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Recommended Citation

Ken Wing, Health Care Reform in the Year 2000: The View from the Front of the Classroom, 26 *AM. J.L. & MED.* 277 (2000).

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Health Care Reform In The Year 2000: The View From The Front Of The Classroom

Kenneth R. Wing[†]

I. INTRODUCTION: WHERE HAVE WE BEEN?

My thoughts about the status of American health care as it enters the twenty-first century have less to do with any theory or model—or even my own politics—and more to do with my efforts as a teacher. For the past twenty-five years I have taught introductory health law courses in law and public health schools. While what I teach and how I do so have changed enormously during that time, my basic objective has changed very little: preparing my students for the political and legal issues that they will likely confront in their individual and professional lives.¹ It is a task that I find endlessly challenging. I have to amass and continually update a tremendous amount of information concerning individual and institutional providers, various financing arrangements, state and federal programs, and all the other things that many Americans only partially understand or ignore altogether. But the real challenge is in delivering this information. It must be presented in some useful and retainable way. As in all other important things, the devils in American health care can only be found in the details; but the trick for a teacher ultimately, is figuring out which devilish details are important, which are not and¹ why, and how to pass all that along to tomorrow's decision makers—whether tomorrow is just tomorrow or whether it is the beginning of a new century.

In the early years of my teaching career I was heavily influenced by my own mentors who insisted that American health care was fitfully, though inevitably, evolving towards some nationalized health care scheme and that I should organize my understanding of it accordingly. For example, I have always taught that the adoption of Medicare and Medicaid in the 1960s was one of the most significant changes in the structure of American health care during the twentieth century and I will continue to

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¹ I have fairly strong, some would say unorthodox, views of what should be included in introductory health law courses. While those views are only tangentially related to this essay, you can find a lengthier explanation of what I teach—and why—in introductory courses in public health schools in the preface to my public health school textbook. See KENNETH R. WING, *THE LAW AND THE PUBLIC'S HEALTH* vii–ix (5th ed. 1999). I have written a similar explanation of what and how to teach introductory health law courses in law schools. See KENNETH R. WING ET AL., *THE LAW AND AMERICAN HEALTH CARE* xxix–xxxii (1998).

do so. Nonetheless, in the early years of my career I followed my own teachers' lead and emphasized what those programs left undone. Neither Medicaid nor Medicare resolved the problems of the working poor or of those for whom private insurance continued to be either unavailable or unaffordable.² Moreover, while committing all that money to health care for the elderly and the poor, Congress and the states had not—yet, I frequently implied—done anything to control costs on those programs, nor had they interfered with the autonomy of private providers or the province of private third party payers. Again, steps yet to be taken, I taught.

The health planning and other regulatory programs that followed in the 1970s fit nicely into that storyline. As health care costs continued to rise rapidly, government began to move again in that inevitable direction, first to control the costs of the publicly funded programs and then, hesitantly but increasingly, those of privately funded health care as well. Regional Medical Programs and Comprehensive Health Planning gave way to Health Systems Agencies and certificate-of-need requirements; there were even experiments with price controls and talk of empowering planners to decertify existing services.³ Each piece was oddly fashioned, but I thought the overall pattern was pretty clear, as was the future.

There were times in the 1970s, when it appeared that we would take the next giant step, and at least I thought so, and I revised my teaching accordingly. As various national health insurance proposals moved on and off the political stage, I quickly reworked my class materials and built many of my classroom lessons around a comparison of the existing structural elements of American health care with what they might look like in the future under various nationalized schemes. I still have a faded chart in my notes contrasting Long-Ribicoff with Kennedy-Mills with the counteroffers forged by Nixon and Weinberger.⁴ In retrospect, I wish I had spent less time on the specifics of these proposals themselves—their details seeming all important at the time and now long forgotten—and presented the national health insurance debates of the 1970s more as I now see them: good illustrations of the conumbral nature of American health politics and the ambivalent values that underlie them. The political lesson would have given my students more insight as to what was really going on at the time and left them better prepared to understand what followed.

It would have prepared me better too. I must confess: I had to reorganize my thinking as well as my teaching rather quickly in the Reagan years. In what seemed like a few short months I stopped teaching Jimmy Carter and his "nine percent solution" and started teaching Ronald Reagan and his New Beginning.⁵ I had to explain why so many Americans who initially had responded so enthusiastically to Carter's promise of national health insurance were now equally enthusiastic about Reagan's plans to march us in exactly the opposite direction.⁶ I realize now that what was actually going on during those years was much more complicated and even more predictable than that, but I think I missed a political lesson or two along the way. Instead, I tried to revise but retain my basic message. Maybe the fruitful journey had

² See WING ET AL., *supra* note 1, at 166–68 (discussing the shortcomings of Medicare and Medicaid).

³ For a longer and more detailed description of these events, see *id.* at 32–43.

⁴ See *id.* at 38; see also PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 381–405 (1982) (discussing the health care crisis with respect to Medicare and Medicaid between 1970 and 1974, and the surrounding political conditions).

⁵ See generally WING ET AL., *supra* note 1, at 44–50 (discussing former Presidents Carter and Reagan's approaches to health care).

⁶ See *id.* at 43–49.

stalled at a crossroads. Maybe it was not “How long?” but rather, “Which way?” After all, my mentors—I will hereafter stop blaming them and take more responsibility for my own short-sighted choices—repeatedly told me that American health care was in a state of crisis and that sooner or later, “something had to be done.” Maybe they were only wrong about the inevitability of the “something.” I started telling my students that Americans were facing some very fundamental choices concerning their collective health care. They had better understand those choices—I frequently paused here for dramatic emphasis—and be prepared to live with the consequences.

That approach worked pretty well for the first year or two. I did not even have to look very hard for usable class materials. In a way not seen before or since, the incoming Reagan Administration set out exactly what it wanted the federal government to look like, program by program, dollar by dollar.⁷ Health care was not its top priority, but the Reagan Administration’s agenda was no less specific: repeal the regulatory efforts of the 1970s, terminate many federal health programs, block grant others, and generally shift more responsibility for American health policy to the States and the workings of the private sector.⁸ In fact, I was convinced—not happy, but convinced—that “Which way?” was largely a rhetorical question. The real questions of the day were how far would we pursue Reagan’s agenda, and how different would the world be from what it might have been had we continued to follow the regulatory path.

As it turned out, that was not quite right either. It quickly became apparent, though I still wonder how quickly, that Reagan would not get everything he wanted, particularly regarding reforming health care. Congress honored his requests for health care deregulation pretty much line for line.⁹ Many 1960s-style federal health programs—again I have forgotten the details but I remember telling my students that the poor and the elderly would find the world a very different place, if they came to be—disappeared. But Reagan’s plans to rework Medicare and, particularly, Medicaid were among his first major legislative losses.¹⁰ Probably more importantly, the huge budget cuts that were supposed to follow from a leaner and more conservative federal health effort never materialized. To the contrary, federal health spending—Reagan and his revolution notwithstanding—continued to rise in the 1980s, as did health care spending generally, in much the same manner that had convinced Carter that he would have to impose big-time regulatory controls if he really wanted to pursue national health insurance.¹¹

By the end of Reagan’s first term in office, Congress was not only refusing to do some of the things that Reagan was asking, but was doing things that did not even fit into the Reagan strategy or, for that matter, any familiar political configuration. On its own initiative, Congress adopted a series of cost-containing measures for Medicare and Medicaid. The most prominent among these measures created prospective inpatient hospital payment based on diagnostic-related groupings, known more commonly, thankfully, as DRGs.¹² Congress also adopted legislation

⁷ See *id.* at 50.

⁸ See *id.* at 50–51.

⁹ See *id.* at 52–53.

¹⁰ See *id.* at 52–56.

¹¹ See *id.* at 1094–97.

¹² See 42 U.S.C. § 1395ww (1994); WING ET AL., *supra* note 1, at 57.

mandating that employers provide insurance to their former employees¹³ and requiring most hospitals to provide emergency care to anyone regardless of their ability to pay.¹⁴ Both these latter measures were added as riders to much larger consolidated omnibus budget reconciliation acts (and thus to this day we refer to them with the contrived acronym "COBRA").¹⁵ Who knows what would have happened if they had been considered apart from the broader budgetary squabbles with which they were bundled. But they were enacted nonetheless over the vigorous objections of Reagan and his allies.

While none of this bothered me at all on a personal level—in fact, I was delighted—it became increasingly problematic for me as a teacher. What was happening did not look like a fundamental decision at a crossroads or a fitful journey. If my job was to describe and explain all this to the next generation, some quick pedagogical footwork was in order. Maybe even a whole new metaphor.

My initial reaction—and here the choice was mine just mine—was to try to stretch some of the same old notions just a little farther. Maybe the political machinations of the mid-1980s could be explained as preliminary skirmishes or as political holding actions as the various forces regrouped for the real confrontation. Maybe it was both "Which way?" and "How long?" In my efforts to make this work, I did something which I very much wish I had not: I pretended that something was happening in the 1980s that never really happened at all—the great competition debate.

I do not remember exactly when all the talk about competition began, but at some point in the 1980s, people who usually knew what they were talking about began talking about ways in which the government could reform private health care delivery and financing along lines that would be consistent with the Reagan-inspired policies of deregulation, reduced federal spending and shifted responsibility.¹⁶ That is the only way I can honestly describe it. Some of us, mostly academics and policy wonks, started talking about it. Not much was heard from the politicians. If Reagan and his political allies were ever interested in the idea at all, they were pretty quick to figure out what it took the rest of us nearly a decade to discover: government-mandated competition was a political non-starter as well as a non-sequitor.¹⁷ But those of us who do not have to be elected every few years (and I think there is a political lesson there too) really got into it. Certainly the literature of the day and many health law courses adopted "regulation vs. competition" as a major

¹³ See Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), § 10001, Pub. L. No. 99-272, 100 Stat. 82 (codified as amended at 26 U.S.C. 4980B) (relating to continuation coverage requirements of group health plans).

¹⁴ See COBRA, § 9121, Pub. L. No. 99-272, 100 Stat. 83 (codified as amended at 42 U.S.C. 1395dd) (relating to emergency medical conditions and women in labor).

¹⁵ See WING ET AL., *supra* note 1, at 59–60 (discussing COBRA).

¹⁶ See generally James F. Blumenstein & Frank A. Sloan, *Redefining Government's Role in Health Care: Is a Dose of Competition What the Doctor Should Order?*, 34 VAND. L. REV. 849, 924–26 (1981) (advocating market-oriented reform, and reduced government spending and regulation in health care); Thomas L. Greaney, *Competitive Reform in Health Care: The Vulnerable Revolution*, 5 YALE J. ON REG. 179, 179–80 (examining the competitive market reform movement in the 1980s and the government's resistance to regulation in health care); Jacob S. Hacker, *National Health Care Reform: An Idea Whose Time Came and Went*, 21 J. HEALTH POL. POL'Y & L. 647, 649 (1996) (discussing federal health care initiatives in the 1980s and early 1990s).

¹⁷ See, e.g., Robin Elizabeth Margolis, *Health Trends*, HEALTHSPAN, Sept. 1993, at 33, 33 (discussing the failure of Reagan's proposed Hospital Medicare Payment and Prospective Payment Systems).

organizational theme. To hear us talk, something still had to happen, most recent events notwithstanding, and if Americans really had rejected big government regulation—which some of us regretted and others of us applauded—then the more likely “something” was a decision by the government to restructure health care into private, decentralized and, above all, competitive markets.¹⁸ It was a nifty sleight of logic argument for some: the Reagan-inspired policies had not been misdirected or unsuccessful; they just had not gone far enough yet. It was an argument with a familiar ring to others. Many of us had relied on similar logic in our explanation of why the liberally-designed health care reforms of the 1960s and 1970s needed to be carried even further if the problems facing American health care were truly to be resolved.

Maybe the niftiness was just too hard to pass up. Maybe debating “regulation vs. competition” was our collective way of filling academic air time while we tried to figure out what was really happening and why. In retrospect, I do not really know why an issue that carried with it no political bona fides at all got so much of our attention. I just know that it did. Rather than grapple with the realities of what was happening in the mid-1980s, many of us acted as if we believed American health care was about to take one of two giant, diametrically opposed steps: either we would return to the regulatory strategies of the 1970s or, and probably more likely, we would require the heretofore unimaginable: competition between and among providers and payers.

Accordingly, we organized much of our scholarship, our academic conferences and, at least for me, our introductory health law teaching around the comparisons of various proposals to create competition. I don't remember very much about the details of each proposal. There is that lesson again. I remember the time and effort I spent trying to explain the differences between making plans compete for enrollees and making providers compete for patients at the point of service, and the differences between pure competition and a half a loaf of competition, and all the variations on all the various conservative themes. At the time, it occurred to me that much of what I was doing was an inverted version of my former presentations of what national health insurance might look like. It took me a while to realize that talking about these individual proposals as if one of them were about to be adopted whole-hog did not mesh at all with what was happening in the real world. Some teacher.

As it turned out, we did not refuel the Reagan Revolution, adopt anybody's version of government-mandated competition in the 1980s or return to the 1970s. Nothing very dramatic happened. To be sure, there was plenty of drama in health care throughout the 1980s, and many things that happened to health care, some of which were quite significant and continue to be so. However, by the middle of the 1980s, most of the more significant things that happened did not fit into the choice-of-one-of-two-pathways metaphor at all. The best I could do when I had to do it was to describe what was happening to American health care as a kind of push-me, pull-me political struggle. Even that description did not seem to capture the essence of it. I had to figure out a way to describe the complicated nature of American health politics as well as their results in a more explicit and realistic fashion.

¹⁸ See generally Alain C. Enthoven, *A New Proposal to Reform the Tax Treatment of Health Insurance*, HEALTH AFF., Spring 1984, at 21 (1984) (discussing the possibility of involving the government directly in decreasing the cost of health care through tax reform); Walter McClure, *Implementing a Competitive Medical Care System through Public Policy*, 7 J. HEALTH POL. POL'Y & L. 2 (1982) (clarifying and proposing public policy strategies to promote competition in the American health care system).

I started doing what I should have been doing all along: tracking various political events on a piece-by-piece basis and then trying to fit those pieces into patterns, rather than vice versa. I also adopted a kind of default focus: rather than immediately gravitating towards any claim, real or contrived, that we were moving towards some mega-reform, I tried to track each piece of health-related legislation somewhat independently, attempting to draw the line between what was important and what was not, but without attempting to shoehorn each effort into anyone's grand scheme or to fit my own bias toward things that I regarded as "fundamental." Don't get me wrong. I continued to scan the political horizon for any sign that some "fundamental" issue was about to ascend into the political sky. I was still prepared to drop everything, including tomorrow's lesson plan, and refocus my teaching on the next national health insurance scheme or mandatory competition reform proposal, if it really looked like such a measure would draw any viable political support. Pending that unlikely event, however, I stuck to my new game plan and tried to focus my teaching on what was really happening. And I tried to make the analysis of the "why" less of an expression of my own views as to what ought to be and more of an effort to draw useful lessons about what was, for better or worse, actually going on.

For example, since the mid- to late 1980s, I have attempted to track each of the budgetary and structural changes in Medicare and Medicaid on a session-by-session, and sometimes, month-by-month basis. I have taught my students that they should do so as well, or at least should have access to the sources that will do it for them. I admit that tracking legislative changes in \$400 billion worth of federal spending programs is not always fun, or even possible. The problem is once again found in the details: You must understand enough detail to see what is really important without getting confused, sidetracked or, more simply, putting yourself or your students to sleep. Any teacher knows that it is much more exciting to debate those fundamental-choices-at-the-crossroads issues than it is to examine the next \$5 billion change in the Medicare program. But if those \$5 billion changes are what is happening, session after session, and the "fundamental" choices are not, then a lot more time ought to be spent on an analysis of the former than the latter, notwithstanding the practical problems of doing so effectively.

Certainly this approach served me and my students better in the George Bush years. Bush may have asked for a "kinder and gentler" brand of politics, but what he presided over was four years of inter- and intra-party bickering and some of the most convoluted health politics in memory.¹⁹ Even with my default focus, I had trouble following, let alone teaching, the budget reconciliation efforts that eventually deconstructed and produced neither budgets nor anything that could be described as reconciliation. But whether or not federal health politics in the late 1980s were easy to follow or explain, some of the results were important, even if not fundamental, and I think I managed to describe them in a manner that had lasting utility for my students.

We tracked the enactment of the Medi-Gap legislation.²⁰ We followed the complicated expansions of Medicaid eligibility that were the product of the

¹⁹ See generally Cathie Jo Martin, *Together Again: Business, Government, and the Quest for Control*, 18 J. HEALTH POL. POL'Y & L. 359, 364, 385-86 (discussing the growth of business involvement in health care delivery, and President George Bush's "Heritage Plan").

²⁰ See Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, §§ 4351-58; 104 Stat. 1388, 1388-125 to 1388-137 (codified as amended at 42 U.S.C. § 1395ss (1994)).

legislative bargaining in 1989 and 1990.²¹ We also watched as Congress reluctantly lifted the upper limit on income subject to the Medicare payroll tax in 1990.²² Were these fundamental changes in the way American health care is delivered and financed? No. Were they significant? I think so. The expansion of Medicaid eligibility standards may have increased the size of the program by over twenty-five percent in the following five years.²³ The increase in the payroll tax was a sizable boost in the taxes paid by many middle and upper income Americans (and one that many Republicans claimed violated George Bush's famous "read my lips" promise).²⁴ Even today, I would have a hard time outlining the odd contours of American health care without some reference to these and many other significant-if-not-fundamental changes that were adopted in the late 1980s. More importantly, in explaining how and when these changes came about, I would describe the political environment within which American health care has evolved, an environment which is, for want of a better term, peculiarly American and, just as importantly, predictably American. No one could understand why we did what we did without understanding that political environment; nor would they be prepared to follow and understand the future.

This approach helped me cope with one of the trickier challenges for those of us who were trying to teach introductory health law courses in the late 1980s: the enactment of the Medicare Catastrophic Coverage Act of 1988,²⁵ followed nine months later by the enactment of the Medicare Catastrophic Coverage Repeal Act in 1989.²⁶ I admit it. I got burned on the details again. Learned them. Taught them. Forgot them. But I did some things with the details that I might not have done a decade earlier and that had some useful results for my students. For instance, I did not present any of the deliberations as a Congressional debate over adopting catastrophic health insurance as a basic federal strategy, or dust off my notes about the Nixon-Weinberger catastrophic proposals that had been proffered in those terms in the early 1970s, as I might have done ten years earlier. With my default focus, the catastrophic health insurance proposal that I saw on the political agenda in the late 1980s was a series of modest but important changes in the existing Medicare and Medicaid programs.

Accordingly, my class examined those changes in a more or less serial fashion: Should Medicare coverage be expanded to include prescription drugs? Should Medicaid impose strict income and resource requirements on the community spouse of a nursing home resident? And so on. Did that lead to impassioned classroom debate? Not often. Did it provide a better insight into what was really happening and why? I think so. I do not think anyone, and certainly not anyone in my classroom, was able to predict how quickly the popular support for the 1988 legislation would dissipate; but we did watch with a kind of wait-until-it-hits-the-fan fascination as the first payments on the surtax on senior citizens' income tax liability became due. In 1989, when the prescription drug coverage and almost all of the rest of the 1988 amendments were repealed, but some important modifications of Medicaid's nursing home eligibility rules were retained, we were surprised, but we were better able to

²¹ See *id.* §§ 4601-06, 4711-23, 104 Stat. 1388-166 to 1388-170, 1388-174 to 1388-194.

²² See WING ET AL., *supra* note 1, at 247-48.

²³ See *id.* at 164-68, 194-95 (discussing increases in Medicare expenditures).

²⁴ See *id.* at 62-63.

²⁵ Pub. L. No. 100-360; 102 Stat. 683.

²⁶ Pub. L. No. 101-234; 103 Stat. 1979.

understand and evaluate the results. We also had, in my view, a more realistic basis from which to evaluate both the politics that led to those outcomes and the likelihood that some of these issues would be reconsidered in the future. One thing of which I am sure, we learned some important lessons about ourselves and our political environment. Whatever else can be said about the rise and fall of the Medicare catastrophic reforms, it was a very American story.²⁷

The same can be said about the Clinton years. Again an admission: I was sorely tempted to backslide into some old habits in those first few months of 1993 in light of the presidential promises that there would be a serious effort to reform the way American health care was financed. Déjà vu all over again. But I resisted. I did not, as many of my friends and colleagues did, get caught up in the details of any of the proposals that were drafted by the now-infamous "Hillary Commission" or its various committees and consultants.²⁸ I did try to understand and to teach the basic outlines of what was cleverly called "managed competition,"²⁹ although even with that I was more interested in the political origins of the concept than in the particular arrangements by which it might have been achieved. For the most part, I waited, watched, and advised my students to do so as well. And what we saw unfold, this time less to my surprise and more to my expectation, was another very American story. National health care reform was a very good election campaign issue and even showed some viability post-election, but as the general promise worked its way into a specific proposal and, most importantly, through the thicket of politics, it lost its political momentum and in the end was decisively rejected.³⁰

One observer later proclaimed that the Clinton plan died and with it any chance of national health care reform for at least another decade.³¹ I do not take issue with the sentiments behind this prediction or even with its accuracy, but when I tell the story of the rise and fall of managed competition to my students, I prefer to end with another observation. The Clinton plan died and with it the near-term prospects for national health care reform, but only because American health politics proved to be very much alive. And from there I pick up another storyline: The demise of health care reform of the fundamental sort notwithstanding, many other important things did survive and some even flourished in that same political environment.

In 1996, Congress adopted important limits on federal welfare programs, but Medicaid, while originally included within the reach of the legislation, was eventually exempted as part of a compromise to secure its passage—again demonstrating Medicaid's underlying popularity.³² The widespread support for Medicare also was confirmed repeatedly, even as the inadequacies of its revenue structure became more visible.³³ The Clinton years also witnessed a number of important-but-not-fundamental reforms such as the adoption of the Health Insurance Portability and

²⁷ For a discussion of the ill-fated legislation, the politics of its repeal and the few provisions that survived, see WING ET AL., *supra* note 1, at 61–62.

²⁸ *See id.* at 1140–42.

²⁹ *See id.*

³⁰ *See id.* at 1142.

³¹ *See id.* at 1146. *See generally* HAYNES JOHNSON & DAVID S. BRODER, *THE SYSTEM: THE AMERICAN WAY OF POLITICS AT THE BREAKING POINT* (1996).

³² *See* Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105 (codified as amended in scattered sections of 42 U.S.C.); WING ET AL., *supra* note 1, at 213–17.

³³ *See id.* at 218–19; *see also infra* note 69.

Accountability Act of 1996³⁴ and the creation of a new State Children's Health Insurance Program in 1997.³⁵

Neither of these measures reworked the structure of American health care. At best these measures require only a slight alteration of the way in which health care delivery and financing is described: add another strip of regulation to the patchwork of government control over private financing; subtract a relatively small but significant number of people from the still-growing number of uninsured. But an alteration here and an alteration there without changing the basic pattern is exactly what was happening in the 1990s and, for that matter, in the preceding decades as well. And that is important, both for that small but significant number of people whose lives were changed by these alterations and for the rest of us who are trying to understand what has happened, and not happened, to American health care.

So where does all this leave me as a teacher as I try to help my students understand the legal and political issues that they will confront in the decades to come? I am no longer looking for a shorthand way to capture the essence of what happened in the 1990s following on what happened in the 1980s, which followed on what happened in the decades before. Nor am I trying to characterize our immediate circumstances or our likely future in terms of some metaphorical reckoning that I think either will be—or ought to be—addressed. Lessons repeated finally learned. I also have no favored theoretical or political template from which I critique where we have been or where we are going. Those that have been offered by the would-be visionaries just do not seem to be that useful to me. At best, they provide one way to describe the shortcomings of where we are—but as compared to a vision that I do not think many Americans share. American health care is not delivered and financed through well-functioning, competitive markets, but I do not think many of us really find that surprising or all that upsetting. Americans have yet to adopt a national health insurance program nor have we equalized either access to health care services or the burdens of their costs. True enough. But I do not think we care quite as much about those facts as I once thought we did. And to the extent that we do care, we have other things that concern us as much, if not more so.

Health care, it turns out, is just one part of the American political puzzle. When I take the pieces from that part of the puzzle and try to put them together in some useful and retainable way, what I find are things that have happened—and things that have very definitely not happened—that make more sense when I remind myself that they are just one part of that very American puzzle. I still find important patterns, patterns which are more complicated than my younger self wanted them to be, but patterns that my older self strongly suspects will be replicated again and again. I find lots of important things that I think my students should know about and some that I think they have to know about. As I said at the beginning of this essay, I still find that effectively teaching my students about those things to be an endlessly difficult task; and as the rest of this essay reflects, I am not particularly impressed with some of the ways that I have gone about doing so in the past. Some time in the next couple of months I will walk into a classroom and start all over once again. Where are we? Where are we going? This time around I know my answers to those questions will be a lot longer and more complicated than they used to be. I hope they will be an improvement over my previous efforts.

³⁴ Pub. L. No. 104-191, 110 Stat. 1936 (codified as amended in scattered sections of 29 U.S.C. and 42 U.S.C.).

³⁵ See 42 U.S.C. § 1397aa–jj (Supp. III 1998).

II. SO WHERE ARE WE NOW?

In 1999, most Americans purchased their health care from a wide array of physicians, hospitals and other private sector providers.³⁶ The vast majority of Americans, roughly two-thirds of the population, paid for these services with the assistance of some private third party financing scheme, generally purchased through their employment under the incentives of federal tax exemption for those benefits.³⁷ These financing schemes and, to a lesser extent, the care they underwrote, were regulated in a variety of ways by both state and federal policymakers. Nonetheless, private rather than public decision makers generally determined which services most Americans received and how those services were paid for, and those decisions varied according to an individual's personal choices, employment status and a variety of other social and economic factors.³⁸

The government played a much more direct role in financing health care for the nation's elderly, the poor and a few other prescribed populations in 1999. The federal Medicare program provided virtually everyone over the age of sixty-four and many disabled people with coverage at least comparable to that purchased by most working Americans.³⁹ Through the Medicaid program, each state provided some level of health care financing for the welfare-eligible population and some, though not all, of their other low-income residents.⁴⁰ Some states also funded programs for high-risk individuals and, in a few cases, the working poor.⁴¹ There has never been, however, a general state or federal "safety net" of public assistance for people who find third party financing either unaffordable or unavailable.

As a result, quite a number of Americans financially fend for themselves in the health care market, and all Americans potentially face substantial out-of-pocket liability. Neither Medicare nor most private health financing arrangements provide

³⁶ See HEALTH CARE FIN. ADMIN., *National Health Care Expenditures Projections: Table 2, National Health Care Expenditure Amounts, and Average Annual Percent Change, by Type of Expenditure* (last modified July 14, 1999) <<http://www.hcfa.gov/stats/NHE-Proj/proj1998/tables/table2.htm>> (estimating expenditures for 1999). The Office of the Actuary in the Health Care Financing Administration (HCFA) maintains the most reliable data on national health spending. For recent updates, see HEALTH CARE FIN. ADMIN., *National Health Care Expenditures Projections* (last modified July 14, 1999) <<http://www.hcfa.gov/stats/NHE-Proj/>>. For a general description of private providers, see WING ET AL., *supra* note 1, at 266-69, 407-12, 458-59, 558-67.

³⁷ See HEALTH CARE FIN. ADMIN., *National Health Care Expenditures Projections: Table 3b, National Health Care Expenditures, Percent Distribution and Per Capita Amounts by Source of Funds* (last modified July 12, 1999) <<http://www.hcfa.gov/stats/NHE-Proj/proj1998/tables/table3b.htm>> (estimating expenditures for 1999).

³⁸ See Bradley R. Braden et al., *National Health Expenditures, 1997*, HEALTH CARE FIN. REV., Fall 1998, at 83.

³⁹ A general description of Medicare and current program expenditures can be found in the sources cited in *supra* notes 36-38. A more detailed analysis of Medicare Part A spending with particular focus on its future solvency is published annually by the Board of Trustees of the Federal Hospital Insurance Trust Fund. See, e.g., BOARD OF TRUSTEES, FED. HOSP. INS. TRUST FUND, 2000 ANNUAL REPORT 17-19 (2000). The Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund publishes a similar annual report. Both reports, containing the data from which estimates in this essay were derived, are available at the HCFA website. See Health Care Fin. Admin., *2000 HI & SMI Trustees Reports* (visited Apr. 4, 2000) <www.hcfa.gov/pubforms/tr/>.

⁴⁰ For a detailed overview of the Medicaid program, see generally KAISER COMM. ON MEDICAID & THE UNINSURED, *MEDICAID: A PRIMER* (1999).

⁴¹ See WING ET AL., *supra* note 1, at 117-77.

coverage for nursing home or other long term care.⁴² Most financing schemes offer fairly comprehensive coverage for inpatient hospital services, but may cover only a fraction of the costs of prescription drugs, rehabilitation or even physician services.⁴³ Both private and public payers limit their liability with a web of service exclusions, reimbursement caps and cost-sharing. But the most problematic consequence of the American way of financing health care is reflected in the fact that as many as forty-five million Americans had no third party financing, public or private, for a good portion of the year.⁴⁴ That figure is neither exaggerated nor aberrational; indeed, it has been slowly but inexorably increasing since the 1970s.⁴⁵ For these people, primarily people in low-paying jobs and their dependents, their out-of-pocket liability was a double-edged sword: For the services that they received, they suffered financially, and in some cases catastrophically; for the services they could not afford, they suffered in other ways.⁴⁶

There is a de facto safety net of sorts for the uninsured. Under the common law of most states and the provisions of the COBRA legislation, most hospitals are required to provide emergency care to people *in extremis* regardless of their ability to pay.⁴⁷ Thus in 1999, few Americans were turned away at the emergency room door and, in fact, once in the emergency room, many found their way into the rest of the hospital.⁴⁸ There are a few other state and federal efforts to encourage and, in some cases, require providers to be available to consumers.⁴⁹ Beyond these relatively marginal efforts, however, in 1999 most Americans got what they were able to purchase, both in the sense that they had to find a provider willing to treat them and they had to pay for what they received. There are few vestiges left of what once was a network of public clinics and hospitals. Many nonprofit institutions continue to claim that they are "community" in character despite the fact that they are structured as private business entities.⁵⁰ For that matter, in most populated areas of the country, there are many providers to choose from. Nonetheless, most of us find and pay for our health care, individually and privately, from private providers who can choose to locate and organize their services relatively free from public constraints.

And we really pay for our health care. In 1999, Americans spent roughly fourteen percent of their gross domestic product on health care, a figure that has been slowing growing for the last three decades.⁵¹ Medicare is the second largest item in

⁴² See *id.* at 412-14.

⁴³ See *id.* at 88.

⁴⁴ See JENNIFER A. CAMPBELL, U.S. CENSUS BUREAU, HEALTH INSURANCE COVERAGE: 1998 (Current Population Rep. P60-208, 1999). For background on the number of uninsured and their characteristics, see KAISER COMM. ON MEDICAID AND THE UNINSURED, UNINSURED IN AMERICA: A CHART BOOK (1998).

⁴⁵ See WING ET AL., *supra* note 1, at 258-62.

⁴⁶ See *id.* at 262-64.

⁴⁷ See 42 U.S.C. § 1395dd (1994) (mandating that hospitals provide "necessary stabilizing treatment for emergency medical conditions and labor"). For a discussion of common law and state statutory proscriptions, see WING ET AL., *supra* note 1, at 301-14.

⁴⁸ See *id.* at 301-36.

⁴⁹ See *id.* at 496-503.

⁵⁰ See *id.* at 266-282.

⁵¹ See Health Care Fin. Admin., *National Health Care Expenditures Projections* (last modified July 14, 1999) <<http://www.hcfa.gov/stats/NHE-Proj/>>; see also Kenneth R. Wing, *The Economic and Policy Environment of Health Care*, in HEALTH CARE CORPORATE LAW: FORMATION AND REGULATION, 1-2 (Mark A. Hall ed., 3d ed. 1995) (providing an historical analysis of health care costs).

the federal budget, and it too has been growing—most recently at rates that exceed the growth of the revenues available to support it.⁵² Medicaid growth rates are more variable, but the costs of maintaining Medicaid, even with federal sharing, are a constant strain on the states' fiscal status and efforts to fund other programs.⁵³ The share of employee compensation devoted to purchasing health benefits has grown steadily over the last three decades.⁵⁴ And, as any consumer who attempts to purchase health financing on an individual basis will discover, there is a rather straightforward explanation for why forty-five million Americans cannot afford to do so.⁵⁵

There is an upside to these costs, however extraordinary they may be. Some of the care that Americans paid for in 1999 could not have been purchased anywhere else in the world. At least since the 1950s, representatives of providers have insisted that Americans have the best medical care in the world.⁵⁶ As an assessment of our technological capabilities they are undoubtedly correct. In 1999, many American consumers received more and better health care than residents of virtually any other country.⁵⁷ They also receive more and better health care than their American counterparts even a generation ago. But there is a downside. They are also spending more for essentially the same services that they have been getting all long. American health care prices have inflated faster than any other item in the economy at disturbing rates since the 1960s.⁵⁸

A few decades ago, I would have had more difficulty using the rhetoric of economics—prices, consumers and so on—to describe the delivery and financing of American health care. In 1999, I can hardly avoid it. Under the pressures to control costs, and in the policy vacuum created by various failed governmental strategies, American health care providers and payers have become much more commercial in their behavior and even in their demeanor. The American hospital industry has gone through several waves of proprietary change. All providers, including those individual physicians who have clung so desperately to their “country doc” image, now market their services and out-source their administrative functions.⁵⁹ Everyone is “doing deals” and organizing independent practice associations and preferred provider organizations and other integrated arrangements.

There is “managed care,” that overused buzzword of the 1990s. It is more than a matter of American health care being managed and organized in a more businesslike fashion—which it surely is in the 1990s. The term's frequent use reflects the emergence of what might be called in street parlance an “attitude,” an attitude that is more than partial to hard-nosed decisions and to efforts to control

⁵² For recent analyses of the financial condition of the two Medicare trust funds, see Health Care Fin. Admin., *2000 HI & SMI Trustees Reports* (visited Apr. 4, 2000) <www.hcfa.gov/pubforms/tr/>.

⁵³ See WING ET AL., *supra* note 1, at 170–72.

⁵⁴ See Mercer/Foster Higgins, *National Survey of Employer-Sponsored Health Plans, 1998*, MED. BENEFITS, Feb. 28, 1999, at 1, 1.

⁵⁵ For data on the costs of privately purchased health benefits, see sources cited *supra* notes 36–38. Note, however, that because a high proportion of private insurance is purchased through the beneficiaries' employment, these aggregated data disguise the higher costs paid by small employers (or any small group purchaser) or any individual purchaser. For a good analysis of this problem, see MARK A. HALL, *REFORMING PRIVATE HEALTH INSURANCE* 16–22, 32–34 (1994).

⁵⁶ See WING ET AL., *supra* note 1, at 22–26.

⁵⁷ See *id.* at 1183–204.

⁵⁸ For a full explanation, see *id.* at 1094–103.

⁵⁹ See *id.* at 1104–17.

costs and utilization. In 1999, much of the health care received by Americans was still determined by the decisions of physicians acting relatively autonomously, but there was a lot more managing of the way that it was done.⁶⁰ More generally, finding and paying for American health care was a lot more like buying other goods and services in 1999 than it had been for several generations.

I said “a lot more” twice on purpose. The changes of the last decade notwithstanding, Americans still do not regard health care as just another bundle of consumable goods and services. As noted above, American health care is still largely financed by public dollars, and even privately financed health care is indirectly subsidized by the tax treatment of employer purchased health benefits.⁶¹ All political indicia point to the fact that we consider those arrangements permanent. There are recurring debates over what to do about the costs of the public programs or whether to add or subtract coverage at the margins, but no one seriously debates the basic public commitment to maintain programs like Medicare and Medicaid—even during times of revenue shortfalls and budget deficits. Americans have a relatively blasé reaction to statistics about the uninsured, but we react with horror to any particular case of health care denied or financial ruin caused by high medical bills. That is not the way we react to stories about people who can not buy a car or afford to go to law school or, for better or worse, the way we view people who find themselves homeless. Health care occupies a unique role in the American scheme of things. It is not quite something that we believe should be socialized, like K through 12 education or the maintenance of public utilities, but it is something that we insist should be more publicly controlled than the distribution of telephones or even the food supply. Americans tolerated the emergence of managed care and the other commercializing changes of the 1990s, but our resentment to those trends has been one of the most significant political developments of the last few years, as witnessed by the “patient’s rights” and “anti-managed care” initiatives that have been attracting so much political attention.

What makes it possible for Americans to tolerate developments and then to resist them so actively? Why are we averse to government efforts to insure access to what we regard as an important social service? Why are we upset and in some cases downright enraged when some people do not get health care but unable to agree on some collective way to avoid such circumstances? Are we just a philosophically neurotic people with strong emotions for a sad story and no stomach for higher taxes? We have an odd mix of private and public financing for a partially regulated but largely private scheme of delivering health care. At least since the 1960s, it has not changed very much—at least in any fundamental way. This is not, as the previous section recounted, from a lack of effort to reform the way we do things. Why? Is there a consistent or logical explanation underlying the way we are and the way we have been for some time?

There are answers to these questions, but like everything else concerning American health care, they are not as simple or as dramatic as many of us would like them to be. They do, however, provide some insight into where we are and where we might go from here. First and probably foremost, many Americans like what they

⁶⁰ See Health Care Fin. Admin., *National Health Care Expenditures Projections: Table 2, National Health Care Expenditure Amounts, and Average Annual Percent Change, by Type of Expenditure* (last modified July 14, 1999) <<http://www.hcfa.gov/stats/NHE-Proj/proj1998/tables/table2.htm>> (estimating expenditures for 1999).

⁶¹ See sources cited *supra* notes 36–38.

have. Americans like what they call their “freedom of choice” and they like the notion of individual private decision making—especially when they are not being reminded of the ways in which those private choices occasionally sort out in the flesh. Most Americans also think they get very good medicine and, in fact most of us do. And even if we think it could be better—which all of us do to some extent—Americans will not give up easily what we now have, especially for what a government we do not quite trust promises will be a different but better future.

Some Americans also like what we have in another, crasser sense. Many—not all, but many—providers of health care do quite well financially, as do many people and institutions that finance and manage their activities.⁶² Collectively Americans spend over \$1.5 trillion dollars every year for health care,⁶³ but few of the Americans who receive those dollars want to give up their current share or the social and other benefits that go with it. These beneficiaries of our spending and their representatives have proven to be very influential in Washington, D.C., state capitols, corporate boardrooms and other loci of political power.⁶⁴ They are the “special interests” that we all loathe except when their interests are our interests. They finance political campaigns; the uninsured do not. I complain when the monthly premium for my health plan goes up. Some of them nod appreciatively. They acknowledge that American health care is problematic—they are way too savvy not to—but they make sure that those problems do not get resolved in ways that will change the things that they need to sustain what they have. This means, most often, that they make sure things do not change very much—and certainly not in any fundamental way. They also are very good at tapping into the American public’s preference for “freedom of choice” and our aversion to government intervention in the defense of what they constantly remind us is the best medical care in the world.⁶⁵

The special interests of health are also very good at doing something that the rest of us do very poorly: they constantly pay very close attention to what is going on with health care. Most of the rest of us worry about our jobs and our families and, if we have time and energy, matters such as our children’s education and whether our retirement benefits are secure. Some of us worry about the way health care is delivered and financed too, but for the most part, only when these things hit fairly close to home. When it was your turn to put your elderly parent in a nursing home, only then were you enraged about the seemingly bizarre pre-conditions to Medicaid eligibility that you had been fortunate enough to ignore for most of your life. The front page of my newspaper had a story about an uninsured woman with three children who needed several hundred thousand dollars for a bone marrow transplant. I have always known that such things happen. But I did not take out my checkbook or write a “do something” letter to my congressman until I read that story.

I know, as I assume all of us know at some level, that I should protect my own special interests as vigilantly as do those for whom I use that label so critically. But I do not, and most people do not when it comes to health care. We worry about other things all of the time and health care only some of the time. That may not be

⁶² See, e.g., U.S. Bureau of Labor Statistics, *1998 National Occupational Employment and Wage Statistics* (last modified Mar. 15, 2000) <http://www.bls.gov/oes/national/oes_nat.htm>; Mary Chris Jaklevic, *Physician Compensation Growth Slows*, MOD. HEALTHCARE, Aug. 2, 1999, at 34, 34 (surveying physician compensation across several specialties).

⁶³ See WING, *supra* note 1, at 1094–95.

⁶⁴ See *id.* at 139–45.

⁶⁵ See *id.* at 1171–73.

economically sensible because we are, after all, paying for it constantly. It may not even be philosophically defensible because statistical victims suffer just as much as real ones. But it is true. Various consumer organizations, labor unions and professional groups try to dissuade us, but we largely ignore them. Many tired, hard-working people find the time to go to PTA meetings, but there is no comparable organization for those concerned about health care, and if there were few would go. Political and community organizers have always regarded health care as a lousy organizing issue precisely because the things that innervate us to collective action happen infrequently and happen one person at a time.⁶⁶ This year, I want to “do something.” Last year it was you. With luck, next year both of us will be concerned about something else. That may be good news for us, but it is not a good formula for sustainable collective action towards resolving any one problem with American health care, let alone anything that could be regarded as a fundamental reform.

We also like the way things are because we are Americans. We are preset to reject any movement towards either more government involvement in our health care or towards a more purely private ordering of things; we prefer, or at least tolerate, our oddly fashioned mix of private and public providers and payers. Moreover, even when we are disposed to look more favorably on governmental involvement, we have a tendency to prefer state and local government strategies to national strategies.⁶⁷ Indeed, many of us identify ourselves by affiliation with our state as much as with our nation. That by itself goes a long way toward answering why we do not have a nationalized health care system like our Canadian neighbors or our many European critics.

It also creates various practical and theoretical problems for any one state attempting to move toward a more governmentally controlled health care system or even stricter regulatory controls over private delivery and financing. Just ask those states that fear that increasing benefits for the uninsured will cause a flood of interstate immigrants, or an exodus of providers and payers. Just consider the history of the federal Employee Retirement Income Security Act and how it has stymied so many potential state reform initiatives.⁶⁸ Constitutional theorists like to remind us that we are governed by a mix of political institutions that we designed purposefully to check and balance each other, in addition to serving as the means for changing things such as health care. I am not sure that Americans think about political institutions in such abstract terms. I just know that constitutional structure is a pretty good fit for our general posture towards government, particularly what we call “big government.” And I know the net result: We like or at least tolerate our health care delivery and financing pretty much the way it is and we have for some time. Even the recurring reminders of things we do not like about health care—rising costs, the

⁶⁶ See *id.* at 1174–75.

⁶⁷ Part I of this Article, concerning how I have taught developments in American health care, focuses exclusively on federal health policy. This is largely for simplicity. A good introductory health law course should trace the developments at the state level as well. Indeed, given what has transpired through the last several decades, it would be a serious error not to do so. While there are obviously different stories to tell in each state, many of the same lessons concerning who we are and where we are—and why—have been played out at the state level. For further discussion and some good state-level illustrations, see *id.* at 1151–83.

⁶⁸ See 29 U.S.C. §§ 1001–1461 (1994). The full story of the Employee Retirement Income Security Act, both the politics behind its enactment (which many so-called health law experts entirely overlooked at the time it was enacted) and its role in delimiting the options available to the states, is an excellent illustration of the conumbral nature of American health care policy. See WING ET AL., *supra* note 1, at 121–24.

plight of the uninsured, the inequitable results for some people—are not enough to overcome our political inertia, not to mention the political influence of those forces that are working hard to reinforce our immobility.

We are Americans. When it comes to health care, our views are ambiguous, loosely defined and, often, contradictory. Americans do not have an identifiable or consistent political ideology concerning their health care, or for that matter, a health-related value system much beyond the idea that many of us like things the way they are most of time. We have some deeply-held values, but for the most part they only make our posture towards changes in our health care all the more ambiguous. Equally important is the fact that many of us do have a political preference or party affiliation. We identify ourselves as Democrats or Republicans or liberals or conservatives, but neither our political parties nor the surrogate organizations that purport to speak for various ideological camps help us critique our health care or sort out what it should look like in the future. Office seekers often speak of the need for health care reform, but they wisely stop just after the rhetorical flourish and before the detailed proposal. They push the right buttons to get our votes and our contributions. They tell us stories of health care denied and managed care that does not manage or care. But they rarely try to educate us as to realistic alternatives or to organize us politically despite our inertial tendencies. Who can really blame them? They know the lessons of history for those who would reform health care, and they know us.

We are Americans and we have a uniquely American way of delivering and financing health care, both in the sense that our way is unlike that in any other country, and in the sense that it reflects some very basic American characteristics. We are Americans and not Canadians or Swedes or inhabitants of any of the multitude of countries that accept socialized health care more readily. We are Americans and not free marketeers or libertarians, at least not to the extent that we could ever buy and sell health care in the same way we are told we would buy and sell widgets. No one set out to create American health care delivery and financing the way that it is today. It can not be justified in terms of any one person's theoretical model or any organized set of principles. Yet what we have is completely understandable given who we are and where we have been.

I can give you a very logical, albeit in some cases lengthy, explanation for each and every twist in the path that led us to where we are. Things did not just happen at random. There are reasons why things are the way they are as we enter the twenty-first century. There are reasons why the way things are looks a lot like the way things were in 1989 and 1979, and even in 1969. That is not a criticism. It is a description of who we are and where we are. For that matter, as far as I can see, it is also a pretty good description of what things will look like in the future. I think the new millennium will look a lot like the old one or, at least, the last half of the old one.

If I am still teaching introductory health law classes in the year 2010, I expect my basic description of American health care will closely resemble what I have set out in this essay. Most Americans will be receiving their health care financing through their employment. The government will be heavily involved in financing programs such as Medicare and Medicaid. A sizable proportion of the American population will be uninsured. And so on. I do not think I will have to add much to update that description a decade from now—and I certainly do not expect to be recounting the emergence of some fundamental change in the way in which health care is delivered and financed.

This is not because I do not think there are powerful reasons to reform. I do. It

is not because there will not be frequent cries of “something must be done” in the coming years. There will be. But there always have been such reasons and such cries and they have always led to much controversy. Yet the net result has rarely been more than modest political movement, one way or the other, but not often, or for long or in one sustainable direction. And that, for better or worse or more of the same, is what I expect will happen again.

Of course health care will be the subject of much controversy in the coming years. It is too important not to be. Consider the several waves of financial crises approaching the Medicare program.⁶⁹ Consider Medicaid, and the role it plays in the lives of tens of millions of program beneficiaries—and, of course, hundreds of thousands of providers; but consider as well the role it plays in the financial health of the state and federal budgets.⁷⁰ Consider all of the complaints from all of the payers—patients, taxpayers, employers—as well as all of the complaints from all of us who get less or, at least, something different than what we expect. Then, of course, there are people among us who are just outright denied what the rest of us get routinely. I admit it, I am tempted, one more time, to say that the stage is set for some fundamental reform. Because it is. But where we are and who we are convinces me that the reforming that will take place is more likely to be measured in small but significant several-billion-dollar increments than in terms of fundamental steps.

⁶⁹ While the details are controverted, the basic outlines of the financial crises facing Medicare are undeniable and fairly straightforward, even as they are sobering. The Medicare Part A trust fund is on the brink of bankruptcy. See WING ET AL., *supra* note 1, at 248. Part B spending has been rising even faster than Part A spending and demanding an ever-increasing share of the federal budget. See *id.* at 252. For the most recent assessments and data updates, see Health Care Fin. Admin., *2000 HI & SMI Trustees Reports* (visited Apr. 4, 2000) <<http://www.hcfa.gov/pubforms/tr/>>. In the next few years, Americans must either contain the costs of both parts of the program or find new revenue sources to the tune of tens of billions of dollars per year. Even if we successfully navigate these waters, a second wave of financial crises will arrive in the second decade of the century. As the baby boomers reach retirement age, the Medicare benefits of a much larger proportion of the population will have to be supported out of the tax effort of a relatively smaller working population. Even tougher choices will have to be made.

⁷⁰ For a discussion of the political history and likely future of Medicaid, see generally WING ET AL., *supra* note 1, at 213–18; Eleanor D. Kinney, *Rule and Policy Making for the Medicaid Program: A Challenge to Federalism*, 51 OHIO ST. L.J. 855 (1990).

