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The Weakening of the States

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The role of the states in American government is *weakening*. There are three main causes:

- *First cause:* The Great Recession has strained state government finances to near the breaking point in many states because state governments are so vulnerable to reductions in income and sales tax revenues; can't run deficits; and because some states have deep, severe, and long-standing structural problems. Meanwhile, service needs are rising in the recession.
- *Second cause:* Medicaid continues to put heavy pressure on the finances of every state. The end of extra funding for Medicaid from the recovery act next year, along with possible further Medicaid spending requirements in a new national health reform law, will cause havoc for state budgets.
- *Third cause:* The information revolution has produced a de-emphasis on states generally by creating the false impression that we don't need them, that more and more of domestic government can be micromanaged from Washington.

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The irony of this situation is that if a national health reform law is passed this year or next, its success will depend heavily on state governments. A new law is only a beginning. Implementation is the short suit of America's governments. Health reform requires deep institutional penetration. Ground level changes in institutional behavior are required to convert the "good" intentions of a new law into good results. I focus on this challenge in this paper. Reforming health care delivery systems to serve more people more efficiently is the biggest institutional challenge for America's governments since the Great Depression. Meeting it requires three things:

1. *First Requirement*. Staffing the federal establishment with exceptional people who make and execute wise decisions.

Reforming health care delivery systems to serve more people more efficiently is the biggest institutional challenge for America's governments since the Great Depression.

2. *Second Requirement*. Doing the same thing at the state level, especially for the establishment and management of health-insurance "exchanges," a likely key ingredient of any new health care reform law. Historically, states have been primarily responsible for policy and regulatory oversight of insurance companies.
3. *Third Requirement*. Making sure that the effects of national and state policy and operational changes reach down to the community level and stimulate and facilitate the restructuring health care service delivery systems.

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The rest of this paper presents examples for these three-level implementation requirements of health reform.

Staffing the Federal Establishment for wise decisions. People matter. As much as anything, the selection and deployment of men and women of exceptional intelligence, integrity, and energy at both the national and state levels to take on new leadership responsibilities will determine whether health reform is successful. Who will they be? How will they perform?

I recommend two books published this year by the national academies of Social Insurance (NASI) and Public Administration (NAPA) for understanding the implementation challenges of health reform.[1] *Administrative Solutions in Health Reform* is a panel report (80 pages) that draws heavily on and synthesizes a second volume consisting of 18 papers by noted health and administrative experts. The regulatory role of government under a new health reform regime is highlighted by both NASI-NAPI volumes. The essential point of a paper by Timothy Stolzfus Jost (paper No. 4) is simple, but often overlooked. The following is from the panel report:

> However one judges the effectiveness of health insurance regulation to date, writes Jost (2009), it is difficult to imagine a reformed health care system without health insurance regulation. Proposals to subsidize or mandate insurance must define the coverage to be subsidized or mandated and establish procedures for assuring that plans comply with the requirements. (p. 41)

At both the national and state levels, huge questions arise: What agencies will play this regulatory role? How will they be organized, headed, and staffed? How well will they perform?

Managing Exchanges. The responsibility for operating the exchanges is unsettled at the time of writing this paper. Whatever results for the assignment of this function (to the states or to the federal government, or jointly), the creation of new insurance marketplaces will require an exceptional level of collaboration for the federal-state partnership for health policy — indeed, there is one, though varied and diverse among the states.[2] Both conceptual and operational questions arise about the role, structure, and

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coverage of the exchanges. But make no mistake, however exchanges emerge under new legislation, they will mature and change over time.

Both the NASI and NAPA reports make extensive references to, and use of, precedents for the role of exchanges. At the state level, the Massachusetts Connector experience stands out like a beacon. The Massachusetts Connector, established in 2006, is an independent public authority overseen by a board of ten directors that has as its primary role offering standardized benefit plans and affordable coverage options to low-income persons and small businesses.[3] How, and how well, will state governments perform and/or contribute to fulfilling this role in other states?

Larry Brown and I, along with colleagues in the states, have conducted field research on this subject. In Massachusetts, in particular, one cannot help but be impressed by the way the Connector is working. It has a small staff (around 50 people) with major support from the health department for vital functions such as record keeping, tracking participants, establishing income eligibility, and organizing outreach. A conscious decision was made in 2006 to assign the Connector the responsibility to provide expanded coverage with the understanding that as it came into operation further legislation would be necessary to define and refine its role — especially with regard to cost containment.

The state followed through on this premise in 2008 by establishing a Commission on the Health Care Payment System to "investigate reforming and restructuring the payment system to provide incentives for efficient and effective patient-centered care and to reduce variation in the quality and cost of care." The commission reported in September 2009, and as this paper is written is involved in efforts to put its recommendations into law.

The recommendations of the Massachusetts health care payment commission are closely in line with what other states have done and are doing and also at the federal level with reports of the Medicare Payment Advisory Commission (Medpac) and other experts and research and policy organizations. Medpac is an independent Congressional agency established by the Balanced Budget Act of 1997. Without going into details, the recommendations of the Massachusetts payment commission for bundling services and capitation arrangements, integrating providers, and creating health care homes (as in Minnesota and other states)[4] are the hard-slogging terrain of what is sure to be a continuing saga for the federal government and the 50 states if a new health reform law is passed — and even if it isn't. Whatever happens, implementation research will be invaluable at all three levels (national, state, and local).

Reform purposes both for expanding coverage and heightening efficiency can and should come together in the work of the exchanges. There is every reason for exchanges to connect the two (the right verb, indeed) by offering enrollment opportunities for service-bundling capitation systems in all of the ZIP codes where

such organizations exist. There are many of them already out there. State governments are major actors in chartering and overseeing such organizations.

Moreover, besides the roles described so far, there is another crucial and little noticed way in which states will be big players under a new health law. Expert estimates suggest that as many as two-thirds of the newly covered people will be covered under Medicaid under terms of the major bills being considered. Medicaid, of course, is a huge federally aided state program with multiple missions and functions involving tremendous variation among and within states.

Let me add a federalism recommendation at this point: There is likely to be an opportunity in the national-state partnership for health care for the federal government to discriminate in working with the states on the implementation of a new health care reform law. Some states that are already out front (Massachusetts, Maryland, Vermont, Maine, Pennsylvania, Connecticut, Minnesota, Wisconsin, and New York) could have a bigger, stronger role under a new regime. Other states, including some that have lagged in health reform, could receive closer monitoring and a generally higher level of oversight. This approach (call it "functional-flexible federalism") could especially come into play for the exchanges. Even if this role is assigned to the states it would be within the terms of national policies and requirements. Our federalism can work this way and it should.

Making Changes at Ground Level. The institutional challenges discussed in this paper should be viewed as part of a federalism compact. The first challenge highlights the role of federal appointees. The second highlights the state role. The third is ground level, where (pardon the expression) the rubber hits the road. Each level involves the others, although their role and focus are different.

The ultimate test of whether and how the United States can achieve institutional change in the delivery of health care depends to a high degree on what happens *locally.* I don't mean so much what local governments do (although that can be important) as the need to observe what is really out there — how people can enroll; how they can be tracked and retained; and how the administrative processes works for establishing and updating vital eligibility information, for example for income, residency, personal status, family composition, citizenship, etc. This will involve a virtual cornucopia of public, nonprofit, and private organizations. The criticality of the delivery-system functions they perform are driven like an iron rod through the literature on health reform. Slogans abound about the need to do this and ways to pay for episodes of care, bundle services, loosen the grip of the fee-for-service culture of health care, pay for performance, integrate services, and connect them electronically.

The challenge of delivery-system reform must be achieved in what has to be described as a monumentally difficult political and organizational environment. As pluralistic, open, active

democracies like ours age, the strongest entrenched interests grow in power.[5] Chief among them in the United States is the health care complex — hospitals, physician specialties, drug companies, medical societies, other providers, and large organizations representing groups of health care workers. In many cases, committed and caring in the fulfillment of their mission, it is nevertheless the case that their political acumen and experience, lobbying muscle, and campaign-support capability make it extraordinarily hard to shift the health care cost curve.

This is not to say or suggest that changes can't be made, only that they are hard to make. Initiatives emanating from all three governmental players (federal, state, and local, best of all acting in concert) have achieved notable successes. These achievements are diverse and wide ranging. This is a big country with a vast health care industry, in fact it is hard to view as an industry precisely because it is so far flung and diverse. Change agents at every level have achieved success — simply not enough of it.

Although the ultimate test of the success of reform will be at the local and community levels, state government leadership and activism is crucial to achieving it. Mentioning Minnesota's health care homes; Maryland's all-payer system; Arizona's Medicaid managed-care system; the Massachusetts Connector and similar reforms in Vermont, Maine, and Pennsylvania; and Badger Care in Wisconsin gives a feel and flavor of the role of the states in digging deeply into this local institutional terrain.

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This brings me to final comments, going back to the point made at the outset of this paper about the weakening of the role of the states in American federalism. This is unfortunate and unfortunately will make it harder to achieve health care reform — with or without a new law. The role of the middle level (the states in our case) in a federal system is the principal distinguishing characteristic of federalism as a governmental system for reconciling unity and diversity. American federalism has served the nation well as a force and source for government innovation, citizen participation, and for the development and training of new leaders, while at the same time reflecting different regional conditions, needs, and community values.

Indeed, there is a cyclicality whereby innovations in American federalism have varied over time. When the mood of the country is conservative, governmental innovations in the out-front states are incubated in the states and later morph to become national when the national mood changes. This was the case in the New Deal and is also true of earlier periods of American history. Well functioning decentralization is, and long has been, essential to the accomplishment of a wide range of historic changes in American domestic government. The agenda for implementing health reform must include this perspective and this need.[6]

Endnotes

1 National Academy of Social Insurance and National Academy of Public Administration, *Administrative Solutions in Health Reform: Report of the Study Panel on Administration Issues in Expanding Access to Health Care,* July 2009, p. 6. Available at http://www.napawash.org/NASI/Health_Reform_July_2009.pdf See also an excellent paper by Linda J. Blumberg and Karen Politz, *Health Insurance Exchanges: Organizing Health Insurance Marketplaces to Promote Health Reform Goals* (Washington, DC: The Urban Institute, undated).

2 See Michael Sparer, "American Federalism: The Next Inter-Governmental Partnership," available at http://www.rockinst.org/pdf/health_care/2009-09-SCI_report_federalism.pdf

3 Based on field research interviews. See also Liz Lowalczyk, "Panel Crafts Plan to Cut Medical Spending," *The Boston Globe*, September 12, 2009.

4 See, for example, Lawrence D. Brown and Richard P. Nathan, "Chicken, Eggs, and Institutions: Minnesota Launches Health Care Homes" (Albany, NY: The Nelson A. Rockefeller Institute of Government, August 2009). Available at http://www.rockinst.org/pdf/health_care/2009-07-Chicken_Eggs.pdf.

5 Mancur Olson, *The Rise and Decline of Nations* (New Haven, CT: Yale University Press, 1982). See especially the chart on p. 74 where he said, "Stable societies with unchanged boundaries tend to accumulate more collusions and organizations for collective action over time," and the section on pp. 75-80.

6 For the author's writings on the characteristics and values of a federal system, see Richard P. Nathan, "Nelson A. Rockefeller and 'The Future of Federalism'" (Albany, NY: The Rockefeller Institute of Government, September 2008, http://www.rockinst.org/observations/nathanr/2008-09-nelson_rockefeller_and_the_future_of_federalism.aspx. See also Richard P. Nathan, "There Will Always Be A New Federalism," *Journal of Public Administration Research and Theory* 16, 4 (February 14, 2006), http://www.rockinst.org/pdf/federalism/2006-02-14-there_will_always_be_a_new_federalism.pdf, and Richard P. Nathan, "Federalism" in *The Oxford Companion to Politics of the World (2nd edition),* edited by Joel Krieger (New York: Oxford University Press, 2001).