

## Federalism and Its Discontents

*The states are drowning. The best life-preserver that Washington can throw at them is to take over Medicaid.*

**A**wash in red ink thanks to the worst economic crisis since the Great Depression, state officials chaotically scrambled over the last year to keep their laboratories of democracy from exploding. With state tax revenues plummeting at the steepest rate on record, and with all except Vermont legally bound by balanced budget constraints, most governors and state legislatures were forced to dampen their local economies further by cutting services and raising taxes. The stock market collapse depleted already underfunded state pensions. Federal stimulus relief slightly dulled the pain, which nonetheless remained severe in most populous states. A majority of states cut funding for public health programs for poor, elderly, and disabled residents; reduced aid to K-12 schools and early childhood education; and slashed support for public colleges and universities.

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All but a handful of governors in populous states saw their approval ratings sink well below 50 percent no matter how they responded to the crisis. In states like Texas, Florida, Missouri, Louisiana, South Carolina, Alabama, and Mississippi, rigid ideological opposition to time-tested responses like increased federal unemployment insurance defied logic and compassion. Thirty-one states raised their taxes, mostly by soaking the poor and working class through higher sales and sin taxes, although eight of those states also increased tax rates on upper-income residents. Gubernatorial scandals and statehouse clownishness further led citizens across the country to equate their state capitals with the word “dysfunctional.”

But while unusually severe this year, fiscal crises in states are neither new nor fleeting. The federal Government Accountability Office (GAO) projected even before the recession that “state and local governments will face an increasing gap between receipts and expenditures in coming years,” primarily because of rapidly rising health care costs that will escalate their Medicaid and state employee medical insurance obligations. Those financial pressures, in conjunction with balanced budget strictures, threaten to keep states in a permanent austerity mode. Scott Pattison, executive director of the National Association of State Budget Officers, told *The Wall Street Journal*, “There are so many issues that go way beyond the current downturn. This is an awful time for states fiscally, but they’re even more worried about 2011, 2012, 2013, 2014.” Don’t even ask about the state budgetary outlook for 2025 or, worse yet, 2035. The consequences for vital public sector services in the United States are profound: Education, law enforcement, social services, mass transit, and other basic connections between average citizens and their government will be continually squeezed, dragging down the nation’s potential for more broadly shared economic prosperity.

Although America’s system of federalism has always been much more decentralized than other democracies’, it has been pushed to the breaking point through a confluence of political forces that date back to the Johnson Administration. One is the conservative movement’s highly effective “devolution” campaign, consistent with long-standing Republican support for “state’s rights,” which advocates shifting responsibilities from the federal government to the states. Another is the state-level tax revolt launched in 1978 with the passage of Proposition 13 in California, a policy earthquake that prompted similar tremors throughout the country and subsequently kept state officials wary of raising taxes, even when obviously necessary. A third factor was the increasing enthusiasm among “Third Way” Democrats, particularly in the 1990s, for “reinventing government,” in part by relying more on state and local governments to innovate because they are closest to their “customers”—which only

added to the burden load. Fourth, the conservative mindset that dominated Washington from 1980 until the 2008 elections virtually precluded domestic reforms that would entail higher levels of federal spending, with a few notable exceptions like the Medicare drug benefit. Fifth, few voters pay much attention to their state governments, which tend to receive only limited media coverage, perpetuating an opaque environment in which scandals brew, inertia prevails, and tough choices get deferred.

And finally, but perhaps most importantly, the nation's inability, until this year, to radically restructure its medical insurance system has left states—along with the federal government, employers, and families—groaning under the weight of soaring health care costs. Even still, the health care proposals now under consideration in Congress seem unlikely to ease those pressures on state governments

significantly and might end up adding to their Medicaid obligations.

**Budget deficits and low taxes, in conjunction with balanced budget strictures, threaten to keep states in a mode of permanent austerity.**

Right-wing activist Grover Norquist may have failed in his notorious quest to shrink government “down to the size where we can drown it in the bathtub” through relentless tax cuts, but serially hacking it into 50 pieces has done much to weaken the

country's ability to govern itself. The result is a vicious cycle: The prevailing perception that the public sector is incompetent will continue, preventing governments from getting the resources necessary to do their jobs. Progressive ambitions for improving economic security and opportunity for all Americans will thus remain elusive.

The solution is to rebalance the federal-state division of labor, with each level concentrating on the responsibilities it has traditionally managed most effectively. By far the most important step would be to federalize parts of Medicaid, the massive health insurance program for the poor, the disabled, and nursing home residents that is jointly financed by the national government and the states. Ideally, federalization would, over time, help integrate Medicaid into a universal, national health insurance system. As Social Security and Medicare demonstrate, federal social insurance enjoys great economies of scale, management efficiencies, and broad popularity while avoiding the unjust state-to-state disparities in coverage and shoddy implementation that have long plagued joint federal-state programs. At the same time, reducing and eventually eliminating the growing share of state budgets devoted to Medicaid would go a long way toward enabling governors to manage their states much more effectively. In the absence of reform,

the states' share of Medicaid is projected to more than double, from \$136 billion in 2007 to \$290 billion by 2017. The grim prognosis could be greatly improved, however, through radical but circumscribed surgery: transplanting as much of Medicaid as possible to the federal government.

### **Roots of Federal-State Dysfunction**

As historian Michael B. Katz documents in his book *In the Shadow of the Poorhouse*, states and localities have long borne the main responsibility for the stigmatized poor, while the federal government has assumed the central role of providing for citizens deemed worthy of social insurance. Before the 1930s, states and localities primarily financed and carried out what limited public services existed; domestic federal spending in 1929 amounted to only one-fifth of state and local spending.

In response to the Great Depression, in 1934 Franklin Roosevelt created the Committee on Economic Security, which made recommendations for providing support to the unemployed, needy women and children, and the indigent elderly. At the time, Roosevelt stipulated that, "Above all, I am convinced that social insurance should be national in scope, although the several states should meet at least a large portion of the cost of management, leaving to the federal government the responsibility of investing, maintaining, and safeguarding the funds constituting the necessary insurance reserves."

The results were varied. Roosevelt's Cabinet and its expert advisory council were deeply conflicted about whether to create a national system or a federal-state program for unemployment insurance. Ultimately it settled on a jointly run program, largely on pragmatic grounds, arguing that it would permit differing state laws "so that we can learn through variation what is best." The committee also concluded, naïvely in retrospect, that if it became evident that a federal system would work better, "It is always possible by subsequent legislation to establish such a system." Likewise, the committee focused on assisting existing state welfare activities for women and children through categorical grants-in-aid with matching funds, rather than creating new federal programs.

At the same time, it recommended rules intended to minimize graft and patronage, including the designation of a single state agency and plan, subsequent to federal approval, that would be in force throughout each state. Southern congressmen rebelled at such constraints, with Virginia Senator Harry Byrd denouncing them as interference in how states deal with "the Negro question." Ultimately, the committee's recommendations were watered down in the Social Security Act's welfare-related provisions, enacted in 1935, leaving states with wide discretion in the use of federal support, including the determination of

eligibility and benefit levels. Only the old-age pension section of the original act remained entirely a federal system.

In 1950, amendments to the Social Security Act authorized, for the first time, federal payments to states for medical services for individuals eligible for public support. Ten years later, Congress passed the Kerr-Mills Act, which extended health care benefits to the “medically indigent”: individuals over 65, not receiving Social Security’s Old Age Assistance, with income “insufficient to meet the costs of necessary medical services.” Kerr-Mills established a “federal matching percentage” ranging from 50 to 80 percent of state outlays, varying inversely with a state’s per capita income—laying the groundwork for the Medicaid formula five years later. As a result, the least populous states, which tend to be the most hostile politically to the federal government, receive far more money per capita from the feds.

In the years between Kerr-Mills and the passage of Medicare and Medicaid, advocacy groups, government studies, and media reports highlighted how rising medical costs were creating widespread hardship, especially among the elderly. State officials complained loudly about the inadequacy of Kerr-Mills, which they mocked as “Cur-Mills.” In response, in his first State of the Union address Lyndon Johnson endorsed programs that would support the “health needs” of older citizens, to be called “Medicare,” and the poor, which would be known as “Medicaid.”

Ever the politician, Johnson was far more interested in Medicare, which would immediately benefit the broad category of voters aged 65 and over, than in Medicaid, with its impoverished beneficiaries. Congress followed suit. In their prodigiously researched book on the history of that program, *Medicaid Politics and Policy: 1965-2007*, public policy scholars David Smith and Judith Moore report that legislative staffers could scarcely recall working on Medicaid and doubted that it took more than an afternoon of their time to draft. Johnson didn’t even mention Medicaid in his speech celebrating his signing of the legislation creating the two programs.

But one person did care deeply about crafting Medicaid: Wilbur Mills, the powerful chairman of the House Ways and Means Committee, who was eager to clear his name of the Kerr-Mills fiasco. A fiscally conservative Democrat from Arkansas, Mills feared that Medicare was the “entering wedge” for a nationwide “compulsory” system of health insurance for everyone. In response, he designed Medicaid to be both independent of Medicare and administered through a joint federal-state system, consistent with existing programs for the poor, making it less likely that Medicare would later expand to cover groups beyond the elderly.

## Devolution's Evolution

As political scientist Timothy Conlan documents in his superb book *From New Federalism to Devolution*, three Republican leaders—Richard Nixon, Ronald Reagan, and Newt Gingrich—defined the federalism debate in the post-Johnson era. All three made federal-state relationships a top priority, although they differed considerably in their motivations and in their particular proposals. Nixon's sweeping "New Federalism" agenda, while partly aimed at weakening the federal bureaucracy and protecting his left flank politically, was mainly geared toward rationalizing roles and responsibilities rather than promoting anti-government ideology. That agenda included nationalizing welfare through a "family assistance plan," consolidating fragmented and overlapping programs through federal block grants, and creating a federal revenue-sharing plan to provide support to states and localities. Of those, he succeeded in passing only revenue sharing. But he also signed into law the Supplemental Security Income (SSI) program in 1972, which established a new federal income floor for the aged, blind, and disabled. He also greatly strengthened and expanded the food stamp program with the creation of uniform federal standards for eligibility and benefits. SSI and food stamps, not incidentally, are widely considered much more effective programs than counterparts that rely more on states for funding, rule setting, and implementation. On matters related to federalism, Nixon's legacy is one liberals generally applaud.

Reagan also had big plans for realigning federal-state relationships, built around what he called "a quiet federalist revolution." In his case, though, the goal was ideological—to remove the federal government entirely from a broad swathe of domestic activities while discouraging states and localities from picking up the slack. Reagan eliminated Nixon's revenue-sharing program, slashed grants to state and local governments, and slowed spending on Medicaid and other safety-net programs. In addition, the large federal deficits created by his 1981 tax cuts and heightened defense spending also became an ongoing justification for continued austerity.

One largely forgotten Reagan initiative was a 1982 grand bargain that would make the federal government entirely responsible for financing Medicaid in exchange for giving states responsibility for more than 40 other federal aid programs, including Aid to Families with Dependent Children (AFDC). Back in 1969, again in 1977, and yet again in 1981, the U.S. Advisory Commission on

**From Reagan onward, policymakers have focused almost entirely on moving social-support responsibilities from Washington to the states.**

Intergovernmental Relations, which comprised officials in all levels of government, had recommended that the federal government assume full financial responsibility for all public assistance programs, including Medicaid. The Commission argued that its ideas would greatly improve an intergovernmental system that had grown “more pervasive, more intrusive, more unmanageable, more ineffective, more costly and above all, more unaccountable.” While Reagan’s plan proposed basically the inverse—moving programs to the states, with the lone exception of Medicaid—few disagreed with the need to do something dramatic to repair a deeply flawed system of federalism. The “sorting out” idea unraveled quickly, though, largely because of opposition from state officials.

The last big flurry of federalism activity occurred during the Clinton Administration, after the cataclysmic 1994 mid-term elections that swept Democrats out of both houses of Congress for the first time in 40 years. Although the GOP’s “Contract with America” didn’t explicitly mention federalism or devolution, almost all of its planks were intended to weaken the national government, including a Constitutional amendment to balance the budget, limits on “unfunded mandates,” welfare reform, and regulatory reform. Newt Gingrich articulated his mission in even more extreme terms than Reagan. “We have to decentralize power out of Washington, D.C., and disperse power,” he said. “That means it actually goes back to the people from whom it comes.”

The budget resolution that passed in the House in 1995 would have cut domestic spending by more than \$1 trillion over seven years, while abolishing three federal departments, 14 federal agencies, and 69 commissions. The resolution would have eliminated or consolidated 283 federal programs while converting an assortment of activities into block grants to the states, including Medicaid, welfare, education, housing, law enforcement, and job training. The Senate’s resolution was similar, albeit somewhat less draconian in the extent to which it cut funding. Clinton vetoed the resulting reconciliation bill; the GOP shut down the federal government, resulting in a public backlash that doomed its grandiose plans.

## **Farewell, Welfare**

One notable piece of federalism legislation that was enacted in 1995 was the Unfunded Mandates Reform Act (UMRA), intended to curtail the ability of Congress to impose costly requirements on states. The law essentially said that any mandate that would cost state or local governments more than \$50 million a year, or private businesses \$100 million, could be subjected to a point of order during debate. Legislators would then have to vote specifically on the issue of whether the benefit was worth the cost. Because many mandates actually came

with matching federal funding, the “unfunded” label was highly misleading. But it served its rhetorical purpose in announcing that the feds shouldn’t treat the states unfairly. Yet most assessments of the law’s impact have been mixed. Although the use of mandates declined to some extent, the National Conference of State Legislatures issued a report in 2008 claiming that \$131 billion in costs had been shifted to the states over the previous five years across a wide range of spending categories, notwithstanding UMRA.

In 1996 Clinton signed his momentous, controversial welfare reform law. The New Deal-era AFDC program, with its open-ended federal entitlement, was replaced with a capped block grant called Temporary Assistance to Needy Families. The block-grant approach allowed states to determine who would be eligible for cash welfare benefits, the size and nature of benefits, and the structure of work and training programs. At the same time, the federal government imposed new mandates on the length of time that benefits could be provided, child support enforcement, and other procedures. The welfare bill relieved the federal government of responsibilities it had carried for more than 60 years, shedding the Democratic Party of a political albatross while weakening support for struggling families in the process.

In short, the reforms to America’s system of federalism sought by Nixon, Reagan, and Gingrich fell well short of their ambitious aspirations. But from the Reagan Administration onward, the thrust of both debate and actual change has focused almost entirely on moving social-support responsibilities from the federal government to the states. Few political leaders at the national level have even broached the possibility of reversing course, so ingrained—and politically expedient—is the idea of shrinking the federal government and doffing off responsibility to the “laboratories of democracy.” But with the states facing a perpetual fiscal crisis that’s potentially even more perilous than the widely recognized long-term budgetary challenges facing the federal government, that pattern needs to change.

## **States in Straitjackets**

Beginning around 1995, scholars began to raise alarms about an increasing danger of “structural deficits” in the states—gaps between spending and revenues caused by factors other than downturns in economic activity. While those concerns subsided somewhat during the late 1990s boom, they have returned and intensified over the last decade to the point where the shortfalls are considered to be “unsustainable.” Policy analysts Robert Ward and Lucy Dadayan of the Rockefeller Institute of Government note “the increasingly visible and chronic nature of state and local fiscal difficulties—[a] heightened concern

about seemingly intractable, long-term imbalance [that] has roots on both the expenditure and revenue sides of government budgets.”

From the early 1970s until the current downturn, combined state and local tax revenues remained within a remarkably narrow band, ranging from 8.8 to 9.8 percent of GDP. That long-term consistency suggests that from a political standpoint, 10 percent of GDP may represent a ceiling on the level of taxation that states and localities can impose on their residents. But state Medicaid costs have risen much more rapidly than the rate of economic growth, swallowing a greater share of state budgets that are constrained from accruing operating deficits. As a portion of state tax revenue, Medicaid climbed from 8.4 percent in 1977 to more than 22 percent in 2006. Over that same period, Medicaid and other health and welfare expenditures, after adjusting for population growth and inflation, rose nearly twice as rapidly as education spending. Though education still constitutes the largest share of state and local spending with about 35 percent of the pie, health and welfare programs have expanded to 26 percent of state budgets.

Medicaid's costs have risen so rapidly in part because of the same forces that drive soaring health care inflation throughout the U.S. system, particularly the rapid integration of expensive new technologies coupled with a fee-for-service system that rewards doctors for performing procedures whether they are medically appropriate or not. But in addition, Medicaid enrollment has expanded significantly over time, more than doubling since the Reagan Administration to about 63 million in 2008. One reason is that eligibility for the program was broadened through a series of legislative expansions, mainly during the George H.W. Bush Administration and then with the creation of the State Children's Health Insurance Program in 1997. The health care reform legislation now before Congress would significantly expand Medicaid eligibility even further.

It's a trend that works for a lot of people. The business community has supported Medicaid enhancements to help relieve pressure on employers to provide coverage for low-wage workers. The insurance industry also has generally favored expanded Medicaid eligibility over other health care reform approaches in order to sustain the existing, profitable framework rather than more radical changes. In addition, as employers have dropped health insurance coverage over time, more low-income workers have become eligible for Medicaid. The recession has further added to the rolls.

The GAO recently estimated the extent of the long-term fiscal challenges facing states and localities, much as the Social Security trustees make projections of that program's outlook long into the future. Obviously, such forecasts have to rely on a variety of demographic and economic assumptions, based in part on

historical patterns, which may prove faulty. But the probability that health care costs will continue to rise much more rapidly than overall inflation is a pretty safe bet, even after the reforms pending before Congress. In addition to expected increases in Medicaid outlays, the recent plunge in state pension fund assets due to the market decline exacerbates strains—the GAO found that more than half of the state and local pension funds it studied pre-crash were inadequately funded, some severely. Over the 50-year period covered in the projection, that chasm amounts to about \$10.6 trillion, or 1.4 percent of GDP. Such forecasts, if borne out, mean that governors and state legislatures year-in and year-out will be under pressure to cut services and raise taxes to comply with their balanced budget requirements.

While the quality of a wide range of public services has already suffered greatly in many major states, the single program that is most problematic across the country is Medicaid. In addition to its rapidly growing costs, Medicaid has been chronically plagued by fundamental shortcomings for years. One is the wide state-to-state variation in eligibility rules and the scope of protections that beneficiaries receive. Another is low reimbursement rates to health care providers, which discourage many doctors from serving Medicaid beneficiaries. Because the program's mostly low-income beneficiaries lack political clout, state legislators habitually slash Medicaid reimbursement rates, which in many states are around half the level as Medicare's, to balance budgets. And as many as half of all citizens eligible for Medicaid in some states don't sign up because of inadequate public outreach and public awareness.

Ultimately, Medicaid's central flaw is that its dual federal-state structure diffuses accountability to the point where no one is clearly responsible for its myriad defects. In contrast to federal programs like Social Security and Medicare, which get far more bang for the taxpayer's buck and have generally become more effective over time, Medicaid has grown without evolving for the better, at great cost to states' long-term fiscal health.

## **Saving Our States**

The perpetual long-term budgetary crunch facing states simplifies the case that can be made for a radical change in course. For anyone who believes that states should be primarily responsible for carrying out basic public services, enabling state governments to shed their Medicaid obligations would give them far greater flexibility and capacity to educate their students, carry out law enforcement, invest in transportation and other infrastructure, avoid deep cutbacks during economic downturns, and, if they choose, reduce state taxes. Supporters of all those other governmental activities ought to be counted on

to rally on behalf of federalizing Medicaid, since doing so would greatly benefit their own causes.

Many proposals suggesting alternative mechanisms for federalizing different elements of Medicaid have been put forward over the years, giving politicians plenty of flexibility in reaching a consensus about how to best make the transition. For example, the process might begin by first federalizing payments to individuals who are eligible for both Medicaid and Medicare. In the health insurance reform bill passed in November by the House of Representatives, the federal government would fully cover the costs for individuals who would become newly eligible for Medicaid under the broadened qualifications included in the bill for two years, and then with 91 percent federal financing beginning in 2015. In its own right, that would be a meaningful foot in the door toward complete federalization.

**Enabling states to shed their Medicaid obligations would give them far greater capacity in education, infrastructure, and law enforcement.**

Senate legislation would still require some state funding for expanded Medicaid coverage, but with much higher federal matching levels than apply now. The willingness of Congress to consider those changes during the current round of health reform bodes well for future moves in the same direction. Simply shifting all

federal Medicaid spending to the higher matching levels in the Senate bill would be a huge positive step.

In the future, Congress might choose to have states contribute declining amounts toward Medicaid over an extended period. Complicated, politically challenging judgments would also have to be made about matters such as eligibility requirements and coverage levels, since some states are far more generous than others. In all probability, some states would likely want to maintain the right to supplement the federal coverage, and federal matching money could be retained to encourage maintenance of past state efforts above new national thresholds.

The Center for Medicare and Medicaid Services, which already administers both programs at the federal level, would gradually take over from the states responsibilities for Medicaid activities such as payment setting, bill processing, and quality oversight. Insurance companies and other intermediaries would handle claims processing under contract with CMS. Ultimately, breaking down the existing administrative barriers between Medicare and Medicaid would be far more efficient.

One of the main virtues of federalizing Medicaid would be to reduce the fragmentation in the U.S. health care system that has so much to do with its

myriad shortcomings. Today's pervasive complexity and paperwork nightmares wouldn't magically disappear by any means, but taking 50 separate state bureaucracies out of the picture would be a meaningful step in the direction of reducing confusion and wastefulness. Moreover, it would create possibilities that don't currently exist for low-income Americans to ultimately gain access to the same insurance options as everyone else under a much more integrated system of universal coverage.

Obviously, federal outlays would increase as the central government absorbed the Medicaid costs previously borne by states, which would arouse stiff resistance from deficit hawks. But as the Obama Administration has emphasized throughout this year's health reform debate, gaining control over runaway, highly inefficient medical spending will require fundamental reforms that will be most effective if implemented broadly. If Medicaid were fully under federal control, cost-containment initiatives adopted for Medicare could be applied as well to Medicaid, in a much more coordinated and systematic way than would be possible under the status quo. Just as health insurance reform requires up-front investments to achieve reductions in medical spending growth later, federalizing Medicaid would add to federal outlays initially but could potentially accelerate the process of reducing the overall rate of growth in health care costs. Moreover, concentrating accountability for Medicaid entirely in the federal government would actually make it easier for members of Congress to exert their power to ensure the program becomes more cost-effective.

Objections to federalizing Medicaid on the grounds of fiscal responsibility fail to adequately weigh the full benefits of the reform along with the costs. Americans pay federal, state, and local taxes. Everything else being equal, shifting part of the cost of a program from the states to the national level requires higher federal taxes, but it also reduces the amount states need to collect. On balance, though, the total obligation would likely end up being higher. Who would end up paying more and who less in that trade-off?

Federal income taxes are far more progressive than state taxes, taking relatively bigger bites the larger an individual's income. On balance, the combined federal-state tax burden on low- and middle-income Americans could be expected to decline, while it would increase for upper-income taxpayers. And because the federal government is not obligated to balance its budget, unlike states, economic downturns would be much less likely to lead to benefit cutbacks. As a result, overall Medicaid spending during recessions would likely be higher than under the status quo, but that would be one of reform's features rather than a bug—cutbacks in Medicaid spending during downturns further weaken the economy while producing more hardship.

In any case, the inevitable growth in public sector health care spending needs to be financed, with or without reform. Despite the widespread consensus that the United States simply can't afford such costs, a little perspective demonstrates otherwise. A recent analysis of the ratio of all taxes to GDP in the 30 OECD countries shows that the United States ranks 26th, in a virtual tie with Japan, with a tax-to-GDP ratio of 28 percent, compared to a median of 36 percent. The only other countries in the sample with lower tax levels are Korea, Turkey, and Mexico. Raising federal taxes by 5 percent of GDP to cover the added health cost burden confronting the nation would still leave overall American taxes at or below the bottom third of advanced nations.

Some advocates will no doubt object that withdrawing Medicaid from the laboratories of democracy would stifle the innovation that has long been touted as one of the virtues of our decentralized system of governance. But particularly with respect to programs that are geared toward low-income beneficiaries like Medicaid, the lion's share of research has found that states don't actually seek out and emulate the best practices of their counterparts. David Super, a University of Maryland law professor, wrote in a law review article titled "Laboratories of Destitution" that "almost all progress in antipoverty law has come from centralized, non-participatory, and non-experimentalist policymaking."

It has been decades since a national political leader has forcefully argued on behalf of the federal government's virtues. But with state governments under a fiscal siege of their own, the time has come to debate how the federal government could help them regain control of their destiny in a way that would be most cost-effective to both taxpayers and beneficiaries. The best solution is to borrow an idea of Ronald Reagan's and turn Medicaid entirely over to Washington. **D**