Federalism and Health Care Reform: Is Half a Loaf Really Worse Than None?

By RICHARD BRIFFAULT*

Health care reform dominates the domestic agenda of the Clinton Administration. Policy analysts, media pundits, and ordinary citizens are abuzz with the once-arcane terminology of health reform—"managed competition," "single-payer," "regional alliances," "global budgets"—as they ponder the merits and demerits of the leading reform alternatives. At the center of the public debate are questions concerning the role of government in constraining health care costs, maintaining quality, and widening access. But in our federal system there are *two* governments that can address most domestic problems—the national government and the states—and, although considerable ink has been spilled over the issues of how large and what type of a regulatory role government ought to play in health care, relatively little attention has been devoted to the question of *which* government ought to do the regulating, or how the two layers of government ought to interact in the pursuit of reform. The general lack of concern over the federalism implications of a national initiative that would affect one-seventh of the domestic economy and define national policies for areas traditionally left to states the is striking. Yet, given the propensity of policy analysts to debate the substance of proposals while ignoring issues of government structure, the inattention to federalism is, sadly, not surprising.

Professor Candice Hoke's Article, "Constitutional Impediments to National Health Reform: Tenth Amendment and Spending Clause Hurdles,"[1] thus, makes a significant contribution to the evolving health care reform debate. Her close review of the elements of the leading health care reform alternatives that bear directly on the states, and her careful assessment of these proposals in light of the law and principles of federalism, provide both informed insight concerning an

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1. Candice Hoke, *Constitutional Impediments to National Health Reform: Tenth Amendment and Spending Clause Hurdles*, 21 HASTINGS CONST. L.Q. 489 (1994).

under-examined aspect of health care reform and a distinctive critical perspective on the ramifications of health care reform for the balance of power within the federal system. Her Article raises thoughtful questions both about how federalism concerns ought to constrain the design of national policy initiatives and of the potential of the Supreme Court's recent *New York v. United States*[2] decision to generate substantial constitutional limits on the federal government's ability to secure the participation of the states in national programs.

This brief Commentary is not the place for a sustained examination of the various and changing health reform initiatives or the constitutionality of each of the health reform proposals that are the subject of Professor Hoke's careful critique. Instead, I would like to address two principal themes in Professor Hoke's article: (1) Her argument that reforms in which the federal government calls upon the states to carry out national goals and secures state participation through a combination of carrots and, especially, sticks, are by their very nature harmful to the values of federalism, with the implication that federalism would be better served by a health care system administered entirely by the federal government than by one that combats federal and state roles; and (2) her elaboration of *New York*'s principle that the federal government may not command state legislative or regulatory action into a broader rule that would invalidate some federal measures short of commands that tend to induce states to join federal programs.

These two themes are intertwined. The assumption, implicit in her analysis, that federal-state programs, with Congress pressing the states to participate, are worse, from a federalism perspective, than outright federal takeover of a field drives the argument for reading *New York* broadly. By the same token, her interpretation of *New York* provides a constitutional underpinning for her opposition to programs that would enlist the states in the pursuit of national reform.

It is less clear to me than it is to Professor Hoke, however, that the values of federalism are necessarily injured by regulatory structures that rely on state and local personnel, give the states some role in implementation, and preserve a space for state policy-making, initiative, and accountability within the interstices of national standards. The institutional interests of the states and the values that underlie contemporary federalism could be advanced by a national program addressing a problem that currently strains state budgets but is proba-

2. 112 S. Ct. 2408 (1992).

bly beyond the capacity of the states to address without some federal assistance. Moreover, a national program that creates the possibility of some state discretion in implementation could promote the values of federalism, even as new federal standards and pressures also constrain the states.

Nor is it clear that *New York* can or should be read as a one-way ratchet, imposing ever-tighter limits on the ability of the federal government to impose pressures—short of commands—on the states to participate in national programs. *New York* leaves intact a variety of intergovernmental devices that, by their very nature, induce the states to implement national programs, even in areas beyond the reach of direct national regulation.[3] These mechanisms facilitate the combination of federal and state roles which, in many settings, may be a better way to promote the interests of both the nation and the states than regulations that require the federal government or the states to act apart from the other level of government. As *New York* itself indicates, federalism does not, and should not, bar joint federal-state action.[4]

I

As Professor Hoke points out, a striking feature of the principal health care reform proposals currently before Congress is the avoidance of what she considers "the most obvious available structure: preempting State and local regulatory authority and substituting a nationally funded and operated administrative agency dedicated to achieving Congress' goals."[5] From a constitutional perspective, the avoidance of federal preemption and the creation of a new federal health care bureaucracy is particularly remarkable because "[s]uch an approach would be initiated by a constitutionally unexceptional use of the commerce power."[6] Instead, all the major health care proposals give the states a significant role in administering new national policies and in implementing the national programs.[7]

3. *See, e.g.,* South Dakota v. Dole, 483 U.S. 203 (1987); Oklahoma v. Civil Serv. Comm'n, 330 U.S. 127 (1947).

4. New York v. United States, 112 S. Ct. 2408 (1992).

5. Hoke, *supra* note 1, at 500.

6. *Id.*

7. Since Professor Hoke wrote her article, Representative Pete Stark (D. Cal.), the chair of the Subcommittee on Health of the Ways and Means Committee of the United States House of Representatives, has proposed a health care reform that would provide insurance for the currently uninsured through expansion of the federal Medicare program. This could be a wholly federal solution to the lack of insurance problem, although it is less clear how expansion of Medicare would address the medical cost problem for individuals

One would think that this would be cause for "federalist" celebration: no new federal bureaucracy, no sweeping federal displacement of state laws and structures, new and expanded regulatory roles for state personnel, continued state involvement in at least some important health care issues. Symbolically, the commitment of most federal reformers to a central role for the states in the implementation of health care initiatives reflects and reaffirms most Americans' deep suspicion of the federal government, as well as the ingrained political and cultural preference, even among federal officials, for state and local—as opposed to federal—action. Federalism, defined as the commitment to decentralized decisionmaking, the avoidance of the concentration of power in the national government, and the provision of a role for the states in areas of domestic policy that directly affect the daily lives of ordinary people, is surely honored when all the federal parties involved in the most important effort in decades to significantly expand the domestic role of government assume that a major part of the expanded government role will be played by the states. Indeed, one can only imagine the howls of opposition from federalism's exponents had health reformers proposed to dispense totally with any state role in the national health care system and to create a new federal bureaucracy to administer a program for the regulation of insurers, health care providers, and health care costs.

A national health care reform that combines federal and state roles would be of more benefit to the states as institutions and to the values that underlie federalism than would a purely federal program. Depending on just how much discretion is left to the states in a particular health reform plan, a combined federal-state reform could give the states some role in determining the scope of health care coverage, the schedule of payments to providers, the mechanisms for cost containment, and the extent of choice in the selection of physicians and treatment. Again, depending on exactly how much interstate variation is allowed, a state might also be able to tailor particular reforms, such as the adoption of alternative dispute resolution in cases involving health care providers, to its particular needs, conditions, or traditions. In other words, the states might enjoy some powers to continue to make policy in areas that have traditionally been within the purview of state authority.

Moreover, vesting some responsibility for the provision of insurance coverage, the assurance of quality, and the containment of costs

and employers relying on private health insurance. *See* Robert Pear, *New Health Plan Stresses Medicare*, N.Y. TIMES, Mar. 1, 1994, at A10.

at the state or sub-state[8] level may actually make it more likely that these goals will be attained. The actions needed to achieve the many ends of health care reform are likely to vary significantly from place to place within the United States. It is doubtful whether a single national bureaucracy would be able to design its rules and requirements to take interstate and intrastate variation fully into account. Delegating responsibility to state and sub-state units increases the possibilities that policies will match local conditions, whether because of differences in the rules of the various jurisdictions or because state and local officials, accountable to state and local politicians and to state and local electorates, will tailor administration of national rules to state and local conditions. Further, such decentralized implementation is likely to improve the monitoring of local outcomes and the revision of policies in light of their real-world effects in differing state and local settings.

Finally, placing responsibility for the implementation of health reform in the hands of sub-national institutions is likely to enhance the possibilities for ordinary people to observe conditions, raise questions, comments, and complaints, and seek changes in the way reform is carried out. A variety of local administrative mechanisms are likely to be more transparent, more open to observation and participation by ordinary people, than a single national one. Moreover, it will probably be easier for people to organize, seek change, and hold public officials accountable with respect to the performance of a program if some responsibility for that program is borne at the state or local level. Increasing opportunities for individual participation in public decisionmaking and enhancing the ability of ordinary people to get government to respond to their concerns is a central value of contemporary advocates of federalism.[9]

To be sure, the amount of power that state officials will actually have to tailor national programs to local conditions, and the opportunities that local people will really have to influence decisions, is uncertain. Much will turn on the specific provisions, rather than the broad contours, of the reform proposals ultimately adopted. It may be that the states will be given relatively little space to develop local solutions or to adapt national standards to local settings. It may be that federal requirements will leave the states with relatively little room to maneu-

8. Under the Clinton health plan, many key decisions will be made by "regional alliances," created by the states, with jurisdictions that will often be less than an entire state. Health Security Act, S. 1757, 103d Cong., 2d Sess. §1311 (1993).

9. *See* Hoke, *supra* note 1, at 547.

ver, that federal rules will operate as ceilings as well as floors. It may be that the substantive federalism benefits in terms of opportunities for local input, experimentation, citizen participation, and policy variation in light of differing local conditions or regulatory preferences will be relatively small. God is in the details, and the details of whatever reform is ultimately adopted could render the federalism benefits of state administration and implementation trivial.

Nevertheless, reliance on the states for implementation and administration of any national health care reform at least increases the possibility of some substantive state role and some opportunities for ordinary people to influence local health care decisions through grassroots political activity. Moreover, state or sub-state administration avoids the expansion of the federal bureaucracy and the creation of a regulatory mechanism which would greatly increase the power of federal officials over the day-to-day lives of ordinary people. Given these factors, how can it be that the combined federal-state programs outlined in the major reform initiatives, including President Clinton's plan, are necessarily worse for the states than no role at all? Is it really the case that for federalism half a loaf—or even a scattering of crumbs—is worse than none?

Although Professor Hoke's Article is primarily critical and she does not propose her own structure for national health reform, her analysis implies that an all-federal reform would be better for federalism and for the states than the proposals currently before Congress that would combine federal policy-making and requirements with state responsibility for administration and implementation. She contends that the purpose and effect of the health care proposals is to force the states to bear the fiscal and political costs of reform. President Clinton and the Congressional health care reformers provide for a large administrative role for the states, she contends, not out of any solicitude for federalism and not to enhance the capacity of the states to structure reform in light of varying local conditions and preferences, but simply because "the Federal government is strapped for cash."[10] By enticing the states "to ante up funds they currently employ for health administration or health services" and by "implicitly conscripting a portion of the States' personnel and budgets," the federal proposals "eliminate or severely restrict the politically unpalatable alternative of raising Federal taxes."[11]

10. Hoke, *supra* note 1, at 500.

11. *Id.* at 500-01.

She argues that, not only does state implementation of health reform get the President and Congress out of a tight political and fiscal spot, it is also fraught with danger for the states. "[T]he kinds of incursions into the State fisc and policy-making apparatus that pervade the pending health reform bills" amount to a federal "pilfer[ing of] the State's coffers for its own projects" that leave "the cupboard bare for the projects and self-determined needs." Moreover, "[b]oth the States and their officials would bear the brunt of popular concern over raised taxes or slashed services caused by national orders." As a result, "[t]he States' personnel, fisc, and control over their political agendas would be greatly impeded."[12] In short, states would no longer be able to pursue their own policies and programs because their revenues would have been conscripted into the national effort. State officials would be blamed, and state governments unfairly discredited, for the inability of the states to pursue local projects and objectives. This would harm the states as institutions and, ultimately, threaten "political participation and its roles in constructing individuals' commitment to their government" because if the nation becomes "the only political entity with real power to set goals and values . . . the range of persons engaged in direct participation . . . will likely fall substantially."[13]

Professor Hoke may be correct in suggesting that the motivation for enacting a state role is the political self-interest of federal officials rather than a commitment to the ideal of federalism, but that is not much of an objection if, nevertheless, the states realize some benefit from a combined federal-state reform, and the values of federalism are served thereby. Thus, the core of her concern must be that the states will be made worse off by national reform because, in the guise of giving the states a place in the implementation of any reform, the federal government will be draining the states of treasure, personnel, and energy. In reaching this conclusion, however, Professor Hoke fails to consider two factors critical to the evaluation of the impact of health care reform on the states: first, the massive health care burdens the states currently bear; and, second, the lack of fiscally and politically viable alternatives to combined federal-state reform.

Central to Professor Hoke's argument is the concern that reform would compel the states to devote their scarce tax dollars to what is essentially a federal program. But the states' treasuries are already funding a significant portion of the nation's health care expenditures, much as health care costs are currently devouring state revenues. Ac-

12. *Id.* at 549.
13. *Id.*

much as health care costs are currently devouring state revenues. According to the Congressional Budget Office, in 1990, state and local governments spent more than one hundred billion dollars of their own funds on health care—or roughly 13% of the total national health care bill.[14] That number is expected to soar to $244 billion by the year 2000.[15] Medicaid alone constitutes the second largest budget line for the states, after elementary and secondary education.[16] Total health care expenditures accounted for 17% of state and local governments' own-source revenues in 1990, with that figure projected to rise to over 27% by the year 2000.[17] As these numbers suggest, without significant reform, health care is likely to account for a substantial share of the real dollar increase in state and local budgets between now and the end of the decade. In short, state budgets are already groaning under the weight of heavy, and increasing, health care costs, and the fiscal burdens of health care are already driving and constraining state policy-making. The ability of the people of the states to use their state governments to develop new programs and pursue new agendas, or even to cut back on taxes and reduce the size of their state budgets, is currently severely restricted by health care costs.

The Clinton Administration estimates that its health reform plan will save the states $46 billion, or 8% of what they would otherwise spend on health care over the next five years."[18] While this estimate must be taken with a considerable dose of salt,[19] some of the proposals for shared federal-state health reform could save the states substantial sums. It is certainly possible that health reform will save the states more in reduced Medicaid and long-term care expenditures than it will cost them in terms of the administrative expenses of implementing federal health reform. And this cost accounting considers only the fiscal implications for the institutional interests of the states. Many of the states have been grappling for years with efforts to provide health care for their uninsured residents who are not eligible for Medicare or Medicaid, but few have had the funds to do so. Many of

14. CONGRESSIONAL BUDGET OFFICE, ECONOMIC IMPLICATIONS OF RISING HEALTH CARE COSTS 7 (Table 1) (1992).

15. *Id.* at 24 (Table 1).

16. Deborah A. Stone, *Why the States Can't Solve the Health Care Crisis*, 9 THE AMERICAN PROSPECT 53, 55 (Spring 1992).

17. CONGRESSIONAL BUDGET OFFICE, PROJECTIONS OF NATIONAL HEALTH EXPENDITURES 8 (1992).

18. Robert Pear, *Administration Outlines Hopes for Health Savings*, N.Y. TIMES, Mar. 2, 1994, at B7.

19. *See id.* (noting New York officials' assertion that Clinton figures significantly overstate the likely benefits to New York).

the federal-state health reform proposals would provide broad coverage funded by billions of new federal dollars, whether from formally denominated federal "taxes" or euphemistically labelled "employer mandates."

There is, thus, at least some possibility that, in terms of reducing the burden on state treasuries and enhancing the ability of the states to advance the welfare of their residents, combined federal-state health reform—even reform that places new administrative burdens on the states—will benefit the states. Although the states may be subject to nominal new administrative and fiscal burdens, health reform might actually give them greater freedom to set their own political and fiscal agendas and to secure their own ends.

Moreover, under present conditions it appears that a combined federal-state structure is more likely to secure the cost-containing, coverage-extending benefits of reform for the states and their residents than either of the two alternative routes within the federal system: states-only reform or federal-only reform. Significant states-only reform is unlikely due to the structural constraints of interstate competition, the limited fiscal resources of many states, and the restrictions on state action resulting from the existing and unchallenged federal interests in the field. Any health care reform aimed at controlling costs and financing insurance coverage for the uninsured is likely to involve new taxes and regulatory burdens on health care providers, insurers, and employers.[20] A general problem that states encounter when they seek to impose new taxes and regulatory burdens is the threat of mobile businesses subject to regulation or taxation to flee the jurisdiction to other less-regulatory or lower-tax states. With states dependent on businesses to provide jobs and on the tax base for state revenues, businesses' ability to exit to another state limits the capacity

20. I do not mean to overstate the case against the likelihood of state-based health care reform. Indeed, "historically the states have taken the lead in health care reform." Deborah L. Rogel & W. David Helms, *Tracking States' Efforts to Reform Health Systems*, HEALTH AFF., Summer 1993, at 27. States have traditionally played the major role in the regulation of insurance, much as they have also been significantly involved in the oversight of health care delivery. In just the last few years, more than a dozen states have taken a variety of actions that fall under the rubric of health care reform, including revision of insurance underwriting practices, "broadening access to medical care and moderating the growth of future spending on personal health services." John K. Inglehart, *From the Editor*, HEALTH AFF., Summer 1993, at 6 (preface to issue focussing on "state models" for health reform, including detailed evaluations of reforms in Florida, Hawaii, Maryland, Minnesota, New Jersey, Oregon, Vermont, and Washington, and brief references to reform efforts in another seven states). My point is merely that, due to the factors I discuss in the text, national policy goals of assuring universal access to insurance and containing rising health care costs are unlikely to be attained by states-only reform.

of any individual state to take action. As the Supreme Court observed nearly sixty years ago in discussing why during the Great Depression most states had failed to adopt their own unemployment compensation laws funded by business taxation, prior to the enactment of a federal scheme, "Many held back through alarm, lest in laying such a toll upon their industries, they would place themselves in a position of economic disadvantage as compared with neighbors or competitors."[21] As the Court recognized, some federal action is necessary to deal with the prisoners' dilemma of competitive interstate federalism.[22]

The fear of insurer, provider, or employer exit in the face of cost-containment requirements or new taxation may significantly constrain individual states from enacting the regulatory programs they might otherwise prefer, or imposing the taxes necessary to fund the programs they might use to provide coverage for the uninsured. From this perspective then, federal legislation that formally burdens the states may actually allow states to reduce their costs and secure the well-being of their residents, because federal standards and requirements would eliminate the fear that other states, not adopting new taxes or regulation would benefit from the flight of firms and taxpayers from the more regulatory and higher-taxing states.

More generally, "state fiscal realities limit the potential subsidies"[23] that states can provide to insurers, employers, or individuals to assure that everyone has health care coverage. Universal health insurance will require billions of new dollars—dollars that the states are simply unable to provide. By contrast, President Clinton's plan, even though it may require the states to incur new administrative costs, provides for tens of billions of dollars per year for health care in new federal taxes, and hundreds of billions of dollars from its fiscal centerpiece, the employer mandate.[24]

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21. Steward Mach. Co. v. Davis, 301 U.S. 548, 588 (1937).

22. On federalism and the prisoners' dilemma, see SUSAN ROSE-ACKERMAN, RETHINKING THE PROGRESSIVE AGENDA: THE REFORM OF THE AMERICAN REGULATORY STATE 166-70 (1992). As Deborah Stone has pointed out, "the corollary of the exit threat in a federal system is the 'magnet fear.' States fear that by offering more generous benefits to the poor than neighboring states they will actually induce more poor people to move into the state." Stone, *supra* note 16, at 59. She suggests that in one instance a more generous Indiana plan encouraged the emigration of some poor from Illinois. *Id.* Whatever the extent in fact of more generous benefits serving as a "magnet," certainly the fear of a magnet effect along with the fear of exit constrain states' willingness to provide new, costly health care benefits.

23. Stone, *supra* note 16, at 54.

24. According to the Congressional Budget Office, in fiscal 1999, the first year in which the President's plan is fully phased in, the federal government would provide $29

Finally, the states cannot go it alone because of existing federal legislation and federal interests in health care and insurance. The federal Medicare program covers the cost of health care for 33 million older Americans. Medicare is a wholly federal program, and it pays for 40% of all hospital costs.[25] The ability of the states to control hospital costs is inevitably limited when, in Deborah Stone's phrase, "the lion's share of the costs is controlled by a lion outside their jurisdiction."[26] Similarly, the Federal Employee Retirement Income Security Act (ERISA) restricts the scope of state action because ERISA broadly preempts state regulation of employee benefit plans. Although the states may continue to regulate insurers, the federal courts have interpreted ERISA as precluding the states from regulating self-insuring employers. When ERISA was enacted in 1974, self-insured employer plans covered only 5% of the people with employee health insurance; two decades later they cover over 50%.[27] With ERISA preemption, "[s]tates cannot require employers to provide insurance or mandate the terms of employee benefits that self-insuring employers provide. States are also prohibited from taxing self-insuring employers to finance care for the uninsured."[28] By placing a large percentage of employers and insured health care consumers out of the reach of state regulation and taxation, ERISA severely constrains the ability of states to determine the scope of health care benefits, pool insureds so as to hold down insurance costs, or raise the revenues necessary to extend coverage to the uninsured.[29]

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billion per year in new federal tax dollars for health coverage. CONGRESSIONAL BUDGET OFFICE, AN ANALYSIS OF THE ADMINISTRATION'S HEALTH PROPOSAL 29 (Table 2-2) (1994). More importantly, the administration's employer mandate would be the source of an additional $290 billion. *Id.* at 38 (Table 2-5). Although some of the funds raised by the employer mandate would replace existing employer payments for health insurance, much of the money would be in addition to the dollars currently available for health care coverage. The administration does not characterize the employer mandate as a new federal tax, but, in the words of the CBO Study, the mandate "represents an exercise of the sovereign federal power" and the moneys raised pursuant to it "should be shown as governmental receipts." *Id.* at xv. Whether or not the mandate is a "tax," it is surely an important new source of funds that significantly complements state efforts.

25. Wendy E. Parmet, *Regulation and Federalism: Legal Impediments to State Health Care Reform*, 19 AM. J.L. & MED. 121, 130-31 (1993).

26. Stone, *supra* note 16, at 55.

27. *Id.* at 57.

28. Parmet, *supra* note 25, at 134.

29. On the effects of ERISA preemption on the ability of states to initiate health care reforms, see generally Parmet, *supra* note 25, at 132-140; Stone, *supra* note 16, at 57-58; Fernando R. Laguarda, Note, *Federalism Myth: States as Laboratories of Health Care Reform*, 82 GEO. L.J. 159, 174-75 (1993). Other federal programs that limit state health care reform efforts include Medicaid and the Americans with Disabilities Act. *See* Parmet, *supra* note 25, at 131-32, 140-43; Laguarda, *supra*, at 176-79.

Although Medicare, ERISA, and other federal statutes, including Medicaid and the Americans With Disabilities Act, constrain state initiatives and can be condemned for their interference with the states' capacity to address health care problems on their own,[30] these statutes do reflect some traditional federal concerns and policies: redistribution for the benefit of the elderly and the poor, protection of victims of discrimination, and national regulation of employer-employee relations for firms in interstate commerce. Even without these statutes, states-only regulations could raise concerns about the adequacy of different levels of support for health care for the poor in different states, or the impact of differing state regulations on interstate commerce.[31] In any event, these statutes do exist, and Professor Hoke has not suggested that they raise federalism problems in terms of the "commandeering" of the states' governments into national programs which is the focus of her concern. Some significant federal component would be necessary in health care reform if only to coordinate the existing federal programs and statutes.[32]

To be sure, Professor Hoke has not criticized proposals for a federal role in health reform; what has drawn her fire is the combination of federal policy-making and state administration. The inference that I draw from her criticism of proposals that assume that the states would play a significant role in the implementation of a new national program is that she would prefer an all-federal structure for reform. An all-federal reform could, in theory, secure uniform national coverage and cost containment without commandeering the personnel or treasury of the states. However, it is not clear "on the merits"—that is, in terms of assuring high quality, cost-effective health care for all Americans—that an all-federal system is the best structure of reform. As previously suggested, utilization practices, health care costs, and background conditions affecting health vary significantly from place to place across the continent. Some aspects of health care administration, such as the interaction of patients with doctors, clinics, or community hospitals, are intensely local, with few extra-local, let alone interstate, ramifications. Additionally, many smaller offices might be better at monitoring local outcomes than a single national bureaucracy. Even Canada's highly-touted single-payer system is in effect a collection of provincial systems, with considerable interprovincial variation in costs and coverage, and provincial responsibility for admin-

30. *See, e.g.*, Laguarda, *supra* note 29.
31. *See generally* Parmet, *supra* note 25.
32. *See* Stone, *supra* note 16, at 53.

istration—and Canada has only one-tenth the population of the United States.

More importantly, health care quality aside, Professor Hoke has pointed to the principal practical obstacle to an all-federal system: the federal budget deficit and the intense unwillingness of federal elected officials to raise federal taxes. Few federal officeholders are willing to utter the "t-word" in the context of health reform. President Clinton has sought to treat most of the health reform financing as an off-budget item, with the hundreds of billions of dollars to be raised under the federal "employer mandate" not considered a tax at all. The other principal reform proposals also look to some combination of tax expenditures, limitations on current tax deductibility, and employer mandates. In the current political and fiscal climate, a fully federally funded and administered system seems unlikely, whatever its substantive wisdom.

Thus, some form of health care reform is likely to be better for the states than no reform at all, and a combined federal-state program, with the states pressed to bear some of the administrative expenses of expanding coverage and containing costs, may be the most realistic—even if not necessarily the most desirable—route to reform. The states might be better off with a cost-free health reform than with a reform program that saddles them with new administrative burdens, but with the states currently straining under the weight of high and rising health care costs, and yet in most cases unable to assure adequate health coverage to all residents, it is far from clear that a combined federal-state program, even one imposing some new costs on the states, is so detrimental to the interests of state governments or to the ability of state residents to use their states as institutions of self-government. Under these circumstances, health reform achieved through combining federal standards, pressures, and funds with some state administration and implementation ought not to be ruled out on federalism grounds. If a combined federal-state program gave the states some discretion to tailor various rules and policies to local conditions and preferences, then surely such a program would advance both the cost-containing and coverage issues at stake in health reform, as well as the values of federalism.

To be sure, the states, or some states, might benefit relatively little from whatever reform is ultimately adopted, yet find themselves saddled with considerable new costs. And certainly, as health reform wends its way through Congress, programs initially enacted will be subsequently amended. And as federal appropriations in the "out-

years" shape the relative burdens borne by the federal government and the states over time, health reform could turn out to be a very bad deal for the states, or at least for some of them. The states will have to struggle vigorously and vigilantly to defend their interests in the national political process and in conflicts with insurer, provider, and consumer interest groups.[33] National health care reform could turn out to be a bad deal for the states, and the question of the federalism impact of a reform that relies on the states' assumption of an important administrative role might have to be reopened. But given the states' current health care burdens and the practical difficulties that beset the other alternatives to reform it is difficult to accept the premise, at this early stage in the health reform process, that national health reform which relies on the states for administration and implementation necessarily violates the values of federalism.

II

As Professor Hoke has indicated, whatever the policy-based assessment of the federalism implications of a national health care reform, the constitutionality of such action is another question, the answer to which is significantly affected by the Supreme Court's recent decision in *New York v. United States*.[34] In *New York*, the Court held that "Congress may not simply 'commandeer[ ] the legislative processes of the states by directly compelling them to enact and enforce a federal regulatory program.'"[35] Even when the subject matter of the federal statute falls within the scope of federal power so that Congress has the authority to pass laws requiring or prohibiting certain acts of private individuals, Congress "lacks the power directly to compel the states to require or prohibit those acts."[36] Congress may regulate interstate commerce, but it lacks authority "to regulate state governments' regulation of interstate commerce."[37]

New York represents the Court's latest effort to write a constitutional law for federalism.[38] As Professor Hoke points out, *New York*

33. States and local governments have enjoyed some successes in protecting their interests in the federal political process. *See, e.g.*, Carol F. Lee, *The Political Safeguards of Federalism? Congressional Responses to Supreme Court Decisions on State and Local Liability*, 20 URB. L. 301 (1988).

34. 112 S. Ct. 2408 (1992).

35. *Id.* at 2420 (quoting Hodel v. Virginia Surface Mining & Reclamation Ass'n, 452 U.S. 264, 288 (1981)).

36. *Id.* at 2423.

37. *Id.*

38. *See generally* H. Jefferson Powell, *The Oldest Question of Constitutional Law*, 79 VA. L. REV. 633 (1993).

calls into serious question "untethered regulatory commands."[39] But *New York*'s anti-"commandeering" principle does not stand alone, and it does not prohibit all federal actions that place fiscal, political, and regulatory pressures on the states. Rather, *New York* is situated in a body of case law and intergovernmental practices that allow Congress to use joint federal-state programs to promote the general welfare, and employ a variety of techniques, in addition to the gift of condition-free funds, to induce the states to participate in such programs.

First, *New York* followed the holding in *Garcia v. San Antonio Metropolitan Transit Authority*[40] in assuming that the Constitution does not reserve to the states those subjects that were traditionally matters of state competence. Indeed,the *New York* Court noted that the Commerce and Spending Clauses together give the federal government broad power to act with respect to activities "once considered purely local."[41] Second, *New York* did not disturb *Garcia*'s ruling that Congress may "subject state governments to generally applicable laws,"[42] such as those that regulate the employment relationship, even though those laws impose substantial costs on the states, and, consequently, may constrain the states' freedom to adopt new programs. Finally, the Court confirmed that although Congress may not order the states to adopt certain laws or carry out federal laws, Congress may deploy a range of tools "to encourage a State to regulate in a particular way" and "hold out incentives to the states as a method of influencing a State's policy choices."[43]

39. *See* Hoke, *supra* note 1, at 552-55. I am also inclined to agree with Professor Hoke's argument that *New York* also calls into question federal statutes requiring states to choose between submitting to federal directives or paying a "fee" that clearly raises more revenue than necessary to fund the program. *Id.* at 558-62 (discussing conditional preemption plus state fee). Although the federal government may charge the states as well as the private sector for services the federal government provides, *see, e.g.*, Massachusetts v. United States, 435 U.S. 444, 460-63 (1978), the charge must not discriminate against the states relative to private payers. Moreover, a charge well in excess of the cost of a service is either redistributive or punitive and is, thus, a tax. Arguably, a charge for a service that the state must accept should also be considered a tax. On the other hand, it could also be argued that the state may be forced to accept the service if its failure to do so imposes costs on other states. If a state's only choices are to carry out a federal directive or pay a tax, that is closely equivalent to the choice between two commands which the Supreme Court ruled out in *New York.*

40. 469 U.S. 528 (1985).

41. *New York*, 112 S. Ct. at 2419.

42. *Id.* at 2420.

43. *Id.* at 2423.

The Court specifically confirmed the continued constitutionality of two federal devices for influencing state policy-making: conditional spending and conditional preemption. With respect to the power to attach strings to federal grants, the Court acknowledged that "the conditions attached to the funds by Congress may influence a State's legislative choices."[44] Indeed, in this era of constrained state budgets, that influence is likely to be quite powerful.[45] Yet *New York* cited approvingly the Court's earlier decision in *South Dakota v. Dole*,[46] which "found no constitutional flaw" in a federal statute directing the withholding of federal highway funds from any state that failed to adopt "Congress' choice of a minimum drinking age."[47] *Dole* is a particularly powerful example of the authority of Congress to "influence" the legislative agenda of the states because, due to the Twenty-first Amendment, the drinking age is arguably the rare subject reserved to the states exclusively and beyond the scope of Congress' Commerce Clause authority. Nonetheless, the Court found that Congress' use of federal funds "to encourage uniformity in the States' drinking ages" was "within constitutional bounds even if Congress may not regulate drinking ages directly."[48] Similarly, *New York* cited with approval *Hodel v. Virginia Surface Mining & Reclamation Association*,[49] and *Federal Energy Regulatory Commission v. Mississippi*,[50] two decisions in which the Court had sustained federal statutes which threatened to preempt state law-making from traditional state fields—land use regulation and public utility regulation—unless the states agreed to regulate the activity in question according to federal standards.[51] Despite the pressure inherent in the threat to preempt the states from acting in areas of longstanding state concern, conditional preemption, like conditional spending, leaves to "the residents of the State . . . the ultimate decision as to whether or not the State will comply"[52] with the federal policy at issue, and, thus, does not violate the anti-"commandeering" principle.

44. *Id.*

45. *See generally* Lewis B. Kaden, *Politics, Money and State Sovereignty: The Judicial Role*, 79 COLUM. L. REV. 847, 874-81 (1979).

46. 483 U.S. 203 (1987).

47. *New York*, 112 S. Ct. at 2423.

48. *Dole*, 483 U.S. at 206.

49. 452 U.S. 264 (1981).

50. 456 U.S. 742 (1982).

51. *New York*, 112 S. Ct. at 2424 (citing *Hodel*, 452 U.S. at 288, and *FERC*, 456 U.S. at 764-65.

52. *New York*, 112 S. Ct. at 2424.

When placed in the context of these other federalism decisions, *New York*'s anti-"commandeering" principle is of indeterminate scope. *New York* may be read either as simply precluding formal orders, or, more expansively, as a general principle barring the federal government from placing pressures on the states to participate in federal programs. If *New York*'s anti-"commandeering" principle is read narrowly and limited to direct commands, its doctrine could be reduced to a mere formality, a matter of *lese état* protecting the dignity of the states but not providing a substantial immunity from federal policy-making. For federal legislators, *New York* would become simply a drafting nuisance, entailing the careful avoidance of Professor Hoke's "untethered regulatory commands" but permitting a variety of other mechanisms that would make non-compliance with federal policy painful for the states. On the other hand, if the anti-"commandeering" principle is read broadly to prohibit federal actions that nominally let the states go their own way but actually place "undue influence" or excessive pressure on the states, then *New York* will quickly come into conflict with the case law sustaining conditional spending and conditional preemption, and could become a real obstacle to the joint federal-state pursuit of national ends.

Professor Hoke would read *New York* broadly to reach many forms of indirect pressure as well as direct commands to the states. Several of her models of "problematic commands to state governments" do not involve commands to state governments at all, but "extraordinary inducements" in the form of either strings attached to Federal grants or burdens to be placed on private actors within states that have chosen not to participate in federal programs.[53] In her view, "the strategic use of federal grant programs threatens the constitutional role of states; the grants may be employed to reduce or eliminate the independence of and regulatory experimentation by State governments."[54] So, too, permitting Congress to place burdens on the private sector in states that have opted out of federal programs would enable Congress to "achieve through the back door what it is barred from doing through the front."[55]

Surely Professor Hoke is correct in assuming that the threat to withhold large sums of federal aid constitutes an "extraordinary inducement" to state action to satisfy the federal terms, much as the

53. Hoke, *supra* note 1, at 562-573. (These are Professor Hoke's models five, six, and seven).

54. Hoke, *supra* note 1, at 572.

55. *Id.* at 565.

private sector penalties, could generate powerful intrastate political pressures on state governments to act. Yet *New York*, by its own terms and when read in the context of the Supreme Court's other federalism decisions, does not limit federal power to attach strings to spending, does not restrict federal power to regulate private actors, and does not proscribe all federal efforts to influence state legislative decisions. The inducements that result from strings attached to spending were specifically validated in *New York*.[56] In older cases the Court sustained federal legislation imposing taxes on the private sector in states that had failed to adopt measures consistent with federal policy,[57] even in the face of arguments and evidence that the federal tax was passed primarily "to coerce the states" into adopting those measures.[58] *New York* is not unidirectional, rendering invalid all federal efforts to press the states to adopt particular policies. Instead, *New York* and the other relevant case law point in conflicting directions, as the Supreme Court attempts to reconcile the overarching power of the federal government to set national policies in now-virtually unlimited areas of national concern and to influence state decisionmaking accordingly, with respect for the autonomy of the states. *New York* limits the federal government, but that limit is not itself unlimited; it must be reconciled with other decisions validating federal authority.

Professor Hoke's extension of *New York* beyond "untethered commands" to federal actions that do not involve direct commands to the states is plainly less a matter of interpreting the holding in *New York* or of attempting to harmonize the anti-"commandeering" principle with the Court's other federalism decisions than an articulation of her vision of federalism and her concern that federalism is threatened by joint federal-state programs. Professor Hoke's central focus is "republican process values,"[59] defined in terms of citizen participation in public affairs and the protection of communities with "particular sets of values" and "'ends different in some respects from other communities'."[60] In her view, federalism is a "basic commitment to actualizing republican process values."[61] Republican process values require autonomous states in which citizens may participate and feel that their participation matters as to policy ends and means chosen. Federalism is, thus, advanced by constitutional rules that protect state autonomy.

56. *New York*, 112 S. Ct. at 2423.
57. *See, e.g.*, Steward Mach. Co. v. Davis, 301 U.S. 548 (1937).
58. Florida v. Mellon, 273 U.S. 12, 15 (1927).
59. *See* Hoke, *supra* note 1, at 547.
60. *Id.*
61. *Id.*

Professor Hoke finds state autonomy threatened by joint federal-state programs which press the states into the service of national policies. Although she would permit Congress to treat "the States as potential partners to be enticed into a joint effort,"[62] she finds some federal "incentives," such as the denial of subsidies or the imposition of taxes or restrictions on the private sector in uncooperative states, "more akin to a shotgun wedding."[63] Professor Hoke would save federal-state joint programs by permitting the "cooperative" ones while invalidating the "shotgun weddings," but her expansive reading of *New York*, and her propensity for finding coercion where others might see the permissible pressures inherent in conditional spending, could render many joint programs unconstitutional—a result which would not serve the state autonomy interests vindicated by federalism.

The elusive distinction between forbidden commands and permissible persuasion will often be difficult to draw, as evidenced by the longstanding difficulties courts and lawyers have faced in attempting to distinguish between voluntary agreement and coerced consent in a wide range of legal arenas. A court or commentator particularly concerned about the potential for federal actions to shape the political setting for state decisions may be quick to see the "coercive" aspects of federal incentives and, especially, the "undue" pressure immanent in federal threats to withhold incentives, while another court might see appropriate efforts by the federal government to assure that the dollars paid by federal taxpayers are put to the goals adopted by those taxpayers' representatives.[64]

Moreover, a finding that federal inducements amount to coercion may reflect certain assumptions about the normative legitimacy of the baseline "uncoerced" activity. From one perspective, federal regulations that penalize private parties in a state that does not participate in a federal program may generate "undue" intrastate political pressure to join the federal program. But if the unregulated program is seen as imposing costs on out-of-state residents, if the absence of a tax in one state allows that state's residents to free ride on the efforts of residents of another state, or if the lack of a tax in one state undermines the ability of other states to collect and enforce their taxes, then from another perspective the unregulated situation is arguably a coercion of out-of-staters which the states, acting through their federal representatives, may seek to cure.

62. *Id.* at 542.

63. *Id.*

64. *See, e.g.*, Oklahoma v. United States Civil Serv. Comm'n, 330 U.S. 127, 143 (1947).

Reading *New York*'s anti-"commandeering" principle expansively with an eye toward finding coercion in many ambiguous situations could constitute a serious threat to joint federal-state programs. If the threat to withdraw funds for failure to comply with the conditions attached to federal grants were treated as coercive, how willing would the federal government be to offer the states funds? If the threat to preempt state regulation of a field where the states did not regulate in a manner consistent with federal policies were treated as coercive, would the federal government be able to adopt programs that combine national standards with state discretion to take local circumstances into account? If the federal government could not tax private activity to level the interstate playing field between states imposing a certain tax to fund a social safety net program and those that do not, would the states be able or willing to run programs like the unemployment compensation scheme sustained in *Steward Machine Co. v. Davis*?[65]

A broad reading of *New York*, thus, threatens to inhibit the creation of joint federal-state programs. That will not advance the "republican process values" Professor Hoke finds vindicated by federalism. To be sure, joint programs make it more difficult for the people to determine which government to hold accountable for a particular program and they allow the federal government to shape state agendas. But the problem of assessing government accountability, that is, of determining which government actors and institutions are responsible for the successes or failures of particular programs may be endemic to any system like federalism in which political power is fragmented among a number of actors and institutions.

Moreover, as I suggested in Part I, joint programs can also be a source of autonomy for the states by providing an alternative to states-only and all-federal regulation in areas of shared federal and state interest. State autonomy is inherently restricted by the differences in state resources and the effects of interstate economic competition. Those states with more resources or states otherwise less vulnerable to interstate competition will be able to adopt more aggressive regulatory programs or more generous social services systems.[66] The other states may lack the taxable resources or may be so "paralyzed by fear" of the loss of taxpayers or businesses that they

65. 301 U.S. 548 (1937).

66. This may explain why the only state to provide for universal health insurance is Hawaii—its nearest state competitors are more than two thousand miles away.

will be unable to pursue the programs their residents prefer.[67] The specter of interstate competition shapes the internal politics of many states, enhancing the position of the most mobile firms and taxpayers who can credibly threaten to exit to other states should the state legislature adopt the regulatory program or the tax to fund it that a majority of the residents of the state might support. Federal programs can increase the autonomy of poorer states and the power of nonmobile people relative to more mobile firms. Thus active, participatory, locally-accountable state governments may benefit from federal restrictions on other state governments. As the Supreme Court recognized, by curtailing the power of the firms that threaten to exit and by lifting the shackles of interstate competition from a state's internal decisionmaking, federal statutes that press or induce all states to adopt a certain tax or participate in a joint federal-state program may "not [be] constraints, but the creation of a larger freedom."[68]

Nor will all-federal programs necessarily be better for the states than joint federal-state programs marked by some federal pressure to participate. Although all-federal programs can allow the states to avoid the costs of administering federal programs, they also eliminate the possibility that the states can have a role in tailoring the programs to local needs, preferences, or conditions, or that locally accountable officials will be responsible for their implementation. "[R]epublican process values" are virtually by definition better served by administrative structures that are more attentive to intrastate diversity and that provide greater opportunities for grass-roots oversight and participation than by programs that consist of federal bureaucrats imposing uniform nationwide standards.

Professor Hoke is concerned that federal-state programs will divert state money, personnel, and energy to federal goals so that the states will eventually be unable to pursue their own ends. She suggests that the states might be better served by total federal takeover of a field, than by federal legislation that relies on the states for administration, since at least the former option would allow the states to use their public resources for their own purposes. I agree with Professor Hoke that the extreme case of an unlimited federal power to place more and more burdens on the states would absorb state revenues, preoccupy state personnel, and, ultimately, crowd state and local initiatives off state agendas. She is also surely correct in contending that a viable federalism requires more than that "States *exist* in some fash-

67. *See Steward Machine*, 301 U.S. at 588.
68. *Id.* at 587.

ion."[69] In a true federalism, the states have important autonomous policy-making roles, so that participation in sub-national politics can matter as to policy ends and the means chosen. Federal domination of the political agendas of the states would be inconsistent with such a true federalism. But so, too, would the extreme version of the all-federal alternative. The all-federal route allows the federal government to completely preempt the states from any field in which there is a federal interest. Given today's integrated national—and rapidly globalizing—economy and the frequency with which traditionally local problems now spill over state borders, there are few fields in which there is no conceivable federal interest. Is the extreme case of a federally dominated state agenda really worse than the alternative extreme case of a succession of federal preemptions which result in no state agenda at all?

Either extreme would be intolerable for the republican process values Professor Hoke has located in federalism. The all-federal route would be no more protective of federalism's values if Congress proceeded far enough down that route than would federal domination of state agendas through the use of carrots and sticks. The question is whether, under present conditions, Congress' use of mechanisms that fall short of direct commands, but that induce or pressure the states to participate in federal programs in a field—leaving open the option of nonparticipation—is so clearly worse for the values of federalism than total federal takeover that joint federal-state programs should have constitutional limits.

This brings us back to health care reform. The states are sorely stressed by the current costs of the health care system. Due to the effects of interstate competition, limited state resources, and existing federal programs, the states acting alone can neither cut costs nor extend coverage as effectively as they could with national assistance. An all-federal program is both unlikely to be adopted and unlikely to provide any room for state discretion to meet local preferences and needs. In this circumstance, a joint federal-state structure can serve the needs of the states and their residents. Such a structure may require nation-wide coverage with concomitant restrictions on nonparticipating states to be effective, and may compel payments from every state, including nonparticipating ones, to be fair. Such restrictions and payment requirements may significantly influence the decisions of individual states concerning whether they will participate in such a program, but so long as the restrictions and requirements are reasonably

69. Hoke, *supra* note 1, at 546.

related to the fairness and effectiveness of the national program and as long as they avoid *New York*'s proscription of direct commands, I would find them worse for the states than either no federal action or a total federal takeover of the field.

Indeed, instead of having an expansive reading of *New York* shaping the design of health reform, perhaps the health reform example can affect our reading of *New York*. As health reform indicates, federal-state relations are quite complex. The states are currently hard pressed by serious and costly economic and social problems. Often a principal restriction on state ability to address these problems is a shortage of resources, the structural limitations of interstate competition, or existing federal statutes that address matters of federal concern, rather than unfunded federal mandates. Federal programs that address these limitations on state autonomy, including federal programs that rely on the states to assume some administrative costs and create incentives (or withdraw discretionary benefits) to secure state participation, may be seen to empower the states even as they press the states into the service of national objectives.

As a result, *New York*'s command/inducement distinction will focus considerable attention on a program's substantive context: to the benefits of the federal program to the states, to the costs of inaction, and to the alternatives to the federal action said to place pressure on the states. We must avoid abstract, semantic examination of the notions of "coercion" and permissible persuasion. Given our extensive contemporary reliance on programs that combine federal financial or regulatory benefits with federal conditions and requirements of the states to address current domestic problems, and the likelihood that Congress will continue to prefer such programs to all-federal action, the burden ought to be on those who read *New York* expansively to demonstrate that a joint federal-state program significantly interferes with state autonomy, particularly if the likely result of barring a joint federal-state program is no legislation to address the underlying economic or social problem at all. Until proven otherwise, our basic operating assumption has to be that half a loaf is better than none.