

FEDERALISM CREATES HEALTH POLICY

Friends in my small town know that I have been involved in national health care reform efforts as well as those in our home state of Massachusetts. When conversation at the local pub turns to health care, they'll ask me questions. Because I'm a political scientist, not a medical doctor, I don't get pelted with questions everywhere I go, so I welcome the opportunity to respond. I only wish that there were better answers.

Jack, a salesman for a high-tech company, thought that the Massachusetts health care reform would allow him to cover his 24-year-old daughter, Meghan, on his employer's health plan. So why did his company tell him that she wasn't covered? I try to explain that larger companies are exempt from state insurance regulations because they self-insure; those businesses use insurance companies like Blue Cross or Aetna only to administer their claims. It is confusing because the same insurance companies actually provide insurance to small businesses, and in those cases they are subject to state regulations. Eyes glaze over, and we quickly return to the fortunes of the Boston Red Sox. Meanwhile, Meghan remained uninsured.

Matthew runs a small financial consulting business. Because of double-digit health insurance premium increases, coverage for him, his wife, and their three boys takes a big bite out of their budget. He wanted to know whether health care reform would offer more reasonably priced health plans. A while back, I had told him that help was on the way: Massachusetts had just created the Health Care Connector, which was intended to provide a choice of plans at lower prices, at least in theory. The Connector did expand coverage to lower-income individuals and families, but it did not lower the cost of insurance for people like Matt and his family. Perhaps I should have told him to hold tight for federal small business tax credits? Or let him know that

health care exchanges created by national reform may offer a better solution soon? But at the risk of losing credibility and a good tennis partner, I turn back to discussing the ball game.

As the country geared up for national health care reform, I traveled from state to state talking about reform efforts in Massachusetts. Everywhere I went, I shared my excitement over the obvious progress in coverage. More than 98 percent of people in Massachusetts have health insurance, by far the highest coverage rate in the nation. Enacted in 2006, state reform added a patchwork of new programs and regulations that built on previous expansion efforts. Over 300,000 previously uninsured individuals now have health insurance coverage and can sleep better at night. But the program is complex and difficult to comprehend—even for policy wonks—and it was not designed to address persistently rising health care costs.

National health care reform was signed into law by President Obama on March 23, 2010. The Patient Protection and Affordable Care Act (ACA) has much in common with the Massachusetts effort. It holds similar promise—and suffers from similar limitations—when it comes to expanding health care coverage to the uninsured. More of the uninsured will be covered, but coverage will be complex to negotiate and cost containment will be just as difficult. Despite its shortcomings, ACA represents a significant political triumph after a series of failed efforts that date back to the Truman administration.¹ Under national guidelines, reform will be administered in large part by the states through existing health plans, insurers, hospitals, doctors, and other health care providers.² States will be critical players in implementing reform and in establishing state-based health care exchanges. Applying national exchange rules to health systems that vary widely from state to state will be a tremendous challenge.

The ACA barely passed Congress, along partisan lines. The Democrats struggled to hold on to more conservative members of their party and used parliamentary maneuvers to avert defeat by filibuster in the Senate. The Democrats in the Senate did not even have the votes to include a relatively modest “public option” insurance plan to help balance private sector offerings and force down administrative costs. However, it is unlikely that anything more progressive could have passed. In fact, after the 2010 election, when the Republicans gained control of the House of Representatives and the conservative Tea Party adherents attacked the ACA as the centerpiece of their “revolution,” the Democrats were fighting repeal.

Universal or near universal coverage has been referred to as the unfinished business of the New Deal. The New Deal represented a major realignment of the political parties in favor of social welfare policy, and efforts to

improve, modify, and build on it have been a subject of political debate for decades.³ In this case, the advantage went to the Democrats. The election of Ronald Reagan in the 1980s represented a realignment against social welfare policy expansion and the national agenda of the Great Society and War on Poverty programs of the 1960s and 1970s. In the 1990s, Speaker of the House Newt Gingrich took the Reagan revolution one step further, taking aim at the New Deal with efforts to privatize portions of Social Security and Medicare.⁴ In this case, the Republicans had the advantage. Today the proper role of government and its role in health care reform is still hotly debated. The success or failure of the implementation of the ACA may well determine which political party holds sway over the next several decades.

Conservative opposition to the ACA represented not only an attack on a particular piece of legislation but an ongoing fight about the legitimacy of the government's efforts to ensure health care security for citizens. While repeal passed the House several times in 2012, the Democrats, who controlled the Senate, protected the law. Even if the Senate were controlled by the Republicans, it would still take sixty votes even to end the debate and have a vote on repeal. The American political system is structured to make passing legislation hard, which makes passing repeal equally challenging.

The ACA also dodged two near-death experiences. The first was the Supreme Court decision in *National Federation of Independent Business (NFIB) v. Sebelius*, which found the individual mandate requiring people to purchase health insurance to be constitutional.⁵ Without the mandate, much of the ACA falls apart. The law prevents insurance companies from denying coverage for people with preexisting conditions and requires them to make products widely available and renewable in their service area. Without a coverage mandate, people could simply wait until they got sick or needed care to sign up for insurance and then drop coverage when they were well. Doing that flies in the face of the concept of insurance. Furthermore, implementing the ACA without the mandate would lead to lower numbers of younger, healthier people enrolling in the health exchanges, leaving disproportionately older and sicker people in what insurers call the risk pool. That would increase costs and make insurance even less attractive to healthier people, creating still higher costs and an insurance death spiral. Finally, the mandate is essential to covering the 30 million uninsured people that the law is designed to cover.

The second bullet was dodged with the reelection of President Obama. His challenger, Mitt Romney, vowed to begin the repeal process through executive orders on his first day in office. A Romney win would have empowered and emboldened opponents of reform in Congress and in state houses throughout

the country. Furthermore, a large number of states were sitting on the fence, awaiting the election results before moving forward in earnest with implementation.⁶ In addition, a Romney administration could have significantly weakened the ACA through the administrative rulemaking process. Nevertheless, the Court ruling and the election merely kept reform alive; the political battle continues through the rulemaking process and state implementation.

Making the ACA a reality will be a complex process fraught with peril. How enthusiastic will the twenty-seven states that were part of the lawsuit against reform be about implementing the major provisions of the law? Further significant opposition continues in Congress, and public opinion on reform is split. In particular, 60 percent of the population is opposed to the individual mandate.⁷ The political right still characterizes the ACA as “socialized medicine” and a “massive government takeover of the health care system.” Certainly it represents an expansion of government intervention, but health plans, insurers, hospitals, and physicians and other providers all remain private or not-for-profit entities. Missteps in implementation will reinforce notions of government incompetence and increase calls for greater privatization. The political and individual stakes are high.

Success would be hard to reverse. Once the policy is in place, a powerful political coalition is likely to develop to protect gains. The program has the potential to enjoy the kind of broad political support enjoyed by Medicare, Social Security, and unemployment insurance. If the plan succeeds in covering 30 million additional Americans, who will be clamoring for the “good old days” when millions could not pay their hospital bills and people were denied coverage for preexisting conditions? Ultimately, the fate of reform rests on implementation and on intergovernmental relations within the framework of American federalism. The states are at the epicenter of implementation, and their actions will be guided by federal rules and regulations.⁸ The interplay between the states and the federal government will determine, for example, how the new health care exchanges will vary between states. It will also dictate the following:

- how federal tax-based subsidies will be administered through state-based health exchanges
- how new insurance regulations will dovetail with existing state laws and systems
- how states can use the new flexibility to alter the benefits for Medicaid beneficiaries
- whether states agree to expand Medicaid to all low-income individuals and families with an income below 133 percent of the federal poverty level

- how the individual mandate for insurance coverage will be enforced
- who will determine what is considered “affordable” for the purpose of enforcing the mandate
- who will set and enforce minimal benefit standards
- how sanctions on individuals and business will be administered.

In short, intergovernmental relations will shape the program and determine whether reform will reach its coverage and cost-containment goals.

If I tried to explain the importance of federalism and intergovernmental relations to Jack and Matt, not only would their eyes glaze over, but the guys would probably get up and leave me at the bar. Yet federal-state interactions determine the success or failure of policy and programs that impact us all. Knowledge about intergovernmental relations is essential to understand the policy process, to evaluate options for effective and politically feasible implementation, and to understand how programs operate. Such insight, which can be obtained only by systematically examining intergovernmental relations for different types of policy across the policy process, is essential for scholars and students of public policy as well as practitioners at the national, state, and local level who struggle to make programs work.

A more comprehensive understanding of American federalism in practice and its impact on programs and policy comes from three case studies—the State Children’s Health Insurance Program (CHIP), the Health Insurance Portability and Accountability Act (HIPAA), and the health care reform enacted by Massachusetts. Each mirrors key elements of the ACA and offers unique insights into policy formulation and implementation. CHIP is an example of coverage expansion, with state flexibility and federal oversight. HIPAA is an example of insurance regulation, with federal standards but limited national resources and weak oversight of state activity. The Massachusetts reform has many similarities to national reform, but within a policy environment that is significantly different from that of the majority of states. Each case demonstrates that states can be a source of innovation for social welfare policy, particularly during times of national policy gridlock. Each case provides lessons in how the ACA might be successfully—or unsuccessfully—implemented.

The book is divided into three sections, each of which addresses one of the three case studies. Within the sections are chapters on federal-state relations as they apply to legislative development, rulemaking, and implementation. The final chapter draws conclusions from all the cases regarding how federalism affects both program development and the policy process and applies what has been learned to the implementation of national health care reform.

CHIP, HIPAA, AND MASSACHUSETTS REFORM

CHIP, passed in 1997, provides grants to the states to expand health insurance coverage to uninsured children whose family income is too high to qualify for Medicaid but who lack access to private insurance. The program has been an enormously successful federal-state partnership resulting in health insurance for millions of uninsured children. In 2010, the program covered more than 7 million children. National reform in 2010 extended CHIP until 2019 and provided supplemental federal funding, along with a requirement that states continue to maintain coverage levels.

As with many policies, a good deal of work occurred before most of the federal rules relating to CHIP were put in place and details ironed out. States were encouraged to innovate by designing alternative programs, and they received incentives to participate through increased federal reimbursements. State implementation was kept in line through significant federal oversight and mandatory reporting requirements. From the outset, CHIP provided states with the flexibility to design their own program or expand Medicaid or to come up with some combination of those two options. Within federal guidelines, states could set eligibility rules, benefit levels, provider payments, and other program requirements. The result was not only a major expansion of coverage but also great equalization in coverage levels across states.

HIPAA, which passed in 1996, had a host of goals, including privacy protection, regulation of insurance, prevention of fraud and abuse, simplification of administrative tasks, and creation of medical savings accounts. The focus here is on the portion of the HIPAA that addresses insurance regulation, including limiting exclusions for preexisting conditions and guaranteeing policy renewal. These aims are similar to those of national insurance reform in the ACA. HIPAA standards were meant to extend federal control in an area traditionally regulated by the states, but unlike with CHIP, federal resources, administrative expertise, and oversight were so limited that states largely controlled the process nevertheless. Ultimately, there remained wide variation between states and the regulations had limited impact, hence the need for significant insurance regulation in the ACA.

The third case, Massachusetts health care reform, served as a model for national reform, even if presidential candidate and former Massachusetts governor Mitt Romney later denied it. Both plans include an individual mandate to purchase insurance, health care purchasing exchanges, expansion of the Medicaid program, and subsidies for low- and moderate-income individuals and families. The reform was based on the notion of shared responsibility, and Massachusetts asked individuals, businesses, and government to

pitch in. Individuals must purchase health insurance if it is deemed affordable, or they face a fine. Businesses with eleven or more full-time employees must provide health insurance or pay a small fee. In order to increase affordability, the state government, with federal support, expanded subsidies to low- and moderate-income residents.

From the beginning, Massachusetts reform depended on support from the federal government. Through a federal government Medicaid waiver, the state was receiving millions of dollars paid directly to hospitals for uncompensated care. The George W. Bush administration threatened to stop providing this money, \$385 million a year, if the state did not shift funding away from hospitals and toward direct coverage of the uninsured. Interestingly, the conservative Bush administration pushed for reform and approved the plan that would ultimately serve as a model for “Obamacare,” which is detested by the political right.

The rules for determining exactly how Massachusetts reform would work were developed in large part by the Commonwealth Health Care Connector Authority Board, which is made up of representatives from government, business, labor, and consumer organizations. With significant autonomy, the board sets benefit and subsidy levels and determines what is considered affordable insurance at particular income levels. Rules for other components of reform, such as Medicaid expansion, tax policy, and business and labor regulations, were written by the appropriate state agencies in collaboration with the Connector board. Under tight deadlines, the job got done, with both the state and the federal government watching every step.

AMERICAN FEDERALISM

Understanding how federalism—the division of power between the federal government and the states—plays out is essential to understanding contemporary health policy. The case studies presented here describe a dynamic intergovernmental relationship that varies dramatically depending on the political context in each case and the manner within each state in which rulemaking and implementation are conducted. Health policymaking is entangled in a complex web of shared, overlapping, and/or competing power relationships between levels of government.⁹ While traditional studies of federalism offer great insight into federal-state interactions, most do little to explain variations in interactions across the policy process. Understanding those variations is essential to understanding the ultimate impact of federalism on programs and policy.

Traditionally, particular models of federalism were ascribed to specific historical periods.¹⁰ Prior to the New Deal in the 1930s, most domestic responsibilities in the United States were handled in the realms of state and local governments, charities, and families. Under the New Deal, the federal government worked with states to address poverty and unemployment, expanding the role of government and building administrative capacity at the national and state levels in the process. States remained active partners, in part because powerful Southern members of Congress fought for control of federal aid to prevent it from benefiting African Americans.¹¹ After victory in World War II and the onset of the cold war, international attention turned to Washington, D.C. Domestically, the postwar period was one of unprecedented economic growth, and people looked increasingly to the national government for services and support. The difference in professionalism between the national and state governments was stark. Around the time that President Kennedy promised to send a man to the moon, the evening news showed a governor blocking African American children from going to school and state police turning fire hoses on peaceful civil rights marchers.

In the 1960s, in contrast to the states, the federal government declared war on poverty and pledged to create a “Great Society” focused on promoting human development, civil rights, the arts, and environmental protection.¹² Under President Lyndon Johnson, efforts to attain those goals expanded the reach of the federal government to every corner of the nation. The federal government often bypassed the states to work with and empower local communities through initiatives such as Head Start, community development block grants, community health centers, and legal aid.

However, that hard-won public trust in the federal government soon waned. The Vietnam War, the resignation of President Nixon, rampant inflation, the Iran hostage crisis, and renewed racial tension and urban unrest weakened the standing and credibility of the national government. Confidence in Washington and its ability to address social problems diminished.

Ronald Reagan’s presidency, in the 1980s, is considered a period of devolution of power from the federal government to the states. Reagan famously stated, “Government is not the solution to our problems; government is the problem,” and that message resonated with many Americans. Taxes were reduced, and government programs were cut or curtailed. The brakes were put on innovation in national social welfare policy. The period also saw a rash of unfunded mandates placed on the states, particularly in the Medicaid program.¹³ Ever-mounting deficits and the national debt further restricted national domestic policy initiatives.

Within that larger framework, much of the research on federalism involving health policy focused on finding a grand theory to describe federal-state relations during a particular period of time.¹⁴ After Bill Clinton failed to enact health care reform, Robert Rich and William White concluded in their 1996 volume, *Health Policy, Federalism, and the American States*, that “we are on the threshold of a new era of federalism in health care . . . decisions made in the next several years may set the course of federalism in health care and other major social policy areas well into the next century.”¹⁵ Some studies described federalism as a pendulum swinging between state and federal dominance.¹⁶ Others explored theories about which models of federalism were most effective in implementing certain types of programs. Paul Peterson grouped policies into distributive, redistributive, and developmental categories, theorizing that certain programs are most effectively implemented under particular models.¹⁷ Other researchers made a case for a certain type of federal relationship that they believed to be spelled out in the Constitution.¹⁸ Most studies focused on the legislative process and neglected rulemaking and implementation.

As a member of President Clinton’s health care task force and later as a fellow for the Senate Finance Committee, I witnessed that round of health care reform fail in a spectacular fashion. Discouraged, I left government, returned to academia and took up Rich and White’s challenge of finding a new model of federalism that would describe federal-state relations. The goal was to get ready for the next round of reform; with diminished opportunity for national reform, I focused on the states and intergovernmental relations.

The problem was that no single model was useful in clarifying how and why federalism plays out in particular ways for specific programs. For example, one overarching theory of federalism helps in understanding the contrast between the growth of the federal government in the 1960s and its lack of growth in other eras, such as the 1980s, when attempts were made to reduce its reach. However, it does very little to explain the completely different intergovernmental relationships pertaining to Medicare (federal health insurance for people over 65 years of age) and Medicaid (health insurance for low-income families administered by the states with federal matching funds), which were passed at the same time.¹⁹ Macro federalism theory does little to explain why, for example, Medicare Part D (which provides prescription drug coverage to seniors) significantly expanded federal government power and spending at a time when conservatives controlled the White House and Congress, an era when power was supposedly leaving Washington and returning to the states.

Understanding how power and authority determine winners and losers in public policy requires building on existing theory and drilling deeper into the policymaking process. It requires more detailed program- and policy-level analysis within the broader context of the American political system. It requires close-up examination of rulemaking and implementation. Peterson, Rabe, and Wong's *When Federalism Works* provides such an analysis of federalism at the program level, with a focus on implementation within the broader political context.²⁰ The journal *Publius* also publishes annual assessments of federalism under various administrations.²¹ The analysis that I present in this volume uses policy and programs as the unit of analysis and shows that increasingly, federalism goals are subservient to political ambitions. This volume also is inspired by the work of a long line of federalism scholars, particularly Timothy Conlan, who says, "Today the design, operation, and performance of most federal domestic programs cannot be understood without an intergovernmental perspective."²² His analysis, which proves that statement to be true, is a springboard for this work.

Building on past theoretical and empirical work, I track intergovernmental relations across the policy process for each of three case studies, which are based on data and evidence that I collected from detailed interviews with federal and state officials, legislators, and staff and consumer and interest group leaders. I also analyze primary and secondary documents—including legislative language, records of hearings and testimony, administrative rules included in the *Federal Register*, and a range of documents concerning implementation. This systematic approach will help in better understanding how federalism shapes policy and affects people.

THE POLICY PROCESS

For the purpose of this analysis, federalism needs to be studied across the policy process, including not only how legislation is crafted but also how administrative rules are written and policies and programs are implemented.

The Legislature

The structure of federal-state relations with respect to any policy begins with the legislative process. For example, the way that Congress structured health exchanges in the ACA set up federal-state relations in a way that has particular policy implications. The law establishes exchanges as state-based organizations through which individuals and small groups can select from a range of health plans. But it did not have to be that way. After rejecting a national public option health plan, Congress chose the Senate plan for

state-based exchanges instead of the House plan for a national health insurance exchange. A national exchange would have maximized federal power to regulate health insurance offerings, creating more uniformity, but reduced state variation and flexibility. State-based exchanges require the federal government and the states to share power and authority. As a result, more variation will occur across state insurance exchanges. Down the road, when health exchanges provide radically different services in Texas and Minnesota, for example, that critical decision will help explain why.

Although more liberal members of Congress were pushing for national exchanges, it is not always the case that conservatives support states' rights and liberals support increased federal authority. Timothy Conlan demonstrates a direct link between a policymaker's position on federalism and policy preferences in his examination of federalism and the policy and program agendas of presidents Nixon and Reagan and Speaker of the House Newt Gingrich.²³ In fact, conservatives have often supported national uniformity to protect their interests, such as national standards to limit abortion services, same sex marriages, and business regulation. For example, during the CHIP reauthorization in 2008, George W. Bush supported national standards in order to deny states the option of providing health insurance to parents of CHIP-covered children and to uninsured middle-class children.

Conversely, liberals support greater state rights when it aligns with their interests, such as stronger consumer protections or increased coverage for abortions. In the case of HIPAA, the late liberal senator Paul Wellstone (D-Minn.) made the strongest pitch that states should have the flexibility to provide health insurance-related consumer protections that exceed federal minimums if they choose. In 2012, Representative Barney Frank (D-Mass.) supported states' right to legislate same-sex marriage laws.²⁴ The findings here support the claim that when ideals about federalism clash with interests, interests win.

Rulemaking

Politics does not end when legislation is passed; it continues into the rulemaking and implementation phases. In making policy, the importance of the rules and regulations developed by the executive branch almost rival the importance of the originating legislation. Although it has recently received more attention, rulemaking has often been neglected in the study of public policy.²⁵ Federal rulemaking is a relatively open process, crafted with input from various stakeholders, including the states. It is more open to interest groups that have the legal and technical resources to follow complex undertakings and far less open to the general public, which has relatively more input into the

legislative process.²⁶ Draft rules are regularly published in the *Federal Register*, with a specified comment period. In the case of health insurance exchanges, the Department of Health and Human Services, in cooperation with other federal agencies, will define operational methods, eligibility for subsidies, minimum benefit levels, maximum out-of-pocket costs, and regulation of premiums. The rule will define the degree to which each level of government sets, defines, and enforces standards. As these critical decisions are made, interest groups have another chance to advance policies that they favor and block or weaken regulations that they oppose. One could imagine that hospitals, physicians, other providers, consumer groups, business, consumer advocacy organizations and various subgroups of these organizations would be very interested in influencing how critical policy questions are answered. Studying the rulemaking process is essential to understanding federalism and the locus of power and authority to make critical program and policy decisions.

Implementation

Once the rules are crafted, it is up to the states, federal government, and stakeholder organizations to implement policy. The American political system has a long-standing bias against government in general and against a strong federal bureaucracy in particular. The case is rarely made for a powerful national bureaucracy, except during wartime. The states, not-for-profit organizations, and the private sector are looked to for implementation. This is true even for the national Medicare program: private physicians and for-profit and not-for-profit hospitals provide the services; fiscal intermediaries are hired to evaluate claims and pay the bills.²⁷ Even contemporary Democratic leaders are against “bureaucracy.” President Bill Clinton declared that “the era of big government is over,” and President Barack Obama campaigned not to make government “bigger” but to make it “smarter.” There is little support in the United States for a one-size-fits-all policy handed down by Washington. As a consequence, arguments supporting federal action are generally indirect, ignoring issues of federalism and instead supporting notions such as “fiscal prudence,” “family values,” or “private sector job growth.” Again, it is important to look behind federalism rhetoric for particular interests.

The law and the rules guide implementation, but the cases presented here make clear that program resources, sanctions, administrative capacity, and reporting requirements and the enthusiasm or support for a policy or program also are important. Historically, it has been difficult to get sovereign states with independent power to faithfully implement policy that they find objectionable. For example, the constitutionally protected civil rights of former slaves, enacted after the Civil War during Reconstruction, dissolved

when federal troops left the South. Much later, court-ordered integration of public schools suffered from lack of effective implementation. In each case, limited federal sanctions, oversight, and resources combined with powerful state and local opposition to thwart national policy. However, strong federal parameters, along with carrots and sticks, could lead states to implement reform that significantly expands access to quality health insurance across the country. Findings from the CHIP case study indicate that state flexibility constrained by federal guidelines can expand access to comprehensive health insurance coverage and allow state innovation in how the health care delivery system is structured. As stated previously, CHIP was well financed and had strong federal reporting requirements and oversight—characteristics that led to a significant degree of uniformity and a high level of health insurance coverage for children across the states. That suggests that the considerable federal funding included in the ACA to expand Medicaid could have similar success, but it is not guaranteed. HIPAA, on the other hand, had weak federal oversight, limited reporting requirements, and insignificant state funding. In part, those deficiencies led to a mix of outcomes across the country and to questionable impact.

Intergovernmental relationships are far from set with the passage of legislation. Structuring these relationships remains a tool during rulemaking and implementation, when interests can attempt to strengthen, weaken, or solidify gains made during the legislative process.

The dance of intergovernmental relations within the federal system is a critical part of policy innovation in the United States. CHIP demonstrated that what began as modest state efforts to expand health insurance coverage for children could lead to a bipartisan effort in Congress to cover millions of children nationwide. The Massachusetts reform demonstrated that significant federal funding and cooperation were necessary for the state effort to move toward universal coverage. CHIP and Massachusetts reform were bipartisan efforts that leveraged considerable federal funding. Both cases suggest that state action is a helpful and possibly a necessary precursor to the enactment of progressive health policy. Richard Nathan refers to such state action as “liberals discovering federalism.”²⁸ Each case, HIPAA in particular, highlights the importance of resources, funding, administrative capacity, and intergovernmental coordination for achieving program success.

IMPLICATIONS FOR NATIONAL REFORM

Lessons from the case studies offer insight into how health policy is constructed and implemented and how it can be applied to the current round

of national reform. As with CHIP, the successful implementation of national reform requires a balance between state flexibility and national accountability. Federal command-and-control regulations will not work, partly because state health care systems are so diverse. Furthermore, states have the political power to resist, either by raising public opposition or by dragging their feet. Alternatively, ceding too much control to the states can lead to wide disparities in achievement of coverage and cost containment goals and increases the danger that funds will be inappropriately spent.

Finding the correct balance is the real challenge. The federal government must have the capacity to compel state action and the ability and willingness to work collaboratively with states to apply rules to their unique health care systems. The federal government can strengthen its authority by tying federal money to state compliance, issuing mandatory reporting requirements, and being able and willing to take corrective action. States can increase their power by taking full advantage of their administrative capacity and expertise. Furthermore, the process of state implementation confers its own flexibility, as federal officials are kept at arm's length. There also needs to be congruence between the goals of the program and the historical mission of the responsible federal agency. That may mean that different aspects of reform are implemented by different federal agencies. For example, the Centers for Medicare and Medicaid Services (CMS) is responsible for working with states on Medicaid expansion. CMS has expertise, established relationships, and a pot of gold to encourage state cooperation, so programmatically, Medicaid expansion should be relatively straightforward.

Setting up national health care exchanges will be a far more challenging task. Again, CMS is charged with taking the lead in writing the regulations and overseeing state implementation. However, this task is not a core element of the agency's historical mission, and it does not have preexisting expertise or routines. Because each state has a unique set of insurance regulations and its own mix of public and private health care insurance options, the task will be difficult, and collaboration will be needed if the effort is to succeed. The federal government should be prepared to work with states more as a partner and less as a regulator. But allowing too much leeway could lead to the same kind of failures that occurred with HIPAA.

The Massachusetts case is both comforting and scary. It demonstrates that the individual mandate is essential to institute insurance market reforms and achieve coverage expansion. Fears that employers in Massachusetts would drop coverage and push people into the state exchange were not realized. In addition, the plan did not increase per capita costs in the state relative to those in the rest of the nation, as some had predicted. Massachusetts reform

was successful in large part because it was bipartisan and stakeholders were engaged and supportive, especially during implementation. While President Obama did a much better job of engaging stakeholders than Bill Clinton did, his plan was passed along purely partisan lines, and that fact will make implementation difficult. Furthermore, Massachusetts showed that the individual mandate will not be self-implementing. It will take significant outreach on the statewide and community level.

Politics is ongoing during rulemaking and implementation. With national reform, the left or right may try to use “maximum state flexibility” to weaken provisions of a bill that they oppose. The right may seek to limit potential adverse effects on business and reduce the overall scope and cost of the law. The left may seek to provide more state flexibility to cover abortion services or permit implementation of a state-based single-payer system. Opponents of national reform have already said that they intend to reduce funding for implementation, threatening to prevent the Internal Revenue Service from carrying out its responsibility to enforce the individual mandate. What should be clear is that understanding federalism and politics at each level of the policymaking process is critical to recognizing where and how critical policy decisions are made and carried out.