Instructor Resources Sample

This is a sample of the instructor materials for *Longest's Health Policymaking in the United States, Seventh Edition,* by Michael R. Meacham.

The complete instructor materials include the following:

- Syllabus planner
- PowerPoint presentations
- Answer guides to the in-book discussion questions
- Test bank

This sample includes the syllabus planner, PowerPoint slides, and answer guide to the in-book discussion questions for chapter 3.

If you adopt this text, you will be given access to the complete materials. To obtain access, e-mail your request to hapbooks@ache.org and include the following information in your message:

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Unit 3: Federalism: The Changing Contexts of State and Federal Health Policy

Unit Learning Objectives

- UO 3: Examine federalism as the context of state and federal health policy.
  - Define *federalism*.
  - Identify the differences in the kinds of policies made by states and the federal government and why those differences are important.
  - Describe how the national federalism concept of today impacts health policy.
  - Describe how states may take similar or more individualized roles in the administration of Medicaid and elements of the Affordable Care Act (ACA).
  - Explain how differences in policy choices among the states impact national health goals.
  - Define each of the six predominant categories of federal health legislation: food and drug supply; disease research and protection; system infrastructure and training for health professionals; developmental and behavioral health; environmental health and pollution; and access to care.
  - Explain why understanding the interlocking nature of federal and state health policy is important.

Readings

Read: *Longest's Health Policymaking in the United States*, Chapter 3: Federalism: The Changing Contexts of State and Federal Health Policy

Recommended: Appendixes 1.1–1.3

Unit Activities

Content Outline: Session 1 Federalism: The Changing Contexts of State and Federal Health Policy

Unit Objectives:

15–20 min

Instructor PowerPoint slides:

Chapter 3: Slides 1–8

- Define *federalism*.
- Identify the differences in the kinds of policies made by states and the federal government and why those differences are important.
- Describe how the *national federalism* concept of today impacts health policy.

Topics:

- A Brief History of Federalism in the United States
    - *Federalism*: a system of government where ruling is shared between multiple levels of government "so that on some matters the national government is supreme and on others the states, regions or provincial governments are supreme (Wilson and DiIuilo 1995, A-49)" (p. 94)
    - The Tenth Amendment in the Bill of Rights "addressed limitations on the national government: The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States… or to the people." (p. 94)
    - "Matters *not* delegated to the federal government include the… power of a state to protect the health… of its people." (p. 94)
        - States have authority to license healthcare providers, regulate healthcare facilities, impose vaccination requirements, etc.
    - Debate: the level of power in the federal government vs. the states
- Preview history—Exhibit 3.1: Evolution of Federalism Timeline (p. 96)
- *Dual Federalism: The Nineteenth Century*
    - *Dual federalism*: "The belief in… duality between the states and national government" (p. 95)
        - Prominent from late 1700s to early 1900s
        - There was little cooperation
        - Nullification: states' rights advocates argued states should be able to "render federal law null and void" (p. 95)

- *Cooperative Federalism, 1901–1960*
  - "[A]dvent of the federal income tax" led to "*grant-in-aid* approach: using federal government revenue to grant money to the states in pursuit of policy objectives" (p. 97)
  - Formulaic funding approach: e.g., Sheppard-Towner Act—"the first time in healthcare that funds" were given "by the federal government" to states in exchange for matching state participation (p. 97)
  - SSA: Individual citizens received "cash payments directly from the federal government" during the Great Depression
- *Creative Federalism, 1960–1970*
  - "[O]ne man, one vote" federal standards (p. 99)
  - "Great Society"—federal government could pursue policy objectives through state and local governments
  - Desegregation
- *Modern Federalism, 1970–2000*
  - Block grants, court cases, and legislation—shifted power back to states
- *Interactive Federalism, 2000–Present*
  - Also known as *national federalism*: states have autonomy to act, "shaped by federal statutes" and often with federal approval (p. 101)
  - States have more flexibility with "federal programs addressing a national purpose" (p. 101), e.g., Medicaid, CHIP, and the ACA

In-Class Discussion

- What are the advantages and disadvantages of a stronger federal government, as shown through the different forms of federalism in the United States? 15–20 min
- How does *interactive federalism* impact health policy today? Give examples of existing programs and how they work in different states.

In-Class Activity

Activity: "Grant-in-Aid" Legislation 15–20 min

Separate students into small groups (pairs or trios). Each group should select an example of federal "grant-in-aid" legislation enacted during the *Cooperative Federalism* period in the United

States to research. They can choose from the list in Exhibit 3.3 on p. 99 in *Longest's Health Policymaking in the United States* or another example from their research. The following questions should guide the groups' research:

- What was the legislation and what issue was it in response to?
- Which body of government enacted the legislation?
- How did the act support federal policy objective(s)?
- Which states opposed the legislation? Why?
- How did the legislation impact national health over time? Does it still have an impact today?

Note: This activity may require students to use the institution's library for research either in person or online. For online courses, have students complete this activity using the available technology of your choice (e.g., through a discussion board or in a video or text chat).

Content Outline: Session 2 Federalism: The Changing Contexts of State and Federal Health Policy

Unit Objectives:

15–20 min

Instructor PowerPoint slides:

Chapter 3: Slides 8–9

- Describe how states may take similar or more individualized roles in the administration of Medicaid and elements of the Affordable Care Act (ACA).
- Explain how differences in policy choices among the states impact national health goals.

Topics:

- Section 1115(b) Medicaid Waivers: Research and Demonstration Projects
    - "Waivers… for experimental or demonstration projects" (p. 102)
    - Enable the federal government to "continue to provide the usual matching funds to… the state… while the state experiments with nonconforming delivery models of innovations" (p. 102)
- Section 1915 Medicaid Waivers: Managed Care or Freedom of Choice Waivers and Home and Community-Based Services Waivers
    - Additional waivers allow states, with approval, "to restrict *freedom of provider choice*… for mandatory managed care programs" (p. 103), e.g., managing Medicaid individually by state

    - Exhibit 3.5: Comparison of Medicaid Waivers Usage (May 2019)
- The Affordable Care Act and State Policy Innovation: Section 1332 Waivers
    - "The ACA also created a waiver process" to allow flexibility with other "elements of the ACA… not directly to Medicaid" (p. 104)
    - ACA federal and state responsibilities:
        - Federal government provides protections for preexisting health conditions, assistance for the indigent, and individual and employer coverage mandates.
        - States have the authority to oversee their insurance marketplace, manage their Medicaid program, create a Basic Health Plan for the indigent, oversee risk adjustment and rate review, and make significant changes.
    - *State innovation waivers* (also known as *state relief and empowerment waivers)* may be granted for: benefits and subsidies, insurance markets, and individual and employer mandates. (p. 105)
    - Guardrails: Any waiver must provide comprehensive coverage and be as affordable as coverage without the waiver. (p. 105)
    - "[T]his flexibility enhances the role of the states in crafting health policy" (p. 106), e.g., state-by-state work requirements (p. 107)
    - Modification—the interpretation of state authority can always change: "While one administration might deny states the opportunity… the next one might permit it (Huberfield 2018)." (p. 108)
    - Example: Legal marijuana—"federal power to regulate interstate commerce and the police power of the states collide" (p. 108)

In-Class Discussion

- What are the advantages of allowing states to manage state-wide Medicaid programs? What are the disadvantages? 15–20 min
- How would Medicaid work differently if it was managed by the federal government for all states?

In-Class Activity

Activity: Implementation 15–20 min

Divide students into pairs or trios. Each group should pick two states that have applied different approaches to using Medicaid waivers. Compare and contrast each state by answering the following questions:

- What rules did each state waive? What was the likely rationale behind these choices?
- How does current Medicaid coverage compare between the states? How might one person who isn't covered in one state be covered in the other state?

Follow-up Activity: Implementation Discussion

Reconvene the class and have the groups present their states and their different approaches for Medicaid waivers. Discuss the impacts of these waivers and how each state tried to tailor Medicaid to fit their specific population and objectives.

Content Outline: Session 3 Federalism: The Changing Contexts of State and Federal Health Policy

Unit Objectives: 15–20 min

Instructor PowerPoint slides:

Chapter 3: Slides 10–12

- Define each of the six predominant categories of federal health legislation: food and drug supply; disease research and protection; system infrastructure and training for health professionals; developmental and behavioral health; environmental health and pollution; and access to care.
- Explain why understanding the interlocking nature of federal and state health policy is important.

Topics:

- Growth in the Federal Government's Healthcare Role
  - "The SSA fundamentally changed the relationship of the federal government and US citizens… [and] became the foundation for… federal interventions in… individuals and in the dynamic between the federal government and the states." (p. 111)
  - Health threats from "adulterated drugs" and "communicable diseases,"—federal government established the FDA, CDC, and NIH (p. 111)
  - Federal legislation falls in 6 categories "that transcend state borders." (p. 112)

- Food and Drug Supply
    - "[N]ew awareness of the impact of impurities in food and drugs" (p. 112) in the early 1900s
    - The federal government takes the lead over states in "[a]ssurance of pure food and unadulterated pharmaceuticals." (p. 112)
    - 21st Century Cures Act changed "drug and device approval pathways through the FDA to support innovation" and development. (p. 113)
- Disease Research and Protection
    - NIH: "foundational research… of disease causes and, ultimately, cures" (p. 113)
    - Rise in funding: Exhibit 3.6: NIH Appropriations, 1945–2019 (in billions) (p. 114)
    - CDC: applies science to protect against disease through "health information," policy, education, and reporting (p. 114–115)
- System Infrastructure and Training Health Professionals
    - "[S]cholarships, fellowships, and other financial incentives" provided by the government for Americans to join the health profession (p. 115)
    - Contributed towards "the number of hospitals" and other "healthcare facilities" (p. 115)
    - Digital protections and records
- Developmental and Behavioral Health
    - Policymakers do not "advance the causes of developmental and mental health" due to "the absence of a clear political constituency." (p. 116)
    - Most initiatives are "federal assistance to state and local" governments for "services for people suffering these afflictions." (p. 116)
- Environmental Health and Pollution
    - Challenging for the federal government because while environmental health risks are severe, there are "considerable economic interests" for businesses "associated with manufacturing and energy production" (116–117)
- Access to Care
    - "[M]ost active area of federal legislation" (p. 118)
    - Five A's of Access—"access (physical), availability (of provider…), affordability (financial), acceptability (cultural), and accommodation (of patient needs)" (p. 118)
    - Improve overall *quality* of care

In-Class Discussion

- Which of the six predominant categories of federal health legislation does the federal government focus on with the strongest and most frequent actions? Why? 15–20 min
- Which categories are most challenging for passing federal policy? Why?
- Are there other categories that the federal government should focus on (or add to the list)?

In-Class Activity

Activity: The External Environment 15–20 min

Divide the class into six groups. Assign each group one of the six categories of federal health legislation—food and drug supply; disease research and protection; system infrastructure and training health professionals; developmental and behavioral health; environmental health and pollution; and access to care. Instruct each group to come up with at least one example of how the federal government partnered with states in regards to specific legislation in their area or *could* partner with states with potential future legislation. Each group should answer the following questions:

- Why was/is it necessary for the federal government to partner with the state?
- What are the obstacles specific to this legislation?
- What would change if individual states were solely responsible for this category of healthcare legislation?

Outside of Class Work (Homework)

Individual Work: Chapter 3 Review Questions

In Microsoft Word, complete Chapter 3 Review Questions 1–5. For each question, write a thorough and well-reasoned response. Support your response by citing the textbook or Internet research.

1. Describe how *federalism* is implemented in the United States.
2. Discuss the pros and cons of requiring Medicaid recipients to work or perform community service to be eligible for the program.
3. Discuss how states and federal government work together to shape health policy. In what ways are they potentially at odds with one another?
4. Explain the source of differences between state health policy and federal health policy.

5. Describe briefly the six general categories of federal health legislation.
    - UO 3: Examine federalism as the context of state and federal health policy.

Discussion Board Questions:

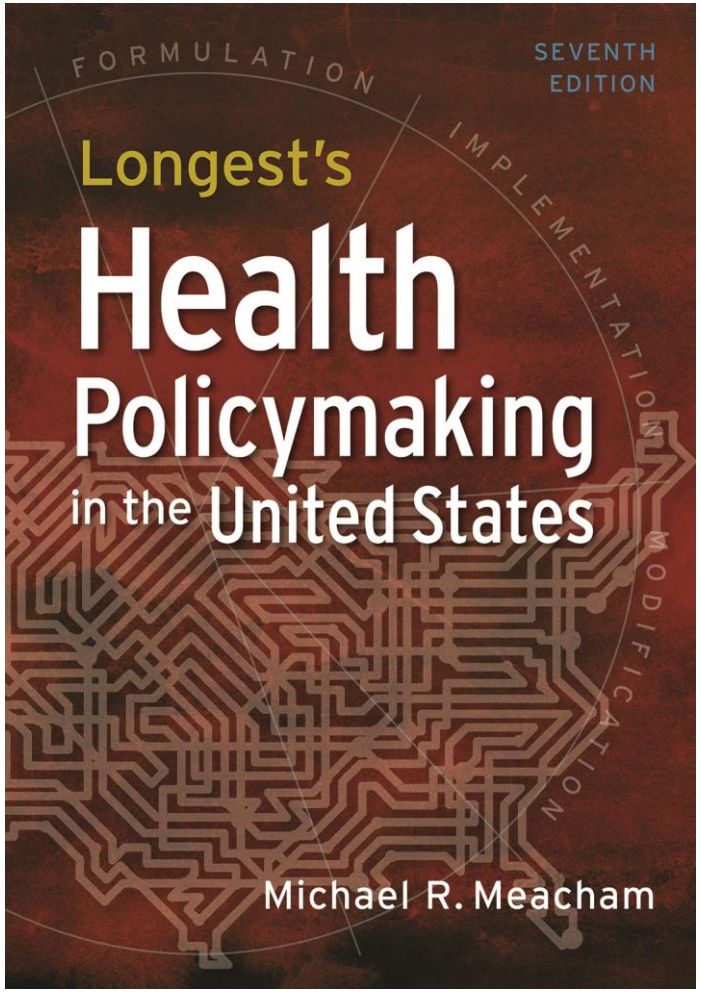
- The Great Depression had a dramatic effect on the federal approach to healthcare, leading to the SSA and eventually Medicaid, Medicare, CHI, and parts of the ACA. What if there was another great depression? Would the current form of federalism need to change to respond appropriately? If so, how? How would the situation be different now than it was in the early 1900s? Support your answer with independent research.
    - UO 3: Examine federalism as the context of state and federal health policy.

- Reread the case study "Legal Marijuana: Federal Intransigence While States Move Forward" on p. 108–110 in *Longest's Health Policymaking in the United States*. Discuss the problems that arise when laws vary between different states and the federal government in this example. What are the advantages and disadvantages of the federal government's choice to slowly cede "to the states the prerogative to regulate marijuana" (p. 109)?
    - UO 3: Examine federalism as the context of state and federal health policy.

- Consider the six main categories of federal legislation that address health in the United States discussed in Chapter 3. Compare and contrast this approach to that of another country with a federalist government. In that country, do the federal or state governments have authority over the same or different categories? How does their approach compare to the approach in the United States?
    - UO 3: Examine federalism as the context of state and federal health policy.

Chapter 3

Federalism: The Changing Contexts of State and Federal Health Policy



Learning Objectives

- Define and briefly describe *federalism*
- Articulate the differences in the kinds of policies states and the federal government make and why those differences are important
- Understand how the national federalism concept of today impacts health policy
- Describe how states may take similar or more individualized roles in the administration of Medicaid and elements of the ACA
- Explain how differences in policy choices among the states impact national health goals
- Discuss and provide an example of each of the six predominant categories of federal health legislation
- Discuss why understanding the interlocking nature of federal and state health policy is important

Brief History of Federalism

- Dual federalism: nineteenth century
  - Little cooperation between states and national governments
  - “states’ rights” vs. “implied power” of national government
    - “necessary and proper” to complete constitutionally delegated authority
    - Supremacy Clause upheld over state nullification efforts
  - Fourteenth Amendment – federal due process applies to states

Brief History of Federalism

- Cooperative federalism: 1901–1960
  - Progressive era – expanded national role
  - Sixteenth Amendment – federal income tax
  - “Grant-in-aid” approach to encourage states re: national goals
  - Sheppard-Towner – children’s health
  - Great depression – Social Security Act
  - *Brown v. Board of Education*

Exhibit 3.1: Evolution of Federalism Timeline

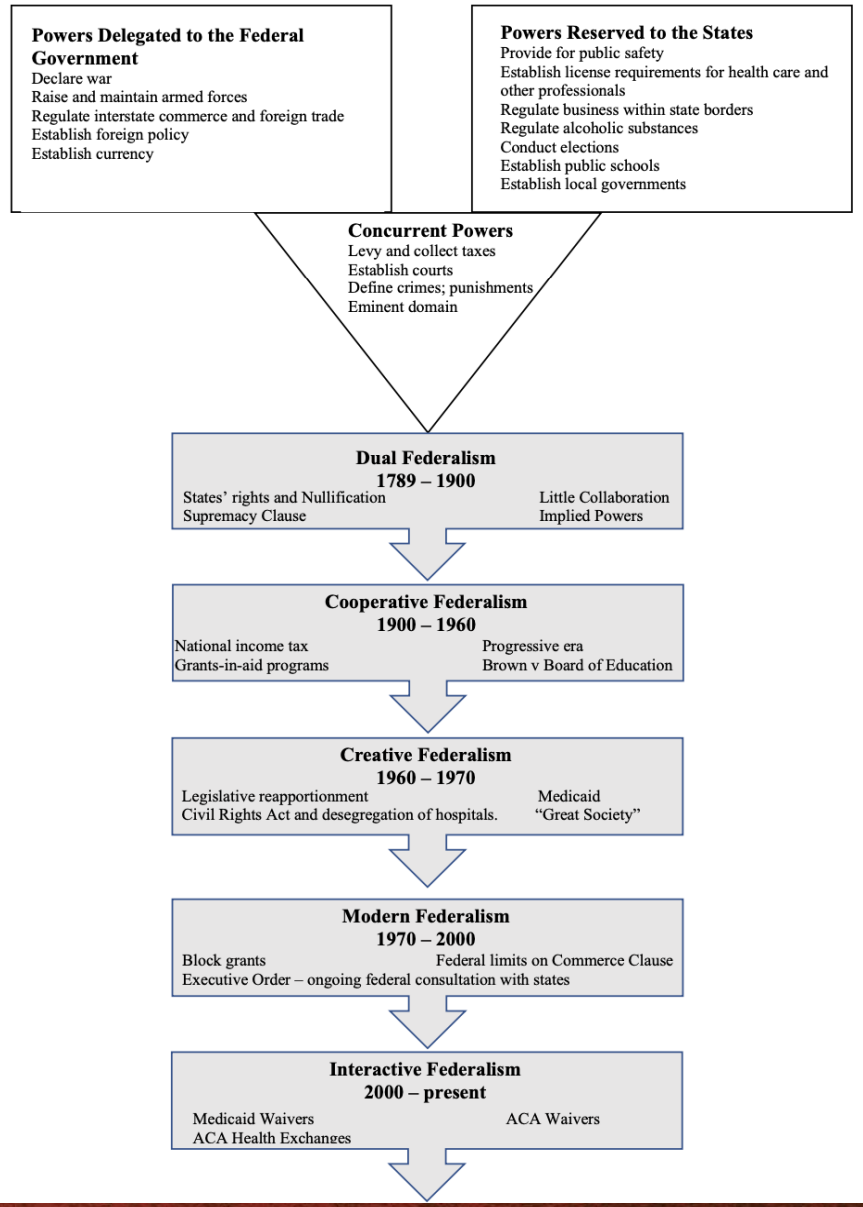


Exhibit 3.3: Selected Federal "Grant-in-Aid" Legislation

Year	Legislation	Key Issue(s) Addressed
1935	Social Security Act	Incentives for maternal and child health; child welfare services and increased assistance for state and local public health programs
1938	LaFollette-Bulwinkle Act	Funding for states to investigate and control venereal disease
1946	National Mental Health Act	Grants for states' mental health activities
1946	Hill-Burton Act	Grants to states in support of hospital planning and construction
1954	Medical Facilities and Construction Act	Expansion of Hill-Burton to include other kinds of health facilities
1955	Polio Vaccination Act	Support for state-administered polio vaccination programs
1956	Water Pollution Control Act Amendments	Technical and financial support to states and municipalities to prevent and control water pollution
1960	Kerr-Mills Act	Support for states to provide care for "medically indigent" elderly
1963	Health Professionals Educational Assistance Act	Construction grants for healthcare professional teaching facilities
1963	Maternal and Child Health and Mental Retardation Planning Amendments	Support for states' efforts to prevent developmental disability through prenatal, maternity, and infant care for at-risk individuals
1964	Hospital and Medical Facilities Amendments	Expansion of Hill-Burton to include modernization and replacement of existing facilities
1965	Medicaid	Support to states to insure medically indigent individuals

Brief History of Federalism

- Creative federalism: 1960–1970
  - Great Society initiatives
  - Civil Rights Act of 1964
- Modern federalism: 1970–2000
  - Block grants
  - Limits on federal authority to take punitive action toward states
  - Federal consultation with states

Brief History of Federalism

- Interactive federalism: 2000–present (aka *national federalism*)
  - State action with federal permission mirrors federal action
  - States more deeply engaged in national issues
    - ACA
      - Insurance exchanges
      - Medicaid expansion
    - Medicaid waivers
      - Work requirements
    - ACA waivers
  - States have greater flexibility to administer Medicaid and ACA
    - Query: Is progress toward national policy goals impeded by state action?
  - Waivers go in either direction depending on presidential administration

Brief History of Federalism

- Federal and state policy toward controlled substances
  - Federal intransigence vs. state permissiveness
    - Medical marijuana possession
    - Recreational marijuana possession
    - Federal prosecutors using prosecutorial discretion

Growth in the Federal Role

- Specific issues wax and wane over time
- Six areas of federal activity: multiple legislative actions over time (appendix 1.3)
    - Food and Drug Supply
        - FDA and predecessor agencies
    - Disease Research and Protection
        - CDC and NIH and predecessor agencies
    - System Infrastructure and Training
        - AHRQ and its predecessor agencies
    - Developmental and Behavioral Health
        - National Institute of Mental Health
    - Environmental Health and Pollution
        - EPA and its predecessor agencies
    - Access to Care
        - CMS and its predecessor agencies

Summary

- Federalism has changed over time
  - Continues to change
- Federal role has become increasingly prominent
- Federal–state interaction inconsistent over time
  - Could lead to disparate results among states

Review Questions

1. Describe what *federalism* means in the United States.
2. Discuss the pros and cons of requiring work or community service to be eligible for Medicaid.
3. Discuss how states and federal government work together to shape health policy. In what ways do they work at odds with one another?
4. Explain the source of differences between state health policy and federal health policy.
5. Describe briefly the six general categories of federal health legislation.

Longest's Health Policymaking in the United States, **Seventh Edition**

Answers to Review Questions

Chapter 3 – Federalism: The Changing Contexts of State and Federal Health Policy

Note: Full citations for the parenthetical references can be found in the chapter-end reference lists in the book.

1. Describe what* federalism *means in the United States.

Federalism is a system of government "in which sovereignty is shared [between two or more levels of government] so that on some matters the national government is supreme and on others the states, regions or provincial governments are supreme" (Wilson and DiIuilo 1995, A-49). In the United States this refers to the federal (national) government and the states that share and divide authority. The notion of "separate spheres," which originated in the US Constitution, has given way to an interlocking relationship in which the federal government possesses one set of power and the states another, with overlapping responsibility in several domains. While there is still considerable separation between the powers of the states and the powers of the federal government, the grant-in-aid approach in which the federal government provides financial support to states to achieve national policy goals has become a predominant policy model in healthcare in the form of Medicaid, the Affordable Care Act, and other areas.

2. Discuss the pros and cons of requiring work or community service to be eligible for Medicaid.

Pros: Because Medicaid is funded by general taxpayer funds from both the states and the federal government, it is only fair to get some bit of value in exchange. This is particularly true in states that have expanded their Medicaid programs because the newly eligible population includes

more able-bodied people capable of work. This means that Medicaid should not be stuck with the stigma of welfare, because people receiving Medicaid are making a general contribution to society in order to receive the benefit.

Cons: Historically, the concept of Medicaid has been, and still is, to expand availability of coverage to those who cannot afford it. Most people who need Medicaid in the expansion populations (people whose incomes are approximately 40 percent to 100 percent of the federal poverty level) are already working, thus negating any meaningful impact of a work requirement. Indeed, the net effect of such requirements would be to bar people from coverage for failure to report sufficient hours of work or community service.

3. Discuss how states and federal government work together to shape health policy. In what ways to they work at odds with one another?

Federalism has evolved to a "national" or "interactive" type of federalism. Even though states undertake national policy goals in conformity with the requirements associated with federal money, their behavior is consistent with their sovereignty. In other words, they "act" in the same way as if there was no federal money or requirement: enacting laws, promulgating regulations, and enforcing policy decisions. Often this process works to promote uniformity in health policy; the creation of state exchanges under the ambit of the Affordable Care Act is a good example. Commonly, however, states obtain waivers from the Department of Health and Human Services Medicaid or ACA requirements to obviate some of the requirements associated with those programs. In other words, HHS grants waivers to states that have the net effect of undermining federal policy goals or, at the very least, support one set of goals in favor of another. In this way, for example, state-imposed work requirements authorized by federal waivers may have the net

effect of reducing Medicaid coverage in contravention of the underlying policy goal of Medicaid: to expand access to coverage and, thus, healthcare services.

4. Explain the source of differences between state health policy and federal health policy.

Federal health policy represents a broad spectrum of interests philosophically, economically, geographically, and demographically. From those interest groups and subpopulations emerges a consensus. Although that consensus will change from time to time based on the social, political, and economic environments, it represents the political majority of all nationally influential interests and subpopulations. State health policy, except in large states like New York, California, and a handful of others, has a narrower range of interests. The interests of a rural population in South Dakota, for example, will hold greater influence in that state than in the national framework. Thus, that state's health policy may not perceive the needs associated with an inner-city population, which possesses a strong voice in the national debate.

5. Describe briefly the six general categories of federal health legislation.

Food and drug supply: legislation that sets standards, created the FDA, and permits that agency to set standards to assure a safe food supply and safe and efficacious pharmaceuticals consumed by the American public.

Disease research and protection: legislation that created and funds the NIH and CDC and that funnels resources to basic research and applied research to prevent the spread of disease.

System infrastructure and training healthcare professionals: legislation that provides resources for training a wide variety of healthcare professionals and that provided resources for the construction of healthcare facilities (Hill-Burton Act).

Developmental and behavioral health: legislation targeting resources and creating infrastructure to support the needs of providers and patients in developmental and behavioral health.

Environmental health and pollution: legislation to mandate beneficial practices or prohibit harmful practices related to the environment in the air, water, and soil.

Access to care: legislation creating programs and targeting resources to expand health insurance coverage to eliminate that barrier to care.