DEVOLUTION IN THE UNITED STATES: THEORY AND PRACTICE

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The United States has a long tradition of state autonomy from the central government. The nation's first constitution, the Articles of Confederation, gave the federal government little authority, vesting most of it in the 13 states that comprised the country during its first few years. In 1787, when the current United States Constitution was ratified, states ceded some of their authority reluctantly to the central government, only after it had demonstrated its inability to curb destructive interstate economic competition, to implement coherent foreign policy, and to deter sporadic insurrections. The states sought assurances against further federal encroachment of their prerogatives in the Constitution's tenth amendment, which provides that "the powers not delegated to the United States by the Constitution, nor prohibited by it to the states, are reserved to the states, respectively, or to the people".

The trend of the last 70 years--a dramatic expansion of the size, scope, and authority of the federal government--has been an historical aberration. As recently as 1930, federal spending accounted for only 31 percent of total governmental outlays by all levels of government. Today that percentage stands at 61 percent.

During the past decade, a number of policymakers and scholars have asserted that more fiscal responsibilities should be "devolved" or returned to the states. The most famous--or notorious--advocate of such devolution was Newt Gingrich, the former discredited Speaker of the United States House of Representatives. When the Republicans gained control of the U.S. House of Representatives in 1994, commentators predicted an imminent "devolution revolution", which would bring about a major "rebalancing" of the nation's intergovernmental relations[1]. Actually, the extent of devolution over the past

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[1] The term "devolution revolution" was coined by Richard P. Nathan (1996). For an assessment of the progress of devolution during the past several years in federal legislation, Supreme Court rulings, and (continues)

seven years has been modest. While the states have been given more discretion in the implementation of some programs, Washington still "calls the shots" to a significant degree.

The devolution revolution has fizzled because its most powerful proponents have had higher priorities. For them, the devolutionary cause has been an intermediate goal, to be bargained away, if necessary, to achieve other ends. Whatever the theoretical merits of devolution, in practice U.S. policymakers have had "other fish to fry". Perhaps devolution will be assigned a higher priority under the Bush Administration, since its cabinet members include many former state officials who have been enthusiastic supporters of a larger role for the states in the nation's governance. Further weakening of the U.S. economy, with concomitant reductions in projected federal surpluses, could also "re-energize" the devolutionist movement. However, initial policy proposals introduced by the new president, such as one for education reform, include considerable federal controls on state behavior.

This paper, an updated version of an earlier piece written by the author (Tannenwald 1998), explains the theoretical justification for devolution from an economist's perspective and identifies the political forces that have thwarted progress towards the devolutionary ideal. It illustrates these forces by analyzing how they have shaped U.S. policies concerning health care for children, health care for low-income households (the U.S. Medicaid program), and federal assistance for primary and secondary education. Most of the supporting evidence comes from policies adopted by Congress under the U.S. Balanced Budget Act of 1997 (BBA).

Presidential recommendations and orders, see Kincaid (1998). Kincaid is also the creator of the term "rebalancing" of the federal system to describe devolution.

1. Devolution from an Economist's Perspective

Other things equal, economists tend to be attracted to policies that promote the efficient allocation of resources between the public and private sector, among competing uses within each sector, and across geographic space. They also tend to favor policies that promote efficient production, whether by encouraging the adoption or invention of more efficient technologies, the implementation of a given technology in an operationally efficient manner, or the adjustment of producers' size to realize economies (or to reduce diseconomies) of scale. Economists supporting devolution in the United States believe that one or more of these various aspects of efficiency would be enhanced if more responsibilities currently assigned to the federal government were shifted to the states[2]. In 1996, Steven Gold identified three intergovernmental fiscal policies that, according to devolutionists, promote efficiency: a reduction in federal aid to the state and local governments, the substitution of block grants for matching entitlements, and greater flexibility for states in implementing grants (Gold, 1996). I would add two more policies to this list: the curtailment of "underfunded" federal mandates and a reduction in the degree to which federal intergovernmental assistance redistributes resources from wealthy to poor states.

When a nation government expands intergovernmental aid, in effect it tells subnational governmental units, "You are spending too little; there are certain public needs and wants that you are not satisfying." Many devolutionists believe that U.S. federal spending has bloated government beyond what citizens in many areas of the country want. In their view, the federal government should give the states more fiscal independence and responsibility, so that they will be freer to respond to the preferences of their citizens.

Matching requirements enhance the budgetary efficiency of grants, that is, the level of state spending for a desired purpose induced per dollar of federal subsidy. States presumably vary in their preferences for the targeted

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[2] For normative economic analyses of federalism and devolution, see Oates (1972); Gramlich (1987); and Inman (1985). For more general analyses of devolution, see Gingrich (1995); Donahue (1997); Nathan (1996); Rivlin (1992); Rich and White (1996); Peterson (1995); Osborne and Gaebler (1992); and Kincaid (1998).

service. Some would be willing to spend more of their own funds on this service if the cost of providing it were lower. Matching requirements achieve such a cost reduction, inducing some states to contribute more of their own funds. Federal grants imposing no matching requirements lack such leverage, in effect giving some states more money than necessary to achieve a given amount of increased spending[3].

However, matching requirements irk many devolutionists because, even though they may give federal aid programs more "bang" for the federal "buck", they distort states' decisions concerning how to allocate their own tax dollars. In order to obtain federal money for a matching grant, states must substitute outlays on the targeted public service for funds that, in the absence of the matching requirement, would be spent for other purposes. In economic terms, matching grants distort the relative per unit costs to states of providing alternative public goods and services. In this manner the federal government imposes its preferences on states. To devolutionists this imposition is different from the coercion of mandates only in degree, not in kind.

A "devolutionary" economist believes that federally imposed requirements dictating how states should administer grant programs diminishes the technical efficiency of government. The most efficient administrative means of attacking a given problem vary from state to state. By giving states more flexibility in implementing grants, the federal government, according to this view, would reduce the "diseconomies of scale" that plague many intergovernmental programs. Such decentralization also promotes policy experimentation and innovation and, therefore, further improvements in technical efficiency, both present and future.

The economic logic of devolution also implies that federal aid should not be allocated among the states according to fiscally equalizing formulas. Such formulas rely on allocative criteria other than interstate differences in preferences for the level of public goods, the key criterion for maximizing economic welfare and, therefore, for achieving an efficient geographical allocation of resources. In effect, fiscally equalizing formulas coerce relatively

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[3] For a theoretical analysis of the fiscal incentives provided by open-ended matching grants, as opposed to block grants, as well as a review of the empirical evidence concerning the relative cost-effectiveness of the alternative approaches, see Chernick (1996).

prosperous states to give some of their resources to relatively poor states. According to the goal of geographic allocative efficiency, transfers among states should be voluntary, not coerced.

2. Priorities Overshadowing Devolution

Whatever the theoretical justification for these devolutionary policies, economic and political forces have weakened support for them during the past seven years. Many Congressional advocates of devolution, most of them Republicans, have viewed these policies primarily as means to reduce the deficit, to dismantle the welfare state, to build support among Republican governors, or to free up money for tax cuts favoring traditional Republican constituencies. The dramatic turnaround in the federal government's fiscal condition, from one of substantial deficit to trillions of dollars of projected aggregate surpluses over the next decade, has undercut one of devolution's most widely embraced rationales. Furthermore, after attempts to confront former President Clinton on budgetary issues backfired in 1995, the Republican Congressional leadership has been more predisposed to compromise with centrist Congressional Democrats[4]. That the Republicans have now captured the White House will not necessarily make them bolder. Given the closeness of the 2000 presidential election and a 50-50 split in the U.S. Senate, they may still find it expedient to sacrifice devolution to achieve other priorities. Indeed, President Bush has suggested that federal programs for improving education should entail a considerable amount of federal control.

3. Federal Policy Toward Children's Health Care-the Children's Health Insurance Program (CHIP)

The large number of Americans without health insurance, especially children, has been an acute concern of federal and state policymakers for many years. According to the General Accounting Office (GAO), in 1994 approximately 10 million American children, or about 14 percent of them, had

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[4] See Weaver (1996), Pierson (1998), and Swope (1997).

no health insurance ("Health Insurance for Children: Private Insurance Coverage Continues to Deteriorate", 1996). By 1999, despite considerable publicity about the problem and extensive efforts to remedy it (such as CHIP), the percentage had fallen only to 12.5 percent (Broaddus and Ku, 2000).

The problem is attributable more to a failure to enroll children in publicly funded programs rather than the unavailability of such coverage. An estimated 40 percent of all uninsured children were eligible for some type of publicly funded coverage in 1996 (Seldin et al., 1998). The percentage of uninsured children in low-income families eligible for such coverage is much higher--estimated at 95 percent at the beginning of the year 2000 (Broaddus and Ku, 2000). Nevertheless, the problem of uninsured children has been exacerbated by a rise in self-employment and, given the escalating cost of health care and increasing competitiveness of the economy, a decreasing willingness of employers to insure employees' dependents.

During 1993-1995, the percentage of children lacking coverage varied dramatically among the states, ranging from a high of 24.9 percent in New Mexico to a low of 6.6 percent in Minnesota and Wisconsin (Table 1, column 1). These young Americans accounted for more than one-quarter of all the nation's uninsured residents. Lack of health insurance was even more widespread among children in families with incomes below 200 percent of the federal poverty level. Approximately 22 percent of these children were not covered; state percentages ranged from a high of 35 percent in New Mexico and Texas to a low of 11.1 percent in Vermont (Table 1, column 2).

Prior to the enactment of CHIP, state efforts to expand children's health-insurance coverage were a textbook example of "laboratories of democracy" at work[5]. As of May 1997, 36 states had voluntarily expanded minimum federal Medicaid requirements for children's coverage, had initiated their own coverage programs for children or families, or were subsidizing privately implemented children's coverage. Of the other 14 states, eight had privately

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[5] Justice Louis Brandeis coined this phrase to stress the advantages of innovative diversity among the states. See *New State Ice Company v. Liebman*, 285 U.S. 262, 311 (1932).

Table 1
Children under Age 19 Uninsured, by State, 1993-1995 and the Estimated Federal Allocation Under Child Health Block Grant

State	umber of Children Uninsured (in thousands)		Percent of Children Uninsured		
	% of US total	% of US total	Total	<200 % FPL	% of US total
Alabama	1,9	2,2	15,9	25,8	2,0
Alaska	0,2	0,1	10	15	0,1
Arizona	2,4	2,6	20,3	29,6	2,5
Arkansas	1,2	1,3	18,9	25,2	1,1
California	17,0	17,9	18,4	26,7	19,5
Colorado	1,2	1,0	11,9	20,9	1,0
Connecticut	0,8	0,7	9,6	18,7	0,9
Delaware	0,2	0,2	12,4	18,8	0,2
District of Columbia	0,2	0,2	16,1	18	0,3
Florida	6,2	6,2	17,1	24,4	6,4
Georgia	3,0	3,0	15,5	24,3	2,9
Hawaii	0,2	0,2	7,8	12,5	0,3
Idaho	0,5	0,4	13,7	17,9	0,4
Illinois	3,3	3,0	10,3	15,8	3,2
Indiana	1,8	1,8	10,9	18,2	1,8
Iowa	0,9	0,9	10,9	21,5	0,8
Kansas	0,8	0,8	10,8	18,4	0,8
Kentucky	1,3	1,3	13,1	18,1	1,2
Lousiana	2,5	2,7	20,1	26	2,3
Maine	0,4	0,3	12,2	18,8	0,3
Maryland	1,5	1,4	12	20,5	1,5
Massachusetts	1,3	1,0	9	14,6	1,1
Michigan	2,3	2,2	8,5	14,3	2,3
Minnesota	0,8	0,7	6,6	12,3	0,7
Mississippi	1,4	1,5	18,5	24	1,3
Missouri	1,5	1,4	11,3	16,8	1,4
Montana	0,3	0,3	11,7	19,2	0,2
Nebraska	0,4	0,4	9,1	16,1	0,4
Nevada	0,7	0,6	18,4	27,9	0,7
New Hampshire	0,3	0,3	10,2	23,3	0,3
New Jersey	2,3	1,9	11,4	22,2	2,1
New Mexico	1,3	1,5	24,9	35	1,2
New York	5,9	5,6	12,5	18	6,4
North Carolina	2,1	1,9	13,1	19,2	1,9
North Dakota	0,1	0,1	8,1	14,9	0,1
Ohio	3,1	2,9	9,7	16	2,9
Oklahoma	2,1	2,3	22,7	33,5	1,8
Oregon	1,0	0,9	12,2	18,5	1,0
Pennsylvania	3,1	2,8	10,1	16,7	3,0
Rhode Island	0,3	0,3	11,4	20,4	0,3
South Carolina	1,5	1,5	14,7	19,3	1,6
South Dakota	0,2	0,2	9,3	14,7	0,2
Tennessee	1,7	1,6	12,2	16,5	1,7
Texas	12,9	14,4	23,2	34,9	12,3
Utah	0,7	0,6	9,9	16	0,6
Vermont	0,1	0,1	7,2	11,1	0,1
Virginia	1,9	1,7	11,7	18,8	1,7
Washington	1,3	1,2	9,7	18,5	1,2
West Virginia	0,6	0,6	14,1	19,9	0,6
Wisconsin	0,9	1,0	6,6	14,2	1,0
Wyoming	0,2	0,2	14,4	26,8	0,2
United States	100,0	100,0			100,0

Sources: Alan Weil, The New Children's Health Insurance Program: Should States Expand Medicaid? (Washington D.C.: The Urban Institute, October 1997), page 2.
Weil's model was based on data from the Bureau of Cenus, Current Population Survey data, Cindy Mann and Jocelyn Guyer, Overview of the New Child Health Block Grant. (Washington D.C.: Center on Budget and Policy Priorities, August 28, 1997).
Mann and Guyer used data from General Accounting Office, August 12, 1997.
Note: The Current Population Survey (CPS) most likely overstates the number of uninsured children because it does not adjust for the underreporting of children who have Medicaid coverage. The number of children reported to have Medicaid coverage on the CPS is substantially below the number of enrollees that states themselves report to HCFA (16.5 million versus 21.4 million in 1995). The Urban Institute's TRIM2 microsimulation model attempts to adjust for this undercount by imputing Medicaid enrollment to individuals to align to HCFA enrollment counts. The result is to increase the number of children on Medicaid and reduce the number of unisured children. The Urban Institute estimates that 4.6 million children below 200 percent of poverty are uninsured as opposed to 7.2 million on the CPS. However, since the S-CHIP statute allocates funds to states on the basis of CPS estimates, those estimates are used in the brief cited above.

financed Blue Cross or Blue Shield Caring-affiliated Programs for Children (Gauthier and Schrodel, 1997). In the federal arena, the defeat of the Clinton Administration's national health insurance plan in 1994 initially discouraged further efforts to expand children's coverage. However, state leadership and compelling empirical evidence of the extent of the problem inspired a variety of fresh proposals for federal involvement, which ultimately led to inclusion of a major initiative in the BBA.

BBA appropriated $46.2 billion from federal fiscal years 1998 through 2007 "to enable [States] to initiate and expand the provision of child health assistance to uninsured low-income children." To put these amounts in perspective, according to the Congressional Budget Office (CBO), they were roughly equal to projected federal outlays over this period on student loans, about three-fourths of spending on farm-price supports, and about one-seventh of outlays for Food Stamps (Congressional Budget Office, 1998)[6]. CBO estimated that by the year 2002, the program, formally known as the State Children's Health Insurance Plan (CHIP), will have extended health care insurance to approximately 2 million children who would not be covered otherwise (Congressional Budget Office, 1997).

To the consternation of devolutionists, the amount ultimately allocated to CHIP was considerably higher than that recommended by the President in his budget for fiscal year 1998 (FY 1998), thanks largely to the efforts of Senators Edward Kennedy (D-Massachusetts) and Orrin Hatch (R-Utah). In early 1997, Kennedy and Hatch unveiled a five-year $20 billion child health-insurance bill to be financed by an increase in the federal excise tax on cigarettes from 24 cents to 67 cents per pack (Hosansky, 1997)[7]. The President's budget proposed no increase in the cigarette tax (U.S. Office of Management and Budget, 1997).

With the support of these two powerful senators from opposite ends of the political spectrum, the Clinton administration was able to insert $17 billion for the extension of children's health-coverage into the budget agreement hammered out with Republican Congressional leaders in early May. The

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[6] The $23.1 billion figure includes approximately $2.8 billion in extended coverage for children achieved through Medicaid.

[7] The Kennedy Hatch Plan was submitted on April 8 as S. 525 and S. 526.

inclusion of this program helped to appease the Democratic left, uneasy with the magnitude of tax and spending cuts that the President conceded in striking the deal. While legislators from tobacco states kept a cigarette tax increase off the table, subsequent efforts by Hatch in reconciliation moved the Senate Finance Committee to approve an increase of 20 cents per pack, enough to generated an estimated $15 billion through FY 2002. Roughly half was earmarked for an expansion of the child insurance program, bringing its proposed total five-year funding to approximately $24 billion, close to the final amount actually appropriated. The tobacco tax increase was eventually scaled back to 10 cents per pack for FY 1998 through FY 2000, rising to 15 cents a pack in the year 2001 (Carey, 1997; Congressional Budget Office, 1997).

3.1 A Block Grant-Matching Grant Hybrid

Keen on balancing the budget, neither Congress nor the administration had any interest in structuring CHIP as an open-ended entitlement. However, neither did they warm to initial suggestions by Majority Leader Trent Lott (R-Mississippi), Senator Arlen Specter (R-Pennsylvania), and Representative Tom Daschle (R-South Dakota) to subsidize the cost of children's health coverage by providing vouchers or tax credits to parents. Such proposals in part reflected a concern that instituting a large public program would induce private employers to curtail coverage for children, leading to a substitution of public for private insurance and consequent increase in CHIP's cost (Hosansky, 1997). Concern about such substitution waned as deficit forecasts became more sanguine.

Ultimately, Congress designed CHIP as a block grant program, stipulating a total appropriation for each of the subsequent ten federal fiscal years as well as a formula governing the allocation of funding among the states. From FY 1998 through FY 2000, allocations were based on each state's number of uninsured low-income children, adjusted for the state's average cost of health care (*Balanced Budget Act of 1997*, 1997, p. 905). This allocation rule penalized states that in the past had most aggressively attacked the problem of uninsured children. Moreover, if extended indefinitely into the future, this rule would have created an incentive for states to postpone extending coverage in the short run in order to augment their allotment in

subsequent years. Partially for this reason, Congress stipulated that, in FY 2001 and beyond, the formula will also take into account the number of all low-income children, covered or not, residing in the state (*Balanced Budget Act of 1997,* 1997, p. 905; Weil, 1997). Each state's estimated percentage of the nationwide CHIP allocation for FY 1998 through FY 2002 is presented in Table 1, column 5.

Contrary to devolutionist philosophy, the program imposes matching requirements on the states. They are more lenient than those required by Medicaid; that is, states will have to spend less to elicit a federal CHIP dollar than a regular federal Medicaid dollar. In effect, a state's CHIP matching rate (the ratio of state to federal funds in total program spending) will equal 70 percent of its Medicaid matching rate (*Balanced Budget Act of 1997*, pp. 908-9; Mann and Guyer, 1997). For example, Massachusetts' Medicaid matching rate is 50 percent; that is, it must spend an additional dollar of its own funds to obtain an additional dollar of federal assistance. Under CHIP, its matching rate is 0.7 x 50, or 35 percent. As a result, it has to spend only an additional 53.8 cents to elicit another federal dollar ((1.00/.538) = (65/35)).

The CHIP matching formula also conflicts with devolutionary principles in that a state's matching requirement increases with its per capita income. As an illustration, currently Mississippi's Medicaid matching requirement is 23 percent. Thus, it must spend 29.9 cents to obtain an additional federal Medicaid dollar ((1.00/.299) = (77/23)). Its CHIP matching rate is .7 x 23, or 16.1 percent; it has to spend only 19.1 cents to obtain an additional federal CHIP dollar ((1.00/.191) = (83.9/16.1)). In this manner, the matching formula favors low-income Mississippi over high-income Massachusetts, effectively leading to the reallocation of resources from the latter to the former, regardless of the relative strength of each state's preference for coverage extension[8].

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[8] However, the CHIP matching formula is less fiscally equalizing than Medicaid's. Thus, while Mississippi's CHIP matching requirement is less than Massachusetts' in both programs, Mississippi's advantage is less under CHIP.

3.2 States' Flexibility in Designing and Implementing CHIP

In addition to the matching requirement, Congress included other stipulations that constrain states' use of federal funds. In general, a state may spend no more than 10 percent of its funds for purposes other than the extension of children's health care coverage (e.g., outreach and overhead). With certain exceptions, extension of coverage is limited to children with family income below 200 percent of the federal poverty line, which in 1997 was $16, 276[9]. The program sets forth standards governing minimum health-care benefits and scope of coverage, limits premiums and the use of deductibles and co-payments, and includes maintenance-of-effort provisions designed to prevent states from substituting CHIP funds for current children's health-coverage programs, whether independent or under Medicaid.

Yet, within these regulatory constraints, and partly because of the variety of children's health-care programs already operating, Congress decided to give states considerable administrative leeway. States have the option of extending children's coverage by expanding Medicaid, augmenting existing state-financed programs, or establishing new ones. Should a state opt to establish or to expand its own programs, it will have the freedom to decide whether to administer its programs through state agencies, to contract with private organizations, or to subsidize the provision of insurance through private markets. Subject to the broad federal regulations alluded to above, it will be able to determine which children to cover. For example, it could elect to limit expansion of coverage to children under the age of six or between the ages of six and 18. As Cindy Mann and Jocelyn Guyer point out, it could limit eligibility to children residing only in certain geographical areas of the state; cap enrollment, putting children in excess of the cap on waiting lists; and even vary waiting lists from county to county. The state would also have the authority to determine which providers will participate in the program, how care will be delivered, and what quality standards must be met by providers (Mann and Guyer, 1997).

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[9] This was the official poverty threshold as of 5 June 1998 for a family of four with two related children, as reported in June 1998 by the U.S. Bureau of the Census.
Internet Citation: http://www.census.gov/hhes/poverty/threshold.html.

4. Medicaid

4.1 A Little Background

For at least three reasons, reforming Medicaid has been one of this decade's most salient and controversial issues in U.S. federalism. First, the program has mushroomed in recent years, growing much faster than outlays for other purposes. Between 1988 and 1992, combined federal and state spending on this program increased by 124 percent, compared to 50 percent for all federal, state, and local outlays. While growth in Medicaid spending has slowed dramatically over the past five years, it still grew by 31 percent between 1992 and 1995, compared to only 12 percent for spending by all levels of government[10].

Second, as discussed in more detail below, the explosive growth in Medicaid spending between 1988 and 1992 was attributable in part to states' exploitation of regulatory loopholes that permitted them to channel federal dollars into programs other than the provision of health care for the poor and uninsured. Although the federal government has since greatly narrowed these loopholes, the measures Congress enacted to accomplish this purpose have been attacked as arbitrary and inequitable in their varying stringency across states. Since the loophole tightening included restrictions on state taxation of health care providers, it also raised constitutional concerns centered around the Tenth Amendment.

Third, access to health care, especially to the poor, is widely considered to be what Musgrave and Musgrave would call a nationwide "merit" good, that is, a service that the nation should provide as a matter of moral necessity and enlightened, long-run self interest (Musgrave and Musgrave, 1976). According to this view, it is one thing to deny low-income individuals an entitlement to cash. It is another thing to deny them an entitlement to medical treatment when they are sick or injured, even when it is expensive to do so.

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[10] Figures for growth in Medicaid spending come from Holahan and Liska (1997), p. 1. Estimates of growth in spending at all levels of government are based on annual calendar-year data from author's calculations using machine readable National Income and Products Accounts data provided by the U.S. Bureau of Economic Analysis.

While Medicaid has been center-stage in many Congressional debates since 1990, lawmakers have failed to enact a comprehensive package of reforms. Apart from legislation curbing the exploitation of loopholes enacted in 1991 and 1993, the most significant Medicaid reforms were spearheaded by states acting under Section 1115 and Section 1915(b) waivers under the Social Security Act[11]. The Medicaid provisions of BBA constitute the most significant reforms of the program since 1991.

The issues raised by these provisions were also broached in debate over the BBA of 1996: Should Medicaid be an entitlement? Should state matching requirements be reduced? Should states have more flexibility in specifying eligibility criteria and the scope and duration of benefits? Should they have more flexibility in negotiating reimbursement rates with providers? Should loopholes exploited by states in recent years be further narrowed?

While the changes introduced by BBA were significant, they were far milder than those under serious consideration as recently as 1996. Medicaid is still an open-ended matching grant entitlement program with mandatory eligibility categories and guaranteed minimum benefits. BBA did not incorporate proposals supported by the Republican Congressional leadership to convert Medicaid into a block grant. Nor did it impose a per capita cap on federal Medicaid matching payments to the states, as proposed by the National Governors Association in 1996 and the Clinton Administration early in 1997[12].

4.2 More Flexibility for the States in Implementing Medicaid

Several of BBA's provisions gave states more flexibility in negotiating reimbursement rates for health providers. For example, the Act repealed the "Boren Amendment" to the Omnibus Budget Reconciliation Act of 1980. The Amendment required states to reimburse hospitals and nursing homes at rates

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[11] Section 1115 "Research and Demonstration" waivers give the states more flexibility. Section 1915(b) "Freedom of Choice" waivers are restricted to programs designed to increase the availability of managed care options and are usually limited to one geographic area within a state. See Holahan and Liska (1997), p. 3; Holahan et al. (1995), and Holahan and Nichols (1996), pp. 48-54.

[12] Swope (1997), p. 1004; Pierson (1998), pp. 153-71; and Holahan and Nichols (1996), pp. 42-7. For an in-depth analysis of the Medigrant proposal, see Holahan and Liska (1995).

that are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards[13]. Opponents of the amendment, including in their ranks many state health officials, argued that health care providers filed law suits (or threatened to file suits) based on the amendment to extract unreasonably high Medicaid reimbursement rates. As another example of enhanced state discretion, BBA in effect relieves states of the cost of compensating providers for the Medicare copayments and deductibles of individuals eligible for both Medicare and Medicaid[14].

BBA significantly increased states' authority to use managed care in the delivery of services to Medicaid patients. Virtually every state program developed under a Section 1115 or Section 1915 (b) waiver as well as all Medicaid reform proposals floated at the national level, incorporate this feature (Holahan and Nichols, 1996, pp. 50-3). BBA gave states the authority, without first obtaining such waivers, to require most Medicaid recipients to enroll in managed care organizations (MCOs) that do business only with Medicaid. Furthermore states can force recipients to choose among only two MCOs and lock them into their choice for 12 months unless a recipient can demonstrate that he or she has been unjustly denied access to covered services. Under prior law, absent a waiver from the federal government, a recipient had the option of "disenrolling" without cause after one month's membership (*Balanced Budget Act of 1997,* 1997, pp. 848-9).

The right to mandate managed care gives states a tool for enhancing the access of Medicaid patients to adequate health care. With fee-for-service reimbursement rates so low, providers have been reluctant to take on Medicaid patients. While in theory states could improve access by reimbursing providers more generously, many have assumed that few providers would respond to such incentives. If this assumption were correct, most of the increased state outlays would simply reward existing Medicaid providers for doing what they would do anyway. By permitting all states to contract with MCOs with an exclusively Medicaid clientele, architects of the BBA hoped to develop

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13 42 U.S.C. 1396a(a)(13).

14 P.L. 105-33, sec. 4714.

institutions with a contractual responsibility to provide care to the poor and uninsured[15].

In addition to giving states greater discretion to introduce potentially cost-saving reforms, BBA gave states two options for expanding coverage for children. (These options are separate from the S-CHIP program and are available to states regardless of whether they choose to implement that program through an expansion of Medicaid). First, they can offer children continuous coverage for a 12-month period after their eligibility has been initially verified. Under prior law, states were required to reevaluate the eligibility of all Medicaid beneficiaries with each change in their financial condition. As a result, monthly or even weekly fluctuations in income, occurring often in low-income families, caused frequent interruptions in children's coverage. Second, states can presume that a child is eligible for coverage on the basis of a cursory screening until their Medicaid agency makes a final determination based on a thorough investigation.

4.3 New Underfunded Mandates

BBA imposed two new underfunded Medicaid mandates on the states: restoration of Medicaid coverage for certain immigrants rendered ineligible by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) and increased costs resulting indirectly from increases in Medicare premiums.

4.3.1 Restored Medicaid Coverage for Immigrants

PWRORA significantly reduced the eligibility of legal immigrants for several means-tested welfare benefits. Those residing in the U.S. at the time of the law's enactment were not spared cuts. They were declared ineligible for Supplemental Security Income (SSI) and Food Stamps; even those receiving

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[15] Medicare and the American Health Care System: Report to Congress (1995). Cited in Holahan and Nichols (1996), p. 45. See also Norton (1995) and Zuckerman and Verrilli (1995). For discussions of the advantages and disadvantages of greater utilization of managed care for Medicaid patients, see Zuckerman et al. (1997), and Schneider (1997).

benefits at the time of enactment were to lose them after a grace period of approximately one year. As a result, some of these legal resident aliens (about one-quarter of them, according to CBO estimates) lost their entitlement to Medicaid benefits, too, because eligibility for SSI is a sufficient condition for Medicaid eligibility. The authority to determine whether they were eligible for Medicaid, Temporary Assistance to Needy Families (TANF), and other federal means-tested programs was vested in the states. These provisions of PWRORA were among the most devolutionary in that they significantly reduced federal spending on welfare and delegated implementation to the states[16].

Proponents of these restrictions on the eligibility of legal immigrants argued that many were bringing relatives to the United States to avail themselves of SSI, Medicaid, and Food Stamp benefits. The resulting increase in the cost of these programs was substantial. Imposing these restrictions would therefore both curtail abuse of these programs and realize substantial savings for the Treasury. However, opponents, President Clinton among them, maintained that these limitations unreasonably discriminated against a group of residents "in the United States legally and making every effort to become productive members of society". Upon signing PWRORA into law in the summer of 1996, the President vowed that, if reelected, he would fight for the restoration of some lost benefits (Carney, 1997, pp. 1134-5). Making good on his promise, the President proposed in his FY1998 budget that immigrants legally residing in the United States as of August 22, 1996 and receiving SSI benefits because they are disabled should continue to receive them. Such immigrants receiving SSI because of their elderly status would lose their benefits, but if they could requalify on the basis of disability, they would be allowed to do so. Any legal immigrants in residence before the August 22, 1996 deadline not receiving SSI disability benefits would be eligible for them if they subsequently become disabled (U.S. Office of Management and Budget, 1998, p. 109).

The Clinton Administration's willingness to fight for these recommendations was bolstered by the increasing political clout of immigrants and the strong support they lent the President during his successful reelection campaign. Under the terms of PWRORA, some 500 thousand immigrants

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[16] See Irene Lurie, (1997), pp. 73-89, and Guyer et al., (1996).

stood to lose benefits, 80,000 in New York State alone. As a result, Asian-Americans and Hispanic-Americans increased their rate of voter registration and lobbied aggressively to have benefits restored. A significantly larger percentage of Asian-American and Hispanic-American voters registered as Democrats and supported Clinton in 1996 than in 1992 (Carney, 1997, pp. 1132-3). The bipartisan budget accord negotiated between the President and Congressional leadership adopted the President's recommendation (Rubin, 1997, p. 995). In the reconciliation phase of negotiations, the House Ways and Means Committee and Senate Finance Committee adopted versions less generous than the President was seeking. The Ways and Means proposal would have grandfathered benefits for all legal immigrants in residence and on SSI rolls on or before the deadline, whether qualifying on the basis of disability or elderly status. However, immigrants subsequently becoming disabled could not qualify. The Senate Finance Committee version differed from that of Ways and Means in that it allowed immigrants in residence before the deadline to receive benefits if they had since become disabled before September 30, 1997 (Katz, 1997a, pp. 1450-1). However, under the explicit threat of a Presidential veto, the full Senate, as well as the Conference Committee negotiating the final budget bill, both supported the Clinton Administration's original proposal (Katz 1997a, p. 1530; 1997b, p. 1848).

This provision not only reversed to a modest degree the previous widening of state discretion in setting immigrant policy but, according to CBO estimates, has increased federal spending by approximately $11.5 billion between FY 1998 and FY 2002. BBA did not restore these immigrants' eligibility for Food Stamps or rescind provisions of PWRORA restricting the access to several federal means-tested programs of immigrants arriving after PWRORA's date of enactment[17].

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[17] *Balanced Budget Act of 1997* (1997), pp. 944-9, and Congressional Budget Office (1997), pp. 62-4. For an analysis of the implications of the provisions of PWRORA and BBA governing aliens' access to welfare benefits for the respective roles of the federal government and the states in crafting the nation's immigration policies, see Fix and Tumlin (1997). For a more general discussion of intergovernmental relations and immigration policy, see Skerry (1995), pp. 71-85.

4.3.2 Increases in Medicare Premiums.

The increases in Medicare Part B premiums included in BBA indirectly impose additional costs on the states because Medicaid pays these premiums, as well as deductibles and copayments, for low-income beneficiaries. Currently the income ceiling determining a Medicare patient's eligibility for this assistance is 120 percent of the federal poverty line. BBA increased this ceiling to 135 percent and, with respect to payments for certain home health services, 175 percent. It established a block grant to the states, with no matching requirement, to finance coverage for this newly eligible group. However, funds for this purpose were appropriated only for five years, from FY1998 through FY2002 (*Balanced Budget Act of 1997*, 1997, p. 880; and Schneider, 1997, pp. 8-9). Moreover, Congress explicitly recognized that the appropriated amount, $1.5 billion over the five-year period, might be insufficient to cover all costs. BBA instructed states to offer the benefit on a first-come first-serve basis and to limit the number of recipients so that the state's allocation will not be exceeded (*Balanced Budget Act of 1997*, 1997, pp. 881-2).

4.4 New Constraints on Disproportionate Share Hospital Payments

Of all the BBA's provisions, those imposing the most severe restrictions on states' flexibility in using federal Medicaid dollars concern payments to Disproportionate Share Hospitals (DSHs)--the costly Medicaid "loophole" alluded to above. The DSH program is a arguably the nation's most graphic example of intergovernmental fiscal pathology. Its history demonstrates the difficulty of targeting categorical grants, containing their costs when they are provided on a matching open-ended basis, and capping them once a large number of states have become financially dependent on them[18].

DSHs are hospitals whose patient mix includes a large portion of Medicaid recipients and people with no health insurance. In recognition of the severe financial difficulties that these institutions face, Medicaid gives states the option of providing special assistance to them through either lump-sum payments or unusually high reimbursement rates for services rendered to

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[18] This section, which discusses the DSH program, draws heavily from Coughlin and Liska (1997); Schneider et al. (1997); and Gold, (1996a).

Medicaid clients. States initially proved reluctant to avail themselves of this option, in part because they still had to put up some of their own money to trigger federal matching payments. To overcome this reticence, the federal government loosened the program's restrictions on states. For example, in 1985 the Health Care Financing Administration (HCFA) allowed states to accept donations from private health care providers to help finance Medicaid services. Using their considerable flexibility in implementing their DSH programs, states were able to pay the donated money right back to the providers, precipitating federal matching funds in the process. In this manner, states were given the capacity to elicit federal assistance while evading their matching obligations. In a similar arrangement, some states imposed a tax on their health care providers and gave them DSH payments in proportion to their tax payments, thereby triggering federal payments.

By the beginning of the decade, states figured out that they could legally use these financial arrangements to channel federal Medicaid money into their general fund, to be used for purposes that have nothing to do with health care for the poor and uninsured. As an illustration, consider the following hypothetical example of a state with only one hospital. The state imposes a tax on the hospital's gross receipts, generating $1,000 in tax revenue. It puts $400 of this revenue into its general fund and $600 into its DSH program. The federal government matches these DSH dollars with $600 of its own. The state makes a $1,200 DSH payment to the hospital. The hospital comes out $200 ahead and the state has generated an additional $400 for its general fund.

As states' fiscal distress deepened during the 1991-1992 recession, the temptation to exploit these "arrangements" became too great for most states to resist. Between 1990 and 1992, federal DSH outlays grew from $1.4 billion to $17.5 billion. The number of states taking advantage of the DSH program grew from 6 to 39. According to a 1993 survey, approximately one-third of all DSH funds were channeled into other programs (Ku and Coughlin, 1995). However, there was considerable variation in the degree to which states exploited DSH financing schemes. In 1992 DSH spending comprised 35 percent of all Medicaid spending in New Hampshire and 43 percent in Louisiana. In several states, by contrast, it accounted for less than 1 percent.

Many state officials defended the use of DSH financial arrangements to extract federal assistance, even though they acknowledged that they diverted

Medicaid dollars from their intended purpose. Some officials saw exploitation of this loophole as just compensation for the costs of such underfunded federal Medicaid mandates as the Boren Amendment and required extension of coverage to pregnant women and new categories of children. Others criticized proposed limits on provider tax schemes on the grounds that they would violate the "reserved powers" clause of the Tenth Amendment of the Constitution. Finally, it was alleged that, given how dependent many states had become on Medicaid funds, sharply curtailing their availability would seriously undermine their financial condition, creating more problems than it would solve.

Despite this opposition, the federal government enacted laws in both 1991 and 1993 intended to curtail "abuses" of the DSH program. The 1991 law 1) generally banned provider donations, 2) stipulated that provider tax revenues could not exceed 25 percent of a state's outlays for Medicaid (net of federal assistance), 3) stipulated that provider taxes had to be broad-based and that Medicaid reimbursements to a particular provider could not be linked to the provider's tax liability (i.e., providers could not be "held harmless"), and 4) capped each state's DSH outlays. Specifically, nationwide DSH payments were limited to 12 percent of total Medicaid costs. If a state's ratio of DSH payments to total Medicaid outlays equaled to or exceeded 12 percent in 1992, the state could not exceed this amount in subsequent years. If a state's ratio was less than 12 percent, it could increase DSH payments at the same rate as increases in total Medicaid outlays[19].

While the 1991 and 1993 limitations cut DSH spending substantially, concerns about the program continued to fester. Attempts to cap spending had created an interstate allocation of funds that tended to favor states who had exploited the DSH loophole most extensively in the early part of the decade. DSH payments per low-income resident varied dramatically among states. These inequities were exacerbated by legislated exemptions from constraints for New Hampshire and Louisiana, the two states with the highest ratio of Medicaid revenues to total spending. In addition the various loophole-narrowing provisions enacted in 1991 and 1993 still left opportunities for

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[19] Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 102-234) and Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66), sec. 13621.

channeling Medicaid funds into state general fund coffers through interagency transfers. Policy makers found arrangements involving transfers from public mental health facilities to be especially objectionable since provision of mental health services are mandated by Medicaid. Finally, the various constraints imposed on DSH payments in some instances worked at cross purposes. For example, these constraints were making it difficult for some states to spend their total DSH allotment granted them in the 1991 legislation (Coughlin and Liska, 1997, p. 5). With these lingering concerns, and the need to cut federal spending to eliminate the federal deficit, the BBA of 1997 scrapped the 1991 allotment rules and substituted new state-specific allotments from 1998 through 2002. After 2002, each state's DSH spending will be allowed to grow at the rate of increase of the U.S. Consumer Price Index and will be capped at 12 percent of the state's total Medicaid outlays. In addition, the Act gradually introduces limits on DSH spending for mental health. By 2003, when these limits are fully phased in, a state's DSH outlay for this purpose will be limited to 33 percent of its 1995 level (*Balanced Budget Act of 1997*, 1997, pp. 873-6.)

According to simulations conducted by the Urban Institute, the new allotments and caps will narrow interstate dispersion in reliance on federal DSH dollars as well as DSH spending per low-income resident. Yet, the allotments partially reflect the outcome of what Kincaid has termed "mediated competition" among states for Congressional favor (Kincaid, 1991). Thus, while New Hampshire and Louisiana have experienced disproportionately large percentage reductions in DSH funding (relative to their 1995 levels), South Carolina, another state relying heavily on DSH financial arrangements, will enjoy relatively small proportionate cuts (Coughlin and Liska, 1997, p. 4)[20]. In addition, opportunities for exploiting such financial arrangements still exist. In fact, CBO assumes that states will respond to BBA's DSH limits by intensifying their exploitation of such opportunities, reducing by 25 percent the gross the federal cost savings that these limits would otherwise achieve (Congressional Budget Office, 1997, pp. 49-50).

While many states have converted the DSH program to something akin to a general revenue program, others have used the program for its intended purpose. Moreover, even in states that have "abused" the program, some of its

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[20] For another state-by-state analysis of the new cap's implications, see Schneider et al. (1997).

outlays have hit its target. Therefore, the DSH limits imposed by BBA have diminished the ability of DSH to serve its low-income, uninsured clientele. The new limits are not the only source of additional financial pressure faced by DSHs. The potentially averse consequences for DSHs have generated pressure on states to shore up these institutions.

5. Whither Devolution under the Bush Administration? Early Evidence from the President's Proposal for Education Reform

Some might surmise that the election of a Republican president will get the "devolution revolution" moving again in the United States. Some of the President's nominations for U.S. cabinet posts suggest that this may be the case. For example, "Tommy" Thompson, former Governor of the State of Wisconsin and the President's choice for Secretary of Health and Human Services, is an ardent believer in the capacity of state's to solve public policy problems if given the necessary autonomy and flexibility. He has put his beliefs into action; Thompson's pioneering efforts at welfare reform in Wisconsin inspired and shaped comparable reforms at the national level enacted by Congress in 1995.

However, President Bush's recent proposals for reforming U.S. education aid demonstrate the same ambivalence toward devolution that has characterized CHIP and reform of Medicaid. On the one hand, the President has proposed that states be given more flexibility in allocating federal grants among competing uses, especially those targeted for low-income school districts. On the other hand, he wants to impose accountability standards on local school districts, varying the amount of federal aid each receives depending on the academic performance of its students on federally mandated tests. His rhetoric reflects his ambivalence. He has lamented the fact that "today, nearly 70 percent of [U.S.] inner city fourth graders are unable to read at a basic level on national reading tests" and that [U.S.] "high school seniors trail students in Cyprus and South America on international math tests." On the one hand, he has asserted that "although education is primarily a state and local responsibility, the federal government is partly at fault for tolerating these abysmal results." On the other hand, he has stated that his program is "based on the fundamental notion that an enterprise works best when responsibility is

placed closest to the most important activity of the enterprise, when those responsible are given greatest latitude and support...." (The White House, 2001).

The political roots of President Bush's education initiative can be traced back at least as far back as 1995. In that year, Congressional Republicans engaged in an ill-fated attempt to dismantle the U.S. Department of Education. Former President Clinton's opposition, backed by that of the majority of the American people, insured that the attempt was unsuccessful. Since then, the American public has consistently characterized the Democrats as more committed to improving education than Republicans. The spectacle that Republican lawmakers made of former President Clinton's impeachment did not help their image. In an attempt to change this perception, Republicans, often with moderate Democratic co-sponsors, have periodically submitted legislation loosening the strings attached to federal aid while simultaneously calling for the federal imposition of standards for education achievement, enforced by financial rewards and punishments. Former President Clinton, with his allies in Congress, fought to maintain federal rules governing how aid should be spent. In particular, he wanted to appropriate over $11 billion to help school district's hire 100,000 new teachers in an effort to reduce average class size (Kirchhoff, 1998).

"Devolutionists" scored a moderate victory in April 1999 with the expansion of the "Ed-Flex" Program (P.L. 106-25). Ed-Flex (short for "education flexibility"), enacted in 1994, gave a dozen states authority to waive a limited number of federal regulations governing the allocation of a limited number of federal education grant programs. In return, the states had to develop a comprehensive plan, subject to federal approval, showing how the waiving of federal regulations would enable them to enhance student achievement. They also had to submit a plan for monitoring student progress and making their evaluations available to parents. P.L.106-25 in affect gave all 50 states the option of applying for the right to wave the regulations covered by Ed-Flex. Republicans and moderate Democrats successfully fought attempts by the Clinton Administration to tack on to the legislation appropriations targeted on teaching hiring (Kirchhoff, 1999a).

In June of 1999, Republicans, buoyed by their initial success, introduced two new expanded "ed-flex" programs that would have consolidated several

other programs into block grants and introduced more lenient waivers of federal regulations. One bill would have allowed school districts to divert much of the money targeted for additional hiring of teachers to training existing teachers, to hire special education instructors, or to increase merit pay. Another broader measure would have given all states the option of converting the bulk of federal education programs into block grant programs, including money targeted for low-income school districts, vocational education, and technology assistance. The first plan passed the House of Representatives. The second, however, was watered down into a 10-state pilot program. Since the Senate deadlocked over both bills, the whole issue has postponed for the Bush Administration to address (Kirchhoff, 1999b; Koszczuk, 1999).

President Bush's education proposals are similar to those introduced by Congressional Republicans during the second half of 1999. The most "devolutionary" component of the Bush Administration's plan would give states or individual school districts the option of entering into a charter agreement with the U.S. Secretary of Education. The charter would spell out a five-year performance agreement between the Secretary and the state or school district spelling out targets for improvement in student achievement. In return for meeting its targets, the state or school district would gain freedom from a wide variety of regulatory requirements constraining the allocation of federal school aid. All schools, even those not subject to charter agreements, would enjoy at least some reduction in regulatory requirements.

However, as in earlier Republican proposals, the price of greater flexibility would be greater accountability. Charter states or school districts would have to meet the objectives stipulated in the terms of their charter or lose their exemption from federal regulations. As a condition of receiving federal aid, all states would have to establish standards of competence in reading, math, history, and science. They would have to implement annual standardized tests for every child in grades three though eight and report student assessment results to parents and to the public at large, disaggregated by race, gender, English language proficiency, disability, and socio-economic status. Schools and states whose disadvantaged students fail to make adequate progress (as judged by national assessment tests) would eventually lose some of their federal assistance for administrative purposes. Under these conditions, disadvantaged students could use federal assistance to transfer to a higher

performing public or private school or to receive supplemental educational services from a provider of their choice (The White House, 2001).

6. Conclusion

BBA and President Bush's education reform proposal reveal the federal government's ambiguous feelings about relinquishing its role as the "dominant senior partner" in U.S. federalism[21]. BBA included new grant programs, including one that inserts the federal government into a policy arena where the states have taken the initiative. However, the Act gave the states flexibility in determining how the major new program, extension of children's health insurance coverage, should be implemented. Moreover, the new grant programs are capped, although most impose matching requirements. The Act left Medicaid as an open-ended matching entitlement, despite numerous previous proposals to transform it into a block grant. The Act restored some previously rescinded mandates, appropriated funds to assist compliance with others, and imposed some new ones. President Bush's proposed school reforms give states and school districts more flexibility in using federal education grants but impose new mandates designed to ensure accountability. All in all, neither BBA nor the President's school reform plan push the nation very far along the devolutionary path. It appears that, while the "devolution evolution" is proceeding gradually, the devolution revolution is on hold.

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[21] In Martha Derthick's "strong senior/weak junior" model of U.S. federalism, the federal government is the dominant partner and the states the junior partner. See Derthick (1989), pp. 34-8.

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