Federalism in Health Care: Costs and Benefits

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FEDERALISM IN HEALTH CARE: COSTS AND BENEFITS

Stephen Utz

I. INTRODUCTION

So far, health care policy in the United States is whatever policy one can impute to a loose constellation of state and federal regulatory efforts, more or less randomly interacting with federal health care coverage for the elderly, for veterans, and for some of the indigent and disabled. The federal government also influences the delivery of health care by subsidizing hospitals directly, by exempting charitable hospitals' income from corporate taxes, and by allowing employees to receive health coverage from their employers tax-free.

There are other powerful institutional forces at work. For years, most large employers and some unions have been committed to outfitting employees with health care coverage as a fringe benefit of employment, but recently, as unions have grown weaker, some unionized employees have lost this fringe on the bargaining table and large employers have substantially weakened health care coverage for non-unionized employees. Insurers that sell coverage to employers and others have,

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2. I.R.C. § 501(c)(3).

3. Id. § 105.

4. As of 1990, two-thirds of Americans under 65 and three-fourths of employees were covered by employer-sponsored plans. Henry R. Aaron, SERIOUS AND UNSTABLE CONDITION 54
as powerful purchasers of health care packages, begun to dictate the structure of some health care delivery.\(^5\) They have also found themselves facing higher prices than the federal government pays for some of the same hospital procedures; some of these private purchasers of health services have complained that the success of federal program cost containment efforts is shifting costs of federally covered procedures to them.\(^6\)

A recent Congress encouraged some of these changes in the health economy by entertaining proposals for a national health care system and then failing to act.\(^7\) A new Congress is now threatening to cut back comprehensive health care for the elderly, the indigent, and the disabled by means that could undermine federal health care cost containment programs that have been working.\(^8\)

Against this messy background, proposals for revamping the U.S. health care economy are difficult to assess. Interesting things are happening in a decentralized way, although only those currently standing to benefit from the changes, primarily employers, are confident that the various health care markets will find a globally desirable solution.\(^9\) The flowering of a number of health care plans mandated or sponsored by state governments can be viewed as an uncoordinated experiment in the design of government-sponsored plans, one that promises to confirm or impugn claims made on behalf of national-level health care schemes.

The topic of this Commentary is whether a federally sponsored health care system implemented through a variety of state plans, can produce a satisfactory general result. Professors Mashaw and Marmor give this topic an engaging specificity. They propose a version of “co-operative federalism” for comprehensive health care (hereinafter, “CHCF” for “cooperative health care federalism”) that allows the states

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\(^6\) President’s Commission on Entitlements (1995).


to experiment and ultimately to differ, within federally imposed limits, and yet work together to provide comprehensive, portable health care coverage with a nationally uniform benefit package. As they point out, the United States has a great deal of experience with cooperative federalism. Medicaid is among the most important examples of such federal/state action, and a comparison of its problems and successes with those of the considerably more ambitious CHCF deserves close attention. Other cooperative federalist legislation, notably in the areas of environmental protection and prevention of employment discrimination, may also be instructive. The limited track record of uncoordinated, more or less comprehensive state health care plans holds further lessons.

At first glance, CHCF may seem unsatisfactory for three reasons: 1) the Mashaw/Marmor plan seems only to graft a few broad federal requirements, deliberately formulated in somewhat vague terms, on a process of individual state experimentation that will probably take place, whether the federal government takes a hand in it or not; 2) their defense of CHCF does not explain how it would achieve any of the goals of recent health reformers other than near universal coverage; and 3) they give no attention to the sluggish tempo of cooperative federalist programs that require states to devise separate plans of implementation, submit them for federal approval, and only then put them into operation. Nevertheless, I believe that in several respects, CHCF would be preferable to a more thoroughly national health system. It could achieve some good things at a smaller cost than a uniform mandatory system.

As a preamble to assessing the CHCF, a restatement of the problems to be addressed through governmentally mandated health care policy is useful. That is the task of Part II. Part III assesses CHCF in terms of these goals. Part IV then considers the advantages and disadvantages of federalism in comparison to uncoordinated state-level evolution of comprehensive health care plans.

II. THE GOALS OF MANDATED HEALTH CARE SYSTEMS

A. Cost Containment

Containing health care costs is the resounding goal of most health care reform in this country. The same is beginning to be true in countries with otherwise successful comprehensive health care systems.10

10. See Marie-Line Cal, Le Nouveau Dispositif de Financement Hospitalier Français: Une
The justification for this goal is often assumed. Why accelerating health care costs are a problem deserves brief exploration. Any federal entitlement program that benefits a majority of voters and grows faster than the economy is a problem for elected officials, because the benefited majority can insist on the continuation of the program and refuse to understand the need for adjustments elsewhere—the curtailment of other programs, higher taxes—to pay for the ballooning entitlement. Medicare and Social Security are the conspicuous examples. Medicare costs have been growing faster than the rest of the economy because these costs are linked to the private market for health care. So, one reason for worrying about accelerating health care costs is a reason for politicians, though it affects us all to the extent that it strains the political process.

Another reason for concern about higher health care costs is that they burden employment or, if employment resists the burden, they burden business profits linked to labor and can create competitive disadvantages between our companies and those in other countries. As has been mentioned, many large U.S. employers until recently had accepted the idea that they would provide most of their employees with generous medical benefit packages. The cost of these packages is presumably growing faster than employer profits and taxable wages. Employees, therefore, may not see this cost escalation as their problem. When employees have the upper hand in negotiations over pay and benefits, employers are forced to pay more just to keep their employees as happy as they were in previous years (because the health benefits are getting more expensive) and may not earn the gratitude of the employees.

Most members of the public, however, probably do not think of the two problems just mentioned—that of the politicians who are expected to preserve an entitlement that is becoming more expensive, and that of firms pinched by employee reliance on medical fringe benefits—as the main reasons for worrying about rising health care costs. They probably think that if paying for health consumes an ever greater fraction of the

Mise en Perspective, Analyse Financière 14 (May 1995) (government payment of hospital costs is expected to undergo radical reform in the light of rising medical costs).


12. Uwe E. Reinhardt, Health Care Spending and American Competitiveness, 8 HEALTH AFFAIRS 5 (Winter 1989) (spokespersons for the automobile industry claim that each U.S. automobile incorporates $500 to $700 for health care costs while producers of foreign cars do not have to bear such costs); but see Aaron, supra note 4, at 100 ("high and rapidly growing U.S. health care costs do not much affect overall U.S. international competitiveness").
gross domestic product, society as a whole is less well off, just as a household suffers if its health costs steadily rise. Apart from political disruption and the creation of private competitive disadvantages, however, that is not necessarily the case. Money spent on health care does not go up in smoke. It goes to pay health care providers' salaries and provide profits for investors in health care and insurance firms. The salaries and profits are spent or saved in this country. Hence, like the disproportionate growth of the military budget during the "Star Wars" program of the 1980s, the growth of the national health budget is balanced at least in part by concomitant growth elsewhere in the private economy. The primary effect of the rapid growth of the health care industry may be its competition with other industries for resources and investment, but that merely resembles the growth of any other industry, such as the automobile industry in the first half of the century or other technology-driven industries (health care is, of course; one of these) in the second half. An important secondary effect, in view of state responsibility for a portion of the Medicaid budget, is the imposition of accelerating costs on states that cannot finance them, as the federal government can. This distortion, however, is rationally removed by federalizing the entire Medicaid budget.13

Accordingly, the significance of accelerating health care costs is not as straightforward as many members of the public assume. If health care cost increases are slowed, the result will be, in part, not just to stanch waste but also to curtail a growing industry that has fewer externalities than others that may replace it. If we don't spend our money on health care, we may spend it on cars or weapons.

Nevertheless, politicians (who of course represent people) feel an overwhelming need to keep the governmental share of the economy from growing out of proportion to the private share and to hold constant the health care share within the governmental share. Given that need, only federal measures to contain health costs will do. This is one of the acknowledged goals of health care reform.

B. Extension of Coverage

Another goal of health care reform is to extend the benefits of

13. At the moment, the Republican Congressional majority is trying to shift more of the Medicaid budgetary responsibility to the states, rather than the reverse. Christopher Georges, Senate Republicans' Medicare Overhaul Would Mean Higher Fees for Recipients, WALL ST. J., Sept. 13, 1995, at A3.
health care to a greater part of the population. There is an obvious tension between this goal and that of containing health care costs, although better health care for the indigent would probably avoid other costs for which the federal or state governments must ultimately take responsibility.

C. Making Coverage Portable

As Professors Mashaw and Marmor note, about ten percent of Americans are, by some estimates, "locked into" employment by the threat of losing their health care coverage.\(^{14}\) CHCF is intended to make health care coverage portable, no matter how individual states' health programs may differ. Although the details are sketchy, CHCF's proposed federal block grants apparently would be conditioned on each state's agreement to provide coverage automatically to other states' citizens or residents who might move to it. Professors Mashaw and Marmor take the interesting position that CHCF should not require the States to cover illegal aliens. They seem to think the federal government might comfortably lend its weight to the trend, in California and elsewhere, of efforts to discriminate between legal and illegal residents in the provision of basic social benefits.

D. Redirecting Expenditures

Redirecting health care expenditures to achieve overall greater benefit per dollar spent is a goal closely related to, and sometimes included in, that of containing health care costs. It is often argued, for example, that much health care is reactive rather than preventive and that the right kind of health coverage would focus on health education and early diagnosis of disease rather than on expensive, though more dramatic, medical responses to full-blown health problems. It is worth mentioning this as a separate goal from cost containment because achieving greater benefit for the same health care dollars is a goal worthy of pursuit apart from the perhaps more politically sensitive goal of cost containment. Moreover, cost containment could be achieved by means that are cost-inefficient, i.e., that lower the benefit per dollar spent.

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E. Research and Related Goals

Health care reform also may focus on a number of goals that have little to do with the fiscal burden of health care. For example, it is frequently lamented that we have begun only to study the effectiveness of particular treatments. "Outcomes research," as it is sometimes called, requires data collection and analysis. It also requires a legal framework adequate to protect the privacy of patients and their freedom from unjustifiable governmental intervention in their decisions. Many have argued that the data necessary for outcomes research is already collected by private parties—physicians, hospitals, insurers, employers, and so forth—and that the expense of collecting this information is partly squandered if outcomes research is not done; private parties, however, have no motive to undertake such research. Federal involvement therefore might be justified by the goal of providing this public good, which is already economically within our grasp.

F. Rationing Scarce Resources

Another health care reform goal that may be subsumed under cost containment, but which deserves separate mention, is that of rationing scarce health care resources. A comprehensive approach to health care might assure a fairer and more rational allocation of donated organs among those who need them—a rationing problem that is more or less independent of cost containment. Such an approach might also assure better availability of health care in less populous and less prosperous parts of the country, and thereto might intervene in medical school funding to assure a supply of appropriate generalists and specialists.

G. Summary

It is evident that the widely, if not universally, decried crisis of health care is not a single problem, at least if these disparate goals of health care reform are all taken seriously. Fashioning a policy response may involve some but not all of these goals. The CHCF appears to respond to multiple goals, just as the Clinton Health Plan did and as do current proposals before Congress for limiting the federal government's

15. Of course, privacy and liberty to decide as one chooses both have constitutional dimensions, under the Fourth, Fifth and Fourteen Amendments. U.S. CONST. amend. IV, V, XIV.
responsibility for health care. Not all health care reform addresses all the same issues, however. The congressional initiatives just mentioned, for example, would do nothing to disfavor wasteful medical technology or respond at all to the impoverishment of the catastrophically ill. The Clinton Health Plan, though premised on the need for health care cost containment, would have slowed the acceleration of health care costs, by its proponents’ own figures, only at a fairly distant future date. What can be said of the goals and likely efficacy of CHCF?

III. CAN CHCF ACHIEVE ITS GOALS?

A. Cost Containment

The goal that Professors Mashaw and Marmor place in highest profile is that of universal (or almost universal) medical coverage. To require coverage to any extent must also be to specify with some precision what that coverage will provide. So, they include among the federal minimum requirements a definition of what is usually referred to as the “benefit package.” The benefit package is the array of health-related treatments and services to which an insured or covered individual is entitled under a given health plan. Hence, their version of cooperative federalism would strive to extend somewhat uniform health care rights to almost all U.S. residents.

To explore this feature of the proposal more fully, it is worthwhile to compare the federal regulatory structure CHCF would require with that of some of our principal environmental regulatory programs. The Clean Air Act,16 for example, announced national standards for controlling air pollution from the release of specified substances into the air. It involved the states in meeting those standards by granting program funding to them in exchange for their enactment of legislation that implemented means of achieving the national standards. The state plans were supposed to be free to vary greatly; national oversight was essentially limited to the review of state plan design at the outset and review of state enforcement of these plans. CHCF, too, would provide block grants for state health care plans that met some basic national health care goals, such as near-universality of coverage.

Like the environmental legislation, the proposed health care scheme could impose design elements on the State block-grant recipients. What

would not be imposed is a single scheme of health care delivery or financing. States would be free to choose to provide membership in HMOs through state-provided grants directly to individuals (either in the form of actual transfer payments or in the form of tax credits), or instead to enroll unemployed residents in state-approved HMOs while mandating that employers provide their employees with similar, but not necessarily identical, coverage through commercial insurance or self-insurance. Professors Mashaw and Marmor also suggest that states might, under their proposal, provide more or less generous coverage, consistent with the mandate that they all provide the same benefit package. How is there room for variation in the "luxury" of different programs if all deliver the same benefits? Although they do not give examples, I take it that Professors Mashaw and Marmor have in mind the following types of variation:

- Plans could differ in the method by which they determine whether a covered individual is entitled to a given treatment, with the result that some plans pay for that treatment on a lower showing of medical necessity than others do. Thus, for example, a state plan might impose "managed care" review of treatment to curtail unnecessary provision of benefits, or use a "gate-keeper" method of review, or adopt any of several already well-tried (if not necessarily proven) alternatives.

- Plans could impose financial thresholds, like the "deductibles" of familiar commercial health care insurance policies, although the federal universal-coverage requirement would presumably outlaw such thresholds for the indigent.

- Plans could perhaps use other systems of explicit rationing, while nonetheless passing muster under the federal universal-coverage requirement.

It is worthwhile to point out that not all familiar methods of rationing seem obviously consistent with the idea of a nationally uniform benefit package. The Oregon Plan, for example, rations health services, so far only to Medicaid recipients and some others, by ranking diagnosis-treatment pairs and funding only those above a certain rank. Thus, in Oregon, an effective drug treatment for gout might be excluded altogether from the benefit package on the grounds that this type of treatment for this disease does not benefit the collective welfare of Oregonians as much as other funded diagnosis-treatment pairs, such as appendectomies for those suffering from acute appendicitis.

Traditional physician gate-keeper rationing, at least if governed by a relatively rigid limitation on funds available for medical treatment, also appears to be inconsistent with a federally defined benefit package. Thus, for example, if the gate-keepers sufficiently embrace the spirit of the financial limits, the result might be that even some for whom the system might provide benefits do not receive these benefits in a given year, simply because others have received other benefits earlier in the year. Since less funding would remain to provide these benefits, the gate-keepers would become additionally reluctant to authorize treatment because of the potential financial shortfall. It is difficult to see how this kind of rationing could be regarded as living up to the mandated provision of certain benefits.

Given that the cooperative federalist health legislation would allow states to vary some of the details of mandated health coverage, does the resulting scheme promise to contain health costs? Despite Professors Mashaw’s and Marmor’s claim that cost containment is a goal of their proposed system, it is not clear how the elements of the cooperative federalism they propose would advance that goal. Here are some possibilities, however, consistent with their proposal. A central federal body, analogous to the Health Security Board to be created by the Clinton Health Security Act, would oversee aggregate federal and state spending, and it would periodically redefine the mandated benefits package or limit block grants to the states to achieve targeted spending limits. This was the core of the Clinton plan. To introduce it into the proposed scheme would be to make the proposed cooperative federalism all but indistinguishable from the Clinton plan. It is true that the latter would have favored a style of “managed competition” that gave primacy to the role of “purchasing alliances” to preserve competition among insurance companies, HMOs, etc., that antedated the national health legislation. The proposed federalist alternative has no such preference for managed competition; even the Clinton plan allowed waivers of this competitive mechanism, and so it deserves to be considered virtually as flexible in this regard.

Another possibility is that CHCF would seek to contain costs by tying block grants to some changing indicator of national and/or state economic product. The simplest version of this limitation would be an

18. I am thinking here of the style of rationing practiced in Great Britain, but I am not sure that my description is still accurate of the British National Health Service. See JEREMY HURST, THE REFORM OF HEALTH CARE: A COMPARATIVE ANALYSIS OF SEVEN OECD COUNTRIES 113-129 (1992) [hereinafter "OECD Study"].
inflexible rule that aggregate block grants to the states for health care could not exceed some permanently fixed percentage of the national gross domestic product. During the writing of the Clinton plan, discussion of the German national health care system often focused on what looks like a cost containment mechanism of this sort.

It is often stated that the German system limits health care costs to an ungraded percentage of income, so that a percentage of national income (measured not in the usual way, but as an aggregate of individual incomes) is the national limit on health care costs. Most advocates of national health care reform admit that the German solution, if it is correctly understood as imposing the kind of limit just described, works only because of Germany's long experience with publicly manipulated bargaining between private parties over health care. Health care providers strain to make the system work; health care consumers strain to be content with the system; and the government strains to find ways not to impugn the good record of the system, e.g., by subsidizing aspects of health care provision that could not otherwise be brought within the payroll percentage formula. If it was implausible to hope to import the German mechanism to this country as part of the Clinton plan, it is not more plausible to have that hope in conjunction with CHCF.

Is cost containment, however, a serious part of the rationale of CHCF? Need it be? The other goals of health care reform obviously have less political pull than does cost containment, for the reasons set forth in Part III above. Cost containment does not simply appeal to politicians, it is positively compelling to politicians, but only as long as the governmental share of health care grows uncontrollably. CHCF promises to change all that by the simple expedient of instituting a block grant system. If our Congress were left to preside over a CHCF system, it would hold the purse strings again over health care, just as the current Republican Congress hopes to do, by instituting a block grant system for Medicare and by simplifying and constraining the existing block grant system for Medicaid.19

Cynically, then, we might say that CHCF is bound to succeed in doing what politicians, the real lobby for cost containment, want done. This is so at least at the federal level. What about state politicians? Some of them too have been suffering from the uncontrollable rise of health care costs, packaged as the state share of Medicaid; others actually have been solving political problems by "gaming" the Medicaid

19. See Fear, supra note 8; Starr, supra note 4.
reimbursement system. At least the political elite in those states that have experienced wrenching cost overruns under Medicaid would probably die before they sought to participate in CHCF, unless it, too, were susceptible of manipulation, as Medicaid has proven to be. 

B. Extension of Coverage

CHCF obviously is intended to assure almost universal coverage. Professors Mashaw and Marmor note that some of those countries deemed to have the most comprehensive health care systems nevertheless do not cover all citizens or residents. Twenty to twenty-five percent of German citizens, for example, do not participate in the German state-sponsored health care system, and approximately five percent have no coverage at all. Those left out of the German health care system, however, are almost exclusively among the extremely wealthy, for whom medical insurance is unnecessary — they can comfortably “self-insure.” Professors Mashaw and Marmor say that CHCF should be considered satisfactory if it extends coverage to the same extent.

It is relevant at this point to compare the resulting pattern of coverage with current, pre-reform patterns. Professors Mashaw and Marmor state that “states should be allowed (with federal approval) to fold Medicare and Medicaid into their reformed health care insurance systems.” This could provide an important political lift, at least from one base of power within the body politic. Around the time the Clinton plan was written, large employers eagerly supported health care reform. It was widely reported that these employers stood to gain by seeing their cost for employee health coverage reduced if all or almost all Americans were covered by a federally monitored plan. Existing federal health programs (Medicare, Medicaid, and other federal governmental health plans) already systematically undercompensated health providers, especially hospitals, through such waste reduction schemes as diagnosis-related group (DRG) ceilings on reimbursement, and large private sector

20. Professors Mashaw and Marmor may intend to refer to the seemingly unjustified variation among states under the current Medicaid reimbursement arrangements when they say that “[t]he size of the total grant (and the per capita components) should vary with a state’s income, its demographic profile and its history of medical inflation.” See Marshaw & Marmor, supra note 14, at 119 (emphasis added).


22. See OECD Study, supra note 18, at 57, 59.

23. Marshaw & Marmor, supra note 14, at 118.
purchasers of health services or group health coverage believed the providers systematically charged them higher fees for services to make up the difference. If federal monitoring were either abolished or extended to virtually all provision of health services, large employers hoped they would no longer suffer from such "cost shifting."  

If this perception continued to be correct in 1995, CHCF would benefit large employers and insurers significantly, at least to the extent that state plans did not deny large employers the option of self-insuring, or merely of self-insuring in the manner they choose, and did not take business away from insurers, e.g., by fostering state single-payer systems. The American Association of Retired Persons (AARP) might, by the same token, be expected to oppose the legislation on the grounds that it would make current Medicare benefit levels more expensive and jeopardize them as state budget items. The AARP, however, could be expected to oppose CHCF on more elementary grounds—it would give states discretion to whittle away at this important benefit for the retired and elderly, for which the AARP fought during the writing of the Clinton plan.

It is also interesting to wonder whether CHCF would take so much away from large employers as to ensure that they would fight the passage of such legislation. Professors Mashaw and Marmor say that "Congress . . . must . . . enact . . . legislation (such as reform of [ERISA]) that allows states sufficient legal discretion to pursue health care reform realistically."  

What they are referring to is the peculiar benefit such employers currently enjoy of exemption from state insurance regulation on the grounds that employer-provided health insurance is an employee benefit regulated by ERISA, that preempts state regulation. Employers, of course, may choose to self-insure for reasons other than escaping state insurance regulation and state taxes on insurance products; they may find it cheaper to self-insure (even if they pay insurance compa-


25. Marshaw & Marmor, supra note 14, at 118.

nies to administer their self-insurance schemes), than to buy insurance from others, because the employers have greater bargaining power with health care providers in some settings than insurers in a splintered insurance market do. Some self-insuring employers achieve significant savings, however, simply by avoiding state regulation and taxes.

C. Making Coverage Portable

CHCF scores an easy victory under this heading, which describes what is certainly one of the paramount goals of health care reform. Professors Mashaw and Marmor do not believe that what interstate variation in health benefits there might be "would not have a major impact on location decisions either of individuals or firms." This is at least controversial. It is true that the literature about governmental benefits and location decisions provides no strongly predictive account of the influence of one on the other. Some states are beginning to invest heavily in efforts to attract new employers, however, especially by removing regulatory burdens and funding employee training. If a state can portray itself as attractive because it has no strong labor unions, schools are good, health care is generous (or self-insurance is leniently regulated), and taxes are low, an employer might well prefer it to a state in which only health care is generous (or self-insurance is stringently regulated).

In other words, by removing health care as an issue for the employer, an otherwise less attractive state may make its few attractions more compelling. No doubt, this possibility is sufficiently diffuse as not to arouse strong opposition to CHCF. The use of state variations in health care to achieve other economic goals is, I think, a very serious possibility, however, especially given other demographic differences among the states. Some have much larger elderly populations than

27. Marshaw & Marmor, supra note 14, at 122.
others; this alone will incline them to rely less on employer mandates for health care than might be the case if the elderly population were quite small. Since some states may have fewer choices, CHCF may become a competitive weapon. Again, however, the upshot is hard to foresee.

D. Research and Related Goals

We have seen that research into the efficacy of medical procedures, drugs, and so forth is sorely lacking in our currently anarchic, though vital, health care economy. It would be natural for CHCF to lodge authority for the regulation of data collection and retrieval at the national level, precisely because the absence of a central authority would encumber states' and private parties' efforts to coordinate such data analysis. At present, the absence of comprehensive federal regulation of hospitals is the single largest impediment to the efforts of insurers and managed care providers to compare outcomes. Structural features of CHCF, however, might deprive such data of some of its comparative value. If one state's health care is rationed by peer review mechanisms while another relies on personal physician gatekeepers, the data these states contribute to a national clearing house are likely to differ in form. Peer review groups must generate written commentary, while physician gatekeepers need not do so, and may do so reluctantly if placed under such an obligation.

E. Allocation of Scarce Resources

Rationing is usually considered in the health care reform context only as a means of achieving cost containment. It is, of course, also a means of assuring fairness and rationality in other respects. However much the country may choose collectively to spend on health care, it should guarantee everyone affected by national intervention in the health economy that health benefits will flow evenly and equitably, at least in so far as sovereign intrusions shape the flow at all.

Private alliances of hospitals and physicians already allocate scarce

30. "Outcomes" research, as it is sometimes called, has only been initiated recently on a large scale in this country. See Aaron, supra note 4, at 49 ("[m]ost common medical procedures have never been subject to controlled evaluation to determine in which cases the procedures produce expected benefits and whether alternative approaches might be superior"); see John E. Wennberg, Outcomes Research, Cost Containment, and the Fear of Health Care Rationing, 322 New Eng. J. Med. 1202 (1990).
medical resources other than money—donated organs, for example. It is conceivable that they do so well or could do so, without governmental interference. Whether such systems operate equitably across large regions of the country is another matter. It is not clear that they must, but if so, it is presumably in the interest of all concerned to foster mechanisms for fair and orderly allocation. No part of the country has privileged access to all its resource needs and none has notably greater needs than another. CHCF actually might encourage healthy decentralized coordination of these efforts.

There is one respect, however, in which government intervention for fairness in rationing may be indispensable. It is sometimes supposed that since marginal health care dollars buy diminishing benefits for individuals, the same must be true for society as a whole, i.e., that the last dollars devoted to health care purchase smaller gains in health. It is probable that many who are confident of the fairness and decency of rationing base their conviction on the slightness, if not complete lack of value, of marginal health care outlays.

The leap from the individual to society, however, is not clearly justified. From the fact, if it is one, that every individual faces a diminishing benefit curve, it does not follow that society faces a similar curve. In other words, if we could add together individual benefits for dollars spent, the resulting curve for all individuals residing in a given country would not necessarily resemble that of the individuals, even if all individuals’ curves were of similar shape. This is so for several reasons. First, the rate at which benefits fall for different individuals may be different, even though all individuals face similarly shaped curves, because the cost of getting different individuals to the same level of benefit can vary enormously: a very ill person may benefit less than a healthy person does from the first $500 spent on health in a given year, because the ill person may require a far more costly regime in order to benefit at all. Second, time frames for reaching the small-benefit portion of the curve may differ for different individuals. Third, health care is full of externalities, so that cutting back on health care for virtually everyone, at virtually no loss to them in overall health, may result in enormous losses to others, who are more at risk from diseases that can be wiped out only if everyone is (e.g., vaccination against certain diseases).

CHCF, by adding universality of coverage to the other desirable outcomes of state-by-state innovation, would have a chance therefore of securing one of the more important goals of a truly national health policy, and probably at a lower cost, since it would not require two full
layers of regulatory effort at the federal and state levels.

F. Redirecting Expenditures

Finally, a federal health care system that allows interstate variation in health care financing and delivery cannot achieve the re-direction of health care outlays as strategically and simply as might a centralized national system. Yet the Clinton plan would have been no better able to redirect outlays, given its deference to reasonable state plans for health care delivery.

IV. What Would Be Lost If National Mandates Were Absent?

Professors Mashaw and Marmor obviously attach high priority to almost universal coverage. Broad coverage and portability are, one might say, the main price they would exact from the states in return for federal block grants for state health care systems. It is worthwhile to ask whether either or both need be required, in order to be realized under a block grant system.

Consider portability first. Many of the costly benefits local governmental units provide their residents are currently available to everyone without length-of-residence requirements—police, fire protection, education. It may be that states are not tempted to discriminate in most cases because of the difficulty of the necessary discrimination. The police may discriminate haphazardly against some parts of the population, but if required to discriminate against only those who have recently arrived, they would surely fail.

Discrimination in the provision of health treatment poses no such problem. Most private and public health plans in most countries require eligible participants to carry appropriate identification. That could be done here too. What state, however, would want to penalize legal immigration from other states? Immigration is essential to provide employees of all sorts during times of economic expansion. Denying health care benefits to those who have them in other states and who would seek employment in this state, where they could be provided with de facto reciprocity for this state’s citizens if they should go elsewhere, would burden the local economy; local businesses would surely lobby for reciprocal provision of health benefits.

The same applies to differences in coverage from one state to the next. If Connecticut were particularly stingy in the design of its state
health care system, should it and its residents not expect that economic growth would come only with added difficulty? Moreover, the state and its employers would find it difficult to keep needed employees here, if better benefits were available elsewhere.

What would CHCF look like without mandated broad coverage and portability? Broadly speaking, this is like asking what would happen if the federal government replaced Medicare, Medicaid, and other federal medical benefit programs with block grants to the states, as some members of the Republican majority in Congress, until recently, advocated doing. Would the block grants be adequate to permit states that wished to do so to maintain benefits for their citizens at current or better levels? How would one compute the amount of the necessary block grant, given that the states are left free to design idiosyncratic health care delivery systems, and given our current lack of consensus about which means are least expensive?

Charles Tiebout argued, in a well-known article on tax policy, that permissive federalism would maximize the welfare of citizens free to choose where they would live, because local governmental authorities would offer those packages of benefits for which there was sufficient demand to generate the taxes necessary to pay for them. It would be fine for different towns to provide fundamentally different programs of land use regulation, or streets of vastly different quality, because people would simply move from one town to another in accordance with their tastes and pay taxes to the municipality of their choice. If enough people choose each town, all would continue to offer their idiosyncratic packages of benefits; if any town fails to attract a sufficient group of taxpayers, it will go out of business or change its public benefit package. Different tastes will be satisfied by the variety of offerings, and welfare will be maximized because those who choose to pay for more expensive public benefits will be those to whom they have corresponding utility, while others will choose less expensive benefits and pay less.

Tiebout's argument depends on important simplifying assumptions. For example, people must be reasonable enough to move to get what they want, and moving must be cheap, relatively speaking. If the real world approximates the model closely enough, the resulting welfare maximum should be achieved with respect to public benefits of all

sorts, including health care benefits. Indeed, it should be achieved even without federal block grants, so long as the federal government does not offer competing benefits.

Sadly, this picture of efficiency through the independence of federally linked local governments is implausible. There is too much friction in the machinery of the market for municipal public goods. People cannot move easily. Jobs and houses are not portable, and the uncertainty and other costs associated with moving are immense for many people.

Does that support the idea of block grants? Perhaps. The lesson of Tiebout's argument is that it shows us by means of its simplifying assumptions, where in the machinery some of the friction is. It is not that local governments are reluctant to innovate for reasons that an influx of money from the central government would remedy. Rather, it is the inability of people to go where the benefits they want are to be had. Block grants would aid state health care innovation, therefore, if they took the form of transfer payments to individuals who wished to move from New Hampshire to Arizona. Block grants to local governments themselves may be useful to persuade them to aspire to near-universal health coverage. The level of these block grants, however, should be just enough to pay for near-universality. Local governments should otherwise be left to pay the cost of their idiosyncratic health care packages with locally raised taxes. Otherwise, we should not expect the political process at the local level to guide governing officials to those benefit packages that, in crazy juxtaposition, will yield the greatest overall benefit.

It will no doubt be objected that few in this country have so much confidence in local government. Health care is too important to be left to the competence and whims of local officials or even to the self-knowledge of local taxpayers. That may well be so, but if it is, we have little to hope for from CHCF, because we have no reason to expect local officials to devise good health care plans.

33. See C. Duane Dauner, Giving Medicaid Back to the States, HEALTH SYS. REV., May/Jun. 1995, at 29, 30 (May/June 1995) (if Medicaid is given back to the states in a form that caps federal funds, services will be cut back, access will be compromised, maintenance and replacement of buildings and equipment will be delayed and new technology will not be acquired); but see Jean I. Thorne et al., State Perspectives on Health Care Reform: Oregon, Hawaii, Tennessee, and Rhode Island, 16 HEALTH CARE FIN. REV. 121 (1995) (states now in the vanguard of health care reform have begun to overcome difficulties through cooperation among themselves and with the Health Care Financing Administration).
My conclusion is that block grants, if given, should be without strings. If this seems unwise, block grants are unwise altogether.