "Gone from the public rhetoric were terms such as 'redistribution of wealth,' 'social class,' and 'economic justice.' The new language of tax reform played down the discussion of income redistribution and social justice while focusing on economic 'efficiency' and 'growth.'" (Hereafter Zelizer, *Taxing America*)
[15] Tony Gidden's *The Third Way: The Renewal of Social Democracy* (Cambridge, UK: Polity Press, 1998; repr.) documents this transformation in Advanced Economy Democratic politics.
[16] W.W. Rostow, "Kondratieff, Schumpeter, and Kuznets: Trend Periods Revisited, " *Journal of Economic History* 35 (Dec. 1975): 749. Cited in Theodore Rosenof, *Economics in the Long Run: New Deal Theorists & Their Legacies, 1933 - 1993* (Chapel Hill, NC: The University of North Carolina Press, 1997), 151. (Hereafter Rosenof, *Economics*)
[17] Rosenof, *Economics*, 129.

recounts: "The dissonance of the 1970s broke apart the neoclassical Keynesian synthesis of the boom decades and sent economists flying in various directions."[18] Further, he writes, "The recession of 1974-75, linked to inflation, triggered the sense that a new era was at hand."[19] The new era was fertile ground for what would lead to Reaganomics. "It led to the resurgence of interest in planning and subsequent industrial policy and to a period of great influence of monetarism and a vogue of jejune supply-side economics."[20]

Generally, in administrative dealings, there was a vital sea change in expertise, as well. The New Dealers, many of them economists, were trained in a tradition that considered historicity, political, social, and cultural climate changes in their design and implementation of the 1935 Social Security Act. Prior to the Nixon era, the link to FDR's Administration was evident; many Administration appointees had institutional memories that went back that far. Also, there was an important link to the University of Wisconsin, where many New Deal economists had been trained. Many of these experts proceeded to play a major role in administrative policy development and Social Security Act politics through the Great Society era, as well.

When Nixon took office, this marked the official retirement -- in official government -- of many of these experts, including Wilbur Cohen who had played a major role in orchestrating Medicaid's passage in 1965. In 1973, the Social Security Administration was further cleared of experts from an earlier era. Notably, Robert Ball resigned as Social Security Commissioner in 1973.[21] In combination with the retirement of Wilbur Mills, many institutional economists who had orchestrated SSA development to that point were in the past.

With the retirement, optional or de-facto by Nixon's Presidential victory, of many of these experts, a link to the New Deal and Great Society past was breached. The Administrative capacity and knowledge base of the Social Security Administration and Health, Education, and Welfare (HEW) agency's links to the "Reform" past were diminished. The new appointees represented a different epoch and many of the

[18] Rosenof, *Economics*, 145.
[19] Rosenof, *Economics*, 164.
[20] Rosenof, *Economics*, 145.
[21] Berkowitz, "The 1970s as Policy Watershed," 10.

economists of this era emphasized static neoclassical economics, now the dominant paradigm in universities. A final trend in Administrative responsibilities that contributed to the watershed moment of the mid-1970s was the continuing de-emphasis of the Council of Economic Advisors (CEA) and also the Joint Economic Committee (JEC) in favor of reliance on the Office of Management and Budget (OMB). The reliance on OMB would become particularly salient in 1981, but indeed it had already been well under way before the watershed 1970s.

Congressional Power Shift

In the early 1970s a series of rule changes in the United States Congress critically affected social policy bargaining. Through enactment of the Congressional Budget Act, Congress had wrestled power from the Executive. They also began making much more specific instructions in legislation to federal agencies.[22] Also, in part stemming from Watergate, accountability was a new catch phrase. The Budget Act of 1974 had created the Senate Budget Committee, created the Congressional Budget Office, and re-organized the power structure in Congress. Also, the massive class of Freshman Democrats in the 94th Congress -- comprising 75 new House members -- further instigated rules reforms that had been brewing for many years.[23] In 1975, Democrats "removed three sitting chairs, pressured another into resigning, and weakened the House Ways and Means Committee."[24]

For Medicaid, the Ways and Means Committee, so instrumental in its enactment and evolution up until that point, went through a major transformation. The progenitor of

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[22] Allen Schick in *The Federal Budget: Politics, Policy, and Process* (Washington, D.C.: The Brookings Institution, 2000), 236 writes: "Since the 1970s, guidance and earmarks have become much more detailed and numerous, leading some to complain that Congress is micromanaging agencies and denying them the freedom to operate efficiently." (Hereafter Schick, *The Federal Budget*)

[23] Nelson W. Polsby, *How Congress Evolves: Social Bases of Institutional Change* (New York, NY: Oxford University Press, 2004), 65.

[24] Julian, E. Zelizer, *On Capitol Hill: The Struggle to Reform Congress and Its Consequences, 1948 - 2000* (Cambridge, UK: Cambridge University Press, 2004), 157. With regard to just how many years the reforms had been brewing, Zelizer writes: "The attack on committee autonomy and the filibuster was the culmination of a sequence of institutional changes that had started in the 1950s." Zelizer, *On Capitol Hill*, 176.

Medicaid, Wilbur Mills decided after reclaiming his Congressional seat in the 1974 election that he would not seek re-election in his now customary post of Chairman of the Ways and Means Committee. Scandal involving an evening swim with an exotic dancer in Washington, D.C.'s Tidal Basin had made national news followed shortly thereafter by an appearance with the same dancer in a Boston night club.[25] The changing institutional rules of the United States Congress coincided with the end of the Congressional career of one of the most influential tax and social policy legislators in American history.

After 1975, Committee appointees were made by the Democratic Steering and Policy Committee instead of Ways and Means; Ways and Means was required to have at least six subcommittees making it more difficult for the full committee to keep controversial items off the congressional agenda; the Committee was enlarged; most markups were held in open as opposed to closed sessions; most bills were considered under a limited rule that permitted designated floor amendments instead of the preferential closed rule enjoyed previously by Ways and Means.[26] Vitally for Medicaid, Energy and Commerce took complete jurisdiction over Medicaid and partial jurisdiction over Medicare Part B. Both were previously under complete jurisdiction of the Ways and Means Committee.[27] In combination with the new budget rules, a new time in Medicaid policy bargaining had begun.

Also, the nature of Democratic party was changing. A contingent of "The Watergate Babies," the freshman Democrats, affiliated more with suburban voters than with the "Reform Politics" of the party's recent past. As James Blanchard (D-MI) said, "Clearly we don't think of ourselves as New Dealers at all -- or proponents of the Great Society either."[28] Organized labor also began to split into different factions outside of the centralized oversight of the AFL-CIO.[29] The Democrat's reform wing was splintering. Julian Zelizer summarizes the discernable change in at least a faction of the party, "In the

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[25] Berkowitz, "The 1970s as Policy Watershed," 10 - 13.
[26] In 1973, H.R. Gross (R - Iowa) had commented, the Ways and Means Committee "for some reason known only to the Lord himself, always gets a closed rule." See 1973 *CQ Almanac*, 573 - 574.
[27] Schick, *The Federal Budget*, 142.
[28] Zelizer, *On Capitol Hill*, 157
[29] Zelizer, *On Capitol Hill*, 157.

minds of many Watergate Babies, suburban voters were not always enthusiastic about the interests of organized labor, were skeptical about welfare, and were eager to limit taxes."[30]

COST CONTROL

The Nixon Administration had inherited a Medicaid program without many built-in cost control mechanisms. In the 1970s, the federalism shift in Medicaid was embodied in the federal role in cost control. While during enactment, the federal government was kept out of cost control because this would have been "federal control," in the Nixon era, Congressional hearings repeatedly pounded the point that there had to be stronger federal direction in order to control federal costs. States also wanted federalization. "While there were, indeed, continuing requests from states for more flexibility in state administration, that was primarily to cut costs; there were few advocates of states' rights pressing for returning welfare medicine to the states…..The states were, rather, pressing for federalization."[31]

The Nixon Administration appeared at times to approach cost control as an obsession and at other times as an afterthought. The Nixon era was filled with idiosyncrasies, many of which indicated mixes of ideologies, policy responses, and even seemingly contradictory policy. At times, rising costs were used as a primary argument for aggressive reform, whereas at other times as the major defense for a guarded policy response. In general, though, a discernible shift was evident in the policy drift towards cost trumping redistribution concerns. Whereas, it had been resolved that redistribution was best placed at the federal level, the role of the federal government in holding down costs was being re-defined. A general wage-price freeze was instituted by the Nixon Administration in August 1971 and re-defined in December limiting doctors' fees to annual increases of 2.5% and hospital charges to increases of 6%.[32]

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[30] Zelizer, *On Capitol Hill*, 157.
[31] Stevens, *Welfare Medicine*, 237.
[32] Starr, *The Social Transformation*, 399.

Cost control was not solely the province of the federal government, as states began to establish certificate of need programs. By the end of 1972, 20 states required medical institutions, usually both hospitals and nursing homes, to get state approval for construction projects and other large capital investments.[33] Some states also ventured into regulation of hospital rates -- some for Medicaid beneficiaries only and some for all payers. While mandatory rate regulation did not truly gain steam until the Ford era, it began in New York in 1971.[34] In 1974 The National Health Planning and Resource Development Act established as the foundation of a new planning system some 200 Health Systems Agencies (HSAs).[35] Also in 1974, ERISA (Employee Retirement Income Security Act) legislation transformed health policy federalism when it superseded state power to regulate self-insured health insurance policies. Instrumental federalism was at work -- even in the age of New Federalism.

At the same time that cost control was pursued, regulation multiplied. The new block grants and general revenue sharing of the Nixon era distributed federal influence into communities in ways that amplified federal power since many localities were exposed to this influence for the first time. The net result was that "Federal expenditures for many domestic functions were increased dramatically, and an unprecedented federal intergovernmental regulatory presence was institutionalized."[36] With this, the irony of the Nixon Administration again was in play. While increased regulation may increase costs; regulation also can structure cost control mechanisms.

Managed Care

The Social Security Amendments of 1970 made health maintenance organizations an option for both Medicaid and Medicare. Further, the HMO Act of 1973 took steps to encourage the growth of managed care -- another example of federal law pre-empting

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[33] Starr, *The Social Transformation*, 398.
[34] Starr, *The Social Transformation*, 399.
[35] Starr, *The Social Transformation*, 402.
[36] Timothy Conlan, *From New Federalism to Devolution: Twenty-Five Years of Intergovernmental Reform* (Washington, D.C.: The Brookings Institution Press, 1998), 91. (Hereafter Conlan, *From Federalism to Devolution*)

state laws when it serves a federal purpose. The Nixon Administration's interest in managed care was defended on both cost and equity grounds, marking again the bridge it played between the Great Society and Reagan eras. On the one hand, HMOS provided cost containment via capitation and on the other they instituted a one-class medical system with Medicaid and private beneficiaries in indistinguishable settings.[37] More often then not though the Nixon defense of managed care was on efficiency and cost grounds. In another juxtaposition, Nixon's Administration recast what had been a "fluffy" far-left concept into a conservative one.

The McNerney Taskforce on Medicaid in 1970 endorsed "the innovative approach of the Administration's Health Maintenance Organization proposal to provide an option for Medicare and Medicaid beneficiaries to elect to receive health services through a single organization that provides coordinated services financed through prepaid capitation."[38] Some states picked up the mantle on managed care. The State of Washington began contracting with GroupHealth in 1970.[39] In 1972 various regional operations of Kaiser-Permanente were accepting Medicaid enrollments in three different states.[40] Finally, Governors Ronald Reagan and Nelson Rockefeller also pushed the HMO concept at the state level.[41]

Medicaid Fraud

In addition to cost inflation, enactment of Medicaid had resulted in major problems with fraud and unscrupulous medical practitioners maximizing their profits through wrangling the federal and state payment systems. Reports were rampant in the media and the U.S. General Accounting Office (GAO), the investigative arm of the

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[37] Stevens, *Welfare Medicine*, 230.
[38] U.S. Department of Health, Education, and Welfare, "Report of the Task Force on Medicaid and Related Programs (McNerney Report): Summary," Chap. 33 in *Medicaid Lessons for National Health Insurance*, eds. Spiegel, Allen D. and Podair, Simon (Rockville, Maryland: Aspens Systems, 1975), 297. Reprint from U.S.HEW, GPO 0-398-052. (Hereafter U.S. HEW, *McNerney Report*)
[39] Andy Schneider, *The Medicaid Source Book*, (Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, July 2002), 1011. (Hereafter Schneider, *Medicaid Source Book*)
[40] Schneider, *Medicaid Source Book*, 1011.
[41] Starr, *The Social Transformation*, 396.

Congress, found its own examples. The Associated Physicians of Cook County Hospital, a non-profit Chicago association of doctors and teachers, had billed the Government a total of $1.6 million within a year. The GAO witnesses reported that in 129 out of 747 cases of billing by the Association there was no evidence that any medical service had been performed.[42] HEW Under-Secretary Veneman pointed the finger at federalism for lack of oversight and accountability: "Federal officials have been lax in not seeing to it that states establish and employee effective controls on utilization and costs, and states have been unwilling to assume the responsibility on their own."[43] For many doctors, Medicaid and Medicare were a lucrative source of added income; for a few, the programs were a goldmine.[44]

RIGHTS ADJUDICATION IN CONSTITUTIONAL AND STATUTORY CASES

The late 1960s and early 1970s proved to be a time of contrasts in rights adjudication. While substantive welfare rights were never found in the Constitution, procedural and statutory cases in federal courts did expand public assistance programs. Since Medicaid eligibility was linked directly to the AFDC programs, many of these cases had direct relevance for the Medicaid program. Also, many of the precedents set in cash program cases extended to other similarly structured means-tested programs, of which Medicaid was one. Two major findings from this era are that a distinction was maintained between Economic Matters and Individual Rights, the former being the province of legislatures and executive power and the latter being in the arena of the courts.[45]

While these seminal cases in welfare rights provide an important framework for understanding the evolution of institutional rules and interbranch relationships during the

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[42] 1969 *CQ Almanac*, 385.
[43] John G. Veneman, HEW Under Secretary, Testimony before the Senate Finance Committee in 1969, *1970 CQ Almanac*, 578.
[44] *1970 CQ Almanac*, 578.
[45] See Elizabeth Bussiere in *(Dis)Entitling The Poor: The Warren Court, Welfare Rights, and the American Political Tradition* (University Park, PA: Pennsylvania State University Press, 1997). (Hereafter, Bussiere, *(Dis)Entitling)*.

Nixon era, another vital development during this era was the establishment via case law of federal rights of action for Medicaid recipients -- both in Constitutional and in Social Security Act statutory claims. According to Timothy Jost, "Unlike the Medicare statute, the Medicaid statute does not explicitly provide for federal judicial review of Medicaid eligibility or claims decisions. Nevertheless, almost from the outset, the federal courts have allowed Medicaid beneficiaries to challenge state Medicaid decisions under 42 U.S.C. section 1983, a Reconstruction-era civil rights law."[46] Between 1968 and 1975, the Supreme Court decided 18 cases involving the AFDC program that firmly established the right of welfare recipients under federal/state programs, including Medicaid, to remedies in the federal courts.[47] A series of several Social Security Act cases moved towards establishing that Section 1983 provided the cause of action for suits challenging violations of the Social Security Act.[48]

Welfare Rights As They Relate to Medicaid Federalism

The area of welfare rights adjudication shifted with the Nixon Administration. The tenor of the Supreme Court was dramatically altered to the conservative right by the narrow Republican Presidential victory. Nixon appointed Warren Burger as the New Chief Justice in 1969; Harry Blackmun in 1970; and Lewis Powell and William Rehnquist in 1972.[49] The change in the make-up of the court, no doubt, affected the majorities in future cases and re-cast the ideological make-up of the Court. However, some scholars have noted that this change is not the about-face that it may seem in welfare rights adjudication. While there was definitely a change in ideology, in leadership, and in political pressures, some have noted that the judicial pathways that

[46] Jost, *Disentitlement*, 35.
[47] Jost, *Disentitlement*, 91.
[48] Jost, *Disentitlement*, 92.
[49] See William E. Forbath, "Social Rights, Courts, and Constitutional Democracy -- Poverty and Welfare Rights in the U.S.," Forthcoming in Julio Faudez, ed., *On the State of Democracy* (London: Routledge, 2006): 20.

failed to find a substantive right to welfare in the Constitution were set long ago.[50] In short, liberal justices had set the pathways for these findings by discrediting natural law ideas in the past.

The 1970 *Goldberg* v. *Kelly* decision[51] "recognized the constitutional rights of welfare recipients to notice and predetermination hearings, established welfare benefits as 'statutory entitlements' and expressly rejected the argument that public assistance benefits were 'a privilege' and not 'a right.'"[52] The Court also famously quoted a *Yale Law Journal* Article by Charles Reich in its decision, which outlined an argument that used the language of classicism -- an argument based on property rights -- to defend the poor. By linking public assistance to property, classical property rights arguments were co-opted for use by the poor. This case was an important precedent for establishing the right for Medicaid recipients to notification and hearing prior to dismissal of benefits. There were some procedural rights for welfare recipients in the Constitution. The case for substantive Constitutional rights was seriously hindered two weeks later in *Dandridge* v. *Williams*. The Court's conclusion: "the intractable economic, social, and even philosophical problems presented by public welfare assistance programs are not the business of the Court."[53] Federal substantive rights for welfare recipients would become the pervue of Statutory cases, with serious Constitutional challenges relegated to cases linked with other vital interests. For example, a line of cases challenged the use of federal Medicaid funding for abortion.

Key to federalism issues, the 1973 *San Antonio School District* v. *Rodriguez* case was "the death knell for the idea that the Constitution protects social and economic rights."[54] The Supreme Court reversed a District Court decision that found wealth a "suspect"

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[50] Specifically, see Bussiere, *(Dis)Entitling*, particularly p. 160: "The problem was not that conservative justices blocked the way of constitutional subsistence rights. To the contrary, it was liberal justices and reformers who inadvertently impeded the later effort to obtain constitutional welfare rights by discrediting both natural-law and maternalist ideas during the Progressive and New Deal periods."
[51] Jost, *Disentitlement*, 28.
[52] Footnote #8 in the Goldberg decision also enunciated Charles Reich's New Property Argument for Welfare Rights. See Jost, *Disentitlement*, 93.
[53] David Kelley, *A Life of One's Own: Individual Rights and the Welfare State* (Washington, D.C.: The Cato Institute, 1998), 19. See *Dandridge* v. *Williams*, 397 U.S. 471, 487-88 (1970).
[54] Cass R. Sunstein, *The Second Bill of Rights: FDR's Unfinished Revolution and Why We Need It More Than Ever* (New York, NY: Basic Books, 2004), 165.

classification and education “a fundamental interest” in the claim that the Texas school financing framework, with its reliance on wide differentials between localities in education financing based on local tax revenues, and thus wealth of districts, was discrimination under Equal Protection.[55] The Court found generally regarding this line of cases that “The lesson of these cases [is that it] is not the province of this Court to create substantive constitutional rights in the name of guaranteeing [equal protection].”[56]

The *Rodriguez* decision was particularly important for Medicaid because it involved a policy situation, in Education, where local fiscal capacity affected differentials in quality of services. The Court did not intervene despite these disadvantages by geography. In the opposite direction, State courts have often found that local education financing disparities due to differentials in local tax capacity are against their state constitutions.[57] This has opened up the possibility that similar challenges to intra-state differentials in Medicaid eligibility and benefits could be successful.

NIXON’S FAMILY ASSISTANCE PLAN AND NEW FEDERALISM -- AT ODDS OR IN SYNC?

For much of his Presidency, Nixon prioritized welfare reform as his Number One Domestic Priority. During this era, Medicaid reform was linked to and sprouted from Welfare reform. When Medicaid reform was proposed, it was part of the income maintenance reform addendums. On August 8, 1969 in a national television address, President Nixon outlined his idea for a national income floor that would be graduated as a family’s income rose so that employment would not completely cut-off benefits. The negative income tax concept was proposed by conservative scholars, Milton and Rose

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[55] Justice Powell in *San Antonio Independent School Dist.* v. *Rodriguez*, 411 U.S. 1, 93 S.Ct. 1278, 36 L.Ed.2d 16 (1973), in Kathleen M. Sullivan and Gerald Gunther (eds.), *Constitutional Law*, 14th ed. (New York, NY: Foundation Press, 2001), 852. (Hereafter Justice Powell, *San Antonio*)

[56] Justice Powell, *San Antonio*, 853. Also, “At least where wealth is involved, [equal protection] does not require absolute equality or precisely equal advantages.” (p. 852) Justice Stewart concurring with the majority, “The function of equal protection, rather, is simply to measure the validity of classifications created by state laws.” (p. 855)

[57] For example, *Serrano* v. *Priest* in California in 1971, *Van Dusartz* v. *Hatfield* in Minnesota in 1971, *Robinson* v. *Cahill* in New Jersey in 1972, *Milliken* v. *Green* in Michigan in 1973 – are all cases where state courts found school financing schemes unconstitutional at the state level. Source: Justice Powell, *San Antonio* Justice Powell in *San Antonio Independent School Dist.* v. *Rodriguez*, 852, Footnote #2.

Friedman, in the 1962 book *Capitalism and Freedom*.[58] This "inspired multimillion-dollar field experiments in the United States in the 1960s and 1970s to measure its effects on labor supply."[59] A major consideration in the debate of how to structure a minimum income requirement is federalism: should the federal government administer a national benefit or require a minimum benefit but leave the states in charge to provide a greater effort if they so chose.[60] Many of these same federalism questions soon would be the focus of proposed Medicaid reform.

Support of national involvement in cash welfare programs was built on economic theory regarding marginal rates of taxation and their effects on work incentives. This incentive by welfare recipients to seek employment was one reason that the national influence towards uniformity received support from conservatives. Liberals embraced the concept because the federal minimum was seen to raise overall welfare expenditures, as well as raise the floor in many states. Interestingly, in Nixon speeches on his minimum floor proposal for the Aid to Families with Dependent Children (AFDC) population, he cites both of these as support for his plan.

This embrace of national minimum standards introduces a baffling character when matched with his New Federalism. In the same speeches in which he vowed "to regain control of our national destiny by returning a greater share of control to State and local governments" he proposed "minimum national standards" for income levels.[61] He seemingly embraced federal control via regulation, cost controls, and national comprehensive planning while at the same time establishing a New Federalism policy agenda. Nixon's New Federalism included: Proposals to group over one hundred categorical grant programs into a small number of block grants; Revenue sharing that used the progressive federal income tax to transfer funds to state and local governments;

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[58] The Friedman's 1980 book, *Free to Choose*, provided greater insight into their ideas on the topic.
[59] Robert A. Moffitt, "The Negative Income Tax and the Evolution of U.S. Welfare Policy," *Journal of Economic Perspectives* 17, no. 3 (Summer 2003), 120. (Hereafter Moffit, "The Negative")
[60] Moffit, "The Negative," 123 - 124.
[61] Richard Nixon, "Address at the National Governors' Conference," September 1, 1969, Item #347, *Public Papers of the Presidents of the United States, 1969* (Washington D.C.: U.S. GPO, 1971), 696 - 697.

Management reforms to improve program coordination; and Nationalizing public sector responsibilities where this would improve performance -- including AFDC and Medicaid.

Supposedly suspicious of fat national government, Nixon's Administration oversaw the "greatest expansion of Federal regulation of state and local governments up until that point in American history."[62] Even in comparison to the Great Society era, Timothy Conlan in his review of American federalism writes,

> By nearly every measure, real and relative, the greatest increases in spending for individuals occurred during the Nixon administration. Entitlement spending -- including both direct payments to individuals and grants for individuals -- more than doubled during this period. Even in constant dollars, spending for such programs rose 76 percent between 1969 and 1974. Still larger increases occurred in programs targeted at the poor. Food stamp outlays multiplied tenfold during this period. Housing assistance to the poor was up five times. The Medicaid budget more than doubled. In contrast to the 1960s, entitlement spending relative to other federal outlays and the national economy as a whole also increased sharply.[63]

Sorting out Nixon's New Federalism in light of his seemingly progressive ideas for the American welfare state involves addressing the incongruence of some policy positions. In attempting to sort out the irony, one explanation is that Nixon favored "rationalization" of government which included federalization of functions when this proved more efficient. In describing his notions of federalism, Nixon said, "If we put more power in more places, we can make government more creative in more places."[64] This faith in the creative uses of federalism to improve government performance is reminiscent of LBJ's creative federalism, and from a similar philosophic thread as FDR's embrace of state governments in certain initiatives, particularly cash welfare.

In other words, Nixon's rationalization of government roles placed several major initiatives of the welfare state clearly in the federal jurisdiction. As Conlan explains, "Thus the Nixon administration sought to decentralize Federal involvement in some traditional state and local fields -- community development, education, and manpower

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[62] Conlan, *From Federalism to Devolution*, 85.
[63] Conlan, *From Federalism to Devolution*, 83 - 84.
[64] Richard Nixon, quoted from Conlan, *From Federalism to Devolution*, 12.

training -- and at the same time proposed a complete national assumption of the costs of income maintenance, on the grounds that a more uniform, effective, and equitable welfare system could best be achieved through greater nationalization."[65] Rationalization of government functions has often been used as reasoning by conservatives to justify decentralization of the welfare state -- or at least devolution, some would say "buck-passing" -- to state governments. Nixon's use of creative federalism to organize welfare state functions at the federal level is, then, an intriguing puzzle.

In the end, the attempt to instill uniformity in the nation's welfare system did not standardize incomes for mothers and children. "Although the Plan was modified, additional opposition came from liberals and the National Welfare Rights Organization. They charged that benefits were set too low and work requirements were to onerous."[66] The provisions for the aged, blind, and disabled did introduce federalization of a minimum floor via the Supplemental Security Income (SSI) program. Also, the Food Stamp program was revolutionized even though FAP did not materialize. "By 1974, Food Stamps constituted a form of minimum national income, albeit at a very low level."[67] Another byproduct of the FAP debates involved the eventual Earned Income Tax Credit (EITC) program. In a spin-off, EITC was neatly tucked into a large tax bill after Nixon left office.

MEDICAID BARGAINING IN THE NIXON ERA, 1969 - 1972

Proposals for Medicaid reform in the Nixon era were attached to his number one domestic priority -- welfare reform. During Senate debates on Nixon's Federal Assistance Program (FAP), the notch effect in the Medicaid program became a major negotiating hurdle. The Senate Finance Committee sent the FAP back to the White House to work out the glitches in the notch effect with Medicaid, Food Stamps, and other "welfare" programs that were connected to income maintenance. The Medicaid reform

[65] Conlan, *From Federalism to Devolution*, 20 - 21.
[66] Conlan, *From Federalism to Devolution*, 81.
[67] Conlan, *From Federalism to Devolution*, 84.

proposal, called the Family Health Insurance Plan (FHIP), was unveiled by Nixon in February 1971, and was shaped to work with his minimum income proposal. So, Medicaid reform was inextricably linked to cash welfare reform.

Other reforms in the Medicaid program were proceeding while the Administration's structural overhaul was incubating. Many of these incremental changes were targeted at reducing costs. In 1969 Congress enacted legislation (PL 91-56) "that permitted states to cut back on nonbasic Medicaid services such as dentistry as long as the state could show it was trying to control costs" and also postponed Section 1903(e), the Comprehensive Care requirement, an original principle behind the Medicaid program.[68] Also HEW regulation was established to limit payments to states for medical practitioners to the 75th percentile of January 1969 customary charges.[69] Several associations included the Health Insurance Association of American (HIAA) called for prospective reimbursement to hospitals.[70] Finally, the use of Utilization Review and Peer Service Review Organizations (PSROs) in medical legislation to control both quality and costs presented new battles regarding who would oversee medical institutions at the local level.

After the House, with an income floor of $2,400, easily passed the Family Assistance Plan, the Senate sent the measure back to the White House after only three days of deliberations. The Committee had proposed that the formulas for the other social welfare programs be revised so that benefits would taper off gradually as income increased.[71] An example of a mother of three in New York City with no income was particularly poignant in showing that increased earnings under the current FAP proposal would in some cases be deleterious to the family because Medicaid and food stamp eligibility would be lost. As John J. Williams (R - Del.) stated on July 23, "Is this a proper (work) incentive? If a man earns $5,000 and his boss offers him a $1,000 raise, he'd better spit in his eye because he'll end up $5 worse off."[72] The dreaded "notch

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[68] 1970 *CQ Almanac*, 579.
[69] 1970 *CQ Almanac*, 579.
[70] 1970 *CQ Almanac*, 580.
[71] 1970 *CQ Almanac*, 1035.
[72] 1970 *CQ Almanac*, 1035 - 1036.

effect" was corrected on the income side of the FAP proposal but not in Medicaid, food stamps, or public housing.

In a statement entitled "Statement Announcing Extensions of Welfare Reform Proposals," the Medicaid reform was first announced on June 10, 1970.[73] Lumped into a group called "Welfare Reform Proposals," Nixon proposed basic amendments to the Family Assistance Act of 1970. "The most important proposal I make today is to reform the Medicaid program. Medicaid is plagued by serious faults. Costs are mounting beyond reason. Services vary considerably from State to State. Benefits are only remotely related to Family resources. Eligibility may terminate abruptly as a family moves off welfare, often losing more in medical benefits than it gains in income."[74] Described as part of the Administration's "income strategy against poverty," more details were promised at the beginning of the next Congress. Still, in the meantime, there was a revised bill sent back to Senate Finance that meshed "Medicaid, food stamp and housing programs with the welfare system."[75]

Less than a week after the health proposals were initially announced by the Administration, the American Medical Association (AMA) and the National Medical Association (NMA) debuted "Medicredit," a structural reform plan that was tied to the federal income tax. Those with $300 or less in income tax --assumed to be the Medicaid population-- would be able to purchase private health insurance at government expense. Those with higher incomes would receive Federal tax credits on a sliding scale to help pay for the costs of health insurance premiums.[76]

Meanwhile, in Senate Finance Committee Testimony the Secretary of HEW, Elliot L. Richardson, provided more information on the Administration's Medicaid reform ideas. His introduction into the Medicaid area of his testimony emphasized the

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[73] Richard Nixon, "Statement Announcing Extensions of Welfare Reform Proposals," June 10, 1970, Item #183, *Public Papers of Presidents of the United States, 1970* (Washington D.C.: U.S. Government Printing Office, 1971).
[74] Richard Nixon, "Statement Announcing Extensions of Welfare Reform Proposals," June 10, 1970, Item #183, *Public Papers of Presidents of the United States, 1970* (Washington D.C.: U.S. Government Printing Office, 1971), 490 - 491.
[75] 1970 *CQ Almanac*, 1035.
[76] 1970 *CQ Almanac*, 581.

need for "significant New Federal initiatives…in the health field," stating further "this [A]dministration is committed to the reform of the [M]edicaid program." He continued, "We believe that this [Family Health Insurance Proposal]…will effectively integrate the Nation's major health program for the poor with the proposed family assistance program -- FAP. This strategy will fundamentally restructure the medical program for families with children."[77] He pointed out as a weakness of Medicaid the "serious geographic and other inequities" resulting from state by state variation where "a disproportionate share of Federal matching funds has been spent…in only a few of our States." Also, "The sudden death loss of Medicaid benefits when income reaches a specified level -- the so-called notch problem -- is an unacceptable defect in the current structure of Medicaid."[78]

"Less Critical Changes" -- In The Meantime Medicaid Reform

Secretary Richardson reported to Senate Finance what he termed as "less critical changes" for the Medicaid program. As intermediate steps prior to Medicaid reform, the Secretary suggested greater federal financing of state-run utilization review and other surveillance. He reiterated Nixon's suggestions for increased matching for selected outpatient services and decreased federal matching for some institutional services in order to encourage the former.[79] This was intended to increase use of Intermediate Care facilities and home health services and decrease nursing home utilization. Finally he suggested that Congress "make changes in title XIX to authorize the States to conduct experiments on a statewide, area wide, county, city, or neighborhood basis. We are interested in encouraging experiments with … the use of different combinations of benefits and different types of benefit packages for different population groups, and limited use of co-payments and deductibles for medically needy." The Secretary thus

[77] U.S. Sen. Comm. on Finance, *SSA Amendments of 1970 Hearing*, 66 - 69.
[78] U.S. Sen. Comm. on Finance, *SSA Amendments of 1970 Hearing*, 66 - 69.
[79] President Nixon's February 26 message to Congress made these suggestions regarding differentials in federal matching percentages based on types of service as a way for the federal government to incentivize particular types of care.

supported intra-category benefit differentials and cost sharing -- striking at two fundamental principles of the original Medicaid design.

Originally, states were required to provide equal medical care to all persons in the broad classes of recipients -- the categorically needy or the medically needy, for example.[80] While providing care to those who were medically needy was at each state's option, once a state decided to have medically needy coverage then they must provide equal treatment. Secretary Richardson's suggestion went against the original grain regarding patient cost sharing. The 1965 law prohibited states from exacting any "deduction, cost sharing or similar charge…with respect to inpatient hospital services…", while requiring that charges for other services be reasonably related to the recipient's income and resources.[81] Finally, the Secretary called for the allowance of experimentation in managed care and pre-paid capitation methods, as well as allowance for State discretion in provider payment. Previously, hospital payment, mirrored that of Medicare's "reasonable cost."[82]

The call for increased state experimentation -- within HEW oversight -- overshadowed the eventual progression of state Medicaid waivers of federal requirements as a primary aspect of Medicaid federalism. Broad SSA 1115 were allowed from 1962 -- and were not specific only to the Medicaid program, allowing for broad based state experimentation. Secretary Richardson proposed though a whole series of targeted experimentation by states that foreshadowed the future of the program. In fact, the "serious geographic and other differentials" in state-by-state programs that the Secretary targeted for correction would only become more pronounced in the future when state and local experimentation exploded through the evolution of Medicaid waivers of various types, and forms. This waiver revolution was in the future -- and so these two ideals, greater geographic equity and state experimentation -- did not seem overly contradictory

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[80] P.L. 89-97, Sec. 1902 (a) (10) (B) (ii); Sec. 1902 (a) (10) (A) (i), from Stevens, *Welfare Medicine*, 63 - 64.

[81] P.L. 89-97, Sec. 1902 (a) (14), from Stevens, *Welfare Medicine*, 68.

[82] Stevens, *Medicaid: Anatomy*, 381. "The 1965 legislation specified that inpatient hospital care….under Medicaid should be reimbursed on a 'reasonable cost' basis…The Medicare interpretation of reasonable cost, defined in regulations by the Social Security Administration, was adopted for interim payments under title XIX."

at the time. These would become the type of dilemmas that Medicaid's federalism would create and deepen over decades.

Health Maintenance Organizations and Medicaid Federalism

While the welfare reform appeared to be floundering, the Administration's attempts to bolster use of managed care were moving forward. The Task Force on Medicaid and related programs, also called the McNerney Commission, in 1970 endorsed "the innovative approach of the Administration's Health Maintenance Organization proposal to provide an option for Medicare and Medicaid beneficiaries to elect to receive health services through a single organization that provides coordinated services financed through prepaid capitation."[83]

The support of health maintenance organizations fit well into the New Federalism and Cost Control themes. Localized delivery organizations could be pre-paid and potentially offer more comprehensive benefits than alternate insurance products. Of course, the federal government was stepping in to encourage growth of these local entities, but the real irony was the degree to which Republicans were coddling the managed care concept. Previously considered part of the bastion of liberal notions of utopian health delivery, President Nixon and, notably California Governor Ronald Reagan, were encouraging the growth of prepaid arrangements. While at the same time embracing managed care, the McNerney Taskforce also recommended converting "Medicaid to a program with a uniform minimum level of health benefits financed 100 percent by Federal funds, with a further Federal matching with States for certain types of supplementary benefits and for individuals not covered under the minimum plan."[84] Federal financing of Medicaid was not antithetical to the use of managed care entities for health care delivery at the local level.

Flexible, decentralized, local networks -- these were all characteristics of managed care that lent themselves to New Federalism. At the same time, managed care

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[83] U.S. HEW, *McNerney Report*, 297.
[84] U.S. HEW, *McNerney Report*, 293.

was being pushed for those with low-incomes as well as the general population, meaning that this delivery method may be the great equalizer. Possibly, HMOs represented the way to finally provide equal opportunity to the poor in the health arena, since the delivery networks would be the same for the employed and those with low-incomes. Equal opportunity was matched with assured quality and the prioritization of preventive medicine for all managed care beneficiaries. Thus, managed care seemed to grasp the qualities of New Federalism, Cost Control, and "Compassionate Conservatism" at the same time.

FAP Within The Broader Social Security Bill Goes Nowhere

In the Senate Finance Committee, the Committee rejected welfare reform on November 20, 1970 by a 10-6 vote and the bill was dropped shortly thereafter -- even though the Nixon Administration attempted to compromise with Senate liberals.[85] Advocates for income recipients thought the work provisions were too harsh and the Federal floor was too low at *$1,600* to a family of four with no income. There were suggestions in testimony by several advocates that the minimum floor at least be brought in line with the Federal Poverty Level. Others held that the minimum federal floor -- and consequent guarantee of federal funds -- would help states with oppressive income program costs. Finally, fiscal conservatives maintained that the plan, as structured, was too costly for the federal government. So, on one side of the spectrum, beneficiary advocates demanded a greater minimum amount, while on the other side, a coalition held that the aggregate proposal was too great an expense for the federal government. The only ones in favor of the proposal appeared to be the Administration and those who hoped it would help states with their own costs. In testimony, some Governors and mayors asked that the federal government take even greater financing responsibility for welfare programs.

[85] 1970 *CQ Almanac*, 1030.

Nixon's Formal Proposals on Health Care and the Family Health Insurance Plan

In his 1971 State of the Union Nixon presented four great goals, the most important was welfare reform. Another was health: "I will propose… a program to insure that no American family will be prevented from obtaining basic medical care by inability to pay."[86] As promised, Nixon outlined his proposals on February 18, 1971 for health reform. His plan for the health sector was broader than one program. He had a multi-faceted health strategy that ranged from initiatives to finding a cure for cancer to supporting state systems for monitoring new building of health facilities to a national insurance plan. The National Health Insurance Partnership emphasized partnership not paternalism and insurance not nationalized health care. These distinctions were particularly important to understanding the nuances of Nixon's mechanism for realizing equal opportunity and economic rights in health. He emphasized four changes for this Partnership -- all in the insurance market. First, he called for greater coverage of outpatient, home, and physicians' office care by plans. Second, he pinpointed greater coverage of catastrophic costs. Third, the President singled out a need for greater access to health maintenance organizations, and fourth, he highlighted a priority for greater access for the poor to the medical system.[87]

He outlined two different initiatives, the National Health Insurance Standards Act and the Family Health Insurance Plan (FHIP). The former would "require employers to provide basic health insurance coverage for their employees" and the latter would "meet the special needs of poor families who would not be covered by the proposed National Health Insurance Standards Act." The National Health Insurance effort was likened to "similar actions to assure workers a minimum wage, to provide them with disability and retirement benefits, and to set occupational health and safety standards." The President

[86] Richard Nixon "Annual Message to the Congress on the State of the Union," January 22, 1971, Item #26, *Public Papers of the Presidents of the United States, 1971* (Washington D.C.: U.S. GPO, 1972), 53.
[87] President Nixon's February 18, 1971 message to Congress on health insurance, 1971 *CQ Almanac*, 38A.

admonished, "Now we should go one step further and guarantee that all workers will receive adequate health insurance protection."[88]

The FHIP was designed for "welfare families" -- those covered by the current AFDC population who were also the target of FAP. The aged poor, the blind, and the disabled would continue under Medicaid. Reform was needed "Because it [Medicaid] is not a national program, its benefits vary widely from State to State… it excludes the working poor…. Benefits can suddenly be cut off when family income rises ever so slightly…And provides an incentive for poor families to stay on the welfare rolls." States would be relieved of what Nixon termed "a considerable burden."[89] Also, the eligibility ceiling for FHIP would be $5,000 for a family of four and would not have the abrupt cutoff of benefits. This $5,000 ceiling was increased through policy bargaining later, but still included a sliding scale on which premium levels were based. Local committees would serve as contractors to the Federal Government to ensure that adequate care was being provided.[90]

Nixon adhered to the broad principles of cost control, equality of opportunity, and quality of care while belying a faith in the private insurance industry to provide the practical mechanism for realization of greater principles. Some saw this faith in the insurance industry as misguided, suggesting that the real benefactors of the President's plan was the insurance industry and not the American people.

Nixon had at an earlier point likened his welfare state agenda to the type of profound change enacted in Roosevelt's 1935 Social Security Act. In his defense of a national health partnership his economic rights language seemed to reflect the New Deal President's Second Bill of Rights precepts.[91] "Just as our National Government has moved to provide equal opportunity in areas such as education, employment and voting, so we must now work to expand the opportunity for all citizens to obtain a decent standard of medical care. We must do all we can to remove any racial, economic, social

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[88] President Nixon's February 18, 1971 message to Congress on health insurance, 1971 *CQ Almanac*, 39A.
[89] President Nixon's February 18, 1971 message to Congress on health insurance, 1971 *CQ Almanac*, 39A.
[90] President Nixon's February 18, 1971 message to Congress on health insurance, 1971 *CQ Almanac*, 39A.
[91] For more on Roosevelt's Second Bill of Rights see Cass Sunstein's *The Second Bill of Rights: FDR's Unfinished Revolution and Why We Need It More Than Ever.*

or geographic barriers which now prevent any of our citizens from obtaining adequate health protection. For without good health, no man can fully utilize other opportunities." At the end of his speech he went further, quoting Gandhi, "It is health which is real wealth, and not pieces of gold and silver."[92]

Repeatedly, in policy practice and rhetoric, Nixon connected health security to income security. He also emphasized geographic barriers to equal opportunity. The same President who described "the essence of the New Federalism" as helping "regain control of our national destiny by returning a greater share of control to State and local governments and to the people"[93] also decried that Medicaid had not accomplished its goals because its "benefits vary widely from State-to-State" and it is not a "truly national program."[94]

If this is seemingly contradictory, it is all Nixon. With policy positions that were contradictory, Nixon was in fact using federalism as an instrumental tool not as the ends. The devil is in the details. Like many in his party, he spoke of returning power to the states and localities -- of the arrogance of the "patronizing idea that government in Washington, D.C. is inevitably more wise….than government at the local or State level."[95] Nixon's use of federalism as an instrumental agent meant that he could pick and chose which aspects of federal power he wanted to utilize in order to achieve his party's own values. He believed in national minimums, in the federal government moving to ensure this minimal level of uniformity, but he flatly shut the door on "nationalized" health care. In a similar way he had denied categorically ever wanting a "guaranteed income" which he said assured everyone a minimum income "regardless of whether or not he was willing to work."[96] A right without any responsibilities was different than a basic minimum income for those in need. In health, he disagreed with a nationalized

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[92] President Nixon's February 18, 1971 message to Congress on health insurance, 1971 *CQ Almanac*, 40A.
[93] Richard Nixon, "Address at the National Governors' Conference," September 1, 1969, Item #347, *Public Papers of the Presidents of the United States, 1969* (Washington, D.C.: U.S. GPO, 1971), 696.
[94] President Nixon's February 18, 1971 message to Congress on health insurance, 1971 *CQ Almanac*, 39A.
[95] Richard Nixon, "Annual Message to the Congress on the State of the Union," January 22, 1971, Item #26, *Public Papers of the Presidents of the United States, 1971* (Washington, D.C.: U.S. GPO, 1972), 55.
[96] Richard Nixon, "Address to the Nation on Domestic Programs," August 8, 1969, Item #324, *Public Papers of the Presidents of the United States, 1969*, (Washington, D.C.: U.S. GPO, 1971), 640 - 641.

system where local hospital budgets and fee schedules were set by Federal personnel and "taking other steps which could easily lead to the complete Federal domination of all of American medicine."[97] Instead, he wanted a national partnership not a nationalized health system. The devil is surely in the details.

The Medicaid reform was not passed in 1971, nor was any national health reform including a national partnership. There were several competing proposals though including the AMA's Medicredit and also The Health Security Act, sponsored jointly by Senator Edward Kennedy (D-Mass.) as S3 and Rep. Martha Griffiths (D-Mich.) as HR22.[98] The AFL-CIO, the United Health Workers, and others supported this plan. It proposed a comprehensive national health insurance system for all Americans financed partially from increased taxes and partially from federal general revenues. Medicare would be abolished and Medicaid would not pay for services covered under the national health plan. In this way, the Medicaid population would become more indistinguishable from people who were employed.[99]

Critics of the Administration plan claimed that there were too many differences between the two schemes -- one for the employed and the other for the poor. By bifurcating the health insurance program for the employee from the FHIP, the Administration had left itself open to the criticism that there existed substantial inequalities between the two plans. Critics threw flak at the Administration plan, claiming it would not cut costs.

"Rationalized Federalism": The States Take One Piece, Feds Take the Other

The Welfare reform provisions, the White House Priority Number One, were removed by House and Senate conferees in the groundbreaking Social Security bill in 1972. The provisions provided for a "partial federal takeover of welfare" but many state officials during the Congressional testimony called for greater national administration for

[97] President Nixon's February 18, 1971 message to Congress on health insurance, 1971 *CQ Almanac*, 40A.
[98] Kennedy was Chairman of the Senate Health Subcommittee of the Labor and Public Welfare Committee and Griffiths was a member of the House Ways and Means Committee. 1971 *CQ Almanac*, 542.
[99] 1971 *CQ Almanac*, 541 - 554.

public welfare. Some spoke of welfare generally, including implicitly the medical component. Others made this understanding explicit. As Preston Smith, the Governor of Texas proposed, the Federal Government should completely take over the funding and operation of the welfare and medical assistance programs and states will have primary responsibility for providing human and social services to citizens.[100]

Federalism in American social policy has involved countless suggestions of how to change key structural components of programs: from means tested to social insurance; from matching to closed grant; from state discretion to federal minimum requirements. Another reform method repeatedly proposed has been trades of entire programs within the social safety network to different levels of government -- or trades of entire policy areas.

This type of bargaining, "I'll take Medicaid, if you take Food Stamps" sometimes attempts to trade according to broad issue areas. For example, the hypothetical proposition, health lends itself better to the Federal Government and income assistance to the states. Sometimes, the trading is arbitrary, recognizing that there are drawbacks to any arrangement and so we may as well flip a coin of which level of government runs which program. At other times, though, the reform suggestions combine Medicaid, income maintenance, and food stamps into a broad group of social welfare programs that should remain connected. And the suggested trade is with other distinct policy subsystems entirely, such as Community Services or Environmental Policy.

Incremental Changes Comprise Biggest Reform Since 1965 Enactment

By the fall of 1972, no action was taken on the "big bang" health proposals but the incremental changes that did pass in the 1972 Amendments were quite significant in their own right. As Wilbur Mills proclaimed, "This bill still contains the most far-

[100] 1972 *CQ Almanac*, 901.

reaching provisions of any Social Security bill since we passed Medicare in 1965."[101] The new provisions most pertinent to Medicaid federalism include:

- Medicare was expanded to the disabled and also to those with end stage renal disease;
- Medicaid's Comprehensive Care provision, Section 1903 (e), was removed;
- The Medicaid program was extended to intermediate care facilities (ICFs), ICFS for the mentally retarded (ICF-MRs), and Mental Hospitals for beneficiaries under age 22;
- States were allowed "to waive Federal 'statewideness' and comparability provisions for Medicaid recipients so that states could (with HEW approval) provide more generous health services than those in the state Medicaid plan through prepaid comprehensive health programs";[102]
- State experiments with provider prospective payment systems were allowed;
- Section 1902(d) -- the "maintenance of effort" requirement -- was repealed -- so that states could reduce expenditures on Medicaid from year to year;
- States were allowed to define "reasonable costs" for Medicaid inpatient care separate from the Medicare definition; and
- The Supplemental Security Income (SSI) program -- further establishing what would be a key Medicaid constituency defined by Federal minimum criteria -- was created.[103]

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[101] 1972 *CQ Almanac*, 914.
[102] Stevens, *Welfare Medicine*, 338.
[103] List compiled using 1972 *CQ Almanac*, various sections, and Stevens, *Welfare Medicine*, 337 - 340 on "P.L 92 -603 Medicaid Provisions."

While these provisions were profound, the original intent of the proposal was much greater. In fact, the breadth of the Administration's social policy agenda had been considered the most ambitious since 1935, the year the Social Security Act was created. Some, however, were unimpressed with the results of the bill, HR1, which had opened the 92nd Congress. Robert Price (R - Texas) left little ambiguity of his opinion of the bill, describing it as "an emasculated, mangled and toothless shadow of the original proposal." [104]

The Federal Government Backs Off of Comprehensive Care and Statewideness Requirements

Notably, the provision from the *original* Medicaid legislation, section 1903(e), requiring states to progress towards comprehensive Medicaid coverage was finally repealed after having been postponed previously to a 1977 deadline. This provision required that states make "efforts in the direction of broadening the scope of the care and services available under the plan and in the directions of liberalizing the eligibility requirements," with the goal of providing comprehensive care.[105] The provision was used in the 1967 Congressional hearings by New York State representatives while explaining their decision-making where one state program surpassed the cost projected originally for the entire federal Medicaid effort. As New York's George K. Wyman stated, "In fact New York is the only State which has met the 1975 deadline established by Congress in Title XIX which requires all States by that time to have provided comprehensive medical care for all needy persons."[106]

The original principles behind Medicaid were slowly being dismantled and re-defined. This marked a reneging of the original principle that states would be expected eventually to use Medicaid to provide coverage to all in need. A major hit for welfare medicine advocates, this ideal was never re-instituted. The Wyman testimony showed

[104] 1972 *CQ Almanac*, 914.
[105] Stevens, *Welfare Medicine*, 67 on "P.L. 89-97, Sec. 1903 (e)."
[106] U.S. Senate Committee on Finance, Hearings on Social Security Amendments of 1967 on H.R. 12080, "Statement by George K. Wyman, New York Senator," 90th Congress, 1rst Session, 1967, 1546 - 1547. From Stevens, *Welfare Medicine*, Chapter 7, "Facilis Descensus Averno," 126, Footnote #64.

the dilemma. Adhering to state's definitions of what they thought 1903(e) comprehensive care meant broke the federal bank. The federal role of redistribution was again hitting against its role for a newly forming federal role in cost control. By allowing for state discretion in defining comprehensive care, the open financing of the Medicaid program seemed limitless.

Other major principles of Medicaid, the Statewideness and Comparability provisions, were also compromised. In the case of Medicaid, with HEW's permission, states could waive the Statewideness and Comparability provisions in order to provide more comprehensive services through prepaid plans than in their State Medicaid plan. Payments to HMOs were allowed for both the Medicaid and the Medicare programs. In combination with de-linking of Medicaid to Medicare payment levels by allowing states to determine their own definition of "reasonable cost" and by the allowance of experiments in provider prospective payment, Medicaid was increasingly becoming a program for state experimentation -- but mostly for cost control methods. The federal rules were changing to prioritize state discretion where it would control costs and not where it would expand eligibility or services. State flexibility was allowed by the federal government when it would increasingly privatize through the use of HMOs and limit payments to providers through the development of prospective and pre-paid payment systems. Benefits and eligibility were controlled more strongly by the federal government through ceilings in the optional medically needy population coverage to 133 1/3% AFDC levels and mandated coverage of ICF institutions.

With the removal of Comprehensive Care in favor of cost concerns and also of Statewideness provisions in favor of State innovation in prepaid health plans, Medicaid was relinquishing its original intent. In combination with the 1967 Amendments placing a ceiling on medically needy eligibility according to state's AFDC limits and the 1969 legislation that allowed states to cutback on Medicaid services, the trend was towards greater state discretion -- which was proven to mean retrenchment. In general, cost control as a precept was embraced. When expansions were allowed by the Federal

Government, it was often through a profound change in another social policy program, like SSI, or because there was a possibility it would lead to lower costs.

Traditionally covered by state dollars, Medicaid was expanded to allow Medicaid coverage of intermediate care facilities (ICFs), ICFs for the mentally retarded (ICF-MRs) and Mental Hospitals for beneficiaries under age 22. The reason for the inclusion in Medicaid of these traditionally state financed institutions was that quality would be increased by inclusion under the federal umbrella. The federal government was necessary to ensure quality standards for particularly vulnerable groups. As time would tell, this federally mandated expansion would increase Medicaid costs in years to come, both for states and for the federal government. However, at this point, the inclusion of intermediate care facilities in the Medicaid program would open up the possibility for transferring inpatient hospital and nursing home patients to less-costly intermediate care settings. The change helped states by providing a federal match for these services, but it also worked to transform Medicaid in the direction President Nixon had wanted, away from overutilization of acute care facilities and towards other care settings.[107]

The Silent Bang: The Supplemental Security Income Program Enacted

Even though the famous portion of HR1, Title IV -- the FAP -- was denied, a little known provision in Title III of HR1 survived. This marked the passage of the nation's first minimum income program. As recorded by Burke and Burke in *Nixon's Good Deed*: "Except for the few persons who engineered it and for governors, who anticipated savings from its federally paid floor for the aged, blind, and disabled, few knew what was in Title III of HR1. Most persons never even read the antiseptic title, 'Assistance for the Aged, Blind, and Disabled.' This title was replaced in the closing months of the debate…by the protective but bland phrase, 'Supplemental Security Income.'"[108]

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[107] Several Nixon speeches reflect this desire, see in particular his reference to the major gaps in current health insurance coverage in the February 18, 1971 message to Congress on health insurance. 1971 *CQ Almanac*, 38A.

[108] Vincent J. Burke and Vee Burke, *Nixon's Good Deed: Welfare Reform* (New York, NY: Columbia University Press, 1974), 197. (Hereafter Burke, *Nixon's Good Deed*)

SSI saved Social Security because minimum incomes of the elderly poor could be buttressed without extending the benefit to all Social Security beneficiaries. This would constitute a windfall for Social Security beneficiaries and would cost the worker huge sums through the regressive payroll tax.[109] The plan was supported by the Holy Trinity: President Richard Nixon, House Ways and Means Chairman Wilbur Mills, and Senate Finance Committee Chairman Russell Long. Assisting passage was the fact that Social Security benefits supplemented the cash assistance payments and also that the provision helped the "deserving poor."

For Medicaid, the passage of SSI -- even if the reasoning was connected to the Social Security social insurance-based retirement program -- meant that this population would be defined by a national minimum standard. For this population, Medicaid eligibility was largely uniform regardless of state of residence.[110] SSI was built from three previous cash assistance programs (AB, OAA, and APTD), and Medicaid was extended to all previous cash assistance recipients. Even though the original provision allowed states to exclude those who became eligible for cash assistance only as a result of the new legislation, in practice many states would offer Medicaid eligibility to these new enrollees.[111] This instituted a fundamental shift in Medicaid politics, linking SSI recipient's Medicaid eligibility to federal standards while the AFDC population remained to a large extent contingent on the states' AFDC vastly differing eligibility policies.[112]

With all the hoopla over a major restructuring of the Medicaid program -- or an even more vast re-engineering of the health insurance system for all Americans -- one of the great shifts in Medicaid policy occurred in silence. Unplanned -- the serendipitous collection of events resulted in attempting to enact a Family Assistance Plan. Then,

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[109] Burke, *Nixon's Good Deed*, 200.

[110] With time, the 209b provision was chosen by some states *freezing Medicaid eligibility at 1972 levels* -- "209b" states may use more restrictive Medicaid eligibility criteria than those for SSI. Thus, a distinction was created between "209b" and "non-209b states." According to Schneider, *The Medicaid Source Book*, "These States may use different definitions of disability, more restrictive income and resource limits, or methodologies for determining income and resources different from those used under SSI."

[111] Stevens, *Welfare Medicine*, 337.

[112] In 1967, Medicaid was amended for the AFDC population to require states Medicaid eligibility not to exceed 133 and 1/3 percent of each state's AFDC eligibility limits -- thereby chaining Medicaid eligibility to each state's AFDC eligibility standards.

interconnected with that effort, the enactment of SSI resulted from an attempt to undergird the Social Security retirement program. As reported, "when the historic law was enacted, politicians ignored it and most newspapers failed to report it. It is probable that many members of Congress who voted for it did not realize what they had accomplished."[113] Was the enactment of SSI a historic event? Yes, but for Medicaid as well as for income maintenance.

State Experiments on Payment Systems

In the 1970s, state experiments were important for cost control efforts in Medicaid, but these experiments proved fruitful for the health care system generally as many of the models developed in these demonstrations were co-opted by Medicare. For example, the New Jersey experiment with DRGs served as a forerunner for the Medicare Prospective Payment System (PPS). Also, prior to Medicare implementing a relative value scale (RVS) for physician payment, several Medicaid states had already adopted physician fee schedules, most notably California's RVS system.[114] State experiments had proven important for state's own cost control, as examples to other states, and, also, as small testing grounds for nationally implemented Medicare reforms. So, Medicare lent its methodologies to Medicaid -- through Medicaid's original use of many of Medicare's statutory definitions, while Medicaid was in fact serving its role as "a laboratory" given its state orientation.

MEDICAID BARGAINING IN THE NIXON ERA: THE 93rd CONGRESS -- 1973 and 1974

By the end of the 92nd Congress, the Administration admitted that its original health proposal left too many gaps in coverage and sent the whole package back to the

[113] Burke, *Nixon's Good Deed*, 195.

[114] Teresa Coughlin, Leighton Ku, and John Holahan, *Medicaid Since 1980: Costs, Coverage and The Shifting Alliance Between the Federal Government and The States* (Washington, D.C.: The Urban Institute, 1994), 133. (Hereafter Coughlin, *Medicaid Since 1980*)

Health, Education, and Welfare (HEW) Department for re-working. HEW Secretary Weinberger promised a new plan by January 1974 after postponing the date several times. Employers would bear most of the cost for standard coverage of their workers while the government would pay for the *same* coverage of the poor.[115] This assurance was important because a major stumbling block to negotiations in the previous round was that the FHIP did not provide similar coverage to the poor as the employee health insurance plan provided for its recipients.

Many previous proposals for national health reform were reintroduced. The AMA's Medicredit proposal, S444 and HR2222, included a provision to cover the entire cost of insurance for long-term illness. It called for a structural financing reform, not a health system overhaul. The Kennedy/Griffiths plan, S3 and HR22, on the other hand proposed a compulsory system run by the federal government with no copayments and broad benefits. Considered disastrous by some and saintly by others -- it would restructure the system instead of building on the existing one. It was maligned by critics alleging its prohibitive costs, and the typical reverberations against "too much federal influence" and "federal meddling in local care" were aimed at this proposal. In an early version of what today has become known as a Medicare for All Proposal, Sen. Jacob Javits (R - N.Y.) sponsored S915 that promised to expand the federal Medicare program to eventually cover all U.S. residents with compulsory participation. Another proposal, pre-dating the Medicare Catastrophic Care Act of the late 1980s, Senator Russell Long (D - La.) sponsored S1416 and then teamed with Rep. Ribicoff on (D - Conn.) S2513. Both were versions of catastrophic illness plans. The latter version proposed to replace Medicaid with a new federally financed program covering the poor.[116] Importantly, the general trend among the proposals was that even those who did not support the Administration's FHIP were in favor of federal financing, albeit via different mechanisms, of the Medicaid population. States were very much in favor of full federal financing of Medicaid.

[115] 1973 *CQ Almanac*, 509.
[116] 1973 *CQ Almanac*, 509.

While the Ways and Means Committee had prioritized several other initiatives above national health reform in 1973, the Administration continued to re-work its own plan. In related legislation, the HMO Act of 1973 took steps to encourage the growth of managed care. It prepared the way for national health insurance and the FHIP to rely on the private market for insurance by correcting perceived deficiencies in that market ahead of time. The HMO Act pre-empted state laws in order to attain federal ends, yet another example of instrumental federalism that increased federal power during the Nixon era.

Incremental changes were in the works but mostly connected to other social policy reform that had tainted Medicaid eligibility in some way. One of the great lessons regarding Medicaid federalism is the profound effect that other social policy, tax, and budget legislation has had on Medicaid itself. While 1972 saw the enactment of SSI, the future still held the 1974 Congressional Budget Act -- which would profoundly alter how entitlements were bargained. Neither one of these were primarily Medicaid bills but both would substantially affect Medicaid and the relationship between the federal and state governments.

In 1973, the incremental changes in the Medicaid program were mostly related to other social policy reforms. A bill signed by the President on January 3, 1974, HR11333 (PL 93-233), made SSI recipients eligible for federal-state Medicaid benefits. The Social Security increase bill, HR 7445 (PL 93-66), protected certain groups of Medicaid recipients from loss of eligibility as the result of the switch to federal welfare support under the SSI program in 1974. It also extended an existing law allowing Medicaid recipients to continue to receive benefits even though a 20 percent Social Security benefit increase in 1972 raised their incomes above Medicaid eligibility levels.[117] In the wake of the indexation of Social Security (OASDI) Benefits in 1972, many other social policy programs followed -- including Medicaid in 1973.[118]

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[117] 1973 *CQ Almanac*, 544.
[118] Ippolito, Dennis S., *Uncertain Legacies: Federal Budget Policy from Roosevelt through Reagan* (Charlottesville, VA: University Press of Virginia, 1990), 172. (Hereafter Ippolito, *Uncertain Legacies*)

The Year the President Resigned and Health Reform was Priority Number One -- 1974

On January 30, 1974, the President reintroduced a new, improved comprehensive health insurance proposal during the 1974 State of the Union Address. This time around was different for national health reform, it seemed. Reform was in the air. It was imminent. The posturing over the past few years would finally result in compromise. The Ways and Means Committee had its dance card cleared in 1973 and now prioritized national health reform. President Nixon at certain points in 1974 named national health insurance his top domestic priority. Since prioritization of a policy item is critical to the bargaining that results in enactment, prospects looked bright.

In his State of the Union Address, much of the language was recycled from the 1971 - 1972 debates, the new plan again called for partnership not paternalism, requiring doctors to work for their patients, not for the Federal Government. More details provided a week later in a Special Message to Congress on February 6, 1974 sounded familiar as well, reiterating the need for economic rights in health. He suggested three parts to his Comprehensive Health Insurance Plan (CHIP): Employee Health Insurance, an improved Medicare Plan, and a Assisted Health Insurance plan covering low-income persons and those not eligible for the other two programs.[119]

Whereas the previous Medicaid reform plan had established different minimum benefits from the national health insurance plan for the general population, this time there were no differences in the minimum benefits between the two programs.[120] Major bills included a re-introduced AMA Medicredit proposal and the Long-Ribicoff Catastrophic medical bill with federal assistance for the poor. Senator Kennedy, though, had switched his support to join a compromise bill with Wilbur Mills. Organized labor considered this

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[119] Richard Nixon, "Annual Message to the Congress on the State of the Union," January 30, 1974, Item #26, *Public Papers of the Presidents of the United States, 1974* (Washington, D.C.: U.S. GPO, 1975),132 - 140.
[120] Starr, *The Social Transformation*, 404.

a retreat and backed the broader Griffiths-Corman bill, which Kennedy previously had sponsored.[121]

The crunch in 1974 between multiple plans resulted in the lesson that pluralism can kill reform. Pluralism can also kill compromise. Almost every member of the Ways and Means Committee was backing one or more of various and conflicting health insurance bills. On May 20, the President in a national radio address emphasized that this was his number one domestic priority. Vice President Ford also iterated in a number of speeches the need for compromise on health reform. The main differences between the Administration plan and the Kennedy-Mills plan were the extent of federal power, cost control, and encouragement of private market competition. April Ways and Means hearings on the issue were centered on issues of Medicaid federalism.

During the debate, Secretary Weinberger stood firm that the federal role in health insurance should be limited, meaning that states should be given a major administrative role in their plan. Mills -- whose Kerr-Mills plan had been the predecessor of Medicaid -- retorted that many states were incapable of running the program well. The Kennedy-Mills bill would set up an independent Social Security Administration to run the program, would limit the role of private insurance carriers to intermediaries as in Medicare, and would be financed by a new payroll tax. The Administration plan, according to Mills, would not tell states "a tinker's thing" about how to get the job done. Weinberger retorted that the states could do the job with federal guidance. After all, they did perform this function in the Medicaid program. Mills, the Chairman that oversaw the drafting and enactment of Medicaid, responded: "You're going to have a hard job proving to me" that the states run Medicaid better than the federal government administers Medicare.[122] Sadly, Mills would later call Medicaid the "most expensive mistake of his career" due to the extreme rise in physician fees and the liberal definitions many states uses in designing the medically indigent.[123]

[121] 1974 *CQ Almanac*, 387.
[122] 1974 *CQ Almanac*, 387 - 390.
[123] Zelizer, *Taxing America*, 262.

The Ways and Means completed its hearing July 9 with differing perceptions of the role of federalism in health care playing a major point of disagreement between various proposals. At this point, though, the impetus for health reform had weakened substantially in the face of Watergate. The President's policy positions did not matter in the face of impeachment proceedings and his priorities on policy were no longer pressing. Even though several factions were ready for compromise, impeachment proceedings and other business took precedence. The events around President Nixon's resignation in August 1974 are well chronicled in other texts. The remarkable thing in terms of Medicaid, which was of course linked to the national health debates, was how quickly the mantle of reform was picked up by President Ford.

Only four days after President Nixon resigned, President Ford called for national health insurance legislation in his August 12 address to Congress. The Ways and Means Committee began marking up a compromise bill, not sponsored by anyone, at the Chairman's direction on August 19, 1974 -- only a week and a half after Nixon's resignation. On August 20 and 21, various aspects of the compromise were voted on with splits of 12-12 and 12-13 and 12-11 on various combinations. As was Mill's tradition, he would not go to the floor until there was greater consensus within his own Committee.[124] In a critical decision, Chairman Mills decided to turn to tax legislation given the lack of consensus on a health bill. There was no further Congressional action on health until after the elections, when a landslide election placed 75 Freshman Democrats into the House. Some of "The Watergate Babies" shied away from Great Society principles,[125] but *en masse* there was substantial backing of the labor-backed health proposal.[126] In fact, 54 Congressmen who had supported the AMA's Medicredit proposal either retired or were defeated, seemingly opening the door to national health reform.[127]

This point was an important tipping point for health reform, including all interconnected reforms proposed for the Medicaid population. With 75 newbie

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[124] 1974 *CQ Almanac*, 391.
[125] Zelizer, *On Capitol Hill*, 157.
[126] 1974 *CQ Almanac*, 393-394.
[127] 1974 *CQ Almanac*. 393 - 394.

Democrats recently elected, President Ford re-iterated his call for national health insurance prior to the conclusion of the 73rd Congress post-election session. At this point, the left may have made a tragic strategic error. Supporters of the labor-backed Griffiths-Corman bill decided to submerge negotiations until 1975 when they felt they would be in the driver's seat in policy negotiations given the November election results. It was a rational decision given how the make-up of the Congress had changed and also that post-election Congressional activity is often a lame-duck undertaking. In many ways, it was this decision to wait for a more powerful hand at the negotiating table that may have cost the country health reform. It is often reported that Watergate and the Nixon connection marked the end of health reform. In fact, President Ford had called for reform and compromise was pushed by many players in the debate. The potential for national health reform did not end in August with President Nixon's resignation.

President Ford had called for national health reform. As Democrats postponed reform in favor of tax legislation and then postponed reform again in order to take advantage of electoral cycles, this left the door open for any unknown external factor to stop reform. In this case, the economy tanked. When President Ford's budget was submitted in 1975, he asked that no new federal initiatives be undertaken given the economy. He did not repeat his call for national health reform given inflation. The following year, in 1976 he only suggested Medicare expansion of catastrophic health costs.[128] Again, national health reform was lost. While Watergate certainly tinged the proceedings, the timing was off, labor wanted to wait for a more definitive hand at the table, and Chairman Mills was not satisfied with the closeness of the Ways and Means Committee votes to take any package to the floor. The next opportunity for a "big bang" in health, the likes of which would be compared to the 1935 Social Security Act, would not occur again for twenty years -- until the 1993 - 94 Clinton Plan.

[128] 1975 *CQ Almanac*, 635.

FORD PROPOSES BLOCK GRANTING MEDICAID

During the Ford era, legislation was proposed to provide health insurance to unemployed workers but did not go past the committee stage. There was increasing committee conflict over jurisdictional claims to health issues. Notably, 1975 is the year that Medicaid's jurisdiction moved from the House Ways and Means Committee to the House Energy and Commerce Committee.

Ford's federalism initiatives emphasized substituting block grants for categorical grants, only Ford's block grant efforts included Medicaid -- notably absent from the Nixon block grant proposals. On February 25, 1976 in a message to Congress Ford posted the following request, "I am asking Congress to enact the Financial Assistance for Health Care Act which will consolidate Medicaid and 15 categorical Federal health programs into a $10 billion block grant to the States. I am proposing that future Federal funding for this new program be increased annually in increments of $500 million plus the amounts needed after 1980 to ensure that no State will in the future receive less under this proposal than it received in fiscal year 1976."[129]

The ambitious proposal was scheduled to be the largest ever established by the Federal Government, larger even than the general revenue-sharing program.[130] Congress extended a number of categorical health programs but did not hold legislative hearings on the Ford proposal. Politically, categorical grants were ways for individual Congressional members to take credit with constituents for attaining funding for favorite programs. If these categorical programs were consolidated into a block grant, legislators would not be able to take credit with constituents for these categorical grant initiatives. Even though the Medicaid block grant proposal was ignored, Ford had formally introduced the concept of block granting to Medicaid. Nixon's Medicaid proposals had remained clearly outside of the block granting realm. He had wanted to convert categorical grants for education,

[129] 1976 *CQ Almanac*, 11-A.
[130] 1976 *CQ Almanac*, 543.

law enforcement, rural community development, and transportation[131] -- but not Medicaid.

CARTER AND THE BUILDUP TO THE 1980 BUDGET PROCESS

Once again, issues surrounding Medicaid were wrapped with national health insurance and with Presidential prioritization of income assistance. A pattern was forming within several different eras of the Medicaid program. Medicaid reform and national health reform mirrored one another. In the event of national health reform, Medicaid reform would be unnecessary -- but if national health reform was stymied, yet again -- then the Administration would need to consider concrete Medicaid reform suggestions. Also, income assistance was seemingly continuously on the reform agenda. The traditional links with Medicaid -- where AFDC and Medicaid were administered in many states by the same agency; where the 1967 amendments had chained optional medically needy Medicaid eligibility to AFDC eligibility; and where medical assistance payments since the 1930s originally were coupled as add-ons to cash welfare payments -- meant that these two were intertwined for the long-term.

President Carter's campaign called for welfare change and national health reform. On August 6, the campaign promises for income assistance overhaul was met when he presented his plan for the welfare system. The Program for Better Jobs and Income (PBJI), Carter's income assistance plan, replaced AFDC, SSI, and Food Stamps with a flat cash payment to families. It was intended to relieve financial pressure on states but not transfer funding completely to the federal government. As the Nixon FAP had, it called for uniform national criteria for welfare benefits. Carter's HEW included Medicaid in its definition of income assistance programs. The chain between medical assistance and income assistance remained intact.

States expressed fears that following the PBJI reform, they would be the governments "stuck" with huge Medicaid populations and costs stemming from the

[131] Conlan, *From Federalism to Devolution*, 31.

combination of the income assistance programs -- including programs with current substantial federal funding -- into one unified group. In the face of the PBJI proposal, Carter officials simply did not deal with Medicaid in its proposal, hoping for a national health insurance plan. In a vague response to states' concerns, Executive officials claimed that states would decide who was eligible for Medicaid in the unlikely event that national health reform was not yet a reality. PBJI participants would not have automatic eligibility for Medicaid.[132]

On April 25, 1977, President Carter in a message to Congress proposed legislation to limit hospital cost increases to 9 per cent in fiscal 1978. National health insurance, a campaign favorite, was the next step after hospital cost containment. The response was lukewarm from Congress while the hospital industry was clear in its opposition. They were still recovering from the lifting of President Nixon's economic stabilization program in the early 1970s when hospital costs exploded. Hospital cost inflation between 1974 to 1975 was the largest jump in history according to the President's Council on Wage and Price Stability (COWPS).[133] Carter defended his plan, which was largely in response to projections for increases in Medicaid and Medicare hospital payments over 20%: "For the federal budget, rising health spending has meant a tripling of health outlays over the last eight years."[134]

In short, Carter's hospital cost ceilings were defeated during his tenure -- all striking disappointments to the President. By the end of the 95th Congress, they were considered "buried,"[135] only to be resurrected in 1979 and buried again. The only plausible hospital cost containment reform by the end of the year were Medicaid and Medicare specific limits. By then, HEW had already moved administratively to adopt some Medicaid and Medicare measures.[136] On July 29, 1978, the President issued a statement of general principles on national health insurance, directing HEW to develop a

[132] 1977 *CQ Almanac*, 471.
[133] 1977 *CQ Almanac*, 500.
[134] 1977 *CQ Almanac*, 499 - 500.
[135] 1978 *CQ Almanac*, 619.
[136] 1979 *CQ Almanac*, 533

national health reform plan for 1979.[137] President Carter finally announced his national health plan on June 12, 1979; it included a provision for combining Medicaid and Medicare into a new federal program, HealthCare.[138]

Chairman Russell B. Long (D-La.), who had repeatedly proposed catastrophic care plans throughout his career, again agitated for one very early in 1979. In short, catastrophic care became a competing national health reform plan. In order to garner conservative and moderate support, Long's version (S 351) eliminated the provisions to federalize Medicaid in order to create uniform national eligibility standards and benefits. Ribicoff, who had co-sponsored the plan since 1971, introduced a second bill (S 350) including Medicaid federalization.[139] There was qualified support for catastrophic care proposals from many camps including the Administration, if cost control and improved benefits for the poor and elderly were part of the package. This, the Administration claimed, would be the "first phase" of national health reform. The AFL-CIO flatly rejected catastrophic coverage, however, fearing it would prevent broader national health reform. Meanwhile, medical and insurance industry spokesman expressed support for an all-federal Medicaid program.[140]

The House also passed the Child Health Assurance Bill (CHAP), HR 4962, which was designed to replace one of the existing Medicaid programs for children, the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, with a broader CHAP bill.[141] Fiscal conservatives had attempted to change CHAP from an open-ended entitlement to an authorization with fixed ceilings, but the House did not support this change to the legislation.[142] Senator Long delayed Senate floor action on CHAP, considering it part of a broader national health insurance action.[143] Medicaid reform was thus caught in the juggernaut of national health reform -- once again.

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[137] 1978 *CQ Almanac*, 630.
[138] 1979 *CQ Almanac*, 539.
[139] 1979 *CQ Almanac*, 537.
[140] 1979 *CQ Almanac*, 540.
[141] 1979 *CQ Almanac*, 499
[142] 1979 *CQ Almanac*, 499.
[143] 1979 *CQ Almanac*, 500.

THE HEALTH CARE FINANCING ADMINISTRATION CREATED, 1977

Also of note was the creation of a new agency, the Health Care Financing Administration (HCFA). Medicaid was organized and linked to the federal-state means-tested cash welfare programs in the Social and Rehabilitative Services Administration. Medicare was organized within the Social Security Administration (SSA) along with the Social Security (OASDI) program, so that federal social insurance funded initiatives were organized together in the same agency.

In 1977, both Medicaid and Medicare moved to the Health Care Financing Administration, with an emphasis on organizing health financing programs together instead of organizing programs according to federal-state means tested initiatives in one Administration and social insurance financed programs in a different Administration. According to an account by the first HCFA Administrator, Robert A. Derzon, Health, Education, and Welfare (HEW) Secretary Joe Califano "was spearheading the integration campaign, albeit quietly, on orders from Jimmy Carter, who had been persuaded by transition staff that the two programs should be integrated administratively, without input from legislators, even though legislation had been introduced in 1976. The failure to include Congress ultimately annoyed some committee staffers and legislators."[144] Part of the reason for creating HCFA was the belief by Secretary Califano that "a unified HCFA would moderate cost inflation."[145]

BUDGET RECONCILIATION COMES OF AGE, 1980

When Ronald Reagan won the Presidential election in 1980, the door slammed on national health reform. Before Carter left office, though, the 1980 budget process ushered in extremely important precedents for how entitlements would be bargained in the Reagan era. Carter ushered in The Budget Era during the 1980 budget process. The

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[144] Robert A. Derzon, "The Genesis of HCFA," *Health Affairs Web Exclusive*, CMS Reflections (July 26, 2005), accessed from content.healthaffairs.org/cgi/content/long/hlthaff.w5.326/DCI on April 15, 2007.

[145] Robert A. Derzon, "The Genesis of HCFA," *Health Affairs Web Exclusive*, CMS Reflections (July 26, 2005), accessed from content.healthaffairs.org/cgi/content/long/hlthaff.w5.326/DCI on April 15, 2007.

rules and mores of the budget game, and thus entitlement bargaining, were about to go through a revolution. Reconciliation became the vehicle by which entitlement and health provisions were bargained. As one HHS lobbyist claimed, the 1980 reconciliation measure was "the largest health bill enacted by the 96th Congress."[146]

The spending cuts effectuated using Reconciliation were modest,[147] but the process that was put into play during Carter's final budget was profound. By accepting the revolutionary use of Reconciliation and the new budget process to re-assess and control entitlements, the stage was set for even greater changes in budget processes and behavior for the Reagan era.[148] In one bill, more than 80 Medicare and Medicaid provisions were agreed to.[149] In the largest conference in the history of the Congress to that point,[150] Reconciliation became a mechanism for mass entitlement reform. There was praise for the process in that it was the "first coherent effort any Congress had made to bring this so-called 'uncontrollable' spending under control" and also it helped lawmakers "fashion a new legislative tool for future years" to save on entitlement programs. Criticisms were prophetic. As Barber Conable Jr. (R-N.Y.) stated: "I am deeply disturbed that it [Reconciliation] seems to have become a new mechanism for holding the government hostage, agglomerating a lot of very important substantive issues in the name of reconciliation, and being accepted only because we are under great fiscal pressure at this point in our budget process."[151]

In reviewing the evolution of the United States Budget, White and Wildavsky have summarized the vital role of the 1980 budget process in setting up the future Reagan reforms: "Without the 1980 reconciliation as precedents committing Democrats to the procedure, that of 1981 might not have occurred. The experience of 1980 also foreshadowed the rules battles, scorekeeping problems and rider vulnerability that would

[146] 1980 *CQ Almanac*, 459.
[147] Ippolito, *Uncertain Legacies*, 247.
[148] Joseph White and Aaron Wildavsky, *The Deficit and the Public Interest: The Search For Responsible Budgeting in the 1980s* (Berkeley, CA: University of California Press, 1989; first paperback publication 1991), 61 - 64. Citations are to the paperback version. (Hereafter White, *The Deficit and the Public Interest*)
[149] 1980 *CQ Almanac*, 130.
[150] 1980 *CQ Almanac*, 130.
[151] 1980 *CQ Almanac*, 130.

make reconciliation a mixed blessing for budgeters."[152] They further note, "It matters that the military buildup and reconciliation preceded Reagan because otherwise one could not explain why, in 1981, the Speaker allowed reconciliation to happen with so little fight over defense."[153] Soon, the OMB and David Stockman would further redefine the rules of the game, particularly of behavior and norms of the process, in the U.S. budget process. This would have profound effects on entitlement, and Medicaid, bargaining. Carter's 1980 use of reconciliation had ushered in the next great year in policy bargaining -- 1981.

CONCLUSION

The Nixon watershed era was a profound crater in American history. In social policy, the debates around attempts at national health reform, Medicaid reform, and welfare reform were now part of the national psyche. Those discussions moved forward how we all as Americans thought about these issues and the opposing sides in those debates. It also displayed examples of how a reform left can stop national health reform because it is waiting to gain more concessions -- on an already "pretty good deal" -- after an election cycle. After the Presidency switched to President Ford, he was behind reform. The economy tanked though and reform was again lost.

Medicaid reform, debated on its own merits on occasion, was also chained to the discussions around welfare reform and the FAP discussion. For Medicaid, the enactment of the Supplemental Security Income Program -- a reform stemming from the FAP debate -- was the profound change. The country was about to enter another profound era. This one would change how Medicaid was negotiated, how federalism was bargained, and how Congress functioned. The Budget Era and Reconciliation procedures would structure most Medicaid and social policy discussions in the United States Congress from 1981 forward. Hardly a Medicaid reform after 1981 was not contained within or began

[152] White, *The Deficit and the Public Interest*, 61.
[153] White, *The Deficit and the Public Interest*, 64.

within a budget process. Ironically, the 1980s, as the next chapter will discuss, was also a decade of Medicaid expansion. Although below the radar screen of most Congressional watchers, Medicaid policy entrepreneurs worked through the budget process to effectuate real, lasting, and expansionary movements in Medicaid. The next chapter reviews the era of Medicaid federalism from President Reagan through President George H.W. Bush.

6. REAGAN'S BUDGET REVOLUTION, SECOND WAVE OF NEW FEDERALISM, AND THE MEDICAID EXPLOSION

INTRODUCTION

If the twelve years of Republican control of the White House from 1980 until 1992 could be characterized in one phrase it would be "The Budget Era." The rules of the entitlement bargaining game were transformed. The game was simply played differently after 1981. Reagan's new federalism was trumped by his interest in big business, and Medicaid was not one of the "sacred" group of protected social programs picked out by the Administration. This era saw a rise in the role and importance of the OMB.

If any public policy scholars are interested in incrementalism at its best -- the apex of successful gradualism, it is a must to study Medicaid in the 1980s. While the budget process was bent on contracting entitlements, certain House Ways and Means and Senate Finance members and staff expanded Medicaid over 30 times. At the time Medicaid was not considered a big-ticket item. In retrospect, it is a study in arduous building of what today in 2007 is a profoundly important health financing initiative. Medicaid is health insurance for millions of Americans. Medicaid is long-term care financing. And, finally, Medicaid is pivotal to America's next major paradigm shift in the aging of our population and the generational issues engendered by aging as a dominant public policy issue. This chapter investigates "The Budget Era," and sets the stage for Part III of *The Medicaid Evolution*, a section comprised of five chapters that focuses on "The Modern Era" in the largest health program in the United States.

MEDICAID COSTS: THE PERPETUAL UPWARD SPIRAL

Following the trend from the Nixon era, the federal government showed itself as the first line of defense against the high costs of health and government health programs. While in the 1960s, equal opportunity and social justice were often associated with federal involvement -- as a mitigator, a defender, a champion -- against unjust state and local governments, today the federal government was the hammer behind deficit reduction. Of course, it was its own deficit that it had to tame. The economic aspects of Ronald Reagan's presidency became synonymous with issues surrounding the federal deficit, and there were claims that he intentionally drove up the deficit in order to force budget cuts in social programs. The oddity during the Reagan era was surely the Medicaid program. Beforehand, there would be no rational prediction for the tumult of the 1980s.

In fact, Medicaid was singular among major programs of the American welfare state by the end of the Reagan era -- singled out because of its multiple expansions. These occurred after the first few years of Reagan's Administration, after several failed structural reform suggestions that would cap or restrict Medicaid's costs. The States and providers who benefited from the program were leery of reforms that would disadvantage them. These trends turned though in 1984 toward use of the Reconciliation process for Medicaid expansion. Between 1984 and 1990, Medicaid eligibility was extended 31 times. Of these 31 eligibility expansions, 19 were mandatory on state governments.[1] Beyond that, its character changed, as it grew into its own -- away from its historical connections with the AFDC cash welfare program -- new Medicaid expansions were defined more often with the Federal Poverty Level (FPL) than within the confines of state controlled AFDC eligibility levels. Still, for those whose Medicaid eligibility was linked with AFDC, key reductions in the early 1980s in the AFDC program also reduced Medicaid eligibility for this particular group. This later time period, one during which the federal government was supposed to be the hammer, had one darling. Strangely, it

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[1] Jean Donavan Gilman, *Medicaid and the Costs of Federalism, 1984 - 1992* (New York: Garland, 1998),. 58. (Hereafter Gilman, *Medicaid and the Costs of Federalism*)

was Medicaid, and many commentators suspected that it had something to do with federalism.

Given the state and federal combined financing responsibility for the program, expanding it by one dollar would, on average, only increase federal expenditures by a little more than half of that. States paid a little less than half of the cost of Medicaid, regardless of if those costs were incurred because of mandatory expansions by the federal government or because of state decision making to draw down federal money for optional coverage. While federalism is not, by far, the only explanation for these expansions during a time of supposed "retrenchment," it makes sense that in policy bargains regarding expansions, a winning reason for going ahead was that some of the cost could be "pushed off" onto the states. In fact, by the end of the deluge, states were drowning. In 1989 and 1990, the National Governors Association (NGA) formally requested an end to Medicaid mandates through a series of powerful letters signed by the State Governors.

The group most often targeted for expansions during this era was pregnant women and children, a group accounting for approximately 22% of Medicaid expenditure growth between 1985 and 1990.[2] While not by any means an expensive group to cover in comparison to the elderly and disabled Medicaid beneficiaries, the sheer numbers of new children enrolled made waves in the expenditure pool. Costs for children enrolled in Medicaid grew from $4.4 billion in 1984 to $13.2 billion in 1991.[3] So, during an era when the federal government was synonymous with domestic cost control, the Medicaid program grew substantially -- in absolute terms. From 1981 to 1992, spending for Medicaid increased more than fourfold, expanding from $27.7 billion to $112.9 billion.[4] At its apex, Medicaid expenditures, in just one year, from 1991 to 1992, grew by over 28%.[5] Breaking these costs down, another major contributor was inpatient hospital spending, which exploded during the late 1980s.

Federalism was the major contributor to this spurt, as special financing schemes and state maximization mechanisms in the Medicaid program were employed by many

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[2] Gilman, *Medicaid and The Costs of Federalism*, 73.
[3] Gilman, *Medicaid and The Costs of Federalism*, 73.
[4] Coughlin, *Medicaid Since 1980*, 2.
[5] Coughlin, *Medicaid Since 1980, xv*.

states to combat mandates and cuts in other federal funding. This is discussed in much more detail in a later section. In general, the Reagan/Bush era -- described as an era of "retrenchment" in the American welfare state -- is not considered historically as one of shifting the American welfare state either to "reverse" or, less judgmentally, the opposite direction of the 1960s -- or of the historical trajectory of the 1930s. In his review of the time period, Paul Pierson concludes, "Although Reagan's reforms at least pushed in the desired direction, it remains true that none of the core social-policy functions of the Federal Government were transferred to the states. If Reagan succeeded in halting the 50 - year trend toward a nationalization of social policy, he did not reverse it."[6]

In short, Reagan slowed, possibly stopped, the general progression, but as the review of Nixon showed, the fundamental watershed moment in American policy had already taken place. The Reagan era occurred after the "bump" -- the big punctuation had happened. The lesson here though is that where there is a titanic punctuation, there may very well be an aftershock. In this case, it was profound. The "aftershock" to the Nixon/Ford era Watershed was OBRA 1981. Assisted by the final Carter budget negotiation, the institutions of policy bargaining were re-defined yet again. This time though, it was mostly through behavior, mores, and attitudes of the White House and the newly omnipotent OMB. Key institutional rule changes to the budget process happened because of actions by policy negotiators that filled in the colors of the 1974 Budget process. Reconciliation had been dormant but the 1981 OBRA constructed the architecture of what would become one of the most powerful institutional policy tools of the modern era. For Medicaid, no one could have predicted at that time that the instrument designed to cut entitlements would be skillfully fashioned to expand this one federal/state joint initiative. During the budget era, health care expansion was only possible where the financing structure embraced federalism. The efforts at "federal welfare state retrenchment" unwittingly leaned on Medicaid when times were tough.

[6] Paul Pierson, *Dismantling the Welfare State? Reagan, Thatcher, and the Politics of Retrenchment* (Cambridge, UK: Cambridge University Press, 1994, repr. 1996 and 1997), 157 - 158.

REAGAN'S NEW FEDERALISM -- "THE SECOND WAVE"

While the Nixon era marked a New Federalism directed by a Republican President, his Administration left the country more centralized than he found it. President Reagan was committed that his federalism, the second wave of New Federalism, would stick. In contradistinction with Nixon, Reagan's New Federalism, in combination with Congressional backing, reduced federal aid to the states and eliminated general revenue sharing.[7] In the legislative blockbuster year of 1981, Congress consolidated 57 education, health, and community service programs into seven block grants, while reducing their funding by 25% in the process.[8] The New Federalism consolidated 21 health programs into four block grants, leaving states with less discretion, greater responsibility, less funding, and sharply rising health costs.[9]

The Reagan era further engrained the conceptual framework that block grants were an instrument of implementing conservative ideology and not a neutral administrative tool.[10] As will be discussed, states' creative financing within Medicaid bolstered dangerously faltering state budgets in the face of the 1982 and 1991 recessions that increased unemployment and, thus, Medicaid rolls.[11] Special financing mechanisms and transference of state functions to Medicaid in order to draw the federal match -- and also to replace state with federal funding -- flourished during the twelve years spanning the Reagan and G.H.W. Bush Presidencies. Former CMS heads shared with the author that there is no way to account for those funds, and it is widely considered that states used

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[7] William T. Gormley, "An Evolutionary Approach to Federalism in the U.S.," Paper Presented at the 6th National Public Management Conference, Bloomington, Indiana, October 19, 2001, 8. (Hereafter Gormley, "An Evolutionary Approach")

[8] 1991 *CQ Almanac*, 56. Also see 1981 CQ *Almanac*, 463.

[9] Drew E. Altman. and Douglas Morgan, "The Role of State and Local Government in Health ," *Health Affairs*, 22-24. (Hereafter Altman, "The Role of State and Local")

[10] Conlan, Timothy, "The Politics of Federal Block Grants: From Nixon to Reagan" *Political Science Quarterly* (Summer 1984) 270. (Hereafter, Conlan, "The Politics of Federal Block Grants")

[11] Thad Kousser, "The Politics of Discretionary Medicaid Spending, 1980 – 1993," *Journal of Health Politics, Policy and Law* 27, no. 4 (August 2002), 649.

the additional federal money generated on several aspects of state budgets beyond health.[12]

The interactions of the Nixon era created but were not shaped by Reconciliation. By 1980, Reconciliation was taking form -- and in fact by 1981 it transformed American Public Policy adjudication. Federalism scholar Timothy Conlan describes how the budget was no longer developed "through the traditional painstaking and incremental work of the appropriations subcommittees, but in a single, massive, ad hoc amendment pasted together in a scramble of last-minute negotiations." House members voted on Amendments [Gramm-Latta II] with very little information on what they were voting on and in a "frenzy."[13] The substantive policy discussions regarding effects of program changes on beneficiaries were largely replaced by bottom-line budget and cost estimates. As will be discussed, Medicaid was expanded several times in the 1980s and early 1990s. It bucked the *apriori* theory that Reconciliation would result in massive budget cuts in the program.

Reagan's New Federalism reversed a trend from earlier Presidencies, LBJ and Nixon, by redirecting previously local government directed funds to the states. In fact, 47 of the 77 domestic programs consolidated into block grants by President Reagan had previously delivered funds directly to local governments.[14] This suggests that the Reagan era also represented -- at least in this dimension -- centralization of sorts, only the centralizing force was from local to state governments.[15] Having said that, Reagan was not pro-state at all costs. In the face of conflicts between business and state interests, Reagan more often than not used federal power to support business interests against state regulation.[16] His Administration also highly prioritized conservative moral values when

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[12] Interview with Author, August 30, 2006.
[13] Conlan, "The Politics of Federal Block Grants," 266.
[14] Altman, "The Role of State and Local," 22.
[15] For more considerations of this see Michael S. Sparer, "Devolution of Power: An Interim Report Card," *Health Affairs* (May/June 1998), 7 - 16.
[16] Robertson and Judd write, "Reagan's policies were more about decentralization than of less government. The fight for states rights stopped at a point where business interests were threatened," 377. Also see Gormley, "An Evolutionary Approach."

in competition with other interests and used federal government power to further these conservative moral values.

In health, Reagan accelerated the process of utilizing federal power for cost control, possibly unwittingly setting the infrastructure in place for federal oversight in many other endeavors in the health area -- even for future national health reform efforts which he surely would not have supported.[17] Political and policy actors do not always know the chains that they send into action. After the fact reviews of the 1980s by fiscal federalism expert Howard Chernick and others have since concluded that the idea of a conservative drift in welfare policy during this period is not supported.[18]

THE FUNDAMENTAL RESTRUCTURING OF THE BUDGET PROCESS IN RELATION TO MEDICAID BARGAINING

The transformation wrought upon the American welfare state in 1981 was pronounced, in particular due to the grand entrance of Reconciliation in the budget process. Entitlements, by definition at odds with cost control, supposedly would be at least tamed by the process. Part of the 1974 budget reforms, it was not until 1980 when Carter and Congressional Democrats utilized the process for moderate cost control that Reconciliation was introduced. This institutional reform had a long hibernation period before being utilized. In 1980, the use of Reconciliation resulted in alterations for the next year. Reconciliation was moved to the beginning of the budget calendar year and instructions for authorizing committees were moved to the first budget resolution from a previous process of including them in a second budget resolution.[19]

While Carter and Congressional Democrats introduced Reconciliation, Reagan and his OMB sharpened their sword to use it as a monumental bargaining instrument. The Reagan Administration, under OMB Director David Stockman's direction,

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[17] Gary M. Klass in "Explaining America and the Welfare State: An Alternative Theory," *British Journal of Political Science* 15, no. 4 (October 1985), 427 - 450 goes as far as to say this "establishes the principles upon which a nation health insurance system would some day rest."

[18] Howard Chernick, "Fiscal Effects of Block Grants for the Needy: An Interpretation of the Evidence," *International Tax and Public Finance* (1998), 221. Chernick cites two studies: Moffitt (comparing 1960 to 1984) and Craig (from 1966 to 1989).

[19] Gilman, *Medicaid and the Costs of Federalism,* 121.

spearheaded a reconciliation effort that affected more than 200 programs, including entitlements and reduced Fiscal 1982 outlays by more than $35 billion.[20] In his textbook account of the federal budget process, Allen Schick notes:

> Reagan's budget was often based on unrealistically buoyant economic assumptions and on "dead on arrival" proposals to cut deeply into domestic programs…Reagan legitimized unrealistic budgeting as a tool of Presidential power. Although Congress made many changes in his budget, the revenue and spending outcomes were closer to his preferences than they would have been had he sent us a realistic budget. But the president's tactical gains came at a high cost -- they made the budget into more of a bargaining chip and undermined its status as an authoritative guide to national policy.[21]

The strategic game of budgeting sustained a substantial shift. Those involved in the 1980 Reconciliation actions were nonplussed by the Reagan Administration's use of it. To them, it represented a club. Chairman of the House Rules Committee, Richard M. Bolling called it the "most brutal and blunt instrument used by a president in an attempt to control the budget process since Nixon used impoundment." One of the principal architects of the 1974 Budget Act, Bolling held that the Reagan Administration was guilty of the "most excessive use of presidential power and license."[22]

Reconciliation introduces a stark contrast between macro budgeting decisions and micro policy substance. The massive budget bills required an up or down vote on the entire measure, left very little time for debate about the substance of particular parts of the bill, substantially altered Committee dynamics and influence, and emphasized concentration on the "bottom line" budget features as opposed to specifics regarding substantive policies and the populations affected. Its frame was a macro budget one, even though the micro policy reforms enacted via the process were enacted just as they would if hundreds of hours of debate had been spent on each micro policy. Reconciliation charges one set of committees with setting aggregate budget goals and another set of committees with deciding where the reforms and cuts would be. Inevitably, conflicts arose.

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[20] Ippolito, *Uncertain Legacies*, 247.
[21] Schick, *The Federal Budget*, 92.
[22] Ippolito, *Uncertain Legacies*, 247.

Major Medicaid-Related Reforms of OBRA 1981

The mix and match of the 1981 OBRA set in motion a number of trajectories that lasted in the 1990s and beyond. First, freedom-of-choice and home and community-based services waiver authorities were created, introducing additional state flexibility.[23] Four health block grants --- shifting to the states responsibility for 19 health programs formerly run by the federal government -- were supposed to provide greater flexibility. Instead, funding was reduced by 25 percent, requiring major reductions in services, and a number of constraining federal conditions were linked to the use of the block grant funds.[24] Block grants do not necessarily equal greater state flexibility. The health related block grants were in many areas -- preventive health, maternal and child health, mental health -- that states successfully transferred costs to the federally matched Medicaid program after the substantial cuts. Just because there are cuts in one area of the budget does not mean states will not find a way to receive federal funding. The list of Medicaid changes in OBRA 1981 include:

- temporarily cut the federal matching share of Medicaid payments over the next three years;
- gave the states greater flexibility in defining their "medically needy" populations -- for those states choosing this option (this was later retracted in TEFRA);
- altered a requirement that states not contract with HMOS in which Medicaid and Medicare enrollees made up more than 50 percent of coverage by raising the limit to 75%;
- unlinked Medicaid hospital reimbursement from Medicare's "reasonable cost" methodology, which is discussed more in a later section;

[23] Schneider, *Medicaid Source Book*, 516.
[24] 1981 *CQ Almanac*, 483.

- initially introduced the DSH program, discussed in more detail in a later section;25
- enacted new waiver authority of federal Medicaid requirements for states, including the ability for states to apply for permission to require Medicaid recipients to enroll in managed care; and
- reduced eligibility for welfare benefits.26

Medicaid Cap and Swap Proposals -- 1981 and 1982

OBRA 1981 was also the scene of a bitter debate over a Presidential proposal to place a hard cap on the Medicaid program. The proposal involved the federal share of the program and the proposed limit capped Medicaid spending to 5% more than it spent in 1981. The matching formula would still operate in the Medicaid program,[27] but the percentage increase in federal spending would have a ceiling thus creating a closed matching grant program as opposed to an open matching one. In fiscal federalism theory, there are numerous deadweight losses associated with closed matching grant structures. The OMB held that a cap was the only way to control Medicaid costs. States, regardless of Governor's party affiliation, stood against the cap.

An important constituency in Medicaid bargaining, the States, are also a bargaining entity that United States Congressional members have a true interest in collaborating with because of their own state level elections. Beyond the argument that states would suffer financially under the proposed arrangement, they also feared a precedent of caps in other "welfare programs."[28] An alternate plan in the U.S. Senate Finance Committee would have capped growth of federal Medicaid spending by 9% and reduced the overall federal match in the program.[29] This proposal also failed.

[25] 1981 *CQ Almanac*, 477 - 478.
[26] Coughlin, *Medicaid Since 1980*, 149.
[27] Grannemann, *Controlling Medicaid Costs*, 46.
[28] 1981 *CQ Almanac*, 478 - 479.
[29] 1981 *CQ Almanac*, 479.

During the OBRA ’81 negotiation process, the Energy and Commerce Committee, the Congressional House Committee that oversees Medicaid, was the only committee that did not recommend reconciliation savings.[30] In a tug of war between two packages from this Committee to include in the final bill, the Broyhill Amendment or the Dingell (D- Mich.) package, a series of shotgun deals were made. The proposed Broyhill Amendment set a Medicaid cap and contained a number of other controversial reforms on Amtrak, Conrail, and low-energy assistance.[31] In order to “rescue the Broyhill substitute,” OMB Director David Stockman recalled in his memoirs he “rented, bought, traded, or begged.” As he wrote, “What deals they were. They ranged from things that turned my stomach to things that made me only faintly ill, from reviving the sugar quota program to exempting state-owned cotton warehouses in Georgia from the new inspection user fee.”[32] Even after all of this negotiating successfully cleared the way for the Broyhill Amendment to be included in the final bill, *Congressional Quarterly* reported at the time, “The GOP leadership finally decided to pull the Broyhill amendment; the Dingell package thus was included in the final bill by default.”[33] In Stockman’s account, he writes: Without even checking with the White House, they [GOP leaders] huddled briefly on the floor and decided to dump the Broyhill amendment entirely -- and with it the Medicaid cap …. that only hours earlier they had won the right to offer.”[34] In this round, the Medicaid Cap proposal was thus defeated. Similar savings were implemented, however, via a series of temporary federal matching rate reductions over three years.

[30] 1981 *CQ Almanac*, 264.
[31] 1981 *CQ Almanac*, 264.
[32] David A. Stockman, *The Triumph of Politics: Why the Reagan Revolution Failed* (New York, NY: Harper & Row Publishers, 1986), 221 - 222. (Hereafter Stockman, *The Triumph of Politics*)
[33] 1981 *CQ Almanac*, 264.
[34] Stockman, *The Triumph of Politics*, 222.

State Waivers of Federal Medicaid Law -- The New Tool of the Executive in Medicaid Policy

In order to help the States meet the spending limits, OBRA 81 included a variety of provisions to increase State flexibility, perhaps the most important of which were the establishment of the section 1915(b) and 1915(c) waiver programs (freedom-of-choice and home and community-based services).[35] These waivers would be extremely important in the future evolution of the federal and state relationship in Medicaid. As part of these provisions, states could apply for a waiver and then require Medicaid beneficiaries to enroll in managed care plans.

The new ability for states to require individuals to enroll in managed care after receiving a waiver eventually erupted into questions of the role of managed care as state actors. Resembling other privatization of state functions debates that are prevalent in public finance policy, they introduced new dilemmas in Medicaid federalism regarding requiring managed care participation. Again, the major original precepts of the Medicaid program were being re-written.

REAGAN'S NEW FEDERALISM SWAP PROPOSAL, CLOSED MATCHING GRANT CAP, AND PARTIAL PROGRAM BLOCK GRANT PROPOSALS

By the 1982 State of the Union, President Reagan attempted a different approach to Medicaid structural reform. This one entailed rationalized federalism -- a clean cut of various social programs to either the federal or the state government, but no longer shared responsibility. As the State of the Union explained, "A maze of interlocking jurisdictions and levels of government confronts average citizens in trying to solve even the simplest of problems. They do not know where to turn for answers, who to hold accountable, who to praise, who to blame, who to vote for or against. The main reason for this is the overpowering growth of Federal grants-in-aid programs during the past few decades."[36] Later in President Reagan's description of his New Federalism initiative, he outlined the

[35] Schneider, *Medicaid Source Book*, 34.
[36] President Reagan's State of the Union Speech to Congress, January 26, 1982. 1982 *CQ Almanac*, 5E.

proposition: "Starting in fiscal 1984, the Federal Government will assume full responsibility for the cost of the rapidly growing Medicaid program to go along with its existing responsibility for Medicare. As part of a financially equal swap, the States will simultaneously take full responsibility for aid to families with dependent children and food stamps."[37] Congress never seriously considered these New Federalism Initiatives, and the President did not submit legislation in order to see the plan through.[38]

As for Governors, they were fully supportive of at least one aspect of the plan -- the transfer of Medicaid fully to the Federal Government. The New Federalism initiative was a "non-starter" with the Governors because they also wanted the Federal Government to assume the AFDC and Food Stamps programs in addition to Medicaid. Governor Lamar Alexander from Tennessee summed up his ideas of rationalized federalism: "Most governors would prefer that the national government took AFDC, food stamps and Medicaid and give us an even amount in programs of a more everyday concern like sewers." Others suggested the federal government take on the three programs and swap to states even greater responsibility for education.[39] A re-package proposal to remove the long-term care portion of Medicaid from this federalization swap and instead fund long-term care through a block grant to the states also sank.[40] In a third attempt at major structural reform, the closed matching grant cap was resurrected in 1985 in the Reagan budget.[41] Based on the ideas President Reagan had first proposed in 1981, it was a non-starter. Swap attempts, closed matching grant caps, partial program block grants -- all Reagan proposals, all went nowhere. Among the reasons for the failure were that states consistently bargained with the Oval Office against the measure. Even Reagan's Secretary of Health Schweiker reportedly struck a deal with the President prior to taking the Cabinet Post against a block grant approach to Medicaid.[42]

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[37] President Reagan's State of the Union Speech to Congress, January 26, 1982. 1982 *CQ Almanac*, 5E.
[38] 1982 *CQ Almanac*, 536.
[39] 1982 *CQ Almanac*, 536.
[40] Paul Gary Wyckoff, Economic Commentary, "Medicaid: Federalism and the Reagan Budget Proposals," *Federal Reserve Bank of Cleveland* (August 15, 1985).
[41] 1985 *CQ Almanac*, 437.
[42] Lynn Etheredge, "Reagan, Congress, and Health Spending," *Health Affairs*, 19.

Series of Medicaid Eligibility Extensions Using Reconciliation

Ironically, the development of the Reconciliation process further into the decade was met with a convergence of policy forces expanding eligibility and reducing inequality in Medicaid. In each year between 1984 and 1990, Congress passed at least one major piece of legislation that required, or allowed, states to either expand Medicaid eligibility or services.[43] By 1990, 31 eligibility expansions had been enacted by Congress, 19 of them mandatory on state governments.[44] An important trend during this six-year time period was counter-intuitive, in that both the federal and state governments expanded Medicaid in order to contain costs. The Federal Government through the open matching grant structure shared the costs of expansions with states, and the states transferred to Medicaid the costs of non-federally funded state functions and other areas of state budgets.

Inequality was reduced, primarily with greater centralization of eligibility requirements to a federal norm, thus mitigating the vast differentials in states' Medicaid eligibility. Between 1979 and 1991 interstate differences in Medicaid coverage, measured relative to the poverty population, fell by about one-half.[45] This reduction in inequality is particularly related to the expansions of coverage for pregnant women, infants, and children to the Federal Poverty Level (FPL) instead of the states' AFDC eligibility rules which differed by state. Also, expansions of Medicaid to low-income Medicare beneficiaries, the dual eligibles, also reduced overall inequality because eligibility is linked to federal criteria.

At first, some states, particularly southern states which had high incidence of low-birth weight babies and high infant mortality rates, were proponents of the Medicaid expansions for pregnant women and children.[46] With time, states through the NGA acted in unison against further expansions. For Medicare and Medicaid dual eligibles, even though the 1988 Medicare Catastrophic Care Act was largely repealed the following year,

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[43] Coughlin, *Medicaid Since 1980*, 35.
[44] Gilman, *Medicaid and the Costs of Federalism*, 58.
[45] Coughlin, *Medicaid Since 1980*, 149.
[46] Coughlin, *Medicaid Since 1980*, 47.

the Medicaid expansions survived. In 1991, these were in fact expanded to the "near poor." By 1989 and 1990, the States -- a very powerful Medicaid constituency -- acted in unison against further expansions. The NGA has called several times since then for the transfer of funding for covering dual eligibles to the federally funded Medicare program.

Medicaid eligibles include several disparate groups of constituencies, some of whom do not vote frequently, particularly children who cannot vote, or do not hold substantial political or electoral capital. Where there is overlap with more politically powerful groups, Dual Medicare/Medicaid eligibles and SSI recipients for example, there is a more substantial power set at the bargaining table in Medicaid negotiations than with other less powerfully connected Medicaid populations. Providers also benefit from Medicaid's distributional effects, particularly nursing homes and hospitals. In fact, the government's distributive role in Medicaid is as vital as its redistributive role. Medicaid's lynchpin role in hospital payment was a major supporting argument -- in addition to States' protestations -- against block granting Medicaid in the Reagan era.[47] As one 1980s study reported, "That Medicaid funding plays a crucial role in keeping many hospitals from closing was an argument made again and again by hospital administrators who testified in opposition to Reagan's proposed cap on Medicaid….Medicaid was saved from the Reagan ax by an exceptionally strong coalition of support that came to its rescue. The coalition consisted of neither Medicaid recipients or the AMA."[48]

Reconciliation encouraged expansions because the budget process involves "must pass" legislation, limited debate compared to other legislation, and is generally more protected from amendments and presidential vetoes than other legislation.[49] While both Presidents Reagan and G.H.W. Bush threatened vetoes of entire budget bills due to Medicaid expansions -- further heightening the program's importance in overall

[47] Gilman, *Medicaid and the Costs of Federalism*, 43.
[48] Gilman, *Medicaid and the Costs of Federalism*, 43.
[49] Gilman, *Medicaid and the Costs of Federalism*, 123.

American public policy adjudication -- the former's threats were not taken seriously while the latter's were respected and greater Medicaid extensions were tabled.[50]

Medicaid's federal/state structure contributed heavily to it being a preferential program in the face of budget bottom lines, which were now enforced by Reconciliation. The fact that states would pay part of the bill for these expansions, made them possible. If the federal government endured all of the costs, it would further break the budget. Stockman wrote of the "required a frontal assault on the American welfare state."[51] In fact, many of the drastic social safety net cuts of OBRA '81 in later years resulted in States "transferring" functions to Medicaid where federal funding was cut and maximizing Medicaid funding to pay for other State budget cuts.

Reagan, his OMB, and Congress also pushed through the largest tax cut in history to that point a couple of days before OBRA '81 passed. The OBRA '81 maneuvers were tied to the Administration's need to "find room" for this tax cut. Administration language of the protected "Sacred Seven" social safety net programs was considered by detractors as a veneer to mask the numerous domestic cuts. By identifying a protected social safety net, the Administration hoped to not appear as draconian to those in both parties who would object. Future years resulted in tax increases, but the history-setting tax cut in 1981 further set Reagan's legacy as a man who wanted to reduce Big Government.

Amidst proposals to change the Federal matching percentages permanently either by dropping the minimum matching rate or by reducing it only for particular services as a disincentive, the federal reforms that did succeed were expansions that increased states' responsibilities. Medicaid's federal/state structure -- unwittingly -- in combination with the new Reconciliation, made it the program to "dump on", to expand, to transfer responsibilities previously either federal only or state only. In fact, the "buck passing" went both ways -- the Feds passed on its responsibilities to the federal/state program and states transferred their previously state-only functions to the federal/state program.

[50] Gilman, *Medicaid and the Costs of Federalism*, 124 - 125.
[51] Stockman, *The Triumph of Politics*, 8.

Medicaid's interdependence of governmental levels, the intertwining of their accountability, again was clear.

Bills resulting in Medicaid expansions during this time period include: DEFRA (1984 Budget Reconciliation -- PL 98-369); COBRA (1986 Budget Reconciliation -- PL 99-272); the Fiscal 1987 Budget Reconciliation (OBRA '86 -- PL -99-509); the Fiscal 1988 and 1989 Budget Reconciliation (OBRA '87 -- PL 100 - 203); the 1988 Medicare Catastrophic Coverage Act (PL 100 - 360); the Fiscal 1990 Budget Reconciliation (OBRA '89 -- PL 101-239); and the Fiscal 1991 Budget Reconciliation (PL 101 - 508).[52] Other legislation extending Medicaid eligibility in the time period included the 1986 Immigration Reform and Control Act (IRCA), and again the 1986 OBRA legislation, which expanded Medicaid coverage to newly legalized aliens and undocumented persons who otherwise would not have been entitled to Medicaid.[53] In addition to this legislation, a number of disabled SSI children were made eligible for Medicaid by the 1990 U.S. Supreme Court decision *Sullivan* v. *Zebley*, which required the Social Security Act to conduct retroactive eligibility determinations back to 1980 for disabled children. This decision alone added 125,000 new SSI recipients.[54] In 1991, a new regulation extended presumptive disability for persons with HIV, greatly facilitating access to Medicaid for more individuals.[55]

While Federalism, Reconciliation processes, and initial State and provider support encouraged Medicaid expansions, an additional force behind Medicaid expansions was the entrepreneurial activities of Congressman Henry Waxman. As one author concludes, "Waxman played a critical role in facilitating the repeated expansion of Medicaid from 1984 to 1990. As the policy entrepreneur, he choreographed the strategy of incrementalism and persistence that exploited the political and institutional circumstances of those years. His own personal and political resources as chair of the powerful

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[52] 1991 *CQ Almanac*, 356 - 357.
[53] Rowland, Feder, and Salganicoff (eds.), *Medicaid Financing Crisis: Balancing Responsibilities, Priorities, and Dollars* (The Henry J. Kaiser Family Foundation, 1993). (Hereafter Rowland, *Medicaid Financing*)
[54] Coughlin, *Medicaid Since 1980*, 42-43.
[55] Coughlin, *Medicaid Since 1980*, 42-43.

Subcommittee on Health of the HECC [House Energy and Commerce Committee], as possessor of sizable financial resources through his PAC, and as a skillful and tenacious negotiator enabled him to exert extraordinary influence over the policy process in the House and in conference committee."[56]

This evidence suggests that while federalism is an important component of these expansions, it is not the sole contributing factor. Several forces, including federalism, pushed Medicaid expansions from 1984 to 1991. In fact, the interaction between these factors created the environment for these expansions. Reconciliation in combination with the role of federalism in Medicaid in combination with the activities of an effective policy entrepreneur all interacted in a dynamic trio that holds considerable explanatory power of the Medicaid expansions from 1984 to 1991.

Revolutions in the institutional rules of the Budget Process itself also favored Medicaid expansion. The Gramm-Rudman-Hollings Act (GRH), officially the Balanced Budget and Emergency Deficit Control Act of 1985, set a goal to balance the budget in five years by setting annual deficit targets and using sequestration -- automatic across the board cuts -- in the event these targets were not met. In all rules, though, there are exceptions and in Gramm-Rudman's case, Medicaid was exempt from the sequestration process, meaning Congress could increase spending in this program without invoking the harsh enforcement instrument. This encouraged the Medicaid expansions from 1985 to 1990. Also, the one-year budget targets of Gramm-Rudman meant that costs of Medicaid could be "hidden" from the next year's budget by programming the costs to take effect after the one-year time horizon. These budget "gimmicks" took many different forms of "moving around" costs.[57]

By 1990, the environment created by Gramm-Rudman was altered substantially again by the Budget Enforcement Act (BEA). BEA established new budget enforcement rules that lessened the appeal to expand Medicaid. As Gilman found, BEA removed the "annual reconciliation bill and its one-year targets from the agenda, forcing advocates of

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[56] Gilman, *Medicaid and the Costs of Federalism*, 150.
[57] Gilman, *Medicaid and the Costs of Federalism,* 119 - 121.

program expansions to be explicit about the long-term costs of such program changes."[58] BEA separated the budget into Entitlement, Social Security, and Discretionary spending, making it impossible for an entitlement program like Medicaid to squeeze out extra dollars from the budgets of discretionary programs.[59] The primary feature of the BEA was the "Pay As You Go" or PAYGO rules. It required that no program extensions were allowed unless they were accompanied by commensurate adjustments in revenues or cuts in other programs.[60] BEA required the sum of entitlement and revenue legislation enacted in a congressional session be deficit neutral."[61] In the case of the BEA, "Medicaid legislation could cause a sequestration, if an eligibility or benefit expansion were not offset by increased revenues or spending cuts. However, Medicaid along with a number of other programs targeted at low-income persons was exempted from sequestration in the event of a breach in the pay-as-you-go requirement."[62] Since BEA resulted in a three-year budget agreement, in 1991 and 1992 Congress did not enact reconciliation bills, thus the avenue for further Medicaid expansions was thwarted.[63]

PROVIDER PAYMENT RULES REWORKING AND SUBSEQUENT FEDERAL COURT ADJUDICATION

In the early 1980s, both nursing home and inpatient hospital provider payment changed substantially. The Boren Amendment was enacted and then amended to effectuate some of the most long-lasting and important changes in provider payment related to Medicaid federalism. The Boren Amendment was enacted in two parts. First, OBRA 1980 established criteria for payment to skilled nursing facilities (SNFs) and intermediate care facilities (ICFs). In the second stage, OBRA 1981 added hospitals.[64]

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[58] Gilman, *Medicaid and the Costs of Federalism,* 133.
[59] Schneider, *Medicaid Source Book*, 477.
[60] Gilman, *Medicaid and the Costs of Federalism,* 133.
[61] Schneider, *Medicaid Source Book*, 477. The exception to this is "unless the President and Congress both declare that the legislation meets an 'emergency.'"
[62] Schneider, *Medicaid Source Book*, 479 - 480.
[63] Gilman, *Medicaid and the Costs of Federalism,* 133.
[64] Gerard Anderson and William Scanlon, Chapter 4, "Medicaid Payment Policy and the Boren Amendment," in Rowland, Feder, and Salganicoff (eds.), *Medicaid Financing Crisis: Balancing*

Nursing Homes and Intermediate Care Facilities

In 1972 via influential amendments to Medicaid, Title XIX of the Social Security Act (P.L 92- 603), it was required that a "reasonable cost-related basis" be used in setting SNF and ICF payment rates. ICFs were included in Medicaid in 1972. In short, states had a choice -- adopt Medicare's principles of retrospective reasonable cost reimbursement or have alternative payment structures approved by the Secretary of HEW.[65] By 1980, there was concern that the HEW approval process and also adjudication by the courts was herding states in the direction of Medicare's cost based reimbursement methods -- thus in an inflationary direction. This instigated the Boren Amendment for SNFs and ICFs in OBRA 1980.[66]

Inpatient Hospitals

The path for hospital payment to Boren was different. Driving all the way back to Medicaid and Medicare joint enactment in the three pronged beginning of America's health financing "sisters," states were required -- not encouraged, but required -- to use Medicare's retrospective cost based payment for hospitals[67] except in cases where a state had a broad based 1115 Social Security Waivers from the federal government.

Importantly, this meant that Medicaid's hospital payment had been inextricably linked with that of the original Medicare hospital payment bargain between hospital administrators and government negotiators. In order to move the joint Medicare/Medicaid bill through the enactment and implementation process, government bargainers had allowed hospitals to "be paid according to principles of their own making."[68]

Responsibilities, Priorities, and Dollars (The Henry J. Kaiser Family Foundation, 1993), 84. (Hereafter Anderson, "Medicaid Payment Policy")
[65] Anderson, "Medicaid Payment Policy," 84 - 85.
[66] Anderson, "Medicaid Payment Policy," 84 - 85.
[67] Schneider, *Medicaid Source Book*, 307.
[68] Feder, *Medicare: The Politics*, 82.

As Judy Feder explained regarding the bureaucratic appeasement, "In fact, officials in SSA's [Social Security Administration] Bureau of Health Insurance did consider the impact of payment policy on Medicare costs, both in the short and long run, and developed payment principles consistent with their view of cost effectiveness and the public interest. When these proposals failed to satisfy hospital demands, however, SSA's preeminent concern with hospital cooperation, reinforced by the consultation process, led to a compromise that contributed to and legitimized the excessive expenditures BHI [the Bureau of Health Insurance] had tried to avoid."[69]

In this way, Medicare hospital payment was not "rationalized" from the beginning to structure a cost-effective payment instrument. Instead, the federal government did a classic "look away," allowing hospital executives to drive the design of payment mechanisms in order for government officials to get them on board in support of enactment. Medicaid hospital payment, through the requirement to follow Medicare's structure, was subject to the same system.

By 1981, the Boren amendment eliminated this statutory requirement that Medicaid hospital payment to individual hospitals resemble Medicare methodology. There was still an important, somewhat vague range, within which states were to stay with regard to how they structured payment methodologies. For example with regard to ceilings, Medicaid regulations established that the *aggregate amount* spent by a State for inpatient services during a year not exceed the *aggregate amount* which would have been spent if the State had used the current Medicare system.[70] Also, payments could not exceed the hospital's customary charges to the public.[71] Finally, State's payment rates had to "be sufficient to attract enough providers so that covered services [would] be as available to Medicaid beneficiaries as they [were] to the general population."[72]

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[69] Feder, *Medicare: The Politics,* 54.
[70] Schneider, *Medicaid Source Book*, 310. Note that The Secretary is prohibited from using this requirement to limit a State's payments to DSHs.
[71] Schneider, *Medicaid Source Book*, 308.
[72] Schneider, *Medicaid Source Book*, 306. This rule was codified by the OBRA 89 but had previously been established by regulation. For more see Jost in *Disentitlement*, 167. The OBRA 89 language (42 U.S.C. 1396a(a)(30)(A) requires that "Medicaid payment levels be 'sufficient to enlist enough providers so that

States or Providers -- Who Benefited from Boren?

The OBRA 1981 wording stipulated that rates must be "*reasonable and adequate* to meet the costs that must be incurred by *efficiently and economically* operated facilities to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards."[73] The "reasonable and adequate" phrasing provided fodder for providers to claim that state payments were inadequate in future line drawing court cases. On the other hand, the language requiring "efficiently and economically operated facilities" gave states the leeway to institute new methodologies that would cut costs. Many states replaced their retrospective cost based systems with prospective payment methodologies.

Until 1981, state Medicaid programs were required to reimburse hospitals according to Medicare methodologies.[74] This meant that Boren would most probably result in more cost effective state-directed methodologies. There were a number of convoluting factors that confused the conclusion of the policy winner from Boren, including changes to Medicare payment methodology in 1983, caps on aggregate Medicaid inpatient hospital expenditures by state tied to the potential aggregate Medicare spending, and disproportionate share hospital payments.

The Amendment trumpeted to be pro-state was written in ambiguous terms. Anderson and Scanlon explain: " The Boren Amendment sets a federal standard for determining the reasonableness of payment rates to hospitals and nursing homes in the Medicaid program. Originally, enacted in 1980 to affirm the states' prerogative to pursue cost containment in setting nursing home payment rates, and amended a year later to encourage similar action regarding hospitals, it has been used repeatedly in recent years as the basis for lawsuits challenging some states' payment rates to both hospitals and nursing homes. While the payment rates of Medicaid programs have frequently been

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services…are available to ….recipients at least to the extent that those services are available to the general population.'"

[73] Anderson, "Medicaid Payment Policy," 84.

[74] Schneider, *Medicaid Source Book*, 307 - 308.

affirmed by courts, there is increasing concern that the vague and imprecise language of the Boren Amendment makes it difficult for the states to defend policies that fall within the range of their discretion."[75]

State 1115 Waivers for Provider Payment Experiments

Since states were required to utilize Medicare hospital payment methodology, the federal government had "passed on" or lent states these methodologies. In addition to inheriting Medicare's institutional rules regarding hospital payment, states also inherited its weaknesses. In order to address these weaknesses, waivers of federal requirements in payment systems were allowed. Waivers allowed "experiments," as instruments of Laboratory Federalism, where federal legislation was exempted for states committed to testing new methodologies.

Beginning in the 1970s, all-payer systems were approved as "Demonstrations" by the Secretary in order to test paying uniform rates to all insurers and payers in the State -- including both Medicaid and Medicare.[76] The New Jersey experiment involved development of Diagnostic Related Groups (DRGs).[77] In a classic example of the purported benefits of states acting as "laboratories" of testing and learning, the New Jersey DRG system would serve as the model for the 1983 enactment of a prospective payment system (PPS) for Medicare.[78] Just as the states had previously borrowed knowledge from the federal government, so the states now offered lessons to the federal government. Federalism provides lessons both ways and is, therefore, endogenous.

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[75] Anderson, "Medicaid Payment Policy," 83.
[76] Schneider, *Medicaid Source Book*, 318.
[77] Other states such as Maryland and Massachusetts used budget-based systems.
[78] When Medicare instituted a prospective payment system (PPS) in 1983, the rules regarding aggregate Medicaid inpatient hospital payments not exceeding what would have been paid in a state using Medicare payment for the aggregate amount, was thus affected. In essence, the Medicare "benchmark" changed in a more conservative direction. It is also important to note the important change in federalism in health policy. For Medicare/Medicaid's enactment, federal officials had to stay passive on cost controls whereas by the 1980s the federal government was acting as "The Razor" on federal social spending.

Provider Federal Rights of Action

The 1990 decision *Wilder* v. *Virginia Hospital Association* "initiated the right of Medicaid providers to proceed directly into federal court to contest payment rates."[79] In a 5-4 decision, the Supreme Court decided that providers do have a right to sue state Medicaid officials under section 1983 authority. Earlier, providers had obtained judgments that state payments were inadequate.[80] By mid-1991, cases had been filed by hospitals, nursing homes, or both in 29 states resulting in court orders or settlements that altered states' reimbursement systems.[81]

In the *Wilder* case, the Court acted despite ongoing questions in cases hinging on policy regarding the ability of the judiciary to intervene where policy expertise weighed in the decision, traditionally the seat of administrative agencies. The *Wilder* v. *Virginia Hospital Association* was an extension of a Reconstruction-era civil rights law that the federal courts used to allow Medicaid beneficiaries to dispute state Medicaid rulings. Now after *Wilder*, providers could bring section 1983 suits, as well as beneficiaries. An individual right to Medicaid entitlement had been established in a line of cases including *King* v. *Smith* and *Maine* v. *Thiboutot*. In a fascinating turn, the work of the LBJ era OEO based legal services lawyers to attain federal rights of action for welfare beneficiaries were used in 1990 to defend provider's rights of action.

The policy lesson of the use of beneficiary right of action being extended to providers is that activist's reform precedents are often used later for completely alternate ends by other major players in the system. There is no guarantee how reform mechanisms will be used, to what ends, or by which coalition on the ideological spectrum

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[79] Jost, *Disentitlement*, 44.
[80] Examples for hospitals include: in Pennsylvania in *Temple University* v. *White* 729 F. Supp. 1093 (E.D. Pa. 1990), cert. denied, 112 S. Ct. 873 (1992); in Michigan in *Michigan Hospital Association* v. *Babcock* (736 F.Supp. 759, 1990); in Colorado in *Amisub Inc*. V. *Colorado* (879 F2d 789, 10th Circuit, 1989); in Washington in *Multicare Medical Center* v. *State of Washington*, (W.D. Wa. C88-421Z, 1991). For nursing homes, examples include *Pinnacle Nursing Home* v. *Axelrod* (719 F. Supp 1173), rev'd. in part on other grounds, 928 F.2d 1306, (2d Cir. 1991); *Health Care Association of Michigan* v. *Babcock* (W.D.Mi, K89-50063 CA, 1990. See Schneider, *Medicaid Source Book*, 309 for additional information.
[81] Schneider, *Medicaid Source Book*, 42.

once a mechanism is developed or once the reform is activated. Not only can actors not always control the stream of reform once it is set in motion, once an instrumental tool is developed, it can be used by others for wholly different ends. In this particular case, though, this lesson is overstated. In fact, some interviewees emphasized how providers in many cases were launching law suits on behalf of beneficiaries. If providers are not compensated adequately, they cannot participate in the Medicaid program. In turn, there are fewer providers to provide access and choice to Medicaid beneficiaries. Also, after *Wilder*, providers had a reason to fight for beneficiaries' entitlement rights because these were now inextricably tied to providers' rights for adequate reimbursement based on access.[82]

The Supreme Court in 1990 did not appear to reflect the ambiguity that was affiliated with who was the real benefactor of the Boren Amendment -- States or Providers. While initially, states were the beneficiaries because they were no longer tied in Medicaid hospital payment to what at that time was a retrospective cost based Medicare payment system, in more recent years hospitals had obtained court judgments establishing inadequacy of state's Medicaid payment schemes.[83] In the *Wilder* case, the Court wrote: "There can be little doubt that health care providers are the intended beneficiaries of the Boren Amendment." Further, the Court said that the Boren Amendment "imposes a binding obligation on states participating in the Medicaid program to adopt reasonable and adequate rates and that this obligation is enforceable under Section 1983 by health care providers."[84]

STATE FINANCING SCHEMES AND TRANSFERRING OF STATE FUNCTIONS TO MEDICAID

In one of the most important trends of the 1980s, states began to use a number of various mechanisms in order to game or maximize the amount of federal funding via the

[82] Interview with Author, August 16, 2006.
[83] Schneider, *Medicaid Source Book*, 309.
[84] Frederick Miles, "Supreme Court Ruling Supports Right to Fair Medicaid Rates," *Provider* (August 1990).

Medicaid program. They also shifted many previously state funded functions to the Medicaid program, whenever possible. By the early 1990s, these various schemes had changed the nature of the program substantially with federalism actively used as an instrument by states for transference of their own costs to the federal government via Medicaid. Health programs were not the only state functions funded using these schemes, but in fact state functions in many policy areas were bolstered using these methods. This was an example of how "superiority" of the federal government to mandate states in eligibility, benefits, payment levels, quality, and other regulatory requirements can be met with strategic manipulation from the states in the other direction to combat mandates and game federally designed structures.

These schemes took several forms and continued to evolve well after the Reagan and G.H.W. Bush eras. In general though there were two approaches: program expansions and state maximization schemes that evolved into important facets of Medicaid federalism. Program expansions involved transferring state funded activities to the Medicaid program in order to reach federal matching funds. Revenue expansions included various state schemes in order to replace state with federal dollars in funding the Medicaid program. The second category of revenue practices included provider donations, provider taxes, intergovernmental transfers (IGTs), and Medicaid Upper Payment Limit (UPL) schemes. Many times, these various federal funded maximization strategies employed by states involved utilizing the Disproportionate Share Hospital (DSH) program in combination with these methods, although there were also maximization efforts that included simply overpaying providers using DSH and getting kick-backs from the hospitals in return.

The Feds Encourage DSH: The 1981, 1985, and 1987 OBRAs

The 1981 OBRA made an effort to increase access to health care both for those covered by the Medicaid program and the uninsured. In this effort, the statutory language included provisions whereby states were instructed to consider the special payment needs of hospitals that serve a disproportionately high share (DSH) of Medicaid and uninsured

patients.[85] In short, OBRA 81 required that States' Medicaid reimbursement systems "take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs."[86] There was a regulation capping aggregate Medicaid reimbursement at Medicare levels -- the so-called "Upper Payment Limit."[87] States did not adopt DSH programs in large measure, and concerns regarding access to care for "uncompensated care" or uninsured individuals grew after the 1983 enactment of Medicare's prospective payment system (PPS). The PPS left fewer "extra" funds with providers in order to cover the care of those who were unable to pay providers. In response to fears of limited access for both the uninsured and Medicaid patients, Congress acted again in 1985, prohibiting the Secretary from limiting States' payments to disproportionate share hospitals -- thus creating a loophole in the Upper Payment Limit (The Consolidated Omnibus Budget Reconciliation Act of 1985, COBRA 85, P.L. 99-272).[88]

Before 1987, the designation of hospitals to receive DSH funding had been left to states. In 1987 Congress amended the DSH provisions which included minimum criteria for defining a hospital as a DSH hospital effective July 1, 1988 (OBRA 87, P.L. 100-203).[89] Congress required states to submit a Medicaid plan amendment describing their DSH policy.[90] Requirements were phased in over a three-year period and were fully effective for inpatient services on July 1, 1990.[91]

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[85] Teresa A. Coughlin. and Stephen Zuckerman, Chapter 5, "States' Strategies for Tapping Federal Revenues: Implications and Consequences of Medicaid Maximization," in *Federalism & Health Policy,* John Holahan, Alan Weil and Joshua M. Wiener (eds.) (Washington, D.C.: The Urban Institute Press, 2003), 153. (Hereafter, Coughlin, "States' Strategies")

[86] Schneider, *Medicaid Source Book*, 319.

[87] Over the years, the agency that administered Medicaid set a series of UPLs. The Upper Payment Limit (UPL) in Medicaid is a tricky concept because it is based generally on Medicare service payment levels but it is organized in compartments of aggregate payments by inpatient hospital services, ICF/MRs, and nursing homes and not by payment for each service provided.

[88] Schneider, *Medicaid Source Book*, 320.

[89] Schneider, *Medicaid Source Book*, 320. These requirements have been amended several times since their enactment.

[90] Jean Hearne, Congressional Research Service (CRS), The Library of Congress, "Medicaid Disproportionate Share Payments," (Updated January 15, 2003), CRS-3.

[91] Schneider, *Medicaid Source Book*, 320.

Provider Tax and Donation Programs

At the same time that legislative changes were happening in the DSH area, there were several converging forces taking form. Provider donations to state governments was one of these areas. A second related area was states taxing providers -- not for general broad-based taxation purposes -- but in money circulating, or more pejoratively, money laundering arrangements, where the end result was eventually returning the taxed funds to providers and replacing state with federal dollars in funding the Medicaid program. For most of the decade, regulation from the agency that administered Medicaid -- at that time called the Health Care Financing Administration or HCFA -- and not statutes from Congress are what organized activities in these two areas.

HCFA regulation until 1985 allowed the use of provider donated funds -- also referred to as voluntary contributions -- for the costs of State administrative staff training.[92] By 1985, a new regulation allowed private donations to finance the State share of Medicaid services or administrative spending within particular conditions.[93] In 1986, West Virginia established the first provider donation program,[94] thus utilizing this flexibility granted by the federal government. Not having enough state funds to reimburse Medicaid services to hospitals, the state set up a system where hospitals "donated" money to the state government. Returning the same funds, states would "pay" hospitals for Medicaid, drawing a federal Medicaid match by this action. While the federal money generated by this roundabout transfer of funds did not fully compensate hospitals, it did result in some payment for services to Medicaid patients that would not have been available otherwise.[95] In a bout of ambivalence and back and forth decision making by HCFA, these Federal matching funds were first approved and then later

[92] Schneider, *Medicaid Source Book*, 500. (former 42 CFR 432.60)
[93] Schneider, *Medicaid Source Book*, 500. The new regulation was 42 CFR 433.45(b).
[94] Tennessee also developed a donation program very early on in 1987.
[95] Coughlin, "States' Strategies," 151.

denied. Upon appeal, the denials were overturned and states again had access to these methods to generate federal matching funds.[96]

The first provider tax program was utilized by Florida in 1984. Working along the same lines as the provider donation program, states would "tax" providers, using the providers funds as the state's share of Medicaid or DSH money in order to generate a federal match.[97] Once the federal match was generated, states would "pay back" providers their tax exaction -- making the provider whole, or better off, at the end of the process and creating a situation where states were no longer paying their "share" of the Medicaid program. Instead, they were utilizing their tax authority to draw down federal funds, allowing the federal government to pay an overall greater share of Medicaid than was intended and saving sparse state funds for wholly other purposes in the state budget. States, thus, were using the open matching structure that was instituted by the Federal Government in strategic ways to subvert it.

This area of Medicaid policy in the 1980s and early 1990s comprised a great deal of back and forth decision making within the Administrative Agency that ran Medicaid, HCFA. It also involved considerable bartering and play-by-play bantering between Congress, the White House, HCFA at the federal agency level, and states. Not only were individual states involved in the submission of state plans, appeals, payments, and day-to-day instructions that it received from HCFA, but the National Governors Association (NGA) played a key role in the actual bargaining with the major branches of government.

Convergence of Several Policy Streams in Medicaid Federalism

The environment surrounding these micro-level actions in Medicaid was, again, darkening. In the late 1980s, recession was again threatening. States' economies were suffering, with searing effects particularly in states with the lowest tax capacity -- and often greater numbers of individuals meeting the federal mandated eligibility categories for Medicaid. The great dragon -- the federal deficit -- continued as a focus in the budget

[96] Schneider, *Medicaid Source Book*, 500.
[97] Coughlin, "States' Strategies," 151 - 152.

reconciliation bills, where now after the watershed of 1974-75 and the revisions of 1980-81, a majority of social policy was negotiated. Some Democrats had even gone as far as to claim that President Reagan had "staged" the spending pressure on social programs early on in his Presidency by pushing what was at that point the largest tax cut in history.[98] Increases in defense spending to build up the Cold War stockpile in the arms race with the USSR was also cited as a rationalized choice made by President Reagan to foreclose other budget options.[99] Following the stock market crash in October 1987, even greater pressure was put on deficit reduction in Presidential budgets in order to "calm nervous financial markets."[100]

In other social policy, the Medicare program was primed for a major reform in catastrophic health coverage -- affecting Medicaid in numerous ways including expansions in dual eligibles and also the introduction of new overlaps in both long-term care and pharmaceutical financing. The 1988 Family Support Act spearheaded another major effort in cash welfare, AFDC, reform. Arkansas Governor Bill Clinton co-chaired the National Governors Association welfare reform effort, forging relationships for Medicaid negotiations, saying "We need to get a handle on the Medicaid mandates or else some of us are going to go broke."[101] In 1988, the Bipartisan Pepper Commission, comprised of members of Congress and Reagan Administration appointees, was created to make recommendations on coverage for the uninsured and on long-term care.[102] Following major Medicare hospital payment reform in the early 1980s was major Medicare physician payment reform in the late 1980s. By the time a new President took his oath of office, a number of policy trajectories had been set for a very active next few years in Medicaid bargaining. George H.W. Bush was on the brink of proposing his own

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[98] 1987 *CQ Almanac*, 558. Rep. Ron Wyden (D-Ore.) said the root cause of the problem was President Reagan's 1981 tax cuts: "The history of this conference was dictated in the summer of 1981, when Reagan deliberately created these deficits to put pressure on social programs." Wyden was referring to the conference negotiations for the budget-reconciliation (HR 3545 -- PL 100-203).

[99] 1991 *CQ Almanac*, 61.

[100] 1987 *CQ Almanac*, 573.

[101] Julie Rovner, "Governors Ask Congress for Relief From Burdensome Medicaid Mandates," *CQ Weekly Report* 49, Issue 7 (February 16, 1991).

[102] 1991 *CQ Almanac*, 350 and 1990 *CQ Almanac*, 607.

ideas for Medicaid reform, as were a number of other prominent players in Medicaid politics.

In this environment, with these external forces pressing on the situation, the micro-Medicaid decisions proceeded. By 1988, OMB and HCFA tried to have state donation and tax programs banned.[103] HCFA worked to produce new regulations stemming the use of donations, a process interrupted when the U.S. Congress intervened -- at least temporarily. The legislation prohibited the Secretary from issuing final rules that would alter the use of voluntary contributions and provider-specific taxes before May 1, 1989.[104] The Congressional prohibition on more restrictive regulations at the agency level was extended a second time, to December 1990, by legislation.[105] In a third move by Congress to stalwart the Executive, OBRA 90 permanently prohibited the Secretary from interfering with provider specific taxes except in very specific cases.[106]

The Medicaid Financing Scheme Debate, Post 1990

Over the next two years, the scenery in Medicaid's political economy began to shift. First, the use of state maximization schemes sharply increased. DSH payments rose from $1.3 Billion in 1990 to $17.7 Billion in 1992.[107] The link between DSH and provider donation and tax schemes was increasing DSH spending exorbitantly as the number of states participating in these maximization plans increased considerably. In 1990, six states had adopted tax and donation programs, whereas by 1992, 39 states had.[108]

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[103] Coughlin, *Medicaid Since* 1980, 98.
[104] Schneider, *Medicaid Source Book*, 500. This legislation was The Technical and Miscellaneous Revenue Act of 1988 (P.L. 100-647).
[105] Schneider, *Medicaid Source Book*, 500. The legislation was OBRA '89.
[106] Schneider, *Medicaid Source Book*, 500. In particular, section 1903(i)(10) of the act states that Federal matching payments shall not be made: "with respect to any amount expended for medical assistance for care or services furnished by a hospital, nursing facility, or intermediate care facility for the mentally retarded to reimburse the hospital or facility for the costs attributable to taxes imposed by the State sole[l]y with respect to hospitals or facilities."
[107] Teresa A. Coughlin and David Liska, "Changing State and Federal Payment Policies for Medicaid Disproportionate-Share Hospitals," *Health Affairs* 17, no. 3 (May/June 1998), 119.
[108] Leighton Ku and Teresa A. Coughlin, "Medicaid Disproportionate Share and Other Special Financing Programs," *Health Care Financing Review* 16, no. 3 (Spring 1995), 30.

In addition to these schemes, intergovernmental transfers were also being increasingly used by states to "game" or maximize state funding. Federal rules stipulate that 40% of the nonfederal share of Medicaid expenses must be from state governments themselves; however, many states require local governments or entities to contribute to financing Medicaid. By September 1991, 14 states required local governments to contribute to Medicaid according to disparate state criteria. Intergovernmental transfers were increasingly used not only to contribute to the state's match "legitimately" -- if you will -- but also in maneuvers to maximize federal funding and returning local governments' "contributions" back to them in order to make them either whole or better off after the circular scheme was completed. These maneuvers increasingly spilled over to local entities including, for example, local hospital districts, in Texas.[109]

The "gaming" of federal matching rules is largely dependent on states' willingness to participate in these schemes -- and so is not distributed "equitably" throughout the country.[110] In a classic struggle for authority in a federalist system, states complained that the Federal Government had no authority to dictate how states collected revenues and the Federal Government, particularly the Executive, retorted that the open matching structure of the program was being fraudulently manipulated.[111]

In order to further explain states' choices in utilizing these strategies, many states cited the numerous federal mandates in eligibility since 1984 via various budget reconciliation measures and the need to find a way to pay for these unfunded mandates.[112] Consistently, year after year Congress had required states to cover additional people, meaning that the federal Congress required states to pay their Medicaid share for these populations. While some 31 federal expansions would occur during this time period, 19 would be mandatory -- without choice on the part of the states as to whether or not they would have prioritized this need considering their own financial situations. These mandates were most severe on poor states that had much less fiscal capacity to collect additional revenues through taxes in order to cover the new federal

[109] Schneider, *Medicaid Source Book*, 495 - 497.
[110] Coughlin, "States' Strategies," 162.
[111] Coughlin, *Medicaid Since* 1980, 98.
[112] Interview with Author, October 24, 2006.

requirements. With the severe increases in Medicaid spending, all states found the situation untenable. Governor Michael N. Castle of Delaware summarized his states situation, "In a year when my budget is going up by 1 percent, Medicaid is going up by 25 percent." The future outlook was frightening for many Governors. Between 1990 and 1995, Medicaid was projected to more than double.[113] On February 5, 1990, the States' Governors approved a policy statement asking Congress to grant them a two-year reprieve from the most recent Medicaid mandates in the Fiscal 1991 OBRA. This eruption at the NGA annual meeting spanned Governors across the ideological spectrum and the country's geographic regions.[114] In 1989, a letter signed by 48 Governors had previously implored Congress to refrain from new mandates for two years. Both letters were ignored.[115]

The 1991 State Maximization Program Reforms

By the Fiscal 1991 budget-reconciliation bill, Congress authorized states to levy specific taxes on health care providers but postponed decision on voluntary contributions. States lobbied for voluntary contributions to be dealt with similarly. On September 12, 1991, HCFA regulations were scheduled to take effect on January 1, 1992 that would ban voluntary contributions outright and limit severely provider tax programs.[116] HCFA Administrator, Dr. Gail Wilensky commented in a Congressional hearing, "The requirement for a state share of payment has always acted as a restraint on the otherwise open-ended Medicaid program."[117] This reflected the sentiment that although Medicaid was not under a capped or closed matching system, it did have several intermediate caps and this very instrumental de facto cap -- the limits that states were willing or able to invest in the program. While states had many micro decisions in the Medicaid program, these aggregated to the sum of what the federal government would match. These

[113] 1991 *CQ Almanac*, 355.
[114] 1989 *CQ Almanac*, 172. Quote attributed to Ohio Governor Rich Celeste, the Democratic Chairman of NGA's Committee on Human Resources.
[115] See 1989 *CQ Almanac*, 171; 1990 *CQ Almanac*, 569; and 1991 *CQ Almanac*, 355.
[116] 1991 *CQ Almanac*, 357.
[117] 1991 *CQ Almanac*, 358.

schemes were subverting the natural cap built into the Medicaid structural financing system.

During the 1990 negotiations for the budget reconciliation bill (PL 101-508), a deal was brokered on these state payments that members of Congress in 1991 felt were broken by the Administration with these new January 1992 scheduled regulations. Again, Congress and the Administration were at odds in State Medicaid Financing. Several members of Congress reflected their own state's concerns on this particular issue, interested in protecting their own state interests. Congress said the ban on provider taxes did not follow the intent of the 1990 deal, even though the ban on voluntary contributions was part of that compact.

This would devastate states, and at this point, even Republicans largely opted to protect their own state's interests against the threatened federal regulatory action. Many were torn -- split between fiscal conservatism and a desire to protect their own states financially. Don Ritter, R-PA, intimated, "This is troubling legislation," but added he would vote for it "as a Pennsylvanian concerned about other Pennsylvanians."[118] Even though Medicaid was just one of a myriad of decisions made in the 1990 budget reconciliation process, members remembered and held to this compromise. In this case, many members stood by their State's interests, thus reflecting that Medicaid is a factor in Congressional electoral politics. At the state level, as a major budget item, Medicaid matters in electoral politics. Members of the United States Congress respected this fact and despite a White House Policy Statement that included a veto threat, the House of Representatives passed HR3595 (PL 1023 - 234) by a 348-71 voting margin. This blocked the Administration's revised rules, further limiting states' discretion through September 30, 1992.[119]

At the time of the House vote, negotiations were underway between Administration officials and representatives of the National Governors Association (NGA). Playing a major bargaining role in the eventual compromise that Congress would adopt, the NGA held that the House vote propelled their cause, anchoring their

[118] 1991 *CQ Almanac*, 358.
[119] 1991 *CQ Almanac*, 358.

position with the G.H.W. Bush Administration. Only two days later, a tentative compromise was reached, which the Senate passed in a voice vote on November 26.[120] Before the conference report was cleared -- and indeed before the Senate had passed the compromise -- several deals were brokered by the Administration, saving what appeared to be a possible "bail out" on the deal by States.

Not only Governors, but particularly members of Congress struck exceptions to the final legislation from the Administration including Democratic Finance Committee Chairman Lloyd Bentsen on behalf of Texas for their local hospital financing program, Democrat John D. Rockefeller for West Virginia's tax program, and Majority Leader and Democrat George J. Mitchell on behalf of Maine. The Thanksgiving break sped up the conclusion moreso than some were comfortable with, particularly Henry Waxman -- who after a string of successful entrepreneurial expansions in Medicaid over the past seven years was finally stymied in a negotiations process.[121]

The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 was the first stand-alone Medicaid law enacted in the program's history.[122] Provisions included bans on provider donations for most reasons; requirements that provider taxes be broad-based across an entire class of providers; and that provider tax revenues be capped at 25 percent of state Medicaid spending.[123] The Amendments also prohibited the Secretary from restricting State designations of DSHs [beyond restricting their use in provider tax programs][124], though setting limits on DSH payments. According to the legislation, during each fiscal year national aggregate DSH payments were limited to 12 percent of total Medicaid spending for that year.[125] For FY 1993 and subsequent fiscal years, each State was to have its own DSH limit according to previous DSH spending.[126] After January 1, 1996 states were given a choice of the 12 percent cap

[120] 1991 *CQ Almanac*, 358 - 359.
[121] 1991 *CQ Almanac*, 358 - 360.
[122] Coughlin, "States' Strategies," 23.
[123] Coughlin, *Medicaid Since* 1980, 90.
[124] 1991 *CQ Almanac*, 361.
[125] Schneider, *Medicaid Source Book*, 321.
[126] Schneider, *Medicaid Source Book*, 321 - 322.

or a new payment limit to be set by Congress.[127] This important legislation also codified intergovernmental transfers which were previously stipulated in regulation.[128]

Transfer of Financing of State-Only Functions to the Federal Government

States also generated greater federal financing through the Medicaid match by transferring state functions to Medicaid and by expanding programs through their state discretion, particularly with waivers, to encompass traditionally state-dependent beneficiaries. For example, beginning in the mid-1980s, states increasingly transferred patients out of state psychiatric hospitals and into the community, as adults age 22 to 64 in institutions are generally ineligible for Medicaid.[129] Also, states have used expanded Medicaid requirements under the EPSDT program for children as a means to make health screening and special education programs operated by school districts eligible for Medicaid reimbursement.[130] The transference of some traditionally state-funded education costs to Medicaid is contradictory to the notion that Medicaid crowds out education spending in state budgets. The 1981 OBRA also created freedom of choice and home and community service waivers, additional instruments for moving state functions to Medicaid. Generally, maternal and child health and home care were areas that moved from state public health budgets to Medicaid in the 1980s -- both by federal and also independently by state actions.[131]

This trend is particularly notable when restrictions in other programs place greater responsibilities on states. When Reagan's OMB steered multiple social welfare state cuts through budget reconciliation processes, some of these cuts in other social programs ended up as expansions in Medicaid programs when states had the option or the creative ability to make it happen. In a series of interviews in 14 states, Gilbert Omenn found, "It

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[127] 1991 *CQ Almanac*, 361.
[128] 1991 *CQ Almanac*, 361.
[129] Coughlin, "States' Strategies," 148 - 149.
[130] James W. Fossett and James H. Wyckoff, "Has Medicaid Growth Crowded Out State Educational Spending?" *Journal of H. Politics, Policy and Law* 21, no. 3 (Fall 1996), 409 - 432.
[131] Coughlin, "States' Strategies," 148.

should be acknowledged that those we interviewed in many states were frank to admit that the open-ended Medicaid match is an irresistible source of substitute funding for social services whose funding under Title XX was capped."[132] During the budget reconciliation process in 1981, Title XX of the Social Security Act -- a social services block grant-- was reduced.[133] Federal actions do not always have the intended effect in a federalist system. When the Federal Government pushed on Title XX funding, the slack was picked up in the Medicaid program in states that were able to find ways for Medicaid to pay for these services.

De Facto Medicaid Block Grant Add-On For States

One perspective on the utilization of state financing schemes was that in the face of Reagan-era cuts in other programs, the open-matching grant in Medicaid was used as a source of regeneration. Cuts in other programs were "picked up" by transference of functions, and funding streams, to Medicaid. Medicaid, after all, had the benefit of preferential treatment in the budget process, not subject to the 1985 Gramm-Rudman sequestration and consistently expanded via the 1980s reconciliation processes. Another perspective is that when the 1980s mandates pressed states, the state fiscal response was "to cut back on other welfare spending by an amount almost exactly equal to the extra cost of the mandates."[134] Probably both of these explanations have some credence.

From a fiscal federalism perspective, the use of provider donations and taxes and intergovernmental transfers by states in combination with the DSH program with no real cost to the state creates a type of "lump sum" benefit for the state. Use of these special financing mechanisms by states -- prominently in this era from the mid-1980s to the early 1990s -- was a way for states to take charge in re-creating the federally determined

[132] Gilbert S. Omenn, "Lessons From a Fourteen-State Study of Medicaid," Commentary, *Health Affairs*, Spring 1987, 121.
[133] 1981 *CQ Almanac*, 488. The Title XX Block Grant provides funds to states for a variety of programs such as day care, family planning, counseling and aid to the mentally retarded.
[134] Chernick, "Federal Grants," 143. This was the conclusion by Katherine Baicker in her study which was published in a 1999 Dartmouth Working Paper.

structure of the Medicaid financing system. Albeit impossible for states to legislate changes in how Medicaid is structured from above, states did accomplish the magical feat of de-facto recreation from below. By utilizing these maximization and transference strategies, states were receiving both federal matching funds for Medicaid and “lump sum grants” in the form of state funding “replacement” via special financing and transference activities.

One reading on federal decision making in the face of this reworking of the federally determined institutional rules of the largest grant program to the American states is that of distant allowance. Disproportionate shared funds, in addition to providing compensation for the uninsured in hospitals, was intentionally allowed to states by Congress as compensation for the costs of new Medicaid mandates.[135] In his review of the issue in the National Tax Journal, Howard Chernick suggests that this exchange -- this intergovernmental fiscal relationship-- “involves continuous bargaining over fiscal incentives to achieve new objectives.”[136] It also suggests, he concludes, we must pay careful attention to the way in which the fiscal relationship between the grantor and the grantee evolves over time. While President Bush’s, and President Reagan’s, attempts at block granting Medicaid did not materialize, there was a de facto lump sum or block grant added onto the Medicaid match during this time period. Congress protected state interests, including Republicans who highly valued fiscal conservatism. Even after acting in 1991, they did so in a way that left loopholes in the DSH and, to some extent, the provider tax legislation. Only voluntary contributions were banned. This was a way to provide a lump sum addition to the already open matching grant structure of Medicaid. When other aspects of federal funding to states were severely cut, Medicaid became a way to bolster state budgets during this time period. Federal Legislators “looked away” because they believed states needed the added lump sum amount in order to cover the cost of Medicaid mandated expansions and for rejuvenation after other federal funding to states was cut.

[135] Chernick, “Federal Grants,” 149.
[136] Chernick, “Federal Grants,” 149.

THE G.H.W. BUSH ERA MEDICAID STRUCTURAL REFORM PROPOSALS

The George H. W. Bush era staged a national debate on proposed overhauls to the United State's health care system that set the groundwork for the infamous Clinton health plan and national health debates of 1993 and 1994. In 1990, the U.S. Bipartisan Commission on Comprehensive Health Care, known as The Pepper Commission, proposed that a federal program replace Medicaid's acute care component to cover all persons without employer-based or Medicare coverage. In the proposed plan, the joint federal-state Medicaid program would continue to offer some long-term care services.[137] In 1990, the Americans With Disabilities (ADA) (PL 101-336) legislation passed Congress, setting the stage for future Medicaid adjudication and expansion of community based services for disabled individuals. Based on the Civil Rights Act model, the ADA further exemplified that landmark Rights-based legislation did not stop at the 1960s.

The ADA would also call into question the viability of a famous waiver proposed by the State of Oregon that limited benefits but expanded eligibility in Oregon's Medicaid program through a waiver of federal requirements. The Oregon legislature passed the plan in 1989 and the state completed it in 1991. Officially, the G.H.W. Bush Administration rejected the Oregon petition for a federal waiver given concern that the state's ranking of prioritized health care condition/treatments violated the ADA, which prohibited discrimination on the basis of health condition.[138]

One state lobbying representative emphasized that the ADA was just one piece of why the Oregon waiver did not go through during the G.H.W. Administration. Also, the ability of states to unilaterally remove Medicaid beneficiaries' entitlement "in a publicly financed program where you were entitled to benefits statutorily" was in question.[139] Some stalwart Medicaid advocates like Henry Waxman (D-Calif.) and other Democratic leaders like Albert Gore, soon to be the Vice Presidential candidate, opposed the Oregon plan, as well. Several disability advocacy groups also stood arms-locked against the idea

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[137] Schneider, *Medicaid Source Book*, 76.
[138] 1992 *CQ Almanac*, 412 - 413.
[139] Interview with Author, October 24, 2006.

of ranking illness-treatment pairs and drawing a line at who would receive Medicaid services and who would not.[140]

The health reform proposals of the G.H.W. Bush-era showed again the pluralistic nature of major national health reform in the United States. There were so many proposals that coalitions were split and re-split, creating pockets of so few supporters behind each of the potential plans that none became frontrunners. Changes to the Medicaid program were pronounced in these more comprehensive proposals, further reflecting that Medicaid reform is tied to national health reform.

Also, the trend of incremental Medicaid reform either preceding or immediately following a major national health reform debate in the United States Congress is a trend to watch for. Since national health reform is a "big event" that has never happened, the efforts are often followed by a portion of the ideas being implemented in a more limited fashion. Oftentimes, this provides incremental progress after so much political energy has been spent on the national discussions.

While some proposals are rolled into OBRA legislation, thus including it in the massive budget negotiations, others are designed as Medicaid reforms rolled into more comprehensive health efforts. For example, Senator John Chafee (R-RI) proposed the "MedAmerica Act of 1987" (S1139) that included the infant mortality amendments, similar to other proposed bills, in a much larger effort to update Medicaid.[141] The Chafee bill proposed that states be able to receive federal funds for providing Medicaid coverage to all people with family incomes less than the federal poverty level. People with incomes between 100 and 200 percent of the poverty level could buy into Medicaid. The strategy in the Chafee bill was to restructure Medicaid so that income level, not categorical eligibility, would define eligibility. The categorical eligibility rules -- fraught with inequalities based on its design, would be removed.[142]

While the Chafee bill did not gain momentum, several other proposals also included the infant mortality amendments. The plurality of similar thoughts on stemming

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[140] 1992 *CQ Almanac*, 412 - 413.
[141] Charles N. Oberg and Cynthia Longseth Polich, "Medicaid: Entering The Third Decade," *Health Affairs* (Fall 1988), 94. (Hereafter, Oberg, "Medicaid: Entering The Third Decade")
[142] Oberg, "Medicaid: Entering The Third Decade," 94.

infant mortality resulted in these particular reform provisions being included in OBRA 1987 (PL. 100-203). While the categorical eligibility rules were not removed as the Chafee bill proposed, there were incremental moves to tie eligibility levels more closely to the federal poverty level and overall inequality was decreased between 1986 and 1990.[143]

In 1991 and 1992, a federalized Medicaid program, or a new public program for low-income persons, was part of a number of universal coverage proposals introduced in the 102nd Congress, while others would leave low-income coverage with the States, possibly with enhanced Federal funding.[144] Federal action was thought not only to address issues of the uninsured, but also cost control. As *Congressional Quarterly* reported, "Congress took no action in 1991 to overhaul the health care system, pushing into 1992 a very loud cry for reform from both political parties. More than three dozen healthcare proposals circulated during the first session of the 102nd Congress and it became increasingly difficult to boil them down into an approach with strong consensus backing."[145] While none of the proposals were considered seriously, President Bush's plan would eliminate the open-ended entitlement status for most of the acute-care portions of Medicaid and convert these to a lump-sum grant.[146] After at least three attempts at changing the structure of Medicaid financing -- for all or part of the program-- to a block grant in the Reagan era, the Bush Presidency also recommended a lump-sum approach. The ball that started rolling with Ford's "go-nowhere" proposition of block granting Medicaid, along with several other health programs, was now a regularly offered menu item in Medicaid reform talks.

CONCLUSION

Medicaid in the 1990s was a curious twist. Caught in a newly evolving budget process, the program was expanded more than 30 times. Intuition would suggest that the

[143] Oberg, "Medicaid: Entering The Third Decade," 94.
[144] Schneider, *Medicaid Source Book*, 76.
[145] 1992 *CQ Almanac*, 401.
[146] 1992 *CQ Almanac*, 405.

pre-eminence of entitlement cutting in the new budget process would result in federal mandates to cut eligibility and benefits, but, in fact, Medicaid through Senate Finance and House Ways and Means member and staff ingenuity was expanded. It was not until the PAYGO was actually used in the 1993 budget process that this tide stopped. While barely visible on the broader public policy horizon, for anyone intrigued by Medicaid policy, the 1980s series of incremental reforms via budget negotiations is a study in unusually adept policy savvy.

The 1980s was an era of push and pull between the federal government and states on Medicaid state financing mechanisms, states maximizing the federal match, and states moving populations and services to Medicaid in what was termed the "Medicaiding" of state functions. While these trends continue to the present day, they began in the mid-1980s. The policy battles between Federal officials in the G.H.W. Bush Health Care Financing Administration and Office of Management and Budget with states over these issues set pathways between federal and state governments. Many of the lessons learned by these officials in the 1980s and early 1990s regarding creative state financing mechanisms -- provider tax and donation programs, DSH programs, school based financing, Upper Payment Limit (UPL) initiatives, intergovernmental grants, and a whole host of other mechanisms -- repeat today in 2007.

The Reagan Administration wanted badly to do something with Medicaid, to block grant it, to federalize it in exchange for transferring AFDC to the states, to cap and control it. Medicaid was not one of the "favored" social safety net programs that the Reagan Administration protected in the face of so many other entitlement cuts. And yet, headed into The Modern Era, Medicaid expanded. The budget process continued to evolve itself.

States began to experiment in the late 1980s and early 1990s with their own comprehensive universal health coverage attempts. President George H.W. Bush's Administration and Congress worked through a number of national health reform proposals themselves. All in time for the Kennedy generation to finally come of age. As President Clinton took office, Medicaid's Modern era (1992 - 2007) began with a

national health coverage discussion that set in motion dozens of streams of potential health reforms that evolved over the next 15 years. This is the topic of the next part, Part III, which investigates The Modern Era and includes information from interviewing the major policy bargainers and elite decision makers in Medicaid politics during this time period.

CHAPTER OUTLINE FOR PART III

THE MEDICAID EVOLUTION

The Modern Era

INTRODUCTION TO PART III

7. PRELUDE TO A NATIONAL DISCUSSION: THE MEDICAID AND STATE FEDERALISM ENVIRONMENT BEFORE THE NEAR BIG BANG

8. THE WAIVER PRESIDENCY: OREGON, TENNESSEE, AND 1115 MEDICAID POLITICS

9. MEDICAID AND THE 1993-1994 NATIONAL HEALTH REFORM DISCUSSION: SETTING THE STAGE FOR THE BLOCK GRANT ERA AND BBA

10. MEDICAID BLOCK GRANT ERA, WELFARE REFORM, AND THE 1997 BBA: NATIONAL HEALTH REFORM LEAVES ITS STAMP

11. MEDICAID TRANSFORMED: MEDICAID FEDERALISM DURING THE GEORGE W. BUSH ERA

INTRODUCTION TO PART III

As the next chapters will discuss, the national discussion on the uninsured, those with low-incomes, and requisite subsidy approaches was vital to the entire 1993-1994 national health debate. Chapter 7 introduces this great national debate. The following chapter briefly reviews two important waivers in the states of Oregon and Tennessee -- horizon-changing state directed initiatives in Medicaid federalism and the policy bargaining that shapes it. Chapter 9 delves into greater detail on why the low-income and uninsured populations so severely leant on the overall design and policy bargaining decisions of the team stretching to enact national health reform. It also reviews competing proposals during the near big bang health reform era of the early 1990s as they reflect on the Medicaid program. Leaving analyses of the overall reform effort to other texts, this chapter concentrates on what the national discussion meant for Medicaid federalism. Chapter 10 continues a more explicit discussion of how the 1992 - 1994 arguments extended to two major debates on whether to block grant Medicaid in the mid-1990s, as well as to statutory reforms in the 1997 Balanced Budget Act (BBA). The 1997 BBA, in combination with the 1996 welfare reform, was the most striking one-two punch in American social policy since the enactment of Medicaid and Medicare in 1965. Generated from discussions during the national health debate and the block grant debates, both the block granting of AFDC and the 1997 BBA leaned in a conservative direction. A final chapter in Part III, Chapter 11, considers how the 1990s policy discussions affected the major reforms in the G.W. Bush era -- particularly the 2005 Deficit Reduction Act (DRA). Time will tell if the DRA, enacted in February 2006, has ushered in an entirely new era in Medicaid political economy.

The major trend line in Medicaid policy bargaining in the 1990s was waiver negotiation reform. The overriding storyline the first five years of the 21rst century is the transcendence of the Administrative state in Medicaid policy bargaining. All in all, the end results by 2007 was a re-definition of the original principles of the Medicaid program (statewideness, comparability of benefits, no cost sharing, single-tier health system,

comprehensive coverage, and freedom of choice). This is happening (1) in new state-directed initiatives; (2) in states winning in defining and redefining state flexibility while maintaining federal funds; and (3) general acceptance of the beneficiary personal responsibility argument, effectuated by increased cost sharing provisions in the DRA.

Neither the importance of budget reconciliation -- the overarching byline of the 1980s -- nor rights adjudication -- the pressing force of the 1960s and early 1970s -- was missing in the modern era (1992 - 2007). These continued to evolve, along with very influential changes, depending on majority party, in Congressional procedural rules. The late 1990s adjudication interpreting the American with Disabilities Act (ADA) -- built on the 1964 Civil Rights Act -- reached Medicaid directly. Federal court disability decisions, such as *Olmstead*, in the 1990s demanded court-directed Medicaid federalism reform. The pluralism of the waiver process and the emergence of the Administrative state, however, were the major new storylines in Medicaid federalism. Overarching the Medicaid policy bargaining environment was the umbrella of an ongoing tension as the legacy of the Great Society tangled with the Goldwater/Reagan/Gingrich mission to dismantle it. The institution of Federalism was an instrument for both sides.

7. PRELUDE TO A NATIONAL DISCUSSION: THE MEDICAID AND STATE FEDERALISM ENVIRONMENT BEFORE THE NEAR BIG BANG

INTRODUCTION

In 1993, President Clinton's list of policy priorities was ambitious and comparisons to the FDR era unabashed. As the *Congressional Quarterly* reported at the time, "Its effect was projected to be at least as sweeping, and like Roosevelt's programs, its economic and social impact was expected to touch every American."[1] The Clinton national health plan blueprint was scheduled for the Administration's first 100 days and passage was expected in the first year.[2] -- a sentiment that played out differently than Roosevelt's Hundred Days in which the country witnessed a "presidential barrage of ideas and programs unlike anything known to American history."[3] The national health plan was to bookend FDR's Social Security Act -- where national health coverage was absent.

Franklin D. Roosevelt had made health security part of his "Second Bill of Rights," a document that transformed how the United Nations approaches economic, social, and cultural rights within its umbrella of Human Rights. President Clinton told a national audience on *Nightline*, "What I feel the pressure to do is to at least pass the legislation and get the security in. I want everybody to have their health security card so

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[1] 1993 *CQ Almanac*, 335.
[2] Hugh Heclo, "The Clinton Health Plan: Historical Perspective," *Health Affairs* 88 (Spring 1995), 96 - 97. (Hereafter, Heclo, "The Clinton Health Plan")
[3] Schlesinger, Arthur, *The Age of Roosevelt: The Coming of the New Deal* (Boston: Houghton Mifflin Company, 1958, print. 1959), 20. (Hereafter Schlesinger, *The Age of Roosevelt: The Coming*)

I know they'll have comprehensive benefits that can't be taken away that they can't lose."[4] Similar to FDR's language in terms of locking in benefits for a new entitlement, the Clinton plan was definitively different in how it made operational the financing of an initiative that would touch the life of every American. Famously, FDR quipped, "With those taxes in there, no damn politician can ever scrap my Social Security program."[5] The anchor of the Social Security program is the earmarked tax, and in its design, FDR's economic security team meant for that anchor to hold. The New Democrat would shun a broad based tax in favor of an employer mandate to pay 80% of costs, an additional tax on employers of more than 5,000 employees who were allowed to opt out, and a cigarette tax.[6] The idea of a tax as anchor was no longer considered effective, especially since this latest national reform effort occurred far after the Social Security and Medicare payroll taxes were in place and there was little room for another one.

On September 22, 1993, the President proclaimed, "At long last, after decades of false starts, we must make this our most urgent priority, giving every American health security -- health care that can never be taken away, health care that is always there."[7] The operational plans for Medicaid would fold the program into the new health alliance system. Medicaid patients would receive the same benefits package as other Americans.[8] The debate teetered on discussions on low-income and uninsured Americans -- the Medicaid subset.

This chapter introduces the Clinton era prior to the national health debate. It also sets the stage for the next chapter, which concentrates on a handful of major Medicaid waivers that occurred just before and contemporaneously with the national health debate. States were not waiting for national health reform. States utilized Medicaid dollars to drive their own ideas via state-directed comprehensive reform. The effects of this

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[4] William J. Clinton, "Remarks in the ABC News 'Nightline' Town Meeting on Health Care Reform in Tampa, Florida," September 23, 1993, *Public Papers of the Presidents of the United States 1993*, Book I (Washington, D.C.: U.S. GPO, 1994), 1571.
[5] Schlesinger, *The Age of Roosevelt: The Coming*, 308 - 309.
[6] 1993 *CQ Almanac*, 338.
[7] 1993 *CQ Almanac*, 48-D.
[8] 1994 *CQ Almanac* (Washington, D.C.: Congressional Quarterly, Inc, 1994), 103rd Congress, 2nd Session, 1994, Volume L, 323.

reverberated to 2006. This chapter reviews the 1993 Budget Reconciliation Process and the institution of PAYGO limits; State Directed Comprehensive Reform Efforts predating the national health debate; and establishes Medicaid's environment before the multiplication of the statewide 1115 Medicaid waivers began.

THE THIRTY YEAR GENERATIONAL CYCLE: 1934-35, 1964-65, 1994-95

After the New Deal was enacted in 1935, it took 30 years for the Great Society's Medicare and Medicaid -- the health annex to the New Deal -- to be enacted in 1965. Many had foretold, including the architect of the Medicaid program, Wilbur Cohen, that the next big reform would be 30 years after the Great Society. Cohen said of this early 1990s plan, "It will have been built upon the experience of Medicare and Medicaid. It will be a tribute to Lyndon B. Johnson…..It will be an American plan worked out by the American Congress on some kind of an evolutionary basis."[9]

Arthur Schlesinger added his prophetic review in 1990 of the expectant decade: "There is nothing mystical about the thirty-year cycle. Thirty years is the span of a generation. People tend to be formed politically by the ideals dominant in the years when they first come to political consciousness….In the same manner John Kennedy touched and formed a political generation in the 1960s. If the rhythm holds, that generation's time will arrive in the 1990s."[10] And so the era was ushered in with the major network's news shows running a weathered photograph of the newly elected president as a young man, William Jefferson Clinton, shaking the hand of President John F. Kennedy. The Kennedy era youth were now running the country, and they had their eyes set on national health reform.

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[9] Wilbur Cohen, "From Medicare to National Health Insurance," Chapter 8 in *Toward New Human Rights: the social policies of the Kennedy and Johnson administrations,* David Warner (ed.) (Austin, TX: LBJ School of Public Affairs, 1977), 152-3.

[10] Arthur Schlesinger, Jr., "The Liberal Opportunity," *American Prospect Online*, (March 21, 1990), http://www.prospect.org/web/prinfriendly-view.ww?id=5352 (accessed on September 20, 2006).

THE THIRD WAY LED BY A FORMER GOVERNOR

Overarching worldviews in political economy were shifting in the early 1990s. Far from Reagan/Thatcherism, there was a Third Way sweeping the world's social democracies. Not your old left, not your old right -- but something President Bill Clinton and British Prime Minister Tony Blair would mold into a new way of governing.[11] In the past, rights based argument met rights based argument in a different wrestling dialectic. On the one side was the "conservative rights-based rhetoric against tax increases and public spending"[12] and opposing it, a rights-based argument for economic rights and social equity. Hence, the crude stereotypes of the Republican fiscal conservative minimizing the social safety net and the tax and spend loving Democrat expanding it.

In the United States, even though Democrats held both the White House and the U.S. Congress, a major distinguishing characteristic of the time-period was that a New Democrat occupied the White House and a multitude of "Old Democrats" returned to Congress in 1992.[13] They were split along an ideological fissure -- "Old-Style Democrats" were primarily concerned with social equity; New Democrats' priority was a stronger economy, greater efficiency, and reform of public programs. With a former Governor in the Oval Office and leading the charge, the Third Way's domestic politics was infused with a New, New Federalism. Given that in the Medicaid policy arena Governors lead the policy bargaining for states, the fact that the Administration would embrace state experimentation was not a point of minor importance. Governors face a multitude of different state legislative requirements that frame their own debate positions. At the same time, on the national stage, they are the primary state actors advised by state Medicaid directors, who they often appoint.

In the Clinton era, Governors would become more active in aggressively advocating, designing, and overseeing the implementation of state specific Medicaid

[11] See Anthony Giddens, *The Third Way: The Renewal of Social Democracy* (1998; repr., Cambridge, UK: Polity Press).
[12] Zelizer, *Taxing America*, 276.
[13] Heclo, "The Clinton Health Plan," 95.

programs allowed by a newly liberalized federal rules waiver process. In fact, the transformation of the Medicaid waiver process under the Clinton Administration would begin to break apart much of the remaining uniformity requirements across states. It also set off effects that would be re-directed and re-packaged when the subsequent George W. Bush Administration substantially strengthened the Administrative State in Medicaid policy via the waiver and state plan amendment processes. The overall emphasis on Executive privilege to some extent transferred to concerns by the legislative branch that the Administrative state was legislating via agency edict.

Policy bargaining in Medicaid was transformed by these events. And bringing the discussion back to the early 1990s, to a large extent the next decade and a half of health and Medicaid policy was shaped by the national discussion on health care that took place between 1992 and 1994. The legacy of this time era was not failure of health reform, as much as about the myriad of more targeted reforms that were set in motion during those debates and negotiations. The policy positions agreed to by the various factions were noted and recycled, rehashed, and reframed for several years thereafter. Once agreed to in response to a competing policy proposal, reform ideas were often implemented in the future rounds of Medicaid debates -- even if the competing proposals were no longer on the table. This was a hallmark of Medicaid's evolution over the next 15 years.

NATIONAL HEALTH REFORM MEETS BUDGET RECONCILIATION AND PAYGO, REFORMING BOTH MEDICAID BARGAINING PROCESSES AND SUBSTANTIVE POLICY

The 1993 Budget Process was important for Medicaid in three major ways. First, the budget process, not in existence in other major health reform eras, sapped a remarkable amount of legislative attention and Executive political capital from the later national health reform debate. Second, the PAYGO rules passed in 1990 -- separating entitlements, discretionary spending, and Social Security -- were getting their first test run in 1993. The BEA required that the sum of entitlement and revenue legislation had to be budget neutral -- or sequestration, across the board cuts on non-exempt entitlements,

were required.[14] While the budget process had sequestration rules in place before, Congress could increase Medicaid spending without invoking sequestration.[15] Under BEA, Medicaid could *cause* a sequestration. Medicaid was exempt, however, from sequestration if PAYGO was breached by another program's increased spending.[16] The new PAYGO rules -- in combination with political realities -- put breaks on the long string of Medicaid expansions. Finally, substantive Medicaid reforms were enacted during the process, particularly another round of DSH restrictions. This move was meant to further restrict states in "effectively increasing their state match rate."

The Budget Process Saps Momentum From National Health Reform

At the launch of the Clinton era, as for New Democrats, they were making fiscal conservatism their own and planning an agenda to address the supply side of poverty. After all, a rising tide raises all boats. On poverty's demand side, scheduled entitlement reform in health and welfare programs targeted those in need. The political manifestation of the Third Way was tinged by early 1990s CBO and OMB budget projections for "unprecedented annual deficits between $350 billion and $400 billion for the foreseeable future."[17] By White House accounting, the 1993 Omnibus Reconciliation bill (HR 2264 -- PL 103-66) was to cut the deficit by $504.8 billion in fiscal 1994 - 1998. It included $250.1 billion in net revenue increases and $254.7 billion in spending cuts.[18] Medicare was cut $55.8 billion dollars and Medicaid by nearly $7 billion as a "down payment" on health reform, according to HHS Secretary Shalala.[19] From the onset, Health Reform had a deficit shadow. The requisite changes in Medicaid policy -- an appendage of the swipe at comprehensive health security -- were slowed also by the major omnibus budget reconciliation initiative.

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[14] Schneider, *Medicaid Source Book*, 477.
[15] Gilman, *Medicaid and the Costs of Federalism,* 121.
[16] Schneider, *Medicaid Source Book*, 479 - 480.
[17] Aaron Wildavsky and Naomi Caiden, *The New Politics of the Budgetary Process*, 5th ed. (New York: Longman Classics, 2004), 108.
[18] 1993 *CQ Almanac*, 124.
[19] 1993 *CQ Almanac*, 366.

Reconciliation sapped political capital at an alarming clip. This was a major distinction from the last substantial attempt at national health reform, in the Nixon era before budget reconciliation existed. The budget process itself had evolved, including PAYGO rules in the 1990 BEA that require balancing any new initiative with a commensurate reduction in the budget elsewhere. These rules stifled any profound restructuring that added to budget totals. The 1993 Budget Reconciliation process itself extended these PAYGO rules through 1998.[20] Combine this with an enormous inherited deficit, a presidential agenda prioritizing several other initiatives before health reform on the all-important legislative timeline, and a New Democrat in the White House pledged to balance the budget -- and the rules of American politics functioned precisely as they were intended to -- by preventing reform.

PAYGO Limits Effects on Medicaid Policy Bargaining

Some interviewees reported that the new PAYGO limit on increases in entitlement programs -- and the requisite requirement of finding offsets in other programs for any increase in program funding -- did not substantially change Medicaid bargaining. Others who were close to the legislative process reported not only a change but a fundamental reworking of how Medicaid policy is negotiated. One policy bargainer who was integral to Congressman Waxman's team -- who in collaboration with Senate Finance Committee members and staff effectuated several major Medicaid expansions in the 1980s -- said of the emerging PAYGO rule, "Yea. Made a huge difference, a huge difference. Well, with fiscal policy generally. It forced people to think about tradeoffs. If they were going to have tax cuts and find offsets. If you were going to expand Medicaid or Medicare, you had to find offsets. It was very good, very healthy. And no problem. So, you could still do in the context of Pay-As-You-Go. You could still make policy changes…or create a mix of policy changes where you are saving money in the program and reinvesting, expanding expenditures as well by adding new populations,

[20] 1993 *CQ Almanac*, 139.

expanding to new services…improving reimbursement levels to particular provider groups, whatever…you could do that, it's perfectly feasible."[21]

A Republican counterpart surmised that "PAYGO was largely a response to Medicaid expansions," meaning in his view that PAYGO did not just act upon the Medicaid bargaining arena but that Medicaid expansions actually were part of the mix of factors that forced the creation of PAYGO.[22] According to this source, they [the Democrats on the Energy and Commerce Committee] hated OBRA '93. It was the first time they got a Medicaid number to meet."[23]

1993 Budget Package Changes in Medicaid, Particularly DSH Tightening

As for Medicaid, the 1993 budget package tightened restrictions on the transfer of assets to facilitate Medicaid eligibility, strengthened requirements to recover the cost of long-term care services in Medicaid estate recoveries, and further restricted DSH hospitals. The new DSH restrictions re-defined how states could identify hospitals for disproportionate share funds, the payments to facilities that served a greater percentage of uncompensated patients. The impetus behind the reform as one Senate Finance staffer recounted, "Medicaid money is crack…there are subvarieties of Medicaid money and one is DSH."[24] DSH restrictions were meant to stop what a Clinton Federal Administrator called "states overdraft account in the sky."[25] This referred to states maximizing federal contributions by tactics that recycled federal funds. These mechanisms were used to generate additional matching funds from the federal government, thereby replacing state dollars. These arrangements worked against the spirit of the Medicaid open matching grant structure.[26]

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[21] Interview with the Author, August 23, 2006.
[22] Interview with the Author, October 13, 2006.
[23] Interview with the Author, October 13, 2006.
[24] Interview with the Author, August 15, 2006.
[25] Interview with the Author, August 3, 2006.
[26] The DSH reform stemmed payments to no more than the costs of providing inpatient and outpatient services to Medicaid and uninsured patients, less that amount the hospital received for those patients either from Medicaid or the patients themselves. From 1993 *CQ Almanac*, p. 135.

As a Democratic Energy and Commerce Congressional staffer reminisced on the policy environment of the time,"There is no doubt that DSH [was] a block grant….In OBRA'90 and tracking all the way down to OBRA'93, the thinking was, we need to limit the federal exposure here. States are making a run on the treasury and then in exchange for that, we are not going to look too hard at who they give the money to and what kind of outcome we get."[27] Agreement with further restrictions on state maximization plans was echoed by a Republican Energy and Commerce staffer who agreed, "Even they agreed that they looked like skunks in the candy shop. I mean it's ridiculous."[28]

STATES AS REFORMERS PRIOR TO THE NATIONAL DEBATE

For Medicaid, the history was vital. President Clinton, when Governor of Arkansas, was the point for the National Governors Association (NGA) in welfare reform during the enactment of The Family Support Act of 1988 (PL 100-485) -- a role which informed an oft-repeated campaign promise that Republicans would later use to hold his feet to the fire to "End Welfare As We Know It."[29] His experiences in bargaining both health care and welfare reform as a Governor imprinted his approach as President. The health reform environment at this time, prior to national health reform, was decidedly state focused. Pre-dating this round of national health reform summits was a good deal of state movement for their own solutions -- stopping at state boundaries -- for state directed comprehensive health reform, above and beyond the strictures of the Medicaid program.

Some states were aggressively pursuing their own state directed initiatives. If the federal government was not able to see a federal level initiative through the checks and balances and institutional structures of American government, then the states would see it through their own state legislatures. Minnesota, Oregon, Massachusetts, Hawaii, and others developed state systems -- above and beyond Medicaid reform -- to accomplish more comprehensive reform at the state level. During the national health reform debate,

[27] Interview with the Author, August 23, 2006.
[28] Interview with the Author, October 13, 2006.
[29] 1993 *CQ Almanac*, 373.

these state directed attempts at comprehensive health reform were cited by the President in his speeches and by members in Congressional hearings on national health reform -- as examples of how a government, in this case state government, can effectuate health reform.[30] States were cited as models for federal reform. This state directed reform pre-dated the Bill and Hillary Clinton led reform, and it informed their ideas for national change. This is further evidence of the endogeneity of federalism -- the lessons go in both directions.

As the NGA lead negotiator remembered, "In the late 80s in the states there was a lot of movement -- you had your Oregon plan, you had your Minnesota plan…you had Massachusetts. The pendulum had kind of swung to state initiatives at that point. When [President] Clinton was [elected], there was a feeling that….the pendulum would swing back to the federal government. That basically stopped all the state work. But again Clinton and the Senate were the only ones who could have gotten it done possibly. [Senator] Chaffee was interesting conceptually, but the centralist groups do this in a lot of different areas and it never gets off the ground."[31]

This is a sentiment very different from the legacy of the 1960s, where states were distrusted in reform efforts. Of the early to mid 1990s, two academics concluded, "it is unlikely that ever again will state and local governments be cast so easily as the adversaries of the poor – they now represent a vast resource to people without means."[32] Possibly stemming from success in developing and implementing research and demonstration projects in hospital, outpatient, and nursing home financing -- and several other areas of health policy -- states have increasingly become the locus of health reform. In the evolution of health federalism, just prior to the Clinton Administration attempt at

[30] See House of Representatives, Hearings before the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, Health Care Reform (Part 5), House of Representatives, One Hundred Third Congress, First Session, Serial No. 103-90, Friday, November 19, 1993, "Health Care Reform: Impact on Medicaid and Low-Income People," Henry Waxman, Chairman of Subcommittee, 548. See also House of Representatives, Health Care Reform (Part 5), Hearings before the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, House of Representatives, One Hundred Third Congress, First Session, Serial No. 103-90, Friday, November 19, 1993, "Health Care Reform: Impact on Medicaid and Low-Income People," Ranking Minority Member of the Subcommittee, Mr. Bliley, 535 - 536.
[31] Interview with the Author, November 2, 2006.
[32] Altman, "The Role of State and Local," in *Prologue*, 7.

national health reform, some states were actively creating state directed universal care models and not passively waiting for federal action.

Roadblocks to State Directed Comprehensive Coverage:
ERISA and Tax Capacity

While states were moving prior to the new health reform era to take the reins on comprehensive coverage proposals, major roadblocks included ERISA restrictions on employer mandates at the state level and the limitations of state tax capacity. States were experiencing first, reduced receipts on sales taxes from goods; second, a siphoning off of state tax revenue from internet sales; and third, an increase in untaxed services. In combination, these two factors, ERISA and reduced state tax capacity, hamstrung states' ability to self-finance comprehensive health reform within their state borders.

ERISA, enacted in 1974, was a "major increase of federal authority," as it preempted state laws that "'relate to any employee benefit plan,' with some exceptions, such as those of state and local governments and of churches."[33] After a series of "broad judicial interpretations of ERISA, it became "conventional wisdom that only the federal government" and not state governments, "could legally mandate [health] coverage."[34] Cutting into the ability for states to establish employer mandates for health insurance coverage, the employer mandate was an instrument of health reform largely left to the federal government. In 1993-94, the Clinton Health Security Plan adopted the employer mandate model and other counter-proposals followed suit. This federal restriction of state authority was referred to in a review of health federalism by the Urban Institute as, "the biggest single shift in federalism until the mid-1990s, reducing state authority while federal authority largely deferred to private action."[35] While one state, Hawaii, did implement an employer mandate, it was only able to do so because it had originally established it in 1974 just months prior to ERISA's enactment. No other state followed

[33] John Holahan, Alan Weil and Joshua M. Wiener (eds.), *Federalism & Health Policy* (Washington, D.C.: The Urban Institute Press, 2003), 366. (Hereafter Holahan, *Federalism & Health Policy*)
[34] Holahan, *Federalism & Health Policy*, 366.
[35] Holahan, *Federalism & Health Policy*, 366.

Hawaii's example, and the general understanding is that states are prohibited from mandated employer insurance for employees.[36]

Even if able to remove the ERISA provision and if there was the drive to make an attempt at state employer mandates to provide health insurance, many state legislatures met the same wall that faced the National Health Reform Task Force in 1993/94 on the national stage -- broad based taxes are infeasible at worst and unpopular at best. With the inability to deficit spend, with generally shorter political decision making horizons to consider, and with compromised tax capacity often based on a dwindling sales tax base -- states require financial assistance from the federal government to tackle comprehensive health care reform. Highlighting the need for federal financing assistance to effectuate comprehensive reform, states began to look to Medicaid statewide waivers of federal requirements for ways to generate the necessary funds and flexibility to make their own state directed comprehensive health reform designs a reality.

As one interviewee who has played leadership roles at both the state and the federal level commented, "So, those two things [ERISA and state tax capacity] really prevent it from happening at the state level, as some states would like it to. But at the federal level, you can't get an agreement. So you are in this no-man's land. And while you are in this no-man's land -- states have these horrible problems."[37]

WHERE MEDICAID STOOD BEFORE THE NATIONAL HEALTH DEBATE

In Medicaid, there was a dramatic upsurge in inpatient hospital care costs; between 1990 and 1992 the number of Medicaid beneficiaries was exploding at between 20% - 30% a year; and most states were no longer shy about using creative financing to maximize the federal match. In 1990, only six states had tax and donation programs; by 1992, this number has grown to 39 states. Also, more middle class beneficiaries were qualifying for Medicaid to finance long-term care costs by taking advantage of loopholes in asset transfer rules. Add to this mix a major paradigm shift both in the American

[36] Holahan, *Federalism & Health Policy,* 366.
[37] Interview with Author, November 1, 2006.

health care system generally and in Medicaid's political economy -- The Managed Care Revolution of the 1990s.

While the two previous decades saw various federal and state attempts at developing pre-paid capitated health care, managed care had not yet taken hold in most Medicaid markets -- with the state of Arizona being one very important exception.[38] The Medicaid managed care trend was stark. In 1990, nearly all Medicaid beneficiaries received care from physicians paid fee-for-service. By 1997, nearly half of Medicaid beneficiaries were enrolled in some from of pre-paid managed care. In part, the reason for this is related to waiver reform, but to some extent the national discussion on health reform that embraced managed care delivery mechanisms for the general population made it more considered generally, including for Medicaid beneficiaries.

CONCLUSION

While states were already in the ring of comprehensive health reform well before the national health debate, the pendulum was about to swing back to federal initiative in health reform. A very important national discussion -- and a near big bang in the American welfare state -- was about to take place. The Budget Reconciliation process in 1993 took some political capital out of the sails of national health reform. The substantial Medicare cuts had been called a "down payment" on national health reform by Secretary Shalala, but it was the first time a major national health reform effort had taken place since Reconciliation became a political reality to be reckoned with in 1981. This experience left many experts after the fact considering whether national health reform

[38] An important exception is the Arizona Health Care Cost Containment (AHCCC) program, enacted in 1982 and updated and expanded since. Arizona did not participate in the Medicaid program until its 1115 waiver instituted a Medicaid system rooted in managed care. Notably, in 2006, Arizona's Governor Janet Napolitano testified before the Senate Special Committee on Aging on how this model may be used as a model in markets nationwide. See Janet Napolitano, "A Review of the Arizona Medicaid Program: Utilizing a Managed Care Approach to Address the Needs of a Growing Senior Population," Written Testimony of Janet Napolitano, Governor of Arizona, Senate Special Committee on Aging, United States Senate, Thursday, July 13, 2006.

would have faired better if staged in the budget reconciliation itself.[39] Still, as the next chapter considers, a major change in Medicaid policy bargaining -- via the 1115 waiver process -- was upon the program. States, realizing that state tax and fiscal capacity was a major impediment to state directed reform began utilizing successfully the Medicaid statewide waiver demonstration process to receive federal financing for their own initiatives. The next chapter considers the origins of this and two important 1115 statewide waivers in greater detail.

[39] Former Senate Majority Leader Tom Daschle (D-SD) reportedly has supported the idea that the Clinton health reform effort's probability of passing was much greater in a budget reconciliation process. Interview with Author, October 12, 2006.

8. THE WAIVER PRESIDENCY: OREGON, TENNESSEE, AND 1115 MEDICAID POLITICS

INTRODUCTION

Preceding and concurrent with the national health debate were important events in the Medicaid waiver process that spearheaded mini reforms throughout the country to 2007. Two of these, the Oregon and Tennessee, 1115 waivers will be discussed in this chapter. The efforts prioritized states in the health care reform process, bolstered state flexibility, opened the door to greater beneficiary cost sharing, allowed limitations on comparability of benefit structures across groups of Medicaid recipients, and several other state-directed reforms. The initiatives, sparked by the 1993 Oregon and 1994 Tenncare waivers, have changed the face of Medicaid in the modern era.

THE WAIVER WAVE: THE OREGON WAIVER AND THE RISE OF THE ADMINISTRATIVE STATE IN MEDICAID POLICY BARGAINING

Introduction

In 1993, the Clinton Administration finally saw through the Oregon 1115 Research and Demonstration waiver after several years of wrangling with the George H.W. Bush Administration. While the Republican Administration did not move on granting the controversial overhaul, partially financed by federal Medicaid dollars, the approval by the Southern Democrat and former Governor's Health Care Financing Administration (HCFA) was an important event. At the time, the controversy

surrounding the Oregon waiver focused on the highly controversial diagnosis/treatment combinations that drew a line where particular combinations would be reimbursed and those that would not. This system of explicit rationing was anathema to many observers on ethical grounds.

For the Medicaid subsystem though, the real paradigm shift triggered by the Oregon waiver was that it was the first of a new era followed by several state-wide and partial abdications of the federal Medicaid laws and rules under the SSA waiver authority enacted in 1962. In 1993 the waiver process was modified to make it easier for states to use the process for state directed health reform. The process and procedures around waivers changed in ways favoring states including allowing an assessment of cost neutrality over the life of the proposed demonstration program instead of a year-by-year cost neutrality requirement.[1] Other influential waivers followed Oregon, including Tenncare in 1994 -- Tennessee's statewide prepaid plan program that expanded enrollment to cover 50% additional lives.[2] In addition, the Clinton Administration made a commitment to states to streamline the waiver process. States rapidly embraced the new flexibility: Between 1993 and 1995 alone, 13 states received 1115 waivers. Before 1993, Arizona was the only state with a statewide 1115 waiver demonstration.[3] As a Republican Energy and Commerce staffer concluded, "….and they approved more 1115 waivers in Medicaid under Clinton than there's tea in China."[4]

The Administration ideology behind the decision to embrace waivers was not isolated to Medicaid but was a fundamental cornerstone of this third wave of reform minded Democratic creative federalism.[5] As one high-ranking Administration official recalled, "My view was that the people of Oregon had had an open and public process

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[1] Mark S. Joffe, "Court Challenge to HCFA's Authority to Approve State Health Care Reform Initiatives," *Medical Interface* (September 1994), 81. (81 - 83). (Hereafter Joffe, "Court Challenge")
[2] Teresa A. Coughlin and Stephen Zuckerman, "States' Use of Medicaid Maximization Strategies to Tap Federal Revenues: Program Implications and Consequences," (02-09), *Assessing the New Federalism Series Discussion Papers* (Washington, D.C.: The Urban Institute, June 2002), 7.
[3] Teresa A. Coughlin. and Stephen Zuckerman, "States' Use of Medicaid Maximization Strategies to Tap Federal Revenues: Program Implications and Consequences," *Assessing the New Federalism Series Discussion Papers* (Washington, D.C.: The Urban Institute, June 2002), 7.
[4] Interview with the Author, October 13, 2006.
[5] The first wave was under FDR and the second was under LBJ.

and they deserved the right to try it. There was opposition in the Department and my view was that if we were going to get fundamental change, whether it was welfare or it was Medicaid we had to try some waivers out. So, we spent a lot of our time doing waivers."[6]

Waiver Purpose -- Research & Development or State Directed Reform

This transformation in Medicaid waiver politics did not unfold without challenge. On June 7, 1994, the National Association of Community Health Centers (NACHC) filed suit against the Secretary of Health and Human Services (HHS), seeking to enjoin HHS from approving Section 1115 waivers for states attempting to implement statewide Medicaid managed care programs in *National Association of Community Health Centers v. Shalala*.[7] The lawsuit was filed on behalf of the 700 community, migrant, and homeless health centers that are members of the NACHC. They held that "the waivers do not assure Medicaid patient's access to the services of FQHCs -- a right that NACHC asserts is guaranteed under the Medicaid law." Further they held that "such waivers were intended only to test unique and experimental programs of limited scope and duration. From a legal perspective, this means that the waivers are contrary to Congressional intent in legislating Section 1115 waiver authority."[8]

Controversial on federalism grounds due to the lack of federal oversight and guidance on waiver parameters, 1115 waivers also teetered on the definition of their "Research and Demonstration" mission. If 1115 waivers were for R&D purposes, (1) they would remain within the five-year limit; (2) they would have a distinct evaluation component; and (3) they would be "testing" a specific hypothesis regarding Medicaid institutional design with the state as a laboratory. The lines around the R&D mission surrounding 1115 authority was cloudy at best with HCFA, the Secretary of HHS, and indeed -- in speeches across America -- the President himself embracing state directed

[6] Interview with the Author, November 6, 2006.
[7] Joffe, "Court Challenge," 81 - 83.
[8] Joffe, "Court Challenge," 82.

reform. He often referenced his own struggles as a Governor in financing competing state responsibilities with limited funds. In the long-term, the ethical dilemmas of the Oregon waiver shaped health ethics, but in terms of Medicaid policy, the Oregon waiver was an important event that redefined Medicaid.

Several major health system reforms for Medicare and Medicaid were bolstered by Research and Demonstration waivers before 1992, including HMO risk contracts, Hospital prospective payment system (PPS), Medicaid managed care, Nursing home reform, Physician payment, and hospital capital prospective payment system (PPS).[9] These were targeted at testing financing, quality, and administrative systems with distinct goals. Most of these, tested at the state level or in state level sites, were later implemented across the country.[10] The Medicaid waiver paradigm shift in the early 1990s included a turn from a specific system being tested in many states where its primary goal was testing an idea for eventual adoption on a nation-wide scale[11] to its general use for state driven "health reform beyond the boundaries of Medicaid."[12] Waiver reforms frequently included expanding the program to low-income workers not previously eligible and requiring managed care participation -- one of the waiver options available to states in Medicaid.

Waiver Negotiations Change the Actors Involved and Shift Decision Making from the Legislative Wing to the Administrative State

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[9] See Joseph R. Antos., Peer Review, "Waivers, Research, and Health System Reform," *Health Affairs* (Spring 1993), 178 - 183. (Hereafter Antos, "Waivers")
[10] See Antos, "Waivers," 181. Examples of Hospital PPS include the Maryland state rate setting, New York PPS per diem, Massachusetts all-payer system, Rochester (NY) Area Hospital Corporation, and the New Jersey DRG all-payer system. Medicaid managed care reform includes the Arizona AHCCCS. Nursing home reform includes the New York RUGS and Texas RUGs systems.
[11] Allen Dobson *et al*. distinguish between four types of Research and Demonstration waivers in "The Role of Federal Waivers in the Health Policy Process, *Health Affairs* (Winter 1992), 75, including: Section 1115 SSA Waivers; Section 402(a) (1967 SSA Amendments) as amended by Section 222(b) (1972 SSA) for provider reimbursement; Section 222(a) (1972 SSA) for prospective provider payment; and Section 2355 of the 1984 Deficit Reduction Act for social health maintenance organization (SHMO) demonstration projects.
[12] Howard M. Dean, "New Rules and Roles for States," *Health Affairs* (Spring 1993), 183.

A severe change for Medicaid politics ushered in with the 1115 Wave was intertwined between, first, the role of policy bargaining, and second, the strength of the Administrative Wing in negotiating with states absent of direct Congressional oversight. Waivers not only undercut Congress and the need for legislation, they subvert the tug-of-war between factions that occurs when any legislative proposal passes Congress. No interest groups testify, no advocacy groups pour over the legislative record, and very few details of the actual negotiations are available for review. In short, the process occurs to a large degree outside of the legislative cycle, absent from the executive record, and without the reasoning of a federal judicial decision. It is the Administrative State at work. Negotiations are between federal agency staff and state agency and budget staff -- vertical autocracies in motion.[13]

In *National Association of Community Health Centers* v. *Shalala*, the NACHC held that the waivers granted by HHS reflect such a major change in waiver policy that to do so HHS must follow the procedural requirements set forth in the Administrative Procedure Act (APA) for promulgation of regulations. The APA requires that federal agencies provide notice and give the public an opportunity to comment on any proposed rule. The position of NACHC is that the policy principles adopted between HHS and NGA constitute rule making, and therefore, their adoption was subject to the APA procedural requirements.[14]

Not only are waiver negotiations not regulation and, therefore, not subject to the APA or regulatory processes, they also occur outside of legislative processes. Representative Waxman (D-CA), then Chair of the Health and Environment Subcommittee of the House Energy and Commerce Committee presented the possibility that "HCFA may use the Section 1115 waiver process as a mechanism to usurp Congressional authority and responsibility to regulate the Medicaid program."[15] This subverted the legislative oversight role of Congress over the Executive given that

[13] Vertical autocracies, a concept reviewed in Chapter 2 on Federalism theory, is the relationship that develops between state level and federal level Administrative or Agency officials, which last over time and results in strong personal bonds that may subvert other governmental processes.
[14] Joffe, "Court Challenge," 82.
[15] Joffe, "Court Challenge," 82.

information on waiver negotiations is below board, but it also removed legislating from the Legislative branch altogether. Agency negotiations prevailed. These negotiations were not legislation or regulation -- but they were binding nonetheless.

This manner of policy bargaining changed the evolution of the Medicaid program in a fundamental way; it increased the probability of wholesale reform instead of the usual incrementalism of Medicaid federalism. Wholesale reform at the state level was commonplace after the Oregon 1115 -- after 1993. This wholesale reform happened state by state and waiver negotiation by waiver negotiation.[16] Compare this to the marginal changes usually enacted during incremental Medicaid reform. As Thad Kousser writes, legislators "really only look at the marginal changes in the Medicaid program….There is a base that is unquestioned."[17]

Waiver of Entitlement?

As a Governor the President had come into office dedicated to providing greater flexibility to states in Medicaid.[18] The vehicle of accomplishing this in Medicaid was the waiver process. The flexibility dimension of this strategy contradicted another principle of the program that Congressional Democrats had traditionally staunchly defended -- entitlement. This left HCFA in the place of balancing both state flexibility with entitlement protections -- a delicate balance. As a Republican Senate Finance Committee staffer recalled, "the argument was, if you have a waiver, you are giving up the entitlement. So, this was a very controversial thing that Clinton did -- or Clinton allowed his people or encouraged his people to do. So, that is why originally a lot of the waivers were very tied to the past, the existing program and you had to show that you were

[16] It should be noted that partial state reform is also available through the application for more than one 1115 waiver -- covering part of the state or select Medicaid populations. Also, several different types of programmatic waivers are available in the program.
[17] Thad Kousser, "The Politics of Discretionary Medicaid Spending, 1980 – 1993," *Journal of Health Politics, Policy and Law* 27, no. 4 (August 2002), 659. (Hereafter Kousser, "The Politics of Discretionary")
[18] Interview with Author, November 6, 2006.

maintaining the individual entitlement to things."[19] As a national state lobbying group representative recounted, the question was " in a publicly financed program where you were entitled to benefits statutorily could a state come in through any mechanism and basically take away some of the entitlement."[20]

Original Principle of the Medicaid Program Eroded-- Uniform benefits across Categories of Medicaid Populations, or Comparability

This removal of the entitlement included redefining the federal mandate for a minimum benefit package across beneficiary groups. An early precept of Medicaid policy was that all groups of beneficiaries had to have access to the same set of federally required minimum benefits under Medicaid law. As one influential staffer with the Energy and Commerce committee at the time said, "and again the Oregon waiver. It was more a discussion of what's the benefit package, what are individuals entitled to. Nobody was arguing, should everyone below 100% of poverty level regardless of category -- childless adults for example -- be entitled to coverage with federal matching dollars? That was fine. The issue was what was the coverage and was this really a back-door way of excusing the state who wanted to come into Medicaid to cover the populations that it had to cover as the price to coming into Medicaid, to cover those populations with a minimum benefit package because, of course, both the mandatory populations and the expansion populations were subject to the same set of rules…and what the Oregon waiver was suggesting was, well maybe you don't have to do that for low-income women and children…you have to offer them some coverage but what's that?"[21]

[19] Interview with Author, November 1, 2006.
[20] Interview with Author, October 24, 2006.
[21] Interview with Author, August 23, 2006.

Waiver Politics and the Evolution of the Block Grant Debate

While medical ethics, the nature of the federal health waiver process, and a new Administrative Legislative capability, and Medicaid benefit structures were all at issue in the new Oregon process, the cost neutrality provision under waivers would also eventually evolve out of these and subsequent state negotiations for 1115s. Cost neutrality acts as a cap on the 1115 negotiation process, meaning effectively that these Medicaid negotiations were not "open" per se as in the open matching grant structure of the non-waiver program. Instead, effectively the program was capped according to the funds that the Health Care Financing Administration (now CMS) accorded as part of the federal funds previously part of the state's system.

An important financing structure twist that would eventually transpire by 2006 from the cost neutrality cap was to what extent these waivers were used to either explicitly at state option to block grant the program or implicitly created a de facto block grant by how HCFA (CMS) had negotiated the terms and conditions with the states. While not a highlight of the Oregon waiver, this event would a decade later get turned around on states as a way to cap federal financial exposure.

WAIVER POLITICS AND A REJUVENATED ROLE FOR MEDICAID MANAGED CARE

TennCare As Major Mandatory Managed Care Reform

After some early success implementing a state employee managed care system in Tennessee, then Governor McWherter began designing an initiative to provide full health coverage to Tennesseans with incomes under 400% of poverty. Benefits would be free up to the poverty line.[22] The theory behind the initiative was to pay for expanded coverage by utilizing mandatory managed care delivery methods. The idea of using

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[22] Michael S. Dukakis, "The Governors and Health PolicyMaking," Chap. 3 in *The New Politics of State Health Policy,* Robert B. Hackey and David A. Rochefort (eds.) (Lawrence, Kansas: The University Press of Kansas, 2001).

managed care for an entire state's Medicaid program was not an entirely new one. The Arizona Health Care Cost Containment System (AHCCCS) -- in place since 1982 -- was a statewide managed care system. Arizona was the last state to join the Medicaid program, insisting on a managed care structure via the 1115 process upon entrance into the program. To some extent prior to Tenncare, AHCCCS was seen as an anomaly given Arizona had never had a Medicaid program prior to 1982 and was a unique market geographically. While not a brand new idea, Tenncare provided an example of utilizing managed care that was seen as a new structure and, indeed, replaced an old Medicaid model with a mandatory managed care one for an expanded population and a reduction in benefits in a metamorphosis of Tennessee health care. Tenncare involved several major reforms that waived the federal rules, including:

- An expansion of the population covered;
- A reduction in benefits provided;
- The ability to use Disproportionate Share Hospital (DSH) financing within the budget neutrality cap; and
- A Medicaid managed care mandate, waiving beneficiaries' federal statutory right to freedom of choice.

All of this was possible within a negotiated 1115 waiver with the federal government. As well as itself being a consequential waiver, the Tenncare initiative was then cited in Congressional hearings on national health reform as a premier example of state directed comprehensive reform. The states now were utilizing the federal contribution from the Medicaid program to effectuate their own state ideas for health care reform within their own borders. This was an ideal way for states to get the health care systems they wanted while alleviating a major roadblock to just such an initiative. States fiscal and tax capacities make this level of reform untenable without federal assistance. While previously attempting major state reform outside the confines of Medicaid, these

new applications of the 1115 process were going a long way to financing these same conceptual frameworks with federal instead of state dollars.

The Energy and Commerce Subcommittee on Health and the Environment was holding hearings on national health reform at the same time that the waiver was approved. Chairman, Henry Waxman, commented, "Yesterday, the Secretary announced her approval of Tennessee's application of waivers for a 5-year Medicaid demonstration under section 1115 of the Social Security Act. Under this waiver, the State will enroll up to 1.5 million Medicaid beneficiaries, uninsured and uninsurables into managed care plans that may serve only the poor. This is the fourth section 1115 waiver, health care reform type waiver, that the Secretary has granted this year. The others have gone to Oregon, Hawaii, and Rhode Island."[23] Examples of comprehensive health reform success, certain states were embraced as if to say, "If they can do it, we -- the Feds -- can do it to." Eventually, while national health reform did not take hold, this same line of argument would be used to bolster reforms so that waivers would no longer be required at all for states to effectuate many of these reforms.

Republicans used Tenncare as a model for one of their national health reform proposals, thereby making a direct connection between a state model and a national level reform proposal. In this case, federal reform and state Medicaid reform plans began to merge. As Representative Bliley commented:

> Now today, we have another major announcement from the administration that the Vice President's home State of Tennessee has won a waiver allowing the State to cash out their Federal disproportionate share money for the purposes of buying health care for their uninsured. We would like to congratulate the administration on this decision because the major Medicaid provisions of the Republican health task force bill, H.R. 3080, are patterned on the Tennessee model and we are glad to see the administration embrace our approach. That is, all States would be allowed to cash out their Federal and State disproportionate payments in order to buy in additional poor people at below 200 percent of the

[23] U.S. House of Representatives, Hearings before the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, Health Care Reform (Part 5), House of Representatives, One Hundred Third Congress, First Session, Serial No. 103-90, Friday, November 19, 1993, "Health Care Reform: Impact on Medicaid and Low-Income People," Henry Waxman, Chairman of Subcommittee, 548.

> poverty line, and subtitle H gives States the flexibility to provide managed care without going through the waiver process.[24]
>
> I would like to make one additional comment concerning the Tennessee program. Tennessee is currently receiving more Federal DSH payments than States like New York or California. The reason for this anomaly was that Tennessee was the pioneer in creative accounting and financing schemes that led to the explosion in provider taxes and DSH payments. Other States went to school on Tennessee to see how it was done, but no State ever approached Tennessee's skill at increasing DSH payments, and Tennessee now has a Federal guarantee to reap the benefits of its grossly inflated DSH payments.[25]

Behind this initiative was a promise for states to use their DSH monies -- regardless of how creative they were in attaining their current level of federal DSH funds -- in order to expand health care coverage to those who needed it. Also, the idea of allowing mandatory managed care outside of the waiver process was proposed. In BBA 1997, this eventually became a reality. It took, however, the pioneering of Tennessee to set this reform in motion. And so, while the Tenncare program has informed federal health policy in many ways, it spearheaded mandatory managed care initiatives at the state level and got the ball rolling on states receiving the flexibility in BBA '97 to enroll many Medicaid beneficiaries in mandatory Medicaid without a waiver.

General Trend Toward Mandatory Managed Care Furthered by the 1993-94 National Health Debate

The Medicaid waiver revolution embraced state applications of mandatory managed care initiatives. The Clinton health plan also was designed around health purchasing alliances buying managed care coverage for most Americans -- thus remaking the American health insurance industry. The national debate and eventual settling on managed care as a model good enough to design the entire system around contributed to

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[24] U.S. House of Representatives, Hearings before the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, Health Care Reform (Part 5), One Hundred Third Congress, First Session, Serial No. 103-90, Friday, November 19, 1993, "Health Care Reform: Impact on Medicaid and Low-Income People, "Ranking Minority Member of the Subcommittee, Mr. Bliley, 535 - 536.

[25] U.S. House of Representatives, Hearings before the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, Health Care Reform (Part 5), One Hundred Third Congress, First Session, Serial No. 103-90, Friday, November 19, 1993, "Health Care Reform: Impact on Medicaid and Low-Income People, "Ranking Minority Member of the Subcommittee, Mr. Bliley, 535 - 536.

the managed care revolution in the early 1990s. Both the architects of the Clinton health plan and the advocates of increased use of mandatory managed care in Medicaid forecasted that greater use of managed care would cut costs. In the longer term, this was not -- or only mildly -- realized. Managed care was found to reduce costs slightly (around 5%) or not at all.

Several reasons contributed to the growth in mandatory managed care, including the national health debate, the Tenncare waiver, and previous development of managed care concepts in the 1980s by groups such as the Jackson Hole initiative. Regardless of the reason, the transformation prioritized state decision making over beneficiary choice. By 1995, federal waivers had allowed twenty-four states to force some of their Medicaid recipients into managed care plans. Fourteen of these states also expanded their coverage to the working poor, who often had to pay sliding-scale premiums, transforming Medicaid from a narrow social service benefit to a wider state-sponsored insurance program.[26] Just as President Nixon had embraced managed care, President Clinton had included managed care as an important delivery mechanism in his health care reform. It is at least possible that the decision by the Clinton health reform team that managed care was viable as the insurance and service delivery mechanism for all Americans in their gargantuan reworking of the U.S. system, helped further the belief that mandatory managed care was acceptable for Medicaid beneficiaries -- in the absence of national health reform.

Original Principle of the Medicaid Program -- Beneficiary Freedom of Choice -- Further Eroded

As just discussed, the design of the Health Security Act around managed care plans was part of the domino effect that tipped states toward greater use of managed care. If anything, simply the two-year national discussion -- often embracing managed care techniques by both the left and the right -- shaped policy positions on the topic. A key difference, though, was that the President's plan would not force Medicaid beneficiaries

[26] Kousser, "The Politics of Discretionary," 649 - 650.

into managed care plans that served only the poor, [27] whereas this was just the feature that had many Medicaid advocates leery of Tenncare and the trend that it was evoking. Another original principle of the Medicaid program, beneficiary's freedom of choice, was being further eroded.

State Choice Still Broad In Mandatory Managed Care Model

While one of the original principles of the Medicaid program for Medicaid beneficiaries, freedom of choice, was removed through the use of mandatory managed care statewide, state choice using managed care delivery techniques was still quite broad. States could chose (1) between models: a Primary Care Case Management (PCCM) Model, a Hospital Organization - Private Physician Model, or a Full or Partial Risk Model; (2) whether to cover urban or rural areas; and (3) the populations to enroll -- the disabled, the elderly, or parents and children. Also, the issues of privatization of traditionally state functions in a managed care model continued to be debated and adjudicated. The offloading of provider payment, beneficiary interface, and other traditional state government functions onto private entities was another controversial aspect of mandatory managed care via waivers.

TennCare a De Facto Block Grant?

At the time, though, even with the budget neutrality rules and the relatively accurately forecasted managed care per capita rates, the extent to which Tenncare was considered a defacto block grant is debatable. As one Medicaid expert recalls, "I don't think people were viewing the TennCare waiver as a prelude to a block grant. It did have a cap but it was perceived at the time as a good bargain for low-income people because the expansion of coverage was so broad on paper, and a lot of federal dollars that might

[27] U.S. House of Representatives, Hearings before the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, Health Care Reform (Part 5), One Hundred Third Congress, First Session, Serial No. 103-90, Friday, November 19, 1993, "Health Care Reform: Impact on Medicaid and Low-Income People," Henry Waxman, Chairman of Subcommittee, 548.

have left the state and might have left that system were captured and retained. So that was generally seen as a good thing."[28] With time, some state waivers would begin to take the form and shape of a de facto block grant, with the budget neutrality rule and various negotiated restrictions with states acting as caps on federal spending.

The evidence is limited that Tenncare at the time was considered or was foreseen as a predecessor of a de facto block grant approach. However, limiting state financial exposure was a driving force behind this significant initiative. It should be noted, though, that as part of the 1995 block grant debate, Tennessee Department of Finance and Revenue Commissioner Bob Corker did advocate for a federal block grant, explaining that as "the spokesman of the only budget-neutral 1115 waiver existing today, I believe that Tennessee has much experience to offer the Nation in this debate."[29] Taking the next step from budget neutrality to considering these waivers capped by budget neutrality rules as a de facto block grant would evolve with time, but the dawn of the discussion was the establishment of Tenncare in 1994.

Under budget neutrality, statewide waivers could not cost the federal government more than the program would cost if the waiver were not in place. The types of funds available within the Cost Neutrality umbrella would, in the future, prove to be an exceptionally important list. Given states' past activities in maximizing federal funds in the DSH program, provider taxes and donations, and various other means that would evolve with time, states would require many of these past investments from the federal government to remain as part of the calculation within Cost Neutrality. Now entrenched over years as financing for their own Medicaid program, they needed these funds included under the budget cap to meet obligations. These early 1115 waivers set precedents for what would be included in the cap. The Tenncare waiver negotiations were significant in this aspect, as well.

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[28] Interview with Author, August 23, 2006

[29] Bob Corker Statement, Commissioner, Department of Finance and Administration, Tennessee, Committee on Commerce House of Representatives, Subcommittee on Health and Environment of the Committee on Commerce House of Representatives, One Hundred Fourth Congress, First Session, July 26, Serial No. 104-108, "Transformation of the Medicaid Program -- Part 3," 64-66.

The Tenncare waiver included DSH funding under the cost neutrality cap. According to nationally recognized Medicaid expert and Director of the Tennessee Justice Center Gordon Bonnyman, this resulted from "shrewd bargaining with federal officials by then Governor Ned Ray McWherter."[30] The maximization of DSH funds from the mid-1980s gained Tennessee a reputation for accomplishing this more successfully than any state. In the 1994 Tenncare statewide waiver negotiation, the state successfully kept all of these gains by included established federal DSH funding levels in Tennessee within the budget neutrality cap. This successful state negotiation set a precedent, as Tennessee established its statewide waiver with budget neutrality rules that they themselves actively defined. Far from being passive takers of federal policy, Tennessee shaped the budget neutrality cap rules.

CONCLUSION

As predecessor to the national health debate, the Oregon waiver furthered the state comprehensive reform discussion to how far states could reach in utilizing federal Medicaid funds -- as well as several major areas of Medicaid policy including benefit comparability structures, the ethics of their explicit rationing design, and the security of the individual entitlement within that waiver environment. Before Oregon, statewide demonstration programs were anathema. As HCFA Administrator Bruce Vladeck noted in 1995 Congressional hearings, "Mr. Chairman, if I may, let me just clarify some of the facts about the 1115 process. Since the Clinton administration came into office, you're correct, we've approved 10 statewide health reform demonstrations. We've approved a total of 34 section 1115 demonstrations. That contrasts to the record under the previous administration, in which a total of 16 1115 demonstrations were approved and a total of zero statewide health care reform demonstrations were approved."[31]

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[30] Gordon Bonnyman, "The Tenncare Cuts: Plunging Into the Unknown," 3, from *The Tennessee Justice Center* website www.tnjustice.org, (accessed August 9, 2006).
[31] Bruce Vladeck, HCFA Administrator, Committee on Commerce House of Representatives, Subcommittee on Health and Environment of the Committee on Commerce House of Representatives, One

Oregon's 1993 1115 Medicaid waiver was tipping point that changed Medicaid's future trajectory. Shortly thereafter in 1994, Tenncare, highlighted important conceptual debates in Medicaid politics as well -- mandatory managed care, expanded coverage, limited benefits, and budget neutrality infused with DSH funding -- and set precedents that would have important implications for at least the next decade and a half.

Hundred Fourth Congress, First Session, July 26, Serial No. 104-108, Transformation of the Medicaid Program -- Part 3, 42.

9. MEDICAID AND THE 1993-1994 NATIONAL HEALTH REFORM DISCUSSION: SETTING THE STAGE FOR THE BLOCK GRANT ERA AND BBA

INTRODUCTION

Within the broader health debate, the attempt at universal coverage, meaning coverage of the uninsured and Medicaid populations was a stumbling block between competing proposals. There were also discrepancies regarding federalism --and what the new state role would be -- in the new health infrastructure. Finally, the national health debate was extremely valuable as a national discussion where multiple coalitions vetted their beliefs regarding the national direction in health care. Medicaid was vital to the national health debate in several ways (to be discussed in this chapter), including proposed financing structures for the initiative planning to shift federally directed Medicaid funds towards financing the national health effort.

Several factors contributed to the Clinton Health Security Plan not passing Congress -- from prioritization, to lost political capital on other legislative initiatives, to splintering of the far left from the moderate Democrats on whether 93% population coverage was acceptable. All in all, the important result was that this well-lit, well-publicized, well- participated in national discussion set the stage for several future health reforms that will be discussed in greater detail in the next chapter. This chapter concentrates on that national discussion and its plans for Medicaid.

MEDICAID, THE STATES, AND NATIONAL HEALTH REFORM

Ending Welfare -- and Medicaid -- As We Know It

While the President's election platform had vowed to "End Welfare As We Know It," a second less well pronounced sideline was an implicit promise to "End Medicaid As We Know It." While the 103rd Congress did not address welfare reform, a Republican plan was generated. This established an initial baseline for welfare reform discussions in the 104th Congress. In the other policy stream, ending Medicaid was not the premise of the Administration. The emphasis was on designing a system of full coverage for every American -- which would have implicitly ended Medicaid by replacing it with a more comprehensive system.

States as Laboratories in Clinton Era Medicaid Policy Bargaining

While the experts on federal Medicaid policy work from the agency that runs the program, the Health Care Financing Administration [now known as the Centers for Medicare and Medicaid Services (CMS)], the President set a distinct tone that encouraged state innovation and liberalized the Medicaid waiver process. While one White House advisor emphasized that the President did not favor particular states for special favors,[1] others emphasized the Administration's states as laboratories policy position in Medicaid, and also for that matter generally in social policy. One Senior Administration official stated, "Everyone that went in believed that how the federal government shaped national policy was testing things out in the states."[2] The official continued, "We used waivers not only in Medicaid but also in welfare…he [President Clinton] saw it from the eyes of the Governor and most of us did not come in with a federal government orientation. We saw our history of social policy making as state

[1] Interview with Author, October 12, 2006.
[2] Interview with Author, November 6, 2006.

experiments and then to see if they were experiments that could really be turned into national policy."[3]

President Clinton's federalism stance, generally and in the health policy area, was no doubt shaped by leading the State of Arkansas in day-to-day decision making. It was also formed by his lead NGA role in negotiating the Family Support Act of 1988 (PL 100 - 485).[4] When President, he addressed the NGA in Tulsa, Oklahoma on August 16, 1993. Regarding health care policy, he commented "and I've been thinking about this seriously now for more than three years, ever since the Governors Association asked me and the then-Governor of Delaware, now a Congressman from Delaware, to look at the health issue."[5] He continued, referring specifically to Medicaid, "The National Government has a lot to learn from the States in tough decisions that some of you have made already. I can honestly say that along toward the end of my tenure as Governor, the most frustrating part of the job was simply writing bigger checks every year for the same Medicaid program when I didn't have the money that all of us wanted to spend on education and economic development and the other important issues before us."[6] Again on February 1, 1994, the President addressed the NGA, "I do believe the States are the laboratories of democracy. I do believe that where people are charged with solving the real problems of real people, reality and truth in politics often is more likely to give way to making progress."[7]

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[3] Interview with Author, November 6, 2006.

[4] 1993 *CQ Almanac*, 373.

[5] William J. Clinton, "Remarks to the National Governors Association in Tulsa, Oklahoma," August 16, 1993, *Public Papers of the Presidents of the United States 1993*, Book II (Washington, D.C.: GPO, 1994), 1386.

[6] William J. Clinton, "Remarks to the National Governors Association in Tulsa, Oklahoma," August 16, 1993, *Public Papers of the Presidents of the United States 1993*, Book II (Washington, D.C.: GPO, 1994), 1384.

[7] William J. Clinton, "Remarks to the National Governors Association," February 1, 1994, *of the Presidents of the United States 1994*, Book 1 (Washington, D.C.: GPO, 1995), 155.

Medicaid's Key Role in the National Health Debate

Medicaid politics played a key role in the national health reform debate in four main ways:

- Arguing that Medicaid was badly broken was a tactic to bolster national health reform;
- The Administration prioritized -- and would not negotiate regarding -- coverage of every American, universal coverage, as opposed to functional universal coverage, defined as 93% coverage;
- The national health reform effort was funded by shifting the cost of Medicaid from the government to private employers; and,
- Finally, Task Force Democrats and Democratic Congressional staff historically involved in Medicaid expansions were not aligned.

First, a key argument in favor of national health reform was that the current system -- including Medicaid -- was broken. Medicaid continued to be an easy target for these types of arguments -- trashing Medicaid as proof that a new system was needed. In debating in favor of national health reform, advocates were caught, at times inadvertently, arguing against the Medicaid program and all of its shortcomings. In effect, the national debate trapped advocates of national health reform in proving their case in part by citing all of Medicaid's shortcomings. As one Congressman exclaimed in an Energy and Commerce Hearing on how Medicaid would be affected by national health reform, "The Medicaid system today is in fact busted, it is broken, it does not work for millions and millions of poor people across the country. Medicaid is a Federal-State partnership, and the partnership is out of whack."[8] One of several examples, supporters

[8] U.S. House of Representatives, Hearings before the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, Health Care Reform (Part 5), One Hundred Third Congress, First Session, Serial No. 103-90, Friday, November 19, 1993, "Health Care Reform: Impact on Medicaid and Low-Income People," Mr. Wyden, 537.

of national health reform found themselves dismantling Medicaid on a national stage to prove that a more systemic restructuring was required in the system as a whole.

Second, the gaps in Medicaid did not cover millions of uninsured Americans that the reform would. Universal coverage was a priority of the Administration -- possibly to the detriment of Congressional passage. At the beginning of the term, what the Administration wanted was comprehensive coverage. Not 93% coverage, not 94% coverage -- but full coverage. Throwing down the gauntlet, the President had claimed in his 1994 State of the Union address, "I want to make this very clear. I am open, as I have said repeatedly, to the best ideas of concerned members of both parties. I have no special brief for any specific approach, even in our own bill, except this: if you send me legislation that does not guarantee every American private health insurance that can never be taken away, you will force me to take this pen, veto the legislation, and we'll come right back here and start all over again."[9] This insistence on full coverage was driven by a desire to finally cover everyone who had fallen through the Medicaid gaps. In short, Medicaid expansions, no matter how numerous over the 1980s had not been enough -- this time the President would not settle for less.

Later in negotiations of various health plans, there appeared to be some softening of this approach. Encouraging Senators to keep at it, "Clinton got into trouble, particularly, when he spoke bluntly of 'functional universal coverage,' which he said meant 'around 95 percent' of Americans."[10] At the same time that Clinton may have softened his approach, some Congressional Democrats to the ideological left would not budge from the President's original stance. In what *CQ* referred to as a "blistering floor speech," Paul Wellstone (D-Minn.), "said the plan would hurt Americans who needed help most and benefit insurers."[11] Even moderate Democrats could not escape the "100% coverage or no deal" mantra. A group of Senators attempted to put together a Mainstream Group compromise plan but Bill Bradley (D-N.J), an original member of the

[9] William J. Clinton, "The State of the Union: Clinton Stresses Welfare, Health Care Reform," January 25, 1994, Volume L, 1994 *CQ Almanac* (Washington, D.C.: Congressional Quarterly, Inc, 1994), 103rd Congress, 2nd Session, 1994, 6-D.
[10] 1994 *CQ Almanac*, 348.
[11] 1994 *CQ Almanac*, 351.

group, said it would leave too many people uncovered and, therefore, would not restrain health care costs sufficiently.[12] One influential Congressional staffer explained in a list of mistakes around the reform effort, "And I think that if Clinton had called coverage 93% coverage instead of full coverage [it would have been more effective]. You know there was this ridiculous fight between he and his wife at a certain point where he wanted to start making deals, and he was going to cut deals where you could leave out small businesses and leave out the last 6%. So there were lots and lots of mistakes."[13]

Third, financing of the Clinton Health Security Act was centered on re-directing funds from Medicaid and other health programs. As one Clinton Health Security Task Force Executive commented, "we were spreading the cost of Medicaid across the employer-population. So, …it was shifted …we shifted the cost of Medicaid off the government rolls [and onto employers]. So, we got a lot of our ability to do what we were doing with limited financing by shifting that responsibility."[14] An important tactic in many health reforms, financing often involves cost shifting between public and private payers and between federal and state governments. In short, this initiative was no different, planning to finance the health reform in part by re-directing previous Medicaid dollars to the initiative and by shifting costs of some Medicaid clients onto private employers.

As Secretary Shalala testified at the time regarding how the Plan would be financed, "And so we intend to finance the system both out of savings which are produced by slowing down the growth in the public system out of new employer and employee contributions, out of two new sources of revenue, one the cigarettes and the other the alliance pieces, and by taking the public money that is currently being spent by the Medicaid system and putting it into the alliances to reimburse the alliances and to pay them for both the premium costs as well as for the other costs associated from the populations that are being phased in, the Medicaid populations."[15] Medicaid would help

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[12] 1994 *CQ Almanac*, 351.
[13] Interview with Author, October 13, 2006.
[14] Interview with Author, August 10, 2006.
[15] U.S. House of Representatives, Committee on Energy and Commerce, One Hundred Third Congress, First Session, Joint Hearings before the Subcommittee on Health and the Environment and the

pay for national health reform, as had been made clear during the previous year's budget reconciliation process when cuts to Medicaid and Medicare were considered a down payment on health reform.

Finally, the group of Congressional Democrat members and staffers who had labored to expand Medicaid over more than a decade were to some degree removed from the hundreds of Task Force members that labored over the Goliath and famously complex Administration Plan. As one interviewee described it, "Yeah, put 500 PhD academics around the table…have a good laugh. I mean they made a lot of mistakes. They didn't like how Medicaid was done. Medicaid was abolished. Every one was rolled into, I think AFDC and SSI [who] had special status still, but other people in Medicaid were not going to still get the same benefit package that they had in the past. So they were not happy. We had one hearing where [Democratic Congressman, and Medicaid Champion, Henry] Waxman was just about as critical as anybody about the way the thing was structured."[16] It is instructive that of five Congressional committees with primary jurisdiction over the 1993-1994 national health reform debate, the House committee with sole jurisdiction over Medicaid, Energy and Commerce, was the only one of the five not to see a bill through committee.[17] Possibly the question is, particularly for those who had a history on the Health Subcommittee, "What is the impetus of reporting a bill on national health reform, effectively deleting a decade and a half of arduous brick by brick building of Medicaid, the country's health financing program for those in need?"

Furthering the critique, one multi-decade veteran of Congressional committee politics offered his view that the effort was "amateur hour," and continuing "this is Washington and there are ways to get things done and no one knew how to get things done like Commerce, Ways and Means, and Finance."[18] In this staffer's view,

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Subcommittee on Commerce, Consumer Protection, and Competitiveness, Serial No. 103-75, October 5, 1993, Statement of Hon. Donna E. Shalala, Secretary, Department of Health and Human Services, 63.

[16] Interview with Author, October 13, 2006.

[17] "On June 28, Dingell notified House leaders that his committee, often seen as a bellwether of congressional opinion, would be unable to act on health care legislation. Energy and Commerce had been paralyzed for months by bipartisan opposition to President Clinton's proposed employer mandate." 1994 CQ Almanac, 335.

[18] Interview with Author, October 13, 2006.

Democrats were splintered. There were Democrats working directly on the National Health Task Force and a separate group of Hill colleagues, having worked for so many years throughout the 1980s and early 1990s on Medicaid expansions, who had mixed views on the comprehensive health reform effort that would effectively "end" Medicaid. Another interviewee recounted this in softer terms, explaining that some Democratic staffers who had worked on the Medicaid expansions in the 1980s and 1990s wondered if the Clinton health reform was "worth it."[19]

Democratic coalitions in the policy bargaining of the era were not aligned and there was a great deal of sunk cost, arduous investment in another health program that stood as a wedge against national health reform. The existence of Medicaid, with all of its entrenched interests in localities, states, businesses, hospitals, nursing homes, and a myriad of advocacy groups did not necessarily help national health reform along. Several commentaries in Medicare politics find this same phenomenon. The entrenchment of the Medicare program acts as a wedge against national health reform. In 1993-94, the importance of Medicaid to state budgets, to local health networks, to state and local economic development, to groups particularly powerful at the state level such as nursing homes was a consideration. In terms of Democratic coalitions -- they are more complex than simply listing one group simpatico in lock step towards national health reform. In fact, while not necessarily working against reform in any way, several extremely highly respected staffers -- considered the most knowledgeable Medicaid experts -- did not want to be left with a system that was a step backward from what they had incrementally built over a very long period of time. Given the complexity of the plan, no one was sure that Medicaid beneficiaries would be better off in the new system.

State Representatives Perspectives on Health Reform In Their Own Words

As for states own perspective, the National State Medicaid Directors Association (NASMD) representative who led their negotiations at the time remembers, "To some

[19] Interview with Author, August 10, 2006.

degree, we felt helpless. We had a sense that it was a powerful engine …we weren't going to be able to have a great deal to say about it. We were invited to the White House a couple of times to talk about it with some of the health team and felt that the [Medicaid] program was going to go away….we were educating some of the staff about the kinds of problems we had run into in cost and access, particularly with services for behavioral health, healthcare for adolescents -- the true cost of serving them well is understated….we felt like we were standing on the shore and we felt a tidal wave was going to come."[20] The National Governors Association (NGA) representative -- an integral body in negotiating on behalf of Governors on federal Medicaid policy -- remembers the national health reform effort, "But to be honest our feeling out of the bag was that this thing was kind of dead on arrival."[21] The primary reason for doubt was the commitment to universal coverage. "We had Bob Dole on the Senate side and we could have negotiated a deal on a partial fairly major step -- but not universal."[22]

As a contact at a national state lobbying organization related, "Well our big issue [with national health reform] was pre-emption and who was going to regulate health insurance. So that was -- the big thing about the Clinton Health Plan at the time was this whole managed care thing….moving from predominant fee-for-service to managed care and who was going to regulate that insurance which was traditionally the role of the states. In retrospect, managed care became a pretty dominant part of our health care policy but at the time states have retained the regulation of health insurance, subject to ERISA. It was really about who was going to regulate health insurance -- was it federal or state working out the details. So Medicaid was a piece of that but that was much more about federalizing health insurance with a managed care platform… because at the time, managed care was not that popular of a concept."[23]

The state lobbying representative continued, "So that was the biggest concern, it was not Medicaid. That was not the central piece. The central piece was moving other people into managed care. Same issues but different population. So we moved forward,

[20] Interview with Author, September 13, 2006.
[21] Interview with Author, November 2, 2006.
[22] Interview with Author, November 2, 2006.
[23] Interview with Author, October 24, 2006.

at least, in that wave with Medicaid Managed Care but not with everybody else. That part didn't happen.[24] The mandatory managed care revolution in Medicaid, helped along by the TennCare waiver in 1994 and formalized in the BBA '97 was sped along by the Clinton Health Plan embracing the concept so closely during the national health reform of 1993 and 1994.

THE CLINTON HEALTH SECURITY ACT PLANS FOR MEDICAID

As for the Clinton Health Security Act, its plans for Medicaid were outlined by then HCFA Chief Bruce Vladeck during Energy and Commerce Committee hearings. Since the Commerce Committee was Medicaid's authorizing committee in the House of Representatives, it was particularly tuned into changes in a program it had labored intensively over since becoming the committee of jurisdiction in the mid-1970s. As the next series of paragraphs will demonstrate, a primary criticism of the Clinton Health Security Act was its complexity. One is left with more questions than answers about what precisely happens to Medicaid beneficiaries -- for moms and kids, for the disabled, for the elderly. For some Congressional staff that specialized in Medicaid policy, the remaining questions left uneasiness.

As Administrator Vladeck described, "Under the Health Security Act, states will continue their shared partnership in the Medicaid program but will benefit from redirected Federal funding and from savings from a new relationship with the private sector through the alliance health plans. The Health Security Act will integrate Medicaid acute services into alliance plans."[25] The plans for Medicaid recipients were separated between those who received cash assistance and those who did not. Dr. Vladeck referred to those who received cash assistance as "the most vulnerable poor" in describing the

[24] Interview with Author, October 24, 2006.
[25] House of Representatives, Hearings before the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, Health Care Reform (Part 5), One Hundred Third Congress, First Session, Serial No. 103-90, Friday, November 19, 1993, "Health Care Reform: Impact on Medicaid and Low-Income People," Statement of Bruce Vladeck, Administrator, Health Care Financing Administration, 541 - 542.

Clinton plan reform proposals. "The most vulnerable poor will receive full coverage while maintaining their ability to choose among the plans…The State and Federal Governments will pay a premium to the alliance for Medicaid individuals receiving cash assistance based on 95 percent of current State per capita Medicaid spending on those covered services trended forward by national growth rates."[26]

Then continuing, "Other low-income individuals who do not receive cash assistance will also receive health care coverage through alliance plans. These individuals will make a premium contribution based on a sliding scale related to income. Employers of low-income employees must pay premiums to the alliance based on private sector rates, as they do for all employees."[27] States were to continue to provide health care to non-cash welfare Medicaid recipients [for services not covered by the alliance] and to make "maintenance of effort" payments to the alliances based on 1993 spending for Medicaid services. States could also continue to provide optional Medicaid services to adult recipients of cash assistance as under current law.[28] Disproportionate share hospital [DSH] payments were not continued since universal coverage removed the need

[26] U.S. House of Representatives, Hearings before the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, Health Care Reform (Part 5), One Hundred Third Congress, First Session, Serial No. 103-90, Friday, November 19, 1993, "Health Care Reform: Impact on Medicaid and Low-Income People," Statement of Bruce Vladeck, Administrator, Health Care Financing Administration, 541 - 542.

[27] U.S. House of Representatives, Hearings before the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, Health Care Reform (Part 5), One Hundred Third Congress, First Session, Serial No. 103-90, Friday, November 19, 1993, "Health Care Reform: Impact on Medicaid and Low-Income People," Statement of Bruce Vladeck, Administrator, Health Care Financing Administration, 541 - 542.

[28] U.S. House of Representatives, Hearings before the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, Health Care Reform (Part 5), One Hundred Third Congress, First Session, Serial No. 103-90, Friday, November 19, 1993, "Health Care Reform: Impact on Medicaid and Low-Income People," Statement of Bruce Vladeck, Administrator, Health Care Financing Administration, 542.

for compensating hospitals for uninsured care. [29] Medicaid long-term care benefits would continue for eligible patients regardless of whether they receive cash assistance.[30]

Medicaid, already the most complex program in the American welfare state, got more complex in the Clinton Health Security Act. Understanding exactly what we were about to get was a primary factor in the National Governors Association (NGA) and other key actors not thinking this was a viable reform effort.

NATIONAL HEALTH REFORM PROPOSALS, SUBSIDIES, AND THEIR IDEAS ON CHANGES TO THE MEDICAID PROGRAM

Several of the health reform proposals in the 1993-1994 era included a subsidy for low-income populations. Others -- like the single-payer model presented by the House Education and Labor Committee (HR 3960), the single payer plan by the House Ways and Means Committee (HR 3600), and Senate Majority Leader Mitchell's proposal (D-Maine) -- planned to replace Medicaid altogether. Several proposals gave states an explicit role in the new national health reform -- often either to establish their own health insurance systems or administer health-purchasing alliances.

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[29] U.S. House of Representatives, Hearings before the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, Health Care Reform (Part 5), One Hundred Third Congress, First Session, Serial No. 103-90, Friday, November 19, 1993, "Health Care Reform: Impact on Medicaid and Low-Income People," Statement of Bruce Vladeck, Administrator, Health Care Financing Administration, 543.

[30] U.S. House of Representatives, Hearings before the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, Health Care Reform (Part 5), One Hundred Third Congress, First Session, Serial No. 103-90, Friday, November 19, 1993, "Health Care Reform: Impact on Medicaid and Low-Income People, "Prepared Statement of Bruce C. Vladeck, Administrator, Health Care Financing Administration, 547.

Chart 2: Clinton Health Reform Debate Timeline

CLINTON HEALTH REFORM DEBATE TIMELINE
September 22, 1993 – President Clinton Speech Introducing the Legislation in a nationally televised speech to Congress
October 27, 1993 – Clinton formally submitted his health care reform bill to Congressional leaders.
January 25, 1994 – State of the Union Speech
End of 1993 – Republican Response to Clinton Health Reform Speech; claim that Clinton blocks many Medicaid waiver requests
March 23, 1994, House Ways & Means Committee, Subcommittee on Health
June 9 – Senate Labor and Human Resources Committee, First Full Committee to act on health care overhaul, (S1757)
June 14, 1994 – Clinton unveiled welfare reform proposal (S2224, HR 4605)
June 30, 1994, House Ways & Means Committee, Approve its version of the Health Care Bill
July 2, 1994 – Senate Finance Committee – Last to complete work in the health care reform bill, approving its proposal (S2351 - S Rept 103-323) by vote of 12-8
July 22, 1994, House Education and Labor (H Rept 103 - 601, Part II)
July 29, 1994 – House Democratic Leadership (1994 CQ, p. 348 - 349)
August 11, 1994 – Bipartisan Group of HOUSE moderates
August 25, 1994 – Crime Bill cleared August 25. . Partisan Bickering, sounded the death knell for health care reform. . In the Clinton Health Care Reform Plan, Medicaid was subsumed into the Health Alliance System. . .
August 26, 1994 – Mitchell scrapped his own plan. . .
September 26, 1994 – Health Reform officially declared dead
September 27, 1994 – Contract With America unveiled
November 11, 1994 – POST REPUBLICAN ELECTION VICTORIES – Speech to the Washington Research Symposium
November 15, 1994– House GOP released text and descriptions of Draft Bills designed to incorporate 10 elements of "Contract"

The Clinton Health Plan, designed by the Task Force on National Health Reform, set the tone by requiring that states establish purchasing groups called "health alliances" to bargain with health plans, pay the plans, and collect premiums from subscribers.[31] The health alliance system was chosen to maximize the bargaining clout of the group by combining larger numbers of people into a collective. Bargaining strength increases with numbers. Several competing proposal followed this leading outline and folded Medicaid populations into mandatory alliances or health insurance purchasing cooperatives with other general population enrollees.

[31] 1993 *CQ Almanac*, 346.

Table 1 outlines in greater detail the plans for Medicaid populations in various major 1993-1994 health reform proposals. Nearly half plans (6 out of 12) proposed covering recipients up to 200% or 240% of the poverty level, with Senate Majority Leader Mitchell's proposal offering pregnant women and children (a traditional Medicaid category) coverage up to 300% of poverty. While Senator Mitchell's plan pre-dated the State Children's Health Insurance Program (SCHIP), enacted in 1997, the idea of extending coverage to children at higher levels of poverty was indeed later a major reason for passage of SCHIP. While the current categories of Medicaid beneficiaries were maintained, proposals generally included subsidies for everyone below a certain defined poverty level regardless of categorical distinction. This change proposed to enhance the equity in the Medicaid program by doing away with categorical eligibility requirements. In Medicaid, if an individual is low-income, but not a member of a particular pre-defined category, he may be ineligible. Many of the 1993-94 reform plans were designed to do away with this provision, thus making income and asset levels the tests for Medicaid eligibility. This change would improve equity between people, previously sorted by categorical groups.

Many of the proposals also wanted to mitigate the notch effect in Medicaid by tapering benefits off gradually as income levels rose. As structured, the notch effect currently creates a sharp drop-off where recipients either "are eligible" or "not eligible" at a particular income point, complicating matters if an individual gets employment which places their income just slightly above Medicaid eligibility cutoffs. This results in completely losing Medicaid benefits -- a disincentive to accepting employment. Many 1993-94 proposals were structured to explicitly address this notch effect by tapering subsidies or vouchers at higher levels of income. Most proposals involved cost shifting, funding new initiatives from former Medicaid dollars, but many proposals drew direct lines to new subsidies for low-income populations to former Medicaid dollars. Some proposals, such as the Senate Mainstream Group proposal, required explicit scaling back of proposed benefits to low-income populations in order to satisfy critics.

Table 1: 1993/1994 Health Reform Proposals and Summary of Plans for Traditionally Medicaid Populations

	MEDICAID POPULATION REFORM
CLINTON PLAN (HR 3600, S1757)	Low-income families with dependent children and those with SSI (60% of Medicaid population). The Government would pay the employer share of the health alliance premium and subsidize the employee share. The remaining 40% of Medicaid recipients would participate in the local health alliance. All DSH payments would be ended. Unemployed would receive subsidies from the federal government.[32]
Sen. John H. Chafee, R-R.I. (S1770, HR3704)	By 1997, make vouchers available to fully subsidize health costs for those earning up to 90 percent of the federal poverty level. Vouchers would be phased in by 2005 on a sliding scale to help cover those who earned up to 240 percent of the poverty level. But subsidies would be available only if the federal government cut Medicare and Medicaid. States could contract with health programs to serve the poor exclusively.[33]
Rep. Jim Cooper, D-Tenn. (HR3222, S1579)	Abolish Medicaid replacing it with a subsidy program that would pay the medical costs of the 36 million Americans earning poverty wages. Those earning up to 200 percent of the poverty level would receive subsidies on a sliding scale. States would be required to take over the long-term care portion of Medicaid. The government would subsidize enrollment in an area's lowest priced plan. Supplemental services that were provided to Medicaid beneficiaries, such as transportation to clinics, would continue only for those below the poverty line.[34]
COMMITTEE PLANS	
Senate Finance (S2351 -- S Rept 103-323)	Provide subsidies to help low-income people buy insurance. The subsidies were to be funded by cuts in Medicaid, a $55 billion cut in Medicare over five years, and new taxes, including an increase in the cigarette tax to $1 a pack from 24 cents a pack.[35]
Senate Labor and Education (S1757)	*Bill largely modeled on the Clinton Health Plan.*
House Ways and Means (HR 3600 - H Rept 103 - 601)	Replace Medicaid with Medicare Part C, a new government-run insurance program to provide health coverage for the poor who were on Medicaid, the uninsured and many employees of small businesses. Only companies with 100 workers or fewer could enroll employees in Part C. Provide subsidies to the poor to defray premium costs. The subsidies, to be fully phased in 2003, would operate on a sliding scale, becoming more generous for lower income individuals.[36]
House Education and Labor -- Single Payer Bill (HR 3960 - H Rept 103-618, Part I)	The bill proposed a nationwide "single payer" system, in which the federal government would collect health insurance premiums and pay providers. The most far-reaching plan under consideration by any Congressional panel, the bill aimed to eliminate the need for health

[32] 1993 *CQ Almanac*, 341.
[33] 1993 *CQ Almanac*, 347.
[34] 1993 *CQ Almanac*, 347
[35] 1994 *CQ Almanac*, 338 - 339.
[36] 1994 *CQ Almanac*, 332.

	insurance companies and give control of most of the health care system to the government.[37]
LEADERSHIP MEASURES	
Senate Majority Leader Mitchell, D-Maine	Insurance costs would be subsidized for people with incomes of up to 200 percent of the federal poverty line and for pregnant women and children with incomes of up to 300 percent of the poverty line. People earning up to 100 percent of the poverty level or less would have their coverage fully subsidized. The bill would eliminate much of the Medicaid program, a strategy designed to save states $232 billion and save the federal government $387 billion over 10 years. The money was to be used to fund subsidies for the poor.[38]
Compromise Bill -- Mitchell -- Mainstream	Provide subsidies, on a sliding scale, to children and pregnant women with family incomes up to 240 percent of the federal poverty line. Subsidies also would be available for individuals and families with incomes up to 200 percent of poverty. Pay for the subsidies largely through drastic cuts in Medicaid and Medicare.[39]
Senate Mainstream Group -- Chaffee/Breaux	The plan proposed drastic cuts in Medicaid and Medicare, in part to cut the deficit and in part to provide health insurance subsidies to people with incomes of up to 200 percent of poverty. It did not give the elderly a break on prescription drug coverage or payments for long-term care. To get an agreement, the group had scaled back subsidies to help the poor.[40]
Senate Minority Leader Bob Dole	Help the poorest, insured Americans pay for insurance by providing a full subsidy for people below 100 percent of the poverty level and subsidies on a sliding scale for those between 100 percent and 150 percent of poverty. The subsidies would drop off sharply for people above poverty. The poverty level for a family of four was $14,800 per year.[41]
House Majority Leader Gephardt	Low-income families and individuals with incomes of up to 240 percent of the poverty level would receive subsidies on a sliding scale to help them pay for insurance. Full subsidies would be available for those at or below 100 percent of poverty. (The poverty line was about $14,800 for a family of four.) The federal government was to pay about $150 billion annually to subsidize the purchase of premiums for low-income people once it was fully phased in -- about the same as was then spent on the government's Medicaid program.[42]

[37] 1994 *CQ Almanac*, 326.
[38] 1994 *CQ Almanac*, 351.
[39] 1994 *CQ Almanac*, 354.
[40] 1994 *CQ Almanac*, 351.
[41] 1994 *CQ Almanac*, 340.
[42] 1994 *CQ Almanac*, 349.

STATE MANDATES AND NATIONAL HEALTH REFORM

The fact that states were to administer this portion of the national health plan showed that the Administration's New Federalism was inclusive of states. The states' role would change from overseer of Medicaid to overseeing the health insurance purchasing cooperative system in the new national health plan environment. The Clinton Administration's New Federalism had FDR and LBJ Creative Federalism characteristics. Reform-minded Democrats explicitly included states in many social policy innovations, but in this case it was for a broad-based reform. In both the FDR and LBJ eras, states were often included in means-tested initiatives. Broad based reforms, Social Security for FDR and Medicare for LBJ, were federal social insurance initiatives. The 1993-94 Clinton health plan did not follow these trends. In this broad based comprehensive coverage proposal, states were scheduled to play a major role.

Several alternate proposals, listed in Table 2, also structured states as organizing health-purchasing blocks. The design that the Task Force presented, while differing in distinct ways in many alternate bills, led to several proposals extending a role to states in the health purchasing process, as well. The idea seemed to catch on after first presented by the National Health Task Force team. One of the striking lessons of Table 2 is the level of responsibility and flexibility that all Congressional Committees and Leaders wanted to give to states. The fact that there appears, according to Table 2, to have been such consensus on the need for greater state involvement and flexibility in the health care system points possibly to why in the Medicaid program, the flexibility argument has been acted upon so strongly in subsequent years. The political will was there in 1993 -94, and even with the 2006 enactment of the Deficit Reduction Act of 2005 (DRA), we may not have seen the full fruition of this apparently very strong sentiment in Congress.

In advocating using the states to manage the health insurance purchasing pools, President Clinton offered two choices, "You either have to have a system where you get rid of insurance all together and have the Government fund it, the way Canada does, or you have to have a system of guaranteed insurance, the way Germany does and several

other countries. I advocate -- and I'll explain why later -- I think we should have a system of guaranteed private insurance with comprehensive benefits, including primary and preventive care which saves a lot of money in the long run, with no lifetime limits, and insurance that you can't lose."[43] Several states had tested various versions of health purchasing alliances in the past either on a statewide or regional basis. Some of these state directed initiatives were very successful, particularly CALPERS, the California Public Employees' Retirement System, which in 2007 covers 1.2 million active and retired state and local government public employees and their family members. It is the third largest purchaser of employee health benefits in the nation, behind the federal government and General Motors. In 1962, CALPERS first offered health benefits.[44]

While the Clinton proposal was an expanded health alliance model with mandatory employer participation, states would manage the alliances. If the Clinton Health Plan had been enacted, on the forefront were state differentials in alliance structure and management. If anything, Medicaid is an example of differential implementation in a health federalism model.

Federalism means pluralism, and, if the Clinton Plan had been enacted, the states explicit involvement meant an acceptance of differentials, variation, and state creativity and innovation in the management process. Not a unique concept to either the United States or federalist systems, countries with universal coverage systems often organize the management of health delivery with subsidiary governments -- framed by national requirements.

States' participation in the Clinton health plan embraced the importance of states from this Administration's worldview. Like FDR's and LBJ's Administrations, the Clinton Administration embraced creative federalism as well. Only in this case, this third wave of creative federalism applied to a national health reform effort with universal coverage in mind. In contrast, FDR's Social Security (OASDI) and LBJ's Medicare had

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[43] William J. Clinton, "Remarks in a Town Meeting on Health Care Reform in St. Paul, Minnesota," April 8, 1994, *Public Papers of the Presidents of the United States 1994*, Book 1 (Washington, D.C.: U.S. GPO, 1995), 646.

[44] California Public Employees' Retirement System (CALPERS) information from "General Facts" and "Health Benefit Facts" from its website at www.calpers.ca.gov, (accessed on January 25, 2007).

reserved a federally administered social insurance model for their universal coverage initiatives. The Clinton Administration had great faith in the power of federalism, and explicitly gave states responsibilities in a national universal health initiative.

Having recognized the Administration's belief in federalism, it also must be acknowledged that the Clinton Administration faced a world where both Social Security and Medicare payroll taxes existed. There seems to be a social insurance tax capacity ceiling in America, and the national health reform or long-term care insurance reform ideas that suggest social insurance financing bump up against that ceiling. Social insurance financing of broad-based programs is a non-starter in the modern social policy reform circle -- and the reason is that we have Big Bang One and Big Bang Two deducted from our paychecks. Any attempt at Big Bang Three will have to address, or work around, this reality.

Table 2: Summary of State Mandates from '93-'94 National Health Proposals

	STATE MANDATES/OPTIONS
CLINTON PLAN (HR 3600, S1757)	Require that states set up large consumer groups called "health alliances" to collect premiums, bargain with health plans and handle payments. All companies with 5,000 or fewer employees would have to buy coverage through an alliance.[45]
COMMITTEE PLANS	
Senate Finance (S2351 -- S Rept 103-323)	Permit the formation of voluntary insurance purchasing pools. If no pools formed by 1996, states would have to create one for underserved areas. Individuals could join the federal plan.[46]
Senate Labor and Human Resources (S1757)	Require states to establish at least one insurance purchasing cooperative that would provide access to community rated insurance plans. Individuals would not have to purchase insurance from the cooperative. Instead, insurance could be bought directly from an insurer or independent agent, or individuals could participate in the Federal Employees Health Benefits Plan.[47]
House Ways and Means (HR 3600 - H Rept 103 - 601)	Allow states to establish their own health insurance systems. Options open to states included instituting a Canadian-style single-payer system in which the government would replace private insurance companies. Companies with more than 5,000 employees nationally would be exempt from state insurance regulations.[48]
House Education and Labor -- Single Payer Bill (HR 3960 - H Rept 103-618, Part I)	Replace mandatory alliances with consumer purchasing cooperatives established by the states, either on a voluntary or a mandatory basis. Most of the regulatory activities that the alliances would undertake according to the Clinton bill would be given to the states.[49]
LEADERSHIP COMPROMISE MEASURES	
Senate Majority Leader Mitchel, D-Maine	Allow states to choose to put in place single-payer systems. All employers in the state regardless of size would have to participate.[50]
Compromise Bill -- Mitchell -- Mainstream	States -- Option of single-payer system and speed-up of waivers
Senate Mainstream Group -- Chaffee/Breaux	The plan proposed drastic cuts in Medicare and Medicaid to cut the deficit and to provide health insurance subsidies to people with incomes of up to 200 percent of poverty. Unlike other proposals that included Medicare cuts, the Chaffee-Breaux bill did not give the elderly a break on prescription drug coverage or payments for long-term care.[51]
House Majority Leader Gephardt	States could choose to set up a single-payer system. In states that did so, all firms would have to comply with the state single-payer system's

[45] 1994 *CQ Almanac*, 346.
[46] 1994 *CQ Almanac*, 346.
[47] 1994 *CQ Almanac*, 346.
[48] 1994 *CQ Almanac*, 332.
[49] 1994 *CQ Almanac*, 346.
[50] 1994 *CQ Almanac*, 351.
[51] 1994 *CQ Almanac*, 351.

	rules. In states without single-payer plans, multi-state firms could remain exempt from statewide insurance rules.[52]

REASONS CLINTON HEALTH SECURITY ACT WAS NOT ENACTED

While there are whole treatises on the topic of why the Clinton Health Plan was not enacted, a few of the major reasons are outlined here.[53] First, the reform -- regardless of the commitment and desire for change -- was not prioritized on the presidential agenda. NAFTA, The Crime Bill, Budget Reconciliation, and several other measures placed health reform as fifth or sixth or lower on the Presidential priorities. This was not the HR1, SI, Priority Number One strategy that resulted in the creation of Medicaid and Medicare in the LBJ era. Second, the Health Security Act was drafted by a Task Force and delivered to Congress without adequate inclusion of the legislative branch during development of the massive proposal. Third, the gargantuan bill was made available so far in advance that it assisted opponents in dissecting it -- and they did. As one staffer said, "You don't make things available like seven weeks ahead of time…That hurt their chances of being successful."[54] Fourth, several influential decision makers have since concluded that including the comprehensive initiative in the Budget Reconciliation process would have increased the chances of passage given the differences in rules and debate.[55]

Fifth, the plan was notoriously complex, meaning that no one understood it -- making it more difficult for members of Congress to support or the public to embrace. Sixth, as mentioned earlier, Health Security Act supporters, as well as many ideologically

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[52] 1994 *CQ Almanac*, 349.
[53] For comprehensive or partial political science reviews of the Clinton Health Plan debate, see *Boomerang: Health Care Reform and The Turn Against Government* by Theda Skocpol, *The System:The American Way of Politics at the Breaking Point* by Haynes Johnson and David S. Broder, *The Road to Nowhere: The Genesis of President Clinton's Plan for Health Security* by Jacob Hacker, *Governing Health: The Politics of Health Policy* (Second Edition) by Carol and William Weissert, and *Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Britain, and Canada* by Carolyn Hughes Tuohy.
[54] Interview with Author, October 13, 2006.
[55] Interview with Author, October 12, 2006. Former Senate Majority Leader Tom Daschle (D-SD) reportedly has supported the idea that the Clinton health reform effort's probability of passing was much greater in a budget reconciliation process.

left members of Congress who had their own bills, continued to insist on full coverage. They were not willing to negotiate on this pivotal point, even if it meant success. Seventh, the opposition -- particularly the Health Insurance Association of America (HIAA) did a masterful job in media relations against the plan. The advertisements with a fictional couple warning to keep the government out of their Medicare program was genius.

CONCLUSION: THE 1994 ELECTION, A NATIONAL REFERENDUM ON HEALTH REFORM? INTRODUCING THE MEDICAID BLOCK GRANT ERA

While the specifics of the national health reform debate did not make or break the 1994 Congressional election, the fallout was a contributing factor, along with tax increases, of a political threshold overload that turned voters against Democrats. As one Republican Hill Staffer recalled, "So [health reform] was a really missed opportunity….and then we had the elections…and that was a total shock to everyone, particularly Republicans."[56] The House of Representatives moved to Republican control after a forty-year draught and the United States Senate moved to Republican leadership after eight years of Democratic control. The subsequent historic shift in the United States Congress was adorned with symbolism. Its manifesto -- the Contract With America -- did not specifically address Medicaid reform, but it did address Welfare reform and Unfunded Mandates to States -- important co-evolutionary and interconnecting policy streams to the Medicaid program. Its General, Newt Gingrich, would wield power unusual to a House Speaker and, in fact, was strong enough to counteract the power of the President.

According to Elizabeth Drew's *Showdown: The Struggle Between the Gingrich Congress and the Clinton White House*, this movement against "big, intrusive government" began in the late 1960s as a reaction to LBJ's Great Society and other forms

[56] Interview with Author, October 13, 2006.

of "social engineering."[57] As Drew writes, "Some said that the 'revolution' Gingrich espoused began in 1964, when the Goldwaterites -- the outsiders -- took over the Republican Party. The next such victory came with Reagan, who also stood apart from the party's establishment; the Goldwaterites expanded and elected Reagan. Gingrich, as it happened, had now become the torch-bearer for the Goldwater-Reagan revolution."[58] With Rep. Newt Gingrich at the helm, Medicaid was slated for block granting. After the national health discussion, the subsequent election opened the door to an era of block grant debates never witnessed before in the Medicaid program. The next chapter will review how these debates and the subsequent 1997 Balanced Budget Act (BBA) were strongly shaped -- sometimes unintentionally -- from the national Clinton Health Security Act discussion.

[57] Elizabeth Drew, *Showdown: The Struggle Between the Gingrich Congress and the Clinton White House* (New York, NY: Touchstone, 1996), 24. (Hereafter Drew, *Showdown)*
[58] Drew, *Showdown*, 24.

10. MEDICAID BLOCK GRANT ERA, WELFARE REFORM, AND THE 1997 BBA: NATIONAL HEALTH REFORM LEAVES ITS STAMP

INTRODUCTION

Two major efforts to block grant Medicaid, one in the FY1996 Budget Reconciliation process, and another in concert with the block grant of cash welfare in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, immediately followed the 1993-94 national health reform debate era. Lines in the sand were drawn and the ideas vetted -- in combination with the history of the national health discussion -- resulted in The Balanced Budget Act (BBA) of 1997. For Medicaid policy bargaining, there was no escaping the macro environment. Newly installed Speaker of the House Newt Gingrich relished Republicans first control of the House of Representatives in forty years.

Speaker Gingrich is quoted as describing his place in history this way, "The coalition Nixon put together in 1972 was ninety-five percent identical with the coalition Reagan put together in '84. It's ninety-five percent identical with the combined Bush/Perot vote of '92. So, you've had this sort of anti-Great Society majority which has not been able to translate into Washington the policies of its politics -- if that makes sense. And what I have tried to do over the last twenty years is think through what are the necessary steps to actually translate the political majority of 1972 into an effective

working majority inside Washington. And what you're watching is the first act of doing that. Part of that is to transfer power back to the states and to local governments and back to families. And back to nonprofit organizations. And this is all a very deliberate strategy that says that the Great Society over centralized and it's not sustainable."[1] By the time the Gingrich era came to a close, his emphasis was identified more as wanting to limit government altogether than devolution of power to the states. While block granting Medicaid was not a part of the Contract with America, it was part of House Republican plans to dismantle the Great Society. Enacted in 1965, it was another Great Society program, similarly structured to the soon-to-be block granted AFDC program. Medicaid's escalating costs were a frustration to both federal and state officials.

As for policy bargaining, the era began with scorched earth tactics by a hungry group of Republican Freshman House members and ended with far more conciliatory conflict negotiation that resulted in the historic BBA 1997. At the beginning of the era, in an old fashioned game of Southern chicken, President Clinton and Republican House members would neither swerve, resulting in two government shutdowns and measures to ensure the federal government did not default on its national debt. This chapter reviews the Medicaid policy bargaining between the federal government and the states during this next step after comprehensive health reform negotiations. Needing a change, voters shifted power to Republicans in Congress and the modern era took a conservative ideological twist.

MEDICAID BLOCK GRANT ATTEMPTS, PRESIDENTIAL PRINCIPLED STAND, AND CO-EVOLUTIONARY WELFARE POLITICS

The 1995-1996 Block Grant Debate was a whirlwind of policy activity. Wrapped with the budget reconciliation process and also with welfare reform, the initiative was met by a Presidential principled stand, a veto that was the first of its kind in a Budget Reconciliation process. By all accounts, President Clinton wanted to protect the Medicaid entitlement, in addition to several other initiatives --Medicare, Education, the

[1] Drew, *Showdown*, 27.

Environment -- that were threatened in the FY 1996 Budget Reconciliation process. Most policy brokers believe a principled stand was made by the President in vetoing the FY1996 Budget Reconciliation Bill -- in part for protecting Medicaid beneficiary private rights of action -- and not a political maneuver. The legislation scheduled to reform the open matching grant structure of Medicaid to a capped funding structure to states, thus maintaining the state entitlement but not the individual beneficiary entitlement, enforceable by the federal courts. Many interviewees who met with the President directly on the issue report that the President "got it" when it came to the "no right without remedy" language of Medicaid's individual entitlement.[2] The National Governors Association (NGA), requiring consensus, did not back the block grant effort. States wanted flexibility but the threat of reduced federal funding was not assuaged. As Texas' Director of Health and Human Services put it, "Our worst fear is a block grant with all the rules, a capped entitlement that says, "Do it this way and do it with less money."[3]

Significant Waivers Set up the Modern Medicaid Block Grant Debate

Some analysts looking back on the Clinton era, dubbed him the "Waiver President." When Clinton took office, only Arizona had a statewide 1115 waiver; when he left office, 18 states had such waivers. When Clinton took office, 50 1915b (freedom of choice) waivers were in effect; when he left office, 100 such waivers were in effect.[4] This increased the bargaining opportunities in the program generally, but also embraced the state flexibility argument. As the Oregon and Tennessee 1115 waivers predated the following year's block grant debate, the idea of liberalizing the process of state directed health reform via Medicaid waivers introduced important concepts that some Republicans used to bolster their push for an aggregate cap on the program. Democrats and Republicans both, in embracing waivers which required a budget neutrality cap, moved

[2] Interviews with Author: August 10, August 23, August 24, October 12, and November 6. All interviews were conducted in 2006.
[3] Kent R. Weaver, "Deficits and Devolution in the 104th Congress," *Publius: The Journal of Federalism* 26, no. 3 (Summer 1996), 66.
[4] Gormley, "An Evolutionary Approach," 20.

toward acquiesance that some stemming of Medicaid's run on the treasury needed revision.

Embracing state flexibility, HCFA Administrator Bruce Vladeck testified before the House Energy and Commerce Committee, "The fact is that AHCCCS is a success, the Oregon program is a success, and TennCare is a success. Nothing that important and that good comes automatically."[5] Tennessee Finance Commissioner Bob Corker added regarding the 1995-1996 Medicaid block grant debate, "Tennessee legislators have great empathy for some of the decisions you're getting ready to make, because about 18 months ago, they were faced with some of the same decisions. And they made the decision that they could no longer afford the status quo, asking ourselves many of the questions that, frankly, you're going to be forced to answer during this debate…..We are close to universal coverage in Tennessee, with 95 percent of all Tennesseans having health care insurance today…The best means of accomplishing this flexibility is through a Medicaid block grant."[6] The progression of the 1115 waiver process was used by some to advocate for an aggregate cap of the entire program.

Medigrant -- The Republican Block Grant Attempt In the FY 1996 Budget Reconciliation Process

As part of the Fiscal Year 1996 Budget Reconciliation process, the Budget called for $187 billion in Medicaid savings over seven years.[7] When receiving the news from the Budget Committee, one Energy and Commerce staffer recalled, "Then we roll into next year and the Budget Committees come to us and say, ok we need $270 out of Medicare and $187 out of Medicaid, over seven…and we are looking at the Budget

[5] Bruce Vladeck, HCFA Administrator, Committee on Commerce House of Representatives, Subcommittee on Health and Environment of the Committee on Commerce House of Representatives, One Hundred Fourth Congress, First Session, July 26, Serial No. 104-108, *Transformation of the Medicaid Program -- Part 3*, 42.
[6] Bob Corker Statement, Commissioner, Department of Finance and Administration, Tennessee, Committee on Commerce House of Representatives, Subcommittee on Health and Environment of the Committee on Commerce House of Representatives, One Hundred Fourth Congress, First Session, July 26, Serial No. 104-108, *Transformation of the Medicaid Program -- Part 3*, 64-66.
[7] 1995 *CQ Almanac*, 2-22.

Committee staff and we are even looking at John Kasich, the Chairman, and when we first heard the numbers, we said, well should we just quit? Because no one has every seen a number in Medicaid more than chump change."[8]

The only way Republican staffers could reduce the program by a number that large was by limiting state allocations. When asked whether the decision to design a block grant was ideological or budget driven, the response was, "Budget driven -- 100%, 100%, 100%."[9] At the same time though, Governors were torn regarding whether to block grant the program. The NGA requires consensus in order to support a legislative proposal and so did not formally embrace the block grant concept. At the same time, it is reported, "Governors across the board were like leave the money at the train station, we know how to spend it."[10] In general, Governors continued to clamor for greater state flexibility with Congressional and Gubernatorial Democrats mostly not supporting the proposal given the removal of the individual entitlement to the program.

A Medicaid task force of Republican Governors, some from high per capita and some from low per capita states, was assembled. The goal was to arrive at a block grant formula distribution for the Medicaid program that would significantly increase state flexibility while disadvantaging as few of the states as possible from their current position. The wranglings over the distributional formula were sources of tension for many Governors and their staffs, who wanted to be sure that their state were in no way disadvantaged over the seven years from where they would have been in the old program. One impediment to the block grants passage, more than forty percent of the projected Medicaid savings from the GOP block grant proposal would have come from California, Florida, New York, North Carolina, Ohio, and Texas.[11] Most reform has policy winners and losers and the proposed GOP block grant formula disadvantaged some politically powerful states.

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[8] Interview with Author, October 13, 2006.
[9] Interview with Author, October 13, 2006.
[10] Interview with Author, October 13, 2006.
[11] Marilyn Werber Serafini, "Medicaid and Medicare: Within Reach" *National Journal* 27, no. 38 (September 23, 1995), 2338.

In retrospect a High Ranking Administration official summarized the block grant dilemma this way, "In AFDC, every Governor, Republican or Democrat, want[ed] a block grant."[12] But when it came to state opposition to the Medicaid block grant included in the FY 1996 Budget Reconciliation package, states were leery "because they were going to get less money. The states want block grants but they want more money along with it. If block grants are a strategy to give them less money, they don't want them. If they do not get the growth factor built in, they are going to oppose it. The Republicans have used the block grant as an argument for containing costs. The Democrats are opposed to it because they thought it would weaken the quality of the program, and the breadth of the program." [13]

As a counter to the Republican blueprint, the President's team was pulled further to the ideological right than it had ever gone on Medicaid restructuring, agreeing to a per capita cap on the program that maintained the individual entitlement to the program.[14] A function of policy bargaining, the ideological right went ahead with its insistence for an aggregated block grant. This established a very important distinction for future Medicaid policy bargaining within waiver negotiations-- the aggregate block grant concept versus the per capita cap. Although not an oft-repeated legislative proposal, the per capita cap concept, in various forms, has been applied and negotiated in various waiver negotiations since this distinction in the 1995-1996 block grant debate. In statutory debates, it appeared again during the Clinton era, in a second block grant attempt that Republicans attempted to wrap into welfare reform. GOP moderates like Senator John Chafee (R-RI) also proposed a per capita block grant that would offer a fixed amount of federal spending per beneficiary, showing some support across the aisle for this concept.[15] According to Republican staffers, Democratic policy officials went to great lengths not to refer to the per capita cap as a block grant. The maintenance of the individual

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[12] Interview with Author, November 6, 2006.
[13] Interview with Author, November 6, 2006.
[14] 1995 *CQ Almanac*, 2 -28.
[15] Marilyn Werber Serafini, "A Senate Barrier to Medicaid Block Grants," *National Journal* 27, no.37 (September 16, 1995), 2276.

entitlement, of course, was a key distinction for Democrats.[16] Under a per capita cap, states would receive more federal dollars for more people but other cost growth factors were fixed.

On November 20, 1995 the Budget Reconciliation Bill passed Congress. This included the plan to revamp Medicaid, thus saving $163 billion over 7 years.[17] A Republican staffer says of the period, "And we knew, there was no way that this was ever going to get signed into law. We as health staff just couldn't believe that the Clinton Administration would ever sign something that was taking $270 billion out of Medicare and basically abolishing Medicaid."[18] Add onto this the impending block granting of the cash welfare program, AFDC, with roots back to the New Deal and the highly increased use of the 1115 waiver process -- and it was framed so that the American welfare state reforms would roll back substantial parts of the Great Society and New Deal.

Republicans, rather than relenting on the Medicaid provisions, stepped up the pressure. As the *Congressional Quarterly* reported, "They threatened to let the government default on its debt unless he capitulated to their reconciliation package. And they made the continuing operation of most federal departments contingent on Clinton agreeing to balance the budget in seven years, using Congress' more conservative economic assumptions." The President called the GOP bluff on December 6, 1995 when he vetoed the FY 1996 Budget Reconciliation Bill (HR 2491).

On December 16, 1995 in *Remarks on the Budget*, the President pointed the finger across the ideological aisle, "As all of you know, yesterday the Republican congressional leaders called the negotiations off unless we would first put much bigger Medicare and Medicaid cuts on the table. I thought that was wrong and unwarranted….We don't believe that decimating Medicare and Medicaid and undermining our investments in education and the environment, raising taxes on working families is a good prescription for America's future. And it is not necessary to balance the budget."[19]

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[16] Interview with Author, October 13, 2006.
[17] 1996 *CQ Almanac*, 6-4.
[18] Interview with Author, October 13, 2006.
[19] William J. Clinton, "Remarks on the Budget," December 16, 1995, *Public Papers of the Presidents of the United States 1995*, Book II (Washington, D.C.: U.S. GPO, 1996), 1896.

Most policy brokers believe this was a principled stand by the President and not a political maneuver. Most do not believe it concentrated only on Medicaid, but, indeed, the President "got it" when it came to the "no right without remedy" language of Medicaid's individual entitlement.[20] In a campaign speech in Michigan, the President made it clear that Medicaid was a distinct portion of his decision making on the historic veto and pair of government shutdowns. As he told a Michigan crowd during the 1996 Presidential Campaign, "Christopher Reeve came to see me in the White House, and he said, 'Mr. President, I am so glad you fought to stop Congress from destroying the Medicaid program and ending its guarantee to the elderly in nursing homes, to poor children, and to people who have disabilities, because not everybody who gets a disability is a wealthy person. And even wealthy people can be driven into poverty. And if it weren't for Medicaid, middle class families wouldn't be able to maintain their lifestyles. That's a part of our community.'"[21] The two government shutdowns and sequence of continuing resolutions so that the federal government would not default on the federal debt were dramatic. Amid the scuffle, Republican Senate Budget Committee Chair Pete Domenici (N. Mex.) warned that any attempt to keep full entitlement status for Medicaid would be a "deal breaker."[22]

Sticking with principles rather than compromise in order to reach a negotiated deal, the Administration stood firm on each and every threat as continuing resolutions expired, federal workers remained idle, and the nation watched. The scorched earth, my way or the highway, negotiating style of the Republican House freshman did not gain them budget reconciliation success. Medicaid was not block granted during this effort -- and the tough make my day antics left the nation worse off, stuck in political rancor, and without a balanced budget. The public largely blamed Republicans for the vicious partisan environment. On January 9, 1996 the President also vetoed a stand alone welfare reform bill, setting up the opportunity for Republicans to attempt another Medicaid block

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[20] Interviews with Author: August 10, 2006; August 24, 2006, November 6, 2006.
[21] William J. Clinton, "Remarks in Kalamazoo, Michigan," August 28, 1996, The American Presidency Project, http://www.presidency.ucsb.edu/ws/print.php?pid=53248 (accessed on September 20, 2006).
[22] 1995 *CQ Almanac*, 2-62.

grant attempt wrapped up in the welfare debate, a reform the President was publicly dedicated to seeing through.

Second Medicaid Block Grant Proposal Wrapped Into Welfare Reform

In his January 23, 1996 State of Union Address, President Clinton challenged Congress to pass a bipartisan welfare plan. In doing so, he was following through on a 1992 election pledge to "change welfare as we know it." Republicans and Governors had in mind changing Medicaid, as well. On February 6, 1996, the nation's Governors endorsed a plan to overhaul welfare and Medicaid in the same reform package.[23] For Medicaid, the myriad of NGA reform ideas did not include a federal aggregate cap but did include an increase in federal financial participation (increase in the FMAP floor from 50% to 60%).[24] While not a block grant, the proposal would remove the beneficiaries' federal right of action, replacing it with a state-centered approach and only one point of access to federal courts -- the U.S. Supreme Court.[25]

Secretary of Health Donna Shalala in a Senate Finance Committee hearing expressed concern with the NGA proposal: "But, while we recognize that the NGA plan is still a work-in-progress, we are concerned that some of its central elements fail to reflect the priorities articulated in the President's Medicaid plan. These are the need for a real, enforceable Federal guarantee of coverage to a Congressionally-defined benefit package, appropriate Federal and State financing, and quality standards, beneficiary protections, and accountability."[26] Another primary point of contention was the NGA

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[23] 1996 *CQ Almanac*, 6-3.
[24] NGA plan according to the U.S. Senate, Committee on the Budget, *Personal Responsibility, Work Opportunity, and Medicaid Restructuring Act of 1996*, 104th Congress, 2nd Session, S. Prt. 104-59, Committee Recommendations As Submitted To the Budget Committee on the Budget Pursuant to H. Con. Res. 178, July 1996, "Medicaid Reform Reconciliation Provisions Summary," (Washington, D.C.: GPO, 1996), 8.
[25] U.S. Senate, Hearings Before the Committee on Finance, One Hundred Fourth Congress, Second Session on the National Governors' Association Policy on Welfare Reform and Medicaid (With Administration and Public Views), Statement of Hon. Donna E. Shalala, Secretary of Health and Human Services, Wednesday, February 28, 1996, 56.
[26] U.S. Senate, Hearings Before the Committee on Finance, One Hundred Fourth Congress, Second Session on the National Governors' Association Policy on Welfare Reform and Medicaid (With Administration and

plan to repeal Medicaid and create a new Title in the Social Security Act: "By repealing Title XIX and creating a new title for the Medicaid program we believe that the NGA resolution could seriously compromise the framework for quality standards for beneficiary and family financial protections, and for program accountability….In conclusion, we believe that we must reform, not repeal, Medicaid. The NGA resolution has made significant contributions to our collective efforts to do just that."[27]

While the Administration was concerned with the NGA proposal, the hearing language made it clear that they were not completely adverse to the proposal. By the time Energy and Commerce designed a bill that included another initiative to block grant Medicaid, the legislation was different enough from the NGA proposal -- and from the Administration's own reform ideas, to instigate a direct veto threat from the Secretary during hearings.[28] "The President has also made clear that the current strategy of the majority in Congress to link welfare reform to unacceptable changes in Medicaid will leave him no choice but to veto the entire package. We call on Congress and on its leaders to abandon this 'poison pill' strategy that is designed to provoke a veto."[29] Secretary Shalala left no confusion, "Let me be very clear. If the current legislation is sent to the President's desk, I would recommend that he veto that legislation and send it back to Congress. But it is my hope that the Congress will instead choose to seek a truly bipartisan approach to Medicaid reform that is consistent with the principles the President has stated."[30]

Public Views), Statement of Hon. Donna E. Shalala, Secretary of Health and Human Services, Wednesday, February 28, 1996, 55.

[27] U.S. Senate, Hearings Before the Committee on Finance, One Hundred Fourth Congress, Second Session on the National Governors' Association Policy on Welfare Reform and Medicaid (With Administration and Public Views), Statement of Hon. Donna E. Shalala, Secretary of Health and Human Services, Wednesday, February 28, 1996, 55 - 57

[28] U.S. House of Representatives, Committee on Commerce, One Hundred Fourth Congress, Second Session on H.R. 3507, "The Personal Responsibility and Work Opportunity Act of 1996," Serial No. 104-102; Statement of Hon. Donna E. Shalala, Secretary, Department of Health and Human Services, June 11, 1996; (Washington, D.C: GPO.,1996), 34

[29] U.S. House of Representatives, Committee on Commerce, One Hundred Fourth Congress, Second Session on H.R. 3507, "The Personal Responsibility and Work Opportunity Act of 1996," Serial No. 104-102; Statement of Hon. Donna E. Shalala, Secretary, Department of Health and Human Services, June 11, 1996; (Washington, D.C: GPO.,1996), 32.

[30] U.S. House of Representatives, Committee on Commerce, One Hundred Fourth Congress, Second Session on H.R. 3507, "The Personal Responsibility and Work Opportunity Act of 1996," Serial No. 104-

The counter-proposal to the GOP strategy presented by the Administration during the House hearings repeated the counter-proposal of a per capita cap (presented as a counterproposal to the previous year's block grant negotiations) and also included reductions in DSH spending to help balance the budget, repeal of the Boren Amendment to provide greater financing flexibility to states, easier waiver procedures, and significant changes in Medicaid managed care requirements.[31] Although the joint welfare-Medicaid reform would not happen, several of these provisions -- now that the Administration was on record in support -- would be effectuated in the near future's BBA 1997 Medicaid reforms.

In terms of policy bargaining, the NGA proposal was held up as a model against the House plans for reform. By the time the House had a proposal of its own on the table, the Administration used an unfavorable comparison to the NGA proposal to bat down the Congressional version, "In February, the National Governors Association issued a bipartisan proposal for Medicaid reform that held significant promise. Last month, Chairman Bliley, Mr. Bilirakis and others, introduced a new Medicaid bill that I will discuss today. Sadly, these new proposals in Congress move away from the bipartisan approach to Medicaid reform envisioned by the Governors….As a result, four leading Democratic Governors have written to Senator Roth saying in part, 'The Republican Medicaid proposal is far from the NGA agreement and appears to be more like the proposal vetoed by the President last year and rejected by the Governors at our winter meeting.' It appears then that we are back on the same track we traveled last year."[32]

In July 1996, after insisting that they would not move a welfare overhaul bill without Medicaid reform provisions, GOP leaders decided to drop the Medicaid

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102; Statement of Hon. Donna E. Shalala, Secretary, Department of Health and Human Services, June 11, 1996; (Washington, D.C: GPO.,1996), 34

[31] U.S. House of Representatives, Committee on Commerce, One Hundred Fourth Congress, Second Session on H.R. 3507, "The Personal Responsibility and Work Opportunity Act of 1996," Serial No. 104-102; Prepared Statement of Hon. Donna E. Shalala, Secretary, Department of Health and Human Services, June 11, 1996 (Washington, D.C.: U.S. GPO, 1996), 37.

[32] U.S. House of Representatives, Committee on Commerce, One Hundred Fourth Congress, Second Session on H.R. 3507, "The Personal Responsibility and Work Opportunity Act of 1996," Serial No. 104-102; Statement of Hon. Donna E. Shalala, Secretary, Department of Health and Human Services, June 11, 1996 (Washington, D.C.: U.S. GPO, 1996), 33-34.

proposals which called for ending the federal guarantee of health insurance to the poor and replacing it with block grants to the states.[33] On July 18, 1996, the House effectively eliminated the Medicaid reform provisions when it adopted the rule for floor consideration of the welfare bill (HR 3734). The same day, the Senate agreed by voice vote to an amendment by Senate Majority Leader Trent Lott, R-Miss., that deleted the Medicaid provisions from the Senate version of the welfare reform bill (S1956).[34] As one Energy and Commerce staffer recounted, "by the time we went through the second time, it was much more of an intellectual exercise than the first time through. [There was] much less tension… We were dropped before it was dropped to the floor….and that ended that."[35] By dropping the Medicaid portion, the door was opened to welfare reform. Pushed well beyond the Administration's hoped for bargaining position on welfare reform, the intense initial hold on Medicaid left little bargaining power on the part of Democrats once Republicans loosened their grip on the Medicaid block grant. Forced to take a far more conservative welfare bill than he wanted, President Clinton signed the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.[36]

A symbolic shift was indicated by this block grant attempt era, in that Medicaid became a program that the President himself would protect -- even with stark consequences. While not the full reason for the FY 1996 budget reconciliation veto, Medicaid's private rights of action were protected by the principled stand by President Clinton -- even though two government shutdowns resulted. In this most recent joint welfare-Medicaid block grant attempt, again the Administration threatened veto. This time the second term election was on the horizon and the Administration threatened to veto welfare legislation it had promised to see through Congress in its initial election campaign -- all in order to protect Medicaid.

As one policy expert onlooker said: "And I can remember being at home and watching C-SPAN and having, I've forgotten who the Press Secretary was by that time --

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[33] 1996 *CQ Almanac*, 1-13.
[34] 1996 *CQ Almanac*, 1-13.
[35] Interview with Author, October 13, 2006.
[36] For an excellent review of this policy bargaining phenomenon during welfare reform, see R. Kent Weaver, *Ending Welfare As We Know It* (Washington, D.C.: The Brookings Institution, 2000) .

maybe Joe Lockhart. I can remember hearing the question, 'So, what's the difference between Medicaid and welfare, aren't you going to end the entitlement for Medicaid. If you are doing it on welfare, why not on Medicaid?' And I am sitting there in my TV room, thinking, 'that is one helluva good question.' And the answer from the Press Secretary was, 'Because people love Medicaid.' And I thought, '…. the guy misread his talking points. You know, people love Medicare; nobody loves Medicaid.' And then I realized in the next day or two, this was not a mistake. [37] A symbolic shift was happening in Medicaid policy. It was becoming a program worth protection and principled stands -- against great odds.

THE BALANCED BUDGET ACT (BBA) OF 1997

The Balanced Budget Act (BBA) of 1997 was a major punctuation in American social policy.[38] Possibly the pinnacle of budget reconciliation maneuvers to that point, it centered largely on changes to Medicare, Medicaid, restoration of welfare benefits to disabled legal immigrants, and entitlement reform. It was the cuts to Medicare that were the starkest. As a senior official said, "We took huge cuts out of Medicare during the Balanced Budget Act (BBA) and protected Medicaid."[39] Not only did the legislation create a wake going back to the Great Society, it was also seen -- in conjunction with the Taxpayer Relief Act of 1997 (HR 2014 – PL 105-34) which provided historic tax cuts-- as perhaps President Clinton's greatest legislative achievements.[40] This subsection will first present an general overview, then outline the major changes in the Medicaid program, and, finally, review how these Medicaid BBA changes were shaped by many of the arguments from national health reform and block grant debates. In many respects, the legacy of the national conversations from 1992 through 1996, first on universal coverage options and then on block granting Medicaid, set the table for the BBA. Conversely, the

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[37] Interview with Author, August 10, 2006.
[38] For an overall review of the passage of the Balanced Budget Act (BBA) of 1997, see Daniel J. Palazzolo, *Done Deal? The Politics of the 1997 Budget Agreement* (New York: Chatham House Publishers, 1999).
[39] Interview with Author, November 6, 2006.
[40] 1997 *CQ Almanac*, 2-27.

BBA would establish a new norm in Medicaid policy, and, in fact, created a new title in the Social Security Act -- the State Children's Health Insurance Program (Title XXI).

Overview of the Historic Legislation

Following the FY1996 budget debacle, a new era of compromise and consensus created the environment for what some have termed the most far reaching social policy legislation since the 1965 enactment of Medicaid and Medicare. In comparing the environment just one year before in the Reconciliation process that resulted in the government shutdowns, one key budget negotiator involved in the policy bargaining relayed: "There was a big difference which was the Reconciliation Bills that triggered to government shutdown in 1996 were written by Republicans for Republicans and simply presented to President Clinton for signature. 1997 was profoundly different because it was designed to be bipartisan…and it was … The President and his team -- Democrats and Republicans together. Unfortunately, that's the last time it's happened."[41]

All in all, the balanced budget was the sum of the 1990, 1993, and 1997 budget deals, along with a strong economy. The 1990 package was worth about $593 billion; the 1993 deal was worth about $487 billion. By contrast, the 1997 agreement was expected to save only about $204 billion over five years.[42] Assisting these budget cuts, the economy had strengthened considerably, leading to the joke that President Clinton and the Republican Congress should seal their deal before the budget balanced itself.

The mood was historic. The federal budget had not been in balance since 1969 and this level of tax cuts had not been seen since Ronald Reagan's early years in office. House Speaker New Gingrich (R-GA) was effusive, "We're going to do everything we can to get the two bills signed by the president."[43] A Democratic policybroker who helped negotiate the deal summarized: "Sure. It was an interesting process. It was really a challenge. I remember President Clinton called together the four principal budget

[41] Interview with Author, August 15, 2006.
[42] 1997 *CQ Almanac*, 2-20.
[43] 1997 *CQ Almanac*, 2-27.

leaders and met with them and said that he would like them, with his team, to come to a budget…a five year or seven year budget that got to balance, and so we met repeatedly….repeatedly….on and on and on and both at the staff level and at the principal level. After a long period of time, we were able to hammer out an agreement get to balance and it included lots of different programs ….from Medicare to Medicaid to Food Stamps…We didn't like everything that was in there but we thought overall it was better than not… it did balance the budget. It was an ordeal getting it through Congress. First, we had to pass a budget resolution and then we had to pass a Reconciliation Bill that the President would sign. And, there were lots of stop and gos before it was finally enacted. It was very contentious. But, in the end, it worked."[44]

Major Medicaid Provisions of the Balanced Budget Act of 1997 (BBA)

Of the several dozen major Medicaid provisions of the Balanced Budget Act (BBA), a few are of particular note for policy bargaining in Medicaid Federalism. Certainly the creation of SSA Title XXI, the State Children's Health Insurance Program (SCHIP) would fulfill a four decade quest for a separate program to address health financing of children who were too well off to qualify for Medicaid but still uninsured. Second, mandatory Medicaid managed care no longer required a waiver for many populations. Third, the 75/25 rule was repealed, meaning that participating managed care plans were no longer required to have no more than 75% of enrollees in Medicaid and Medicare. The repealed provision had attempted to ensure that Medicaid and Medicare beneficiaries were mixed in plans with at least 25% of private enrollees. Fourth, the Boren Amendment was repealed after a decade and a half of setting a minimum standard for states to reimburse providers. Further restrictions to DSH were also included, placing specific caps on state DSH allotments. DSH is typically described by experts as a block grant or revenue sharing arrangement, whereby the federal government compensates hospitals for providing uncompensated care.

[44] Interview with Author, August 15, 2006.

Table 3: Select Major Provisions of the Balanced Budget Act of 1997 (BBA)[45]
--Creation of the State Children's Health Insurance Program (SCHIP)
--In 1997, CBO estimated federal savings of $13 Billion over 5 years from reductions in Medicaid spending under the Balanced Budget Act.
--**Eligibility**, BBA adds new state eligibility options for children and disabled persons; expands premium assistance for low-income Medicare beneficiaries; and restores Medicaid coverage to children and immigrants who lost SSI benefits as a result of the 1996 welfare reform legislation.
--**Benefits,** Adds a new PCCM benefit option and liberalizes eligibility requirements for Medicaid assistance under home- and community-based care waivers.
--**Cost Sharing**, the new law permits states to impose cost sharing on beneficiaries enrolled in managed care organizations to the same extent as is permitted in the fee-for-service program.
--**Provider Reimbursement and Participation**, Most of the reductions in federal Medicaid spending are achieved through reductions in provider payments, the most significant of which are targeted to disproportionate share hospitals. Boren Amendment repealed. Phases out cost-based reimbursement for FQHCs and RHCs. Also allows states to pay Medicare providers the Medicaid reimbursement rate for services provided to Qualified Medicare Beneficiaries and dual eligibles
--**Managed Care**
Permits states to require most Medicaid beneficiaries to enroll in a managed care organization without first obtaining waiver approval from HCFA.
Permits the establishment of Medicaid-only plans without Secretarial approval by eliminating the existing 75/25 Medicare-Medicaid/private coverage composition requirement. Increases to $1 million the threshold for prior federal approval of managed care contracts.
Establishes certain new managed care consumer protections but exempts Section 1915 and Section 1115 waiver states from its new requirements.
--**Long-Term Care** --Establishes an optional program, Program of All Inclusive Care for the Elderly (PACE), for duals who are 55 years of age or older, require nursing facility-level care, reside in the PACE program service area, and meet other applicable conditions of eligibility permitted under the program.
--**DSH** --The law places additional caps on state DSH allotments, beginning FY 1998, with the specific amount established per state until FY 2002; thereafter, the allotment is increased by CPI.

[45] For an in depth review, see Sara Rosenbaum and Julie Darnell, "A Comparison of the Medicaid Provisions in the Balanced Budget Act of 1997 (P.L. 105-33) with Prior Law," Center for Health Policy Research, The George Washington University Medical Center for the Kaiser Commission on the Future of Medicaid, October 1997.

The Evolution and Design of the Medicaid BBA Reforms

The Medicaid reform provisions enacted in the BBA were mostly rehashed from previous debates. Some of those had been debated, re-debated, and re-re debated for decades. The enactment of the State Children's Health Insurance (SCHIP) program is just one example of this. Wilbur Cohen in 1968 had generated idea papers around a social insurance program to cover kids not covered by Medicaid. After several proposals throughout the years to create such an initiative, enactment came in the BBA of 1997. The policy lesson from this is that over the years if a reform idea is presented enough times, it will become law eventually. Policy actors want to be the ones at the helm designing the delivery and financing mechanisms when the actual reform does take hold because once in place institutional rules are much more difficult to change later.

Among the items dropped before the deal was announced May 2 was a resurrected per capita cap proposition on Medicaid spending that had infuriated liberal Democrats and Governors of both parties.[46] The per capita cap idea was rehashed after being negotiated originally as part of the failed Medicaid block grant attempt in the botched FY 1996 budget reconciliation bargaining process and later again in the Republican joint Medicaid/welfare rework. During the negotiations, the National Governors Association issued a letter, signed by 39 Governors that began this way, "Dear Mr. President: As budget discussions continue to move forward, we wanted to reiterate our concerns regarding the role of Medicaid in a deficit reduction package. No single decision made in the context of balancing the budget will be of greater importance to states than the treatment of the Medicaid program." Later in the letter they expressed a primary concern, "We adamantly oppose a cap on federal Medicaid spending in any form."[47]

As a high-ranking official noted, "That [the per capita cap proposal] was all about politics. We wouldn't have come up with that as anything but a counterproposal."[48] This

[46] 1997 *CQ Almanac*, 2-20.
[47] National Governor's Association letter to The Honorable William J. Clinton, April 14, 1997.
[48] Interview with Author, November 6, 2006.

was a policy bargaining case of one side of the debate having enough political sway that they were able to pull the other side to a policy proposal they would not have arrived at otherwise. Several books have reviewed the basis of this phenomenon, from 1994 to 1996, when House Freshman led by House Leader Newt Gingrich rivaled the power of the Executive branch so effectively.[49]

The new legislation first made it possible for states to enroll beneficiaries in managed care plans on a mandatory basis without a waiver, and second repealed the 75/25 requirement which set a minimum percentage (25%) of private beneficiaries that must be enrolled in managed care plans served by Medicaid. BBA 1997 legislated away the freedom of choice requirement for many Medicaid populations. Once a major tenet of Medicaid beneficiary rights, freedom of choice had lost ground via freedom of choice, 1915b, waivers and also increasingly in the Clinton era through increased waiver of freedom of choice via the 1115 waiver process. The ability to place Medicaid beneficiaries in mandatory managed care was a "huge fulcrum when first presented" according to one policy negotiator. "People were like, we really should not make people do this. Then it [Mandatory Managed Care] did not turn out to be that big. Most states would have done this with a waiver regardless."[50]

The other facet of the major Medicaid managed care revisions, the undoing of the 75/25 rule, made All-Medicaid HMOs -- without any private beneficiaries -- a possible delivery mechanism. As one policy broker involved in Capitol Hill negotiations in Medicaid said, "I think All-Medicaid HMOs are a terrible thing. In the past, the HMO had to be good enough or a beneficiary could vote with their feet and get out but conservatives repealed this. This was the market way to protect quality of care. With All-Medicaid HMOs, there were effectively only one not two choices in many areas like there was supposed to be. Private patients kept the system honest."[51] Essentially, according to statute, many Medicaid recipients not only could no longer chose a non-managed care option for care, but they may in practice not even have the required two

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[49] See in particular Drew, *Showdown*.
[50] Interview with Author, August 3, 2006.
[51] Interview with Author, August 3, 2006.

choices of plans. And the managed care plan they were assigned to could potentially only serve Medicaid clients.

The National Governors Association (NGA) had tacked on repeal of the Boren Amendment in suggestions for Medicaid reform during the national health debate in 1994.[52] States won repeal of these federal Medicaid minimum provider payment standards in BBA '97. One Centers for Medicare and Medicaid Services (CMS) head made it clear that this repeal was much worse for nursing homes, which are more financially dependent on Medicaid than Medicare. He explains, " You've got a much smaller base of Medicare patients and commercial patients to cost shift to, so its must tougher on nursing homes. The Boren Amendment was much tougher on nursing homes because when it was repealed, states started to chronically underpay nursing homes and they had very little cost base to shift it to. It was much worse for nursing homes than hospitals."[53]

State Children's Health Insurance Program: Huge Success and Intentionally Designed to Be Different From the Medicaid Program

The SCHIP design revolved around capped funding. States could choose from several options, such as broadening their existing Medicaid coverage or enrolling uninsured children in private health plans. Benefits packages had to be equivalent to one of several benchmark plans, such as the standard Blue Cross/Blue Shield preferred provider option offered under the Federal Employees Health Benefits plan.[54] During SCHIP design, an explicit decision by those involved was to make sure it was unlike Medicaid.[55] According to one interviewee, those involved in the SCHIP design in the Congressional ranks worried that putting the new capped funding design on the ground

[52] U.S. Senate, Hearing before the Committee on Finance, 103rd Congress, Second Session, March 24, 1994, "Medicaid Issues Under Health Care Reform," Prepared Statement of Raymond C. Scheppach, S.HRG.103-937 (Washington, DC: GPO, 1994), 63.
[53] Interview with Author, August 30, 2006.
[54] 1997 *CQ Almanac*, 6-12.
[55] Interview with Author: November 6; Interview with Author, August 22; Interview with Author, October 13; Interview with Author, August 10; Interview with Author October 24.

"was a disaster."[56] Although SCHIP was designed to a completely different population, kids in families too wealthy to be covered by Medicaid but not well enough off to purchase private coverage, there was concern that SCHIP's capped funding and lack of individual entitlement may provide a slippery slope for a possible Medicaid re-design in the future. Another Centers for Medicare and Medicaid official in the Clinton Administration emphasized that a goal was to make SCHIP coverage look like private insurance as much as possible.[57]

Medicaid waivers were credited with developing the concepts around SCHIP.[58] A High-Ranking Official commented, "We would have preferred an entitlement but we knew we weren't going to get it and [Bill Sponsor and Senator] Kennedy made it clear that we weren't going to get it. And we figured we would build upon it."[59] Policy decision makers often get what they can at the moment, hoping and planning to build upon the proposal in later years. The Administrator continued, "Well it wasn't just the entitlement, we wanted to expand it. We were trying to build a political constituency. With Kennedy -- this program was designed to get a foot in the door."[60] Some interviewees suggested that it was children's advocates who first proposed a closed match, i.e. block grant, design for SCHIP.[61] By the ideological left starting bargaining at a block grant instead of insisting on individual entitlement, passage was more assured but at that point and time -- in that particular debate cycle -- the individual entitlement was not within the range of possible negotiating outcomes at all. By starting at capped funding as the left most point on the bargaining table, Democrats were certainly not going to get individual entitlement in this round.

A Democrat Hill Staffer felt the SCHIP design was more purposeful in its efforts to influence Medicaid reform in a conservative direction in the future: "In terms of bargaining this is the Holy Grail of Executive Branch bargaining and it started in '97….

[56] Interview with Author, August 10, 2006.
[57] Interview with Author, August 22, 2006.
[58] Interview with Author, November 6, 2006.
[59] Interview with Author, November 6, 2006.
[60] Interview with Author, November 6, 2006.
[61] Interview with Author, August 10, 2006.

Again, I'm not inside their heads. But I think what happened…that after the dust had settled on the Medicaid transformation -- which is what Newt called the block grant. And after Clinton vetoed it. They just decided we can't do this straight on again. We'll take a different route. It's more this. We see that there's all this interest in kids. Let's get our policy structure in place, using kids as a cover --SCHIP. And then over time SCHIP is the good program, Medicaid is the bad program. Governors love SCHIP. They hate Medicaid, and we'll see if over time we can't persuade Medicaid or part of it into SCHIP. We are about to enter that discussion for reauthorization [SCHIP reauthorization in 2007]."[62] Other interviewees did not see the planning as explicit for converting Medicaid eventually to the SCHIP model but did not necessarily deny that it may provide policy lessons for Medicaid federalism as it evolves over time. Most interviewees, including many Democrats, thought that the populations between SCHIP and Medicaid were too different for there to be considerable parallelisms drawn between the financing arrangements.

When given a chance to respond to the claim that Republicans were thinking ahead of time of re-working Medicaid based on the SCHIP model, a Republican responsible for drafting and designing the SCHIP design denied the pre-meditated notion, "I never foresaw Medicaid becoming CHIP in terms of the benefit package because the population [was so different]."[63]

CONCLUSION

The National Health Reform Debate in 1992 through 1994, the following nearly-enacted block grant and per capita cap proposals, and the Balanced Budget Act were a power health policy trio in the 1990s. Ending the decade were several follow-up bills. The type of policy maelstrom created by this type of trio tends to have spin-off twisters. In BBA's case, the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act

[62] Interview with Author, August 23, 2006.
[63] Interview with Author, October 13, 2006.

of 2000 (BIPA)[64] were the BBA II and BBAIII, if you will. The former bill, HR3194, was sometimes dubbed "The Givebacks Bill." After passage, several provider groups launched a lobbying blitz to readjust upward BBA Medicare payment reductions. Providers affected by these reductions included hospitals, nursing homes, rehabilitation therapists, managed care plans, and home health agencies.[65] BIPA closed some of the new state Medicaid maximization strategies, the Upper Payment Limit (UPL) loopholes.

A master tobacco case settlement by the State Attorney's General and the Emergency Supplemental Appropriations for FY 1999 (P.L. 106-31) Act by Congress transferred the federal share of settlement funds from national tobacco litigation to states.[66] Considered beyond the scope of this project, the tobacco wars cost state Medicaid programs over decades in addressing the health needs of smokers and the late 1990s saw a correction of the financial burden of this sordid history.

More generally, there was also a greater trend toward privatization with several different Medicaid initiatives headed in that direction. BBA '97 had already allowed mandatory managed care without state waives to the federal agency. Also, Medicaid was forging into greater privatization in at least three ways towards the end of the decade. First, there are certain beneficiaries who also have access to employer-based group health insurance.[67] Some states have pursued Health Insurance Premium Payment (HIPP) programs, where state Medicaid officials aggressively pursue cost savings by paying premiums, deductibles, and coinsurance on behalf of Medicaid beneficiaries eligible for enrollment in employer-based group health plans when cost-effective.[68] Oftentimes, entire families are covered with varying levels of state investment under these programs. Paying premiums for employers encourages small employers to offer health insurance coverage.

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[64] H.R. 5661, P.L. 106-554.
[65] 1999 *CQ Almanac*, 16-31.
[66] Schneider, *The Medicaid Resource Book*, 177.
[67] This practice is based on section 1906 of the Social Security Act, added by Congress in 1990, requiring states to pay premiums, deductibles, and coinsurance on behalf of Medicaid beneficiaries eligible for enrollment in employer-based health plans when it is cost effective to do so.
[68] U.S. Government Accountability Office (GAO), "Three States' Experiences in Buying Employer-Based Health Insurance," Report to the Chairman, Committee on Commerce, House of Representatives (GAO/HEHS-97-159) (Washington, D.C.: U.S. Government Accountability Office, July 1997), 1 - 2.

In a second privatization model, states are now going beyond that where they are allowing some private employers to buy into Medicaid for employees. Many states Medicaid programs already offer, for example, Blue Cross/Blue Shield plans, making it advantageous for a small business to "buy into" Medicaid if a state negotiates a win/win scenario. In this case, the employer pays the match that the state traditionally would have paid. It is for low-income individuals, and caught on among states. One National Association of State Medicaid Directors interviewee estimated that in 2006, an additional eight states pursued these initiatives.[69] States offer "buy-ins" for employers and for individuals.

In a third privatization trend, states have continued to develop programs where they loosen the reigns in particular cases, allowing Medicaid beneficiaries to be consumers in purchasing their own care through Health Savings Accounts (HSAs) and Cash and Counseling programs. The original Cash & Counseling demonstration was begun in 1998 in only three states -- Arkansas, New Jersey, and Florida.[70] This late 1990s initiative was just expanded in the 2005 Deficit Reduction Act, making it available to all states.[71] In one success story, "One gentleman in New Jersey called up and said, 'I want to buy dirt. Can I buy dirt with my money.' And they said, 'Why do you want to buy dirt.' 'Well, if I fill in my lawn, I can get my wheelchair out to the back and I won't need an aide to get the car and I'll only need an aide once a day instead of twice a day. So, I want to buy dirt.' And of course they said, 'Sure, buy dirt.'"[72] The privatization trends of the 1990s, not stymied by the Democratic Administration, fed the upcoming developments of the post-2000 Medicaid re-engineering.

For the disabled, the federal courts in 1999 also decided on a momentous civil rights Medicaid case, while at the same time setting state fiscal priorities. In *Olmstead* v. *L.C. ex. rel. Zimring* (527 U.S. 581 (1999),[73] the U.S. Supreme Court held that within the

[69] Interview with Author, September 4, 2006.
[70] Cash & Counseling, http://www.cashandcounseling.org/about/background, (accessed on March 25, 2007).
[71] Interview with Author, September 4, 2006.
[72] Interview with Author, September 4, 2006.
[73] For an in-depth legal analysis, see Sara Rosenbaum, Joel Teitelbaum, and Alexandra Stewart, "Symposium: Barriers to Access to Health Care: Olmstead v. L.C.: Implications for Medicaid and Other

Americans With Disabilities Act states were required to provide services to persons with disabilities in community settings rather than institutions, if certain conditions were met.[74] Developments out of *Olmstead* in the late 1990s included the Ticket to Work and Work Incentives Improvement Act of 1999 (P.L. 106-170), allowing the working disabled -- with incomes as high as 450% of the federal poverty level -- to keep receiving Medicaid.[75]

In closing a chapter on a whirlwind decade, there are so many points of difference when one Executive Administration changes power to another. In this case, consider a similarity between both Republicans and Democrats who held similar administrative roles in the Centers for Medicaid and Medicare services.

Medicaid was soon to enter the George W. Bush decade. With a new set of actors, some of the federal administrator lines of thinking would show a synchronicity. Just before the Presidential Administration changeover in 2000, a key Medicaid decision maker in the Clinton Administration offered a bargain to the states that he believed would benefit them for many years to come. He suggested closing the state financing loopholes in exchange for the federal government giving states a permanent 2% increase in FMAP. As he recounts "I suggested at the last National Association of State Medicaid Director's Meeting… that states be given a 2% permanent increase in the FMAP across the board. They wouldn't go for it given that some of the states were in so deep [in utilizing state creative financing mechanisms]." He said that for states such as "Pennsylvania and New Jersey, a 2% increase in the FMAP would have been a loss for them. Then there are some states that had not started implementing UPLs. So, the outcomes would have been very different for the various states." He continued, "My argument was, 'Hey, we are going to close Loopholes, let's bargain and trade on it.' The Governors are only looking at the short-term budget prospectus, and not considering the long-term." In short, the

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Publicly Funded Health Services," *Case Western Reserve University Journal of Law-Medicine* 12 (Winter 2002), 93 - 138.

[74] Sara Rosenbaum, "The Olmstead Decision: Implications for Medicaid," Policy Brief, Kaiser Commission on Medicaid and the Uninsured (March 2000).

[75] Sara Rosenbaum and Joel Teitelbaum, "Olmstead at Five: Assessing the Impact, Policy Report, Kaiser Commission on Medicaid and the Uninsured (June 2004).

States flatly turned him down.[76] States did not accept the federal offer and incremental reforms continued to wind on from there.

When the next Administration took the reins of the Medicaid program, the Secretary and the Republican Administrator also offered a new, improved Medicaid reform idea that they believed was too good to be true for the states. It went nowhere.[77] Different ideologies, different ends in mind, different relationships with states -- but there is a unifying thread between Federal Medicaid administrators, Democrat or Republican. Any Medicaid reform to re-divvy the pot of money creates 25 winners and 25 losers. Whether Democrat or Republican, Federal Administrators expressed very, very similar frustrations with states, as well as lessons they had learned about state responses to federal offers for policy bargains in the Medicaid program. The next chapter reviews a new Republican Administration, the George W. Bush Administration, and their Medicaid Transformation.

[76] Interview with Author, August 3, 2006.
[77] August 30, 2006.

11. MEDICAID TRANSFORMED: MEDICAID FEDERALISM DURING THE GEORGE W. BUSH ERA

MEDICAID FEDERALISM IN THE G.W. BUSH ERA

Moving towards pre-eminence of the Administrative State in Medicaid politics, the G.W. Bush Administration has re-defined waiver negotiations towards limiting federal financial exposure. Unintended consequences include, for example, the creation of a universal coverage system by Massachusetts. The legislative movement was slow until the Deficit Reduction Act of 200, which re-defined comparability and statewideness requirements in the Medicaid benefit package. As this chapter will outline, states were at the table for the DRA negotiations but absent for the Medicare Modernization Act. That Act created a Medicare prescription drug benefi, thereby handing the states an edict regarding dual eligible Medicaid costs. An Administration Medicaid program capping proposal was largely ignored by states, even though they faced extremely difficult financial times at the beginning of the decade.

THE DEFICIT REDUCTION ACT OF 2005 (THE DRA)

The G.W. Bush era, still underway, has formed into a potentially momentous one for Medicaid federalism with the enactment of the Deficit Reduction Act (DRA) in February 2006. With time, the DRA may prove to be the most profound Medicaid

federalism statute since the Nixon Watershed Era, which itself is only trumped by the enactment of Medicaid in 1965 in terms of importance. The possibility that it is the third most influential action in Medicaid history will be proven or not with time. Expected to cut Medicaid by $4.8 billion over the next five years and $26.1 billion over the next ten years, beneficiary cost sharing was bolstered and states were given the option of replacing in some cases the existing federally mandated benefits package with a more limited, more state specific one.[1] Original principles of the Medicaid program --around minimizing cost sharing for beneficiaries, around a minimum benefits package for mandated populations, and around uniformity of benefits across categories of beneficiaries were re-written. For some, the changes did not go far enough. Mississippi Governor Hailey Barbour remarked, " Medicaid is a vital program which serves the neediest in our society. However, the increasing costs of health care have threatened the solvency for this program. To maintain this program for those who rely upon it, federal law needs to be further changed to all states to sue the laws of insurance to design benefit packages that best meet patients needs at affordable costs."[2]

Of particular interest in the DRA are "benchmark plans" that were built on the exact statutory language of the SCHIP program. In describing more about benchmark plans, The Kaiser Commission on Medicaid and the Uninsured writes, "The DRA would allow states to replace the existing Medicaid benefits package for children and certain other groups with 'benchmark' coverage. Like SCHIP, this "Benchmark" coverage would include the standard Blue Cross Blue Shield Plan offered under the Federal Employee Health Benefits Plan, health coverage for state employees, or the health coverage offered by the largest commercial HMO in the state. "Benchmark" coverage would also include any coverage proposed by the state that CMS determines provides "appropriate" coverage for the populations affected."[3] A distinct move in the direction of changing Medicaid from a defined benefit to, at least in principle, is a defined

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[1] Kaiser Commission on Medicaid and the Uninsured, "Deficit Reduction Act of 2005: Implications for Medicaid," February 2006.
[2] Interview with Author, December 15, 2006.
[3] Kaiser Commission on Medicaid and the Uninsured, "Deficit Reduction Act of 2005: Implications for Medicaid," February 2006.

contribution model. At the very least, this model attempts to make Medicaid look more like private insurance. This attempt at transforming Medicaid to look more like private insurance is a reiterated theme from the G.W. Bush Administration with regard to Medicaid policy; in 2003, a Medicaid program financing reform attempt according to the Administrator was, "trying to make it like a private insurance contract."[4]

As mentioned, the statutory language of the SCHIP enacting legislation describing benchmark plans was simply lifted into the DRA statutory language -- basically verbatim. In fact, some Democrats claim that this was a hope of Republicans at the time SCHIP was designed and that it became reality in 2006 when the DRA was signed into law.[5] A former Democratic Hill staffer connected the dots between the DRA and SCHIP: "Well I don't think there's any doubt that the proponents of the SCHIP approach were seeing it as one way to limit the federal financial exposure -- that's always the bottom line…because if they had used a Medicaid open-ended financing model, it doesn't work for them. Secondly, not having the defined benefit package…having the benchmark benefit package, which is now in the DRA. I think it took them longer than they thought to get to DRA [Deficit Reduction Act of 2005]. But that's where the model came from….the benchmark for Medicaid."[6] A former Republican Hill insider, however, involved in the SCHIP drafting process does not accept the conspiracy theory that the SCHIP modeling for the DRA was somehow strategic, stating"I think they benchmarked off of CHIP because I don't think they knew what else [to use]. They never understood the CHIP benchmarks up there."[7]

According to the Senate Finance staff who negotiated the DRA, "Benchmark Benefit Plans were very much a state idea. The states were strongly in support of that. It allows them to essentially waive comparability and statewideness in Medicaid populations. You have a Medicaid population that is healthy, generally speaking, and that is Healthy Moms and Kids. They're cheap to insure. As a matter of fact, if you put them in another state plan -- state employee plan -- that has a population that is not so

[4] Interview with Author, August 30, 2006.
[5] Interview with Author, August 23, 2006.
[6] Interview with Author, August 23, 2006.
[7] Interview with Author, October 13, 2006.

healthy, you are bringing everyone's costs down. Why can't states do that? Because they are required to provide uniform benefits to everyone. One of the nice things about a benchmark plan is that it allows them to provide a different benefit for different populations. Comparability is waived, early on. The states wanted to testify with us [Senate Finance] -- with Energy and Commerce. They brought in Governor Warner. They brought in Governor Huckaby. They did their papers and we reacted, 'We think we can work with these things to turn them into real policy.'"[8]

In terms of drafting the legislation, the House version of the DRA,which was the version adopted in conference negotiations for the final legislation, was the plan to a large degree submitted by the National Governors Association. The Medicaid provisions were designed in large part by an eleven governor task force dedicated to Medicaid reform over the past few years. NGA lobbied for flexibility in the Medicaid benefit structure over several years. So the new benefit flexibility wasa realization of several Medicaid debates over time and not just 2005.

In the case of the DRA, NGA was not only at the table, it played a dominant role in designing the legislation itself. As the NGA reports, "We put down a wish list of the things we'd like to see and we did that mostly in sort of a policy vacuum. In the sense of in a perfect world, what would we like to see? And we put that down. And then sort of transmitted that up to Congress and then they said, 'Do what you can and we'll work with you to get done what you can.' They came pretty close to everything we wanted on benefits and on cost sharing. A lot of the way, part of the way on long-term care and drug costs. But given that there are very, very powerful forces at work there in those realms, I think it's not terribly surprising that we weren't given carte blanche."[9]

The DRA negotiations, according to the Senate Finance Republican staff, evolved as "The Budget Committee came to us and said 'You Shall Cut' and we went off and tried to find billions of dollars. Now how many billions of dollars that at some point in time -- those varied, but generally we got in the range of ten billion is what we were trying to find in savings out of the Medicaid program. The advocacy community was not

[8] Interview with Author, August 15, 2006.
[9] Interview with Author, August 16, 2006.

going to be happy. The Democrats weren't going to be happy. We had no friends in this. The only friends that we had were when we did one or two things which were arguably state hits."[10]

Democratic Budget leaders thought the entire Deficit Reduction Act did not reduce the deficit at all. "The DRA is a misnomer. The term Deficit Reduction Act -- the term they use for it -- is really misapplied because the savings they claim through the spending cuts were more than offset by the tax cuts. So, in truth the Reconciliation Bill, they separated the two really for display purposes to claim that the DRA was really reducing the deficit. It was if they were saying 'Don't look at the tax cut.' Generally, when Congress has Reconciliation Bills, they reduced the deficit, they didn't increase the deficit. But what they did this year, they separated the spending from the tax cut. So they had the so-called DRA which didn't save anything but $40 billion dollars and then they had the tax-cuts, which were well in excess of $40 billion dollars and so together they actually added to the deficit, they didn't reduce the deficit."[11]

Plagued by procedural snags, House members filed suit to stop the DRA's Medicaid reforms. As one advocacy group wrote, "Congressman John Conyers, Jr., the ranking member on the House Judiciary Committee, and ten other ranking member of Congress have filed a lawsuit to stop the federal government from implementing the Deficit Reduction Act of 2005 (DRA). The legislation was signed by President Bush on February 9 but it has since been revealed that the President, apparently knowingly, signed a version of the bill that was passed by the U.S. Senate but not the U.S. House of Representatives."[12] The Newsletter of the National Health Law Program reported that there were at least five lawsuits challenging the legislation as unconstitutional.[13]

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[10] Interview with Author, August 15, 2006.
[11] Interview with Author, August 15, 2006.
[12] ElderLawAnswers, "House Members File Suit to Block Law Changing Medicaid Rules," August 15, 2006.
[13] Newsletter of the National Health Law Program Health Advocate, "The Deficit Reduction Act of 2005: Congress Targets Beneficiaries for Cuts," no. 224 (Spring 2006).

THE CLAWBACK -- DUAL ELIGIBLES PRESCRIPTION DRUG COSTS TRANSFERRED TO MEDICARE

The G.W. Bush era also saw the transfer of financing of pharmaceutical costs for those eligible for both Medicaid and Medicare to the federal government from the states. The overall macro environment of the Medicare Modernization Act of 2003 was tinged by the historic floor vote. Usually 15 minutes in length, as the precedent set in 1973, this vote was open for two hours and fifty-one minutes. *The New York Times* reported the floor environment to involve "an extraordinary bout of Republican arm twisting to muster a majority."[14] A small step towards accomplishing a broader National Governors Association (NGA) goal of complete transfer of the financing for dual enrollees from Medicaid to Medicare, it was surprising that so many state representatives consider the "Clawback" -- as it is called -- pejoratively.[15] State officials -- not at the bargaining table during the Medicare Prescription drug debate -- were stung by several aspects of the required transfer of funds from the states to the federal government.

The Clawback resulted in legal challenges by some states. Kentucky Attorney General Greg Stumbo sued the federal government over its demand for $7.5 million per month in prescription drug "Clawback' payments from Kentucky, beginning January 2006. It was estimated that the Clawback will take $88 million in state funds from Kentucky's Medicaid program in 2006. Attorney General Stumbo said, "It is my job to protect taxpayers from unlawful demands on their money." Stumbo continued, "Never before has the Federal Government made such a bold, and I believe unconstitutional, attack on Kentucky's right to control the spending of its own tax money."[16]

An example of a "reverse block grant," with movement of funds from states to the Federal Government is unique in health federalism. Perspectives on the Clawback

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[14] Thomas E. Mann and Norman J. Ornstein, *The Broken Branch: How Congress is Failing America and How to Get it Back on Track*, (New York, NY: Oxford, 2006), 1-6.

[15] A call for federalization, the transfer of financing to Medicare, was made by the NGA over several years. When asked, the NGA said there was never a reason to design a specific way to make the general proposal operational. A general idea paper is available, entitled "Dual Eligibles: Making the Case for Federalization."

[16] State of Kentucky, "Attorney General Stumbo to Challenge State 'Clawback' Provision of the Medicare Drug Prescription Act," October 19, 2005, http://ag.ky.gov (accessed on August 21, 2006).

provision were as starkly contrasting as they come with one state representative saying, "I think that was probably the worse legislative defeat states have ever had. Absolutely. Without a doubt."[17] And in contrast on the other side, a federal official integral to negotiating the Medicare Prescription drug plan explained why states did not need to be at the bargaining table, If I was going to show up and say, 'I'd like to give you a couple hundred million bucks,' do you think you'd need to be at the table. States were at the table. States got a huge windfall! Every single one of them was a huge winner. It's not that they lose anything."[18]

The official went on to say, "I mean if you look at it state by state -- it was the biggest windfall, probably, in the history of state government. Every state -- despite their whining -- was a huge winner. The biggest, fastest growing expense was seniors' drugs in the Medicaid program. We totally bought it out and so they had to pay back 90% of their static baseline in year one going down to 75% in year -- whatever it was, four or five. It's a joke. It was…a huge windfall to every state."[19] The States view was antithetical. A NGA official held that the federal government structured the Clawback in a way so that states would help fund a federal Medicare reform that they would not be able to get through Congress without another contributing financier. In this case, the states via Medicaid. As the head of the NGA explains, "Infinitely we are supposed to pay 75%…that was the last deal cut. They needed more money for the rest of the program and it was out of our hide. The fact is that they all lied by factors of 50 to 100 % of what the total cost of the program was going to be."[20]

As this shows, states expressed concern that there is not currently a schedule to bring their contribution percentage down to zero. As one state organization leading official exclaimed, "Where we are a line item in the funding of a federal program. It's never occurred before!"[21] Another state lobbying representative was blunt about states

[17] Interview with Author, October 24, 2006.
[18] Interview with Author, August 30, 2006.
[19] Interview with Author, August 30, 2006.
[20] Interview with Author, November 2, 2006
[21] Interview with Author, October 24, 2006.

take on the Clawback, as well, "We got screwed on that…It's a very interesting story. There were some states that tried to go to the Supreme Court."[22]

There remained concerns on the part of states if their purchasing power for drug products in the long-run would be compromised by giving up a high-utilization group to Medicare, thus decreasing the rest of the state Medicaid program's drug purchasing power with pharmacy benefit managers. States said only time would tell how removing dual eligibles from their overall Medicaid pharma purchasing pools would affect their purchasing power and the deals they could negotiate in the future.

On the other side, Federal Administration officials who designed the Medicare Prescription Drug benefit thought the attainment of duals prescription drug benefit responsibility by Medicare may in fact be the reason for its success. "One reason why -- if you remember the debate during the Medicare Prescription Drug benefit --when it went through there was the thought that nobody was going to show up. Well, too many contractors showed up and there are complaints about that now It's 'Oh my God, there's 40 per region'…But if you remember at the time, we had to do this fallback because we had people convinced that in places like North Dakota and South Dakota, nobody would show up. Well, in North Dakota, there are 42 plans. So people showed up in droves. One of the things that I did not anticipate was what caused people [pharmaceutical benefit managers] to show up in droves was the dual eligibles. The Medicaid dual eligible population -- which is probably six million people-- has turned out to be the fundamental contracting base of the program because that is a big, guaranteed block of people. So, the fact that we put the Medicaid population in the Medicare drug benefit, which we didn't foresee at all…was actually one of the things that made it work so well. If you notice, the cost of the Medicare drug benefit has turned out to be about 30% lower than projected. And year after year…the last year, the beneficiary premium and the total cost of the program last year was already 30% lower than anticipated and the premiums from 2006 to 2007 were going to drop by 10%."[23]

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[22] Interview with Author, August 16, 2006.
[23] Interview with Author, August 30, 2006.

Prior to the measure, states received the best price for pharmaceutical products after the Veterans Affairs system. 1990 legislation advantaged these two buyers in pharmaceutical pricing. After the Medicare prescription drug plan was enacted in 2003, Medicaid, at best, received the third best price, according to interviewees.[24]

One of the most interesting stories in Medicaid federalism, the contribution by states to the Medicare prescription drug program is a historic twist. States were not at the table during the Medicare prescription drug debate given that Medicare is a federal program. While the NGA advocated for more than a decade to have dual eligibles transferred to the Medicare program, the NGA says the Clawback experience makes some states think twice about asking for this reform. "And people say, don't ask for it because of what you get."[25] Never considered seriously enough for the NGA to draw together a detailed plan, the call for Medicare to take back responsibility for duals stems from several federal mandates where states were required to pay Medicare Part B premiums for some individuals eligible for both Medicaid and Medicare. As one state representative explained, "Every time the Medicare Part B premium goes up, every $10 the premium goes up, that's a billion dollars that states are spending. It's a billion dollars! That is completely invisible to anyone in the outside world."[26] In the aftermath of the Clawback, states are concerned that any volunteering on the federal government's part to take financial responsibility of dual eligibles may only be if states can help fund a federal initiative.

NONSTARTER: MEDICAID CAPPED FUNDING PROPOSAL AMID STATE FISCAL STRESS

At a January 31, 2003 press conference, HHS Secretary Tommy Thompson announced that as part of his fiscal year 2004 budget, President Bush was proposing "sweeping financing and programmatic changes for Medicaid and the State Children's

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[24] Interview with Author, October 24, 2006.
[25] Interview with Author, November 2, 2006.
[26] Interview with Author, August 16, 2006.

Health Insurance Program."[27] As one analysis assessed, "In exchange for giving up open-ended federal financing, the block grant option would offer states," in the words of Secretary Thompson, "'carte blanch' flexibility to change eligibility, benefits, cost sharing and other key features of the program for so-called optional groups.'"[28] The capped funding attempt was largely considered a non-starter.

Secretary Thompson and CMS Administrator Tom Scully advocated an option for states to choose a per capita cap for certain parts of the program. The early years of the Bush Administration were very difficult economic times for the states and the initiative was offered as a way to dodge the immediate state fiscal crisis. As a high-ranking Administrator said, "We wanted to move the program more towards a private insurance model."[29] States, leery of being in a much worse financial position in the long run with this Medicaid option, stayed away.

As one operative explained,

> At that time the baseline was projected to be going very fast and we said, 'We'll give you your current spending and we'll build it on that,' which would have been a windfall for them. And said, 'We're doing this to try to get rid of the gaming, to get rid of the incentive for all this churning through all these gimmicks…and we'd like to get back to a rational financing system where we understand what we are paying for….if we give you $10,000 dollars a patient, we'll give you 7, you spend 3 and it's easier to audit and match and we're willing to basically pay out of our inflated baseline in order to get to do that and they all thought, 'No, no -- we'll fight it.' And we all come back and year later and Thompson and I probably had 17 or 18 bi-partisan governors in Thompson's conference room for 2 days going over this and we're trying to get the NGA to support doing this….as a way to transition back to a rational policy and the Democrats on the Hill went crazy. I forget ….we pretty much had a done deal….the main guy was Vilsack from Iowa who thought it was a good idea and was ready to go with it and a couple of the other Governors are ready to go with it. And Congressman Dingell and some others on the Hill called up and said that this was anti-Democrat and this was terrible and you're selling out the Medicaid program. I don't think they knew what they were doing. And what happened was, which you knew was going to happen, was that the next year because of how the Federal budget works the baseline comes down and the states had had a one time shot in 2001 and 2002 to basically lock themselves in at a higher growth rate with fair

[27] Cindy Mann, "The Bush Administration's Medicaid and State Children's Health Insurance Program Proposal," Institute for Health Care Research and Policy, Georgetown University, February 10, 2003.
[28] Cindy Mann, "The Bush Administration's Medicaid and State Children's Health Insurance Program Proposal," Institute for Health Care Research and Policy, Georgetown University, February 10, 2003, 4.
[29] Interview with Author, August 30, 2006.

> rules that would have been easier to manage the program and they came back the next year and said, 'We'd like to get that deal you offered us last year,' and we said, 'Sorry, it's gone.' The baseline was built on a higher number and this year it's projected down and we told them it was going to happen and they said we'd love to build on those 8 or 9% inflation rates you were talking about last year. And we said, "Sorry, now the inflation rate is 3%. See you later."[30]

According to G.W. Bush Administration officials, the proposal was not capped funding and not a block grant, "Well we tried that [capped funding for Medicaid] in Bush I and it's not a cap and it's not a block grant. The Democrats all screamed that it was a block grant. It really wasn't."[31] The dance away from the term "block grant" to describe any Medicaid proposal that suggested any form of limits on the open matching grant in the overall Medicaid program was not only a Republican phenomenon, the Democrats also ran away from the claim when their "per capita cap" proposal was in existence from 1995 through 1997. Officials described the 2003 plan,

> Let's figure out what you're spending per capita on the three big groups of people: women and kids; the disabled; and nursing homes…those are the three big pots of money….Let's figure out the caps…the caps by state, what you are spending per capita and come up with a federal match rate per capita and we'll pay you per capita because right now we don't just pay on the volume of services….we'll give you …it's not a block grant…if the number of people goes up, you are in a recession, the number of Medicaid people goes up you'll get more….if the number of Medicaid people goes down, you'll get less.[32]

The reasoning behind the FY 2004 Medicaid reform proposal was to " get back to a rational financing system where we understand what we are paying for." State financing maximization of mechanisms of all types -- school based financing, DSH, provider taxes and donations, intergovernmental transfers, and the most recent phenomenon of upper payment limit (UPL) maximization strategies -- create a system where no one knows what the "real" federal matching rate is anymore. According to G.W. Bush officials, it is much higher than the matching rate tables claim. "The federal government is not a voluntary actor and has absolutely no idea what's going on…the

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[30] Interview with Author, August 30, 2006.
[31] Interview with Author, August 30, 2006.
[32] Interview with Author, August 30, 2006.

money is going out the door in truckloads and there's no auditing; there's no understanding of how it goes on; it's basically a pilfering of the federal treasury without anybody knowing it. I don't blame the states for trying it; it's just outrageous that they get away with it."[33]

The proposal was scheduled to apply to optional groups of Medicaid beneficiaries, but it remained unclear to many onlookers if the G.W. Bush Administration was dedicated to protecting federal rights of action for mandatory Medicaid beneficiaries. Further, as one expert testified before the House Budget Committee, "…it is unclear whether these exemptions would apply to all the services these groups currently receive. New types of restriction may apply to optional services."[34] Republicans calling for state flexibility and rationalization of Medicaid's funding formula were willing to place the individual entitlement on the brink; whereas Democrats largely stood in defense of private rights of action. Again, entitlement status for Medicaid was at issue. As for the states, the proposal was plain and simple -- in their view -- not good for them. Even two former Governors, President G.W. Bush and Secretary of Health Tommy Thompson, now seeing health financing from a wholly different world-view could convince the nation's Governors to come on board for this Medicaid re-working. The Fiscal Year 2004 Presidential Budget Proposal for a cap on portions of the Medicaid program was largely a non-starter.

THE RISE OF THE ADMINISTRATIVE STATE IN MEDICAID FEDERALISM POLICY BARGAINING

Finally, in possibly the strongest trend of the era, waiver politics pushed power towards the Administrative State. CMS legislated through agency decision making and state negotiations on waivers. Also acting via Executive Orders on Medicaid, Medicaid politics in the G.W. Bush era tilted away from legislative politics until the Deficit Reduction Act of 2005. Agency and Executive decision making power trumped

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[33] Interview with Author, August 30, 2006.
[34] Judith Feder, "Impact of the President's 2004 Budget on Medicare and Medicaid," Testimony before the House Budget Committee, U.S. Congress, February 26, 2003.

legislative action for the first term and into the second term. This played out in the macro trends as well, as Norman Ornstein of the American Enterprise Institute and Thomas Mann of The Brookings Institution penned "Our Pathetic Congress" in the *Los Angeles Times* and *The Broken Branch: How Congress Is Failing America and How To Get It Back On Track*. They wrote, "After 37 years in Washington -- 18 elections -- we are pretty well inured to these shenanigans. But even those of us with strong stomachs are getting indigestion from the farcical end of the 109th Congress."[35]

Waivers increasingly took on "stealth" properties, as so much of the negotiations happened outside of a public record. As one Congressman suggested, waivers were now seen as a way to pass on responsibility to the states and be done with it instead of a federal-state partnership.[36] As opposed to waivers being used as a means for state directed comprehensive coverage, waivers became a way for the federal government to minimize their financial exposure and shift risk to the states. This capping occurs via negotiations with states and takes on either a per capita cap or aggregate cap structure. Recently, in 2006, Vermont accepted as part of an 1115 negotiation two aggregate caps for their Medicaid program -- one for acute care and another for long-term care. A Medicaid expert shared this, "One theory of 1115 waivers is towards block grants. For many federal and state policymakers there was one objective. They are not going to get up and say it often, but clearly capping the federal financial exposure, whether an aggregate cap basis or a per capita cap basis. And in Vermont's case I am virtually certain that they are both aggregate caps. And it's clear in the terms and conditions[37] that Vermont is assuming risk for not just per capita growth. So that's pretty different. Now obviously there are a lot of 1115 waivers…where there are per capita caps and the feds still continue to share in the risk of enrollment growth."[38]

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[35] Thomas Mann and Norman Ornstein, "Our Pathetic Congress: Little Has Been Done in the Final Days of Congress," *Los Angeles Times*, September 27, 2006.
[36] Conversation with Author, August 2006.
[37] The Terms and Conditions of Medicaid waivers are available on the Centers for Medicare and Medicaid Services (CMS) website, www.cms.hhs.gov.
[38] Interview with Author, August 23, 2006.

The Administrative State Loses Control of a Reform That They Instigated: Passing the Buck Politics Results in Unintended Consequences in Massachusetts

One oft-repeated theme in Medicaid federalism is "Passing the Buck Politics." This bargaining behavior works in both directions, with the federal government in some cases trying to pass responsibilities to states , often through unfunded mandates, and the states trying to maneuver for the federal government to take greater responsibility, as in the NGA's repeated calls for the federal government to take financial responsibility for dual eligibles.

While waiver negotiations between states and CMS are largely off the public record, the recent Massachusetts waiver negotiations reportedly pitted CMS against the State over the ability for the state to continue to use certain funds historically obtained through creative state financing mechanisms within its statewide waiver budget neutrality limit. CMS was taking a hard-line stance on the use of these funds as a way to limit federal financial exposure.

As one onlooker remembers, 'As I'm sure you know the whole Massachusetts miracle this time around is essentially done with a gun to their head for the dismantlement of Medicaid because of the IGTs (Intergovernmental Transfers). They were going to close BMC (Boston Medical Center) and Cambridge basically. Same in Tennessee. Same in Florida. Same in Missouri. All these states caught in an IGT squeeze, having to agree to slap a limit on the amount of federal funds they would get; give up essentially what they believed they were entitled for in the way of IGTs and agree to set up an insurance plan -- right, for a demonstration group -- even though there are no benefits in it; even though Massachusetts doesn't know how the hell it's going to come up with an affordable package to cover everything for what it has to spend."[39]

While CMS had planned to reduce the amount of federal outlays to the states using these tactics, it did not work in certain cases. The newfound power of the Administrative State intended to transfer responsibility for Medicaid to the states through these types of limitations in waiver bargaining. Outside of legislative or regulatory

[39] Interview with Author, October 31, 2006.

review, the waiver process would be an ideal bargaining arena to accomplish "buck passing." In this case, the budget neutrality cap, already a cap on statewide Medicaid waivers, would have the noose tightened by further reducing the cap level. The amount allowed under the budget neutrality cap would shrink through these negotiating tactics of the federal government no longer allowing funds states had gained over the years through state financing schemes.

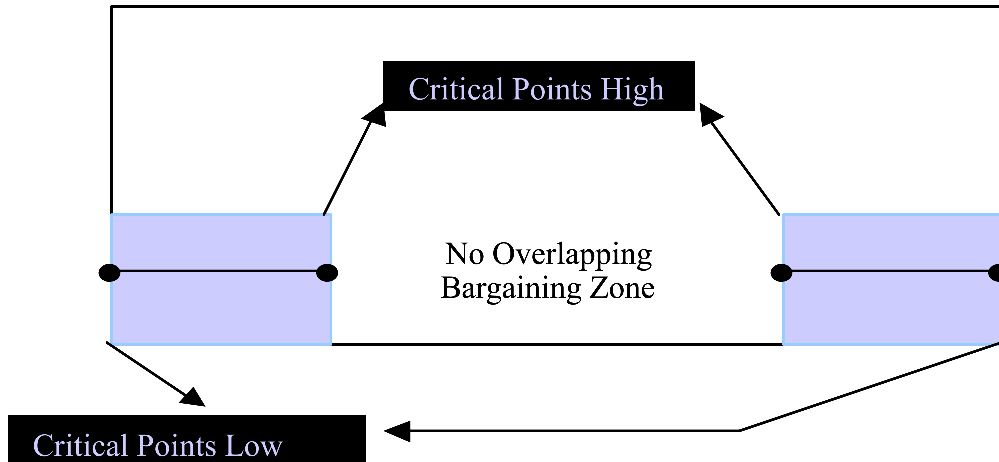
In response to the G.W. Bush CMS stance, the states of Massachusetts devised a universal coverage system to get around the CMS provisions for an agreement on the statewide waiver. One Massachusetts official said "There's nothing we could do but some form of universal coverage because of the way the uncompensated care pool and DSH payments worked in Massachusetts. If we had lost that money it was like a billion dollars. So, the fact is that they pushed us into doing something in Massachusetts that is going to be heralded as Universal Coverage which we probably wouldn't have ended up doing."[40]

As Figure 4 depicts, given there was no overlapping bargaining zone, the state of Massachusetts removed the debate to a different venue altogether, creating a universal health coverage system in order to remove itself from this particular bargaining paradigm, where there was no overlapping bargaining situation.

[40] Interview with Author, November 1, 2006.

Figure 4

1115 Statewide Waiver Negotiation for Mass. 1115



The hard bargaining tactics and strong use of The Administrative State on the part of the Bush Administration had unintended consequences -- pushing the states towards universal coverage. As one state official said, "I think ironically, the Bush Administration may actually end up causing a health reform revolution because of the kinds of changes that they are seeking administratively and through the waivers and an example of that, in effect, is Massachusetts."[41] Enacting a universal coverage system, the state was "pushed" into it -- unintentionally during Medicaid waiver negotiations with CMS. A state official described the situation, "The threat was that they were not going to allow a series of waivers that we had in Massachusetts that allowed us to collect these payments -- the tax. And then pay particular hospitals in particular ways. And we had special arrangements for Boston Medical Center and the Cambridge Health Alliance. And they were going to declare that those were not acceptable. There's no way that we could have survived in Massachusetts without that money."[42]

[41] Interview with Author, November 1, 2006.
[42] Interview with Author, November 1, 2006.

And in describing the unintended consequences of the CMS bargaining tactics, "So, the response was to create a health insurance system that basically requires everyone to sign up for health insurance [an individual mandate] and the state to subsidize to use that same money to subsidize the purchase of insurance that will be through some of these entities. So, it's an interesting --- it's an interesting kind of catalyst -- that really came from the federal level. Otherwise, I don't think the negotiations between the Governor and the legislature would have actually happened. Because it is very controversial. There are lots of cases of it that are very tough and controversial."[43] According to the source, "There's nothing we could do but some form of universal coverage because of the way the uncompensated care pool and DSH payments worked in Massachusetts. If we had lost that money it was like a billion dollars. So, the fact is that they pushed us into doing something in Massachusetts that is going to be heralded as Universal Coverage which we probably wouldn't have ended up doing."[44]

[43] Interview with Author, November 1, 2006.
[44] Interview with Author, November 1, 2006.

Table 4: Passing the Buck Politics Negotiating Outcomes of the Massachusetts 1115 Statewide Waiver Negotiations

	CMS	State of Massachusetts	Result
Issues	Wants IGT program stopped in order to attain cost control and cost rationalization	Needs IGT programs to keep Boston Medicaid Center, Cambridge, other hospitals open	State of Mass. scraps negotiations, creates a universal health model for the entire state
Priorities	Cap Medicaid Administratively waiver by waiver, piecemeal instead of through aggregate cap via Congressional action	Wants to maintain its intergovernmental transferred dollars within the budget neutrality limits to keep hospital financing afloat	State of Mass steps outside of the negotiation process to find an altogether different universal health coverage solution
Bargaining Zones		Bargaining zone does not include the use of intergovernmental transfers to fund the Massachusetts Medicaid program	Some variation of use of IGTs in creative ways that goes beyond the standard use within the current Medicaid Mass. program structure
Critical Points - High	CMS prefers that IGTs be abolished in favor of a strict budget neutrality cap that does not include these funding mechanisms.	Mass. required the IGT funds to keep hospitals afloat so their critical point was quite high.	The Bargaining structure was turned from a zero sum game to an integrative one by a switch in what type of initiative was bargained -- Medicaid only vs. state comprehensive health coverage
Critical Points - Low	Unknown at what point CMS would be willing to maintain some form of IGT structure.	The low critical point for Mass. is a bare bones solution to keep hospital funding afloat.	IGTs were used but not in the way that either party originally intended
Positions	CMS does not want IGT to be used.	Mass. requires IGTs be used to keep health care providers afloat	The Two-Dimensional Position framework was subverted for a wholly new model of how to use IGT funding in an integrative bargaining scheme.
Interests	Must institute caps on the Medicaid program waiver by waiver since the overall aggregate capped funding option is not a viable possibility	Must pay hospitals reliant on IGT funds	Mass. interests were better served in this case, but were pushed into a scenario they would not have considered without the G.W. Admin. pressure. Unintended consequences from the hard-line tactics of the G.W. Bush Admin.
BATNAs (Best Alternative to a Negotiated Solution)	CMS has more power in the BATNA area. It is in their interest to get Mass. Medicaid waiver in plan but on CMS terms.	Very weak BATNA, Mass. needs the IGT funds for their health institutions to stay afloat financially	By turning a zero-sum negotiation into an integrative one, the state of Mass. creative a wholly new solution that benefited them.

PRESIDENTS, POLITICS, AND MEDICAID BARGAINING

Previous compacts with previous Administrations and CMS Administrators had allowed, even encouraged, the creative state financing programs. According to one CMS chief, "Well, in some states the waiver negotiations was to give them these schemes. Well, to give you an example when I was in the Government I spent a lot of time trying to straighten out California's mess. But the problem with 1996 when Clinton was running for re-election, Nancy Ann-Deparle and Bruce Vladeck had both tried to slow down the California scams and make them less damaging. He continued, "President Clinton went out there in '96 and came back and promised the loosening up, 'Yea, we'll take care of it. Don't worry about it. We'll bail out the public hospitals in L.A. and we'll give you more money.' He came back and directed them to give them more money -- so it got worse instead of better."[45]

To be fair, Presidential political trading with Governors and Congress using Medicaid waivers on these issues was not limited to President Clinton. According to one source, "The last thing President [G.H.W.] Bush did on the way out was to give Michigan a $500 million dollar approval the day after I left over my objection…According to Andy Carr, the only subject in the one hour meeting between Clinton and [G.H.W.] Bush during the Administration switch-over was Medicaid Disproportionate Share. Specifically, though not present, Carr said that Clinton asked Bush about the Medicaid scams. "What's going on and what are you going to do?" Carr went on to say that "on the last day out President Bush gave $500 million bucks to Michigan and I had been sitting on about $350 for New Jersey for two years. It was totally bogus. And the first day he came in, Clinton gave New Jersey their $350 million bucks. It was all about money and politics. They didn't understand. If they really understood what was going on, they would have been outraged -- both of them. But it was all about the Governors and the Congress."[46] In another account by a Democrat, "In the Upper Payment Limit

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[45] Interview with Author, August 30, 2006.
[46] Interview with Author, August 30, 2006.

(UPL) Regulation in 2000, Bush re-opened the issue, let three Republican Governors get into the schemes -- Florida, Virginia, and Wisconsin -- and then kept to phase out."[47]

Generally, interviewees emphasized the degree to which Presidents stayed out of Medicaid politics, but it is striking when and how they are directly involved. It generally involves deal making and the Presidential budget numbers chosen for Medicaid annually.

HIFA WAIVERS: REPACKAGING

A new waiver authority, The Health Insurance Flexibility and Accountability (HIFA) initiative, was underway in August 2001, with the intent of increasing "the numbers of individuals with health insurance coverage within current-level Medicaid and SCHIP resources."[48] By several accounts both within and outside the Administration, HIFA waivers were a re-working of what was already going on with the 1115 waiver authority. One state representative labeled HIFA waivers "repackaging." A federal official in charge of its creation agreed the G.W. Bush Administration was already doing the same thing via the 1115 process and formalized it via HIFA waivers.[49]

HURRICANE KATRINA AND MEDICAID WAIVERS

Waivers also were the instrument of choice when Hurricane Katrina required a Medicaid response across state boundaries. Instead of legislation, the Medicaid waiver process was utilized for financing of health needs of the evacuees. Medicaid, and its waiver process, was now also an instrument of the post 9-11 Homeland Security State.

While in an interview, Hailey Barbour, Governor of Mississippi and a former Republican National Committee Chairman, said Mississippi had received the support it needed from the G.W. Bush Administration during the Katrina disaster.[50] Governor Barbour claimed he was very pleased with the federal government's response to the health care needs of Mississippians following Hurricane Katrina. "The Congress and

[47] Interview with Author, August 3, 2006.
[48] Alan, Weil, "There's Something About Medicaid," *Health Affairs* 22, no. 1 (Jan./Feb. 2003), 13 - 30.
[49] Interviews with Author, October 24 and August 30, 2006.
[50] Interview with Author, December 15, 2006.

President Bush provided more than $500 million to pay for uncompensated care in the disaster area and to help with the increased burden on our state's finances through our Medicaid program. In addition, the federal government provided $128 million of Social Services Block Grant funds to help restore the health care and human services infrastructure in the affected areas. The use of Medicaid waivers across state lines provided a easy administrative process to quickly provide health care for eligible displaced individuals."[51]

Some Democrats, however, questioned whether the use of the waiver to address Medicaid financing for Katrina was politically motivated.[52] For example, Rep. Bennie G. Thompson of Mississippi, the Chairman of the House Committee on Homeland Security, noted that a bipartisan effort had been made to extend Medicaid coverage to those affected by Katrina. "The Administration took the easy way out. As a result, a lot of good people who were dislocated and disenfranchised in the Gulf Coast region suffered. These folks found themselves moved to other states where they weren't able to get the Medicaid benefits they absolutely needed. They deserved better."[53]

Some held that the Bush Administration did not want to set a precedent of the Federal Government financing health services during times of crisis because it may be used as a possible wedge in support of the federal government funding national health reform, or an expanded Medicaid program, in the future.[54] By this argument, if the federal government must respond with federally financed health care in a broad catastrophe, it must have the same responsibility in the everyday catastrophes that happen in individual lives across the country -- Specifically, it must deal with the everyday catastrophe brought on by people who cannot finance their own health care when they desperately need it. Others were less damning, pointing more to facts than assessing motive in identifying that the Bush Administration's preferred Administrative handling of Hurricane Katrina's health financing of evacuees across state boundaries via Medicaid waivers to Congressional action.

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[51] Interview with Author, August 15, 2006.
[52] Interview with Author, August 10, 2006.
[53] Interview with Author, October 12, 2006.
[54] Interview with Author, August 10, 2006.

Congressional Action was proposed in such bill as the *Emergency Health Care Relief Act of 2005* (S.1716), introduced by Senate Finance Chairman Chuck Grassley of Iowa and Max Baucus (D - Mont.) on September 14, 2005. The Bush Administration, however, strongly preferred Executive branch decision making and state directed action to federal pre-emption of Medicaid financing issues after Katrina. The legislation provided for temporary federally funded Medicaid coverage to low-income individuals affected by the hurricane. It also planned to provide $800 million for uncompensated care provided to the uninsured hurricane victims. The hurricane created a Diaspora of more than a million evacuees to every state in the nation.[55]

As one state lobbying organization said, "What was Governor Huckaby's reaction when this waive of Katrina and Rita evacuees came into Arkansas? 'Get them on Medicaid -- it doesn't matter; we'll figure it all out later' It was the figuring it out that made you realize just how complicated it was. You know, it was fascinating for me because one day we were in the weeds on DRA specifics and the next day it went to just silence and then we went straight from that to figuring out what the heck to do on Medicaid and Katrina victims."[56]

In the end, waivers were preferred because neither the federal government nor states wanted to extend the Medicaid entitlement to a broad base of people -- Katrina evacuees -- as opposed to Medicaid enrollees. So, the federal government established a system of Medicaid waivers plus an uncompensated care pool. Medicaid enrollees were covered via Medicaid waivers and the uncompensated care pool covered everyone else. As a NGA representative said, "You know one thing that is interesting that you bring up and it's one of the biggest complications is that -- for something like that is -- what happens once a person enrolls in Medicaid and all the rights and responsibilities that are related to that. Especially when you are not able to control somebody coming in. In some places thousands of them -- you know they may not have their documents. They may not have … but once they're in; the state has all sorts of responsibilities -- and that is what we were bumping up against -- and it may be because of situations in New York,

[55] Jeanne M. Lambrew and Donna E. Shalala, *JAMA* 296, no. 11 (September 20, 2006).
[56] Interview with Author, August 16, 2006.

I'm not sure[57]…but there was a real hesitancy from some Governors and CMS to opening up Medicaid to all of these people for that period of time."[58]

Many overnors did not want severely enhanced Medicaid roles. They did not want Medicaid becoming a universal coverage program, and neither did the G.W. Bush Administration for that matter. As one NGA representative continued, "You had a number of Governors after Katrina say, 'We don't want all of these people on Medicaid. Yes, it's the quickest way to get people health care but the headaches of having to deal with that are too great.' We saw back in 2002 when states were in the budget pit with the fiscal relief money and we would argue that's an effective way of getting money to flow quickly, but that starts this huge political debate about the role of Medicaid. I think that's a much more vitriolic debate at the federal level than the state level."[59]

As for the President, the NGA representative stated that he "did not want to set a precedent for putting everyone, regardless of categorical eligibility into Medicaid -- there is no precedent for that…it was held to that this did not happen in Medicaid…the President was able to hold to that precedent."[60]

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[57] After the 9-11 terrorist attacks, Medicaid waivers were used to address immediate health needs of thousands of victims.
[58] Interview with Author, August 16, 2006.
[59] Interview with Author, August 16, 2006.
[60] Interview with Author, August 15, 2006.

CONCLUSION

The Deficit Reduction Act (DRA) may be a watershed event in Medicaid politics over the long-term. The state flexibility and benefits changes were spearheaded by the NGA -- as they had a prominent spot at the bargaining table. The Medicare Modernization Act on the other hand left states out of the mix, with the federal government handing states a new deal on the dual eligible prescription drug benefit. States remain unhappy with an arrangement where they continue to contribute to drug costs for dual eligibles but do not benefit from the high utilization population enhancing their bargaining position for their other pharmaceutical costs.

While the Bush Administration attempted a capped funding initiative in 2003, it was largely a non-starter with no states electing the uptake option. Of the general trends of the era, the transcendence of the Administrative state in waiver bargaining is of note. Medicaid politics in the Bush era up until the DRA, which was signed in February 2006, was largely negotiated in vertical autocracies -- from federal agency to state agency or from federal agency to Governor. Waiver politics now involves transfer of federal financial exposure to the states via explicit or implicit caps, both of aggregate and per capita cap varieties. Possibly, the idea on caps is stated best though comments made by Mississippi Governor Hailey Barbour, "For all Governors, Democrat and Republican, there is already a cap on Medicaid expenditures; that cap is each state's budget."[61] Moving into the future, as Medicaid is asked to do more -- as it has with each subsequent decade -- state tax and fiscal capacity will still be a reality in Medicaid's Political Economy.

[61] Interview with Author, December 15, 2006.

12. SUMMARY AND CONCLUSIONS

INTRODUCTION

The Medicaid Evolution: The Political Economy of Medicaid Federalism is anchored in Institutional Economics and on a compilation of political science theories organized in a conceptual framework for this Dissertation called The Macro Public Policy Framework (MPP). The conceptual framework weds Institutional Economics and a compilation of political science theories (the MPP). This work traces the economic history of the demand side of poverty -- of a program designed in 1965 to largely ameliorate the demand side of poverty in health care.

In 1965, Medicaid was designed as the basis for national health insurance. No one knows if the original institutional structure was maintained, even through very difficult initial years of cost inflation beyond original expectations, if the program today would cover more people at the same -- or even lower cost. The program is currently broaching $350 billion joint federal and state dollars annually and is plagued by a lack of rationality in the financing structure due to a history of differential state bargaining over decades with the federal government. Even at this cost, 45 million Americans are uninsured. And that number keeps climbing.

ORGANIZATION OF THIS WORK

The Dissertation is organized in four parts, consisting of an Introduction and twelve chapters. In the Introduction, the Primary Research Questions are presented. Part I, in two Chapters, reviews the "Policy and Federalism Theory" that serves as the

conceptual framework for this work. Part II, "Medicaid In Retrospective" concentrates on four eras, one chapter per era, in Medicaid policy history from 1934 - 1992 including:

1. The First Big Bang: FDR's Pre-Enactment Years;
2. The Second Big Bang: LBJ's Rights Era;
3. The Watershed Era: Nixon's Near Big Bang and New Federalism; and
4. The Budget Era: Reagan and Medicaid Expansions.

Part III focuses on "The Modern Era," defined for this work as 1992 - 2007, and consists of five chapters broken out by "The Waiver Presidency: The Clinton Era" in four chapters, and "The Rise of the Administrative State: The G.W. Bush Era" in one chapter. Part IV, this chapter, provides "Summary and Conclusions." **Figure 5: The Medicaid Evolution Timeline** depicts Medicaid's six eras along with moments of particular importance in the Political Economy of Medicaid Federalism

METHODOLOGY

The methodological grounding for the Dissertation is constructed by several building blocks including extensive review of archival and research collections at the ***LBJ Presidential Library***, ***The Center for Legislative Archives at the National Archives*** in Washington, D.C., ***The Law Library at the Library of Congress***, ***The National Library of Medicine***, and multiple research centers at the ***Library of Congress***. Several periodicals and newspapers were reviewed in a systematic way including *The Congressional Quarterly Almanac* from 1960 - 2004 and several major national and regional news sources. The most prolific decision makers in Medicaid politics in the modern era were interviewed for the project from the federal and state ranks, legislative and executive branches, and the leading legal minds in the field. Several search engines, such as ***EconoLit***, ***JSTOR***, and ***PubMed***, were reviewed. Hundreds of secondary sources inform this research. A more detailed Methodology description is in the Introduction.

FIGURE 5: MEDICAID EVOLUTION TIMELINE, p. 1

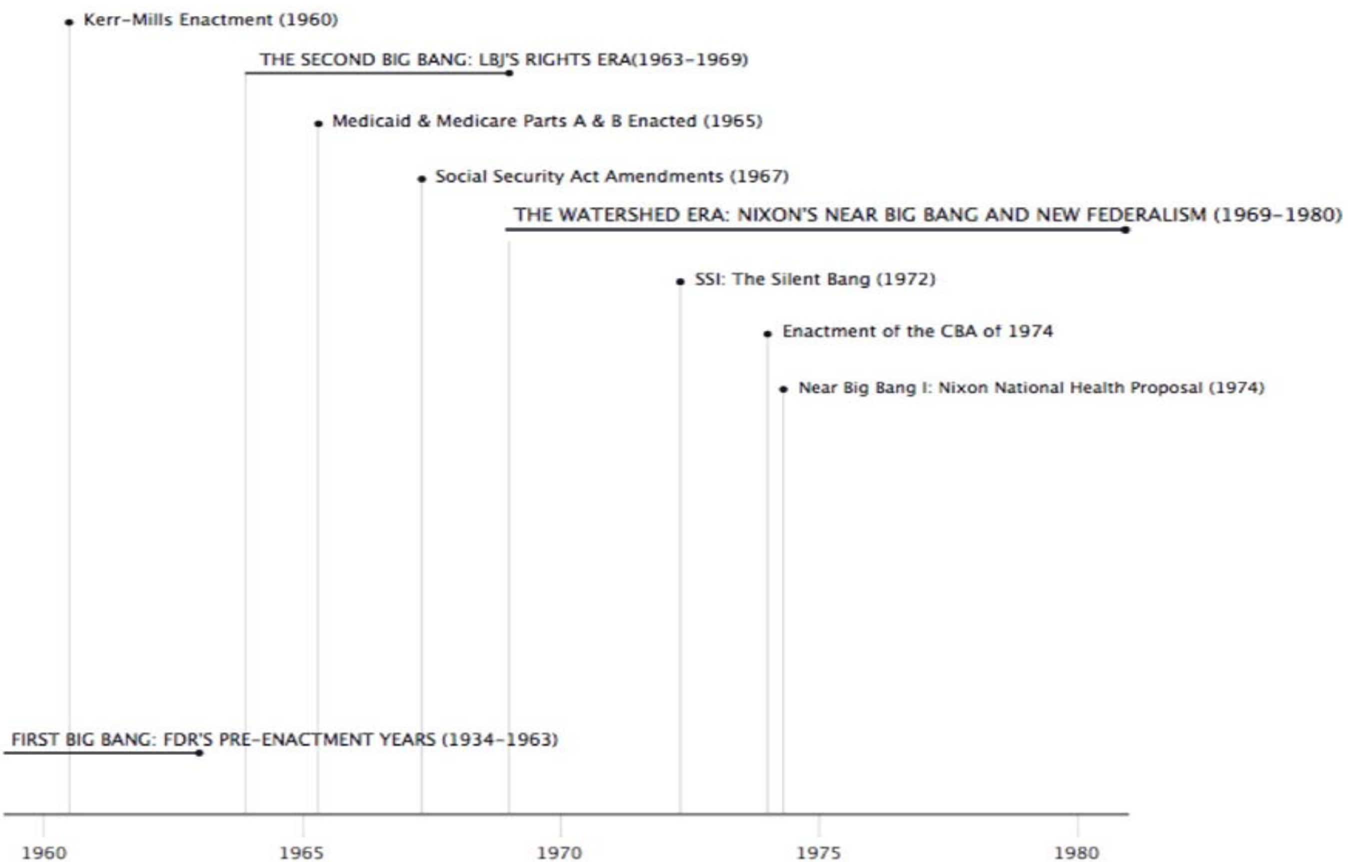
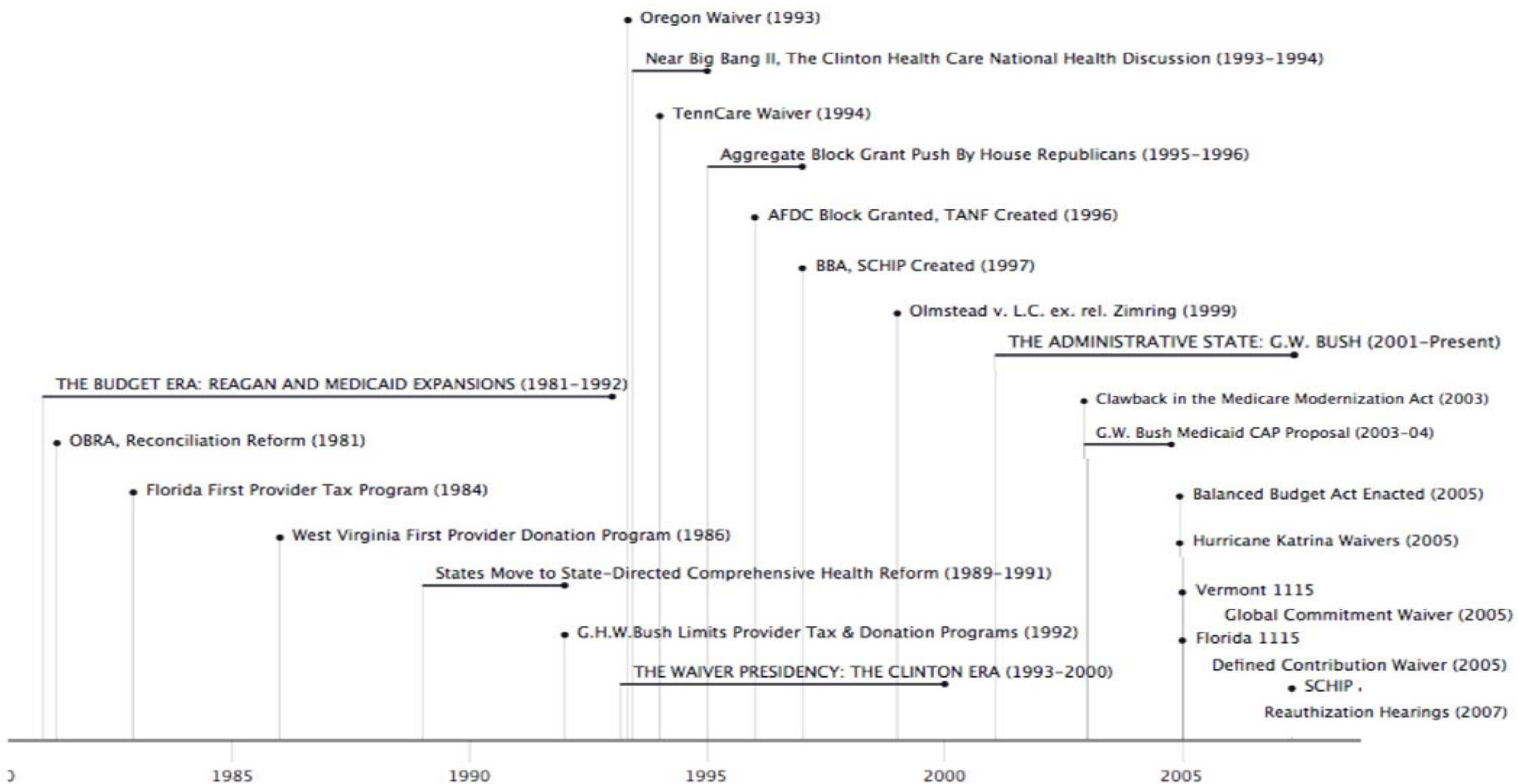


FIGURE 5: MEDICAID EVOLUTION TIMELINE, p. 2



PRINCIPAL FINDINGS

There were 35 major findings from this work. In this "Summary and Conclusion," three are the focus:

1. The Use of State Flexibility as a Bargaining Chip;
2. State Financing Mechanisms Through Reiterative Negotiations Over Time has Resulted in a Complete Lack of Rationality in Medicaid Financing; and
3. The Policy Bargaining That Has Resulted in Loss of the Original Principles of the Medicaid Program.

The Use of State Flexibility as a Bargaining Chip

State Flexibility is the G.W. Bush Administration's strongest bargaining chip. In exchange they demand greater cost and overall control over states explaining how they fund their Medicaid programs, their certified public expenditures (CPEs), and interference with state taxing authority. They are demanding to get an accounting of the Revenue side, not just the Expenditure side of Medicaid. The relevance of this goes beyond Medicaid. It broaches a line in the sand that states have drawn in American Federalism, "How we fund programs is our business, not that of the Federal Government." In Medicaid, the current Administration is using state flexibility to draw states away from this deeply held principle of state rights, and potentially infringing on states' 10th Amendment rights.

The change in the use of the State Plan Amendment (SPA) after the Deficit Reduction Act of 2005 only furthers this. State Flexibility is being used to incentivize states into accepting terms during state-by-state waiver negotiations for their Medicaid programs that address the Administration's more deeply held values, such as moving Medicaid financing towards a Defined Contribution approach, the Purchase of Privatization Products, and State-by-State capping of the Medicaid program.

So, how did the evolution of Medicaid federalism contribute to this? Since the flexibility argument was basically won by the states after the 1993-1994 national health discussion, it was easier for the G.W. Bush Administration to piggy-back on the precepts accepted by both Democrats and Republicans and engrained in Clinton's Waiver Presidency. The first major 1115 waivers, Oregon in 1993 and Tennessee in 1994 firmly established President Clinton's Administration as supporting the states as laboratories concept.[1] President Clinton's years as Governor of Arkansas affected his approach to policy related to the American welfare state and garnered him the title "The Waiver President." During the 1995 - 1997 Medicaid block grant debates, the States won the Flexibility Argument -- and to some degree the Personal Responsibility argument. The G.W. Bush Administration has cashed in on this by using state flexibility as a bargaining instrument in exchange for Medicaid reforms that further their more strongly held values. Medicaid federalism is used instrumentally, using state flexibility as a bargaining chip, in order to, first, move Medicaid financing towards a Defined Contribution approach; second, encourage the use of Medicaid funds to purchase private insurance products; and, third, to institute State-by-State capping of the Medicaid program.

State Financing Mechanisms Through Reiterative Negotiations Over Time has Resulted in a Complete Lack of Rationality in Medicaid Financing

The single largest inhibitor to future reform in the Medicaid program is the history of negotiations that each state has had since 1984 and 1986 around creative state financing mechanisms with HCFA/CMS. This history began in 1984 when Florida started the first provider tax program and in 1986 when West Virginia began the first provider donation program. Between 1990-1992, the G.H.W. Bush Administration intensely pressured states to stop the money laundering that was funding not only the Medicaid program -- but being used openly by Governors to balance state budgets. At

[1] The State of Arizona received a 1115 waiver when the state entered the program in 1982, but this was the lone 1115 and a very special case. After the Oregon and Tenncare waivers in 1993 and 1994, these waivers were adopted state-by state until today when many states hold multiple 1115 waiver agreements with the Centers for Medicare and Medicaid Services (CMS).

that time, Congress intervened on behalf of the states -- and, interestingly, some members of Congress believed not only that they were acting on behalf of states by doing so, but on behalf of beneficiaries. It was alright for states to institute schemes to maximize federal funding as long as they did not cut optional eligibility or services. Since that time, there has been a back and forth on these state financing schemes.

In interviews with Federal Administrators, they speak of the Medicaid program as being a blank check for states, a big overdraft account in the sky, and one influential Congressional staffer says at times the state money laundering has been so ridiculous that even they admit they look like “skunks in a candy shop.” But what truly muddled the issue was the advent of the statewide 1115 waiver process, instigated by the negotiations with Tennessee over their 1994 Tenncare program. During those negotiations, Tennessee was allowed to keep within the budget neutrality requirement of the waiver process a whole host of funds -- these are the DSH or Disproportionate Share Hospital funds -- that they had garnered through a state money laundering arrangement designed to maximize the federal match. They were allowed to keep the same level of Medicaid funding under the waiver agreement even though HCFA knew that these funds were generated through a creative state maximization program. For those interested in Public Finance Theory, this resembles The Flypaper Effect. Money sticks where it hits. And this precedent stuck.

States that are creative in state financing schemes have more money to operate with in 1115 negotiations with CMS. Bad actors are rewarded. Every five years, 1115 Medicaid waivers are re-negotiated. The history of these state-by-state negotiations has created such differentials in federal financing arrangements with states, that no one truly knows what the federal matching rates to states are, regardless of what the Federal Medical Assistance Percentage (FMAP) table says.[2] One CMS Administrator thought that in the early 1990s it was feasible that the federal government was approaching 100% match rates in the Medicaid program. There is no way to audit these “fathom” charges.

[2] The Medicaid FMAP table reports the official match rate that the federal government will give states for each dollar the state spends on the Medicaid program. The FMAP rates are based on a formula highly dependent on a state’s per capita income. FMAP levels are supposed to mitigate the inequality that exists between wealthy and low-income states in dedicating state dollars to their Medicaid programs.

Medicaid financing is inequitable and is the result of a series of reiterative bargains between states and CMS over the past two decades. There is no longer any rationality in the Medicaid financing arrangements and this greatly hinders future reform.

The Policy Bargaining That Has Resulted in Loss of the Original Principles of the Medicaid Program.

With the advent of the Deficit Reduction Act of 2005, the Original Principles of the Medicaid program are officially history -- a thing of the past. If the DRA stands, it is possible that in five years it will be seen as a Watershed event in Medicaid policy bargaining. To the extent this happens, the Original Principles of the Medicaid program may truly be talked about only in policy history accounts and not in terms of current policy negotiations shaping the program. From the anonymous legislative counsel's drafting of the original statutory language of Medicaid in 1965, Medicaid was the basis of national insurance. The original drafter wrote Medicaid to eventually grow into a national insurance model. The original skeleton of the program, the closest thing to a legislative history of the program, is officially entitled the "Handbook of Public Assistance Administration -- Supplement D: Medical Assistance Programs Under Title XIX of the Social Security Act." This guidance was such a powerhouse that one of the first acts of the Reagan Administration was to place notice in the *The Federal Register* repudiating them. In the words of one of this country's most highly respected Medicaid experts, "Medicaid, how it was originally drafted, was brilliant, far more impressive than Medicare."[3]

Some of the original principles of the program were reneged on early. For example, in the 1967 Social Security Amendments, almost immediately, the program was re-structured to limit the populations that it would cover. This was the first half of the "Deal with the Devil,"[4] where the government took back its 1965 pledge on the

[3] Interview with Author, October 31, 2006.
[4] Interview with Author, October 31, 2006.

Expenditure side, placing much more strict limits on what was included in the federal match.[5]

The Comprehensive Care Provision, 1903(e), of the original 1965 Medicaid, was postponed, postponed, and then -- as the LBJ Rights Era came to a close -- was dropped altogether. While 1903(e) may sound like common or drab statutory language, consider its significance. This provision required states to work towards providing health coverage for all low-income people, without regard of categorical distinction, by 1975. It was the basis for covering the uninsured. It was the basis for national health insurance.[6]

The original principles of Comparability of Benefits and Statewideness have been worn away to some degree over several Medicaid eras, but generally required waiver authority. This began with the 1972 SSA Amendments that Wilbur Mills proclaimed, "contains the most far-reaching provisions of any Social Security bill since we passed Medicare in 1965."[7] Those Amendments allowed prepaid arrangements by waiver if it "provide[d] more generous health services than those in the state Medicaid plan."[8] In the Reagan era, OBRA '81 created 1915(b) Freedom of Choice waivers, allowing states by waiver to enroll Medicaid beneficiaries in managed care. The first statewide 1115s which erupted during Clinton's Waiver Presidency basically further eroded the notion of Comparability of Benefits and Statewideness.

In terms of effects on beneficiaries, after the Deficit Reduction Act of 2005, it is debatable whether principles of freedom of choice, comparability of benefits, or statewideness will exist at all in the set of events triggered by that legislation.
In terms of effects on states, this is where we find the second half of the "Deal with the Devil." First in 1967, the federal government pulls back on its initial pledge on the

[5] The details of these 1967 SSA Amendment restrictions are reviewed in Chapter 4, "The Second Big Bang, 1965: The LBJ Rights Era."
[6] The Comprehensive Care Provision, 1903(e): The Secretary shall not make payments under the preceding provisions of this section to any State unless the State makes a satisfactory showing that it is making efforts in the direction of broadening the scope of the care and services made available under the plan and in the direction of liberalizing the eligibility requirements for medical assistance, with a view toward furnishing by July 1, 1975, comprehensive care and services to substantially all individuals would meet the plan's eligibility standards with respect to income and resources, including services to enable such individuals to attain or retain independence or self-care. See Stevens, *Medicaid: Anatomy*, 365.
[7] Reference from Chapter 5; Source from 1972 *CQ Almanac*, 914.
[8] Reference from Chapter 5; Source from Stevens, *Welfare Medicine*, 338.

Expenditure side so that states are no longer allowed to spend what was originally designed by the 1965 legislation. In the DRA 2005, the second half of the Deal with the Devil is being realized where states must provide much greater transparency on the Revenue side of how they fund their programs. A program, originally designed to be the basis of national health insurance is now a program where states are hamstrung by the federal government on both the Expenditure and the Revenue side. Some believe this is an intentional ploy on the part of the current Administration to push states to opt out of the program altogether.[9] Some states, such as Missouri, have hedged in that direction.[10]

GENERAL CONCLUSIONS

We are headed towards a program that will be Defined Contribution and explicitly capped, not on a Federal basis by Congressional action, where elected officials debate and vote on law. But instead in state-by-state negotiations with CMS where they continue to use waiver -- and now State Plan Amendment -- negotiations and The Administrative State to incentivize states in this direction. The 2005 Florida and Vermont waivers demonstrate this.

If the DRA of 2005 is not rolled back by the new 2007 Democratic Congress, it may very well be a watershed period in Medicaid as important as the 1974 time period that is written about so extensively in Chapter 5 of the Dissertation. Entitlement bargaining was never the same after the 1974 Congressional Budget Act was fully operationalized in the 1981 OBRA process. Likewise, the DRA has that potential watershed capacity in Medicaid political economy. Politics will decide the policy direction of Medicaid. Another reason the 2008 elections are so important.

[9] Interview with Author, October 31, 2006.
[10] Interview with Author, August 15, 2006.

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VITA

Gloria Nicole Eldridge focuses on economic rights and social justice, political theory and federalism, institutional economics, and U.S. and international health and pharmaceutical policy. International and national appointments include Adviser to the United Nations World Health Organisation-Europe (Copenhagen, Denmark); Investigator for the U.S. Government Accountability Office (Wash., D.C.); Consultant at The Lewin Group (Wash., D.C.) and Quintiles Transnational (London, UK); and Researcher at Georgetown University (Wash., D.C.) and The London School of Economics Health Institute (London, UK). Among professional accomplishments, the WHO pharmaceutical financing effort networked policymakers from over 50 countries throughout Europe and Eurasia. Gloria Eldridge was born on September 15, 1972 in Knoxville, Tennessee. Her father, Owen C. Eldridge, Jr., is a theoretical physicist. Her mother, Ileana Spagna Eldridge, was a sociologist who also held a law degree.

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