

# A Federalist Approach To Health Reform: The Worst Way, Except For All The Others

Federal encouragement of state health reform will advance both the state and national reform agendas.

by **Henry J. Aaron and Stuart M. Butler**

**ABSTRACT:** Support for state action should be part of any strategy to expand health insurance coverage. Decades-long political deadlock in Washington has frustrated national efforts to expand coverage. Some states have already undertaken to do this; others show a determination to do so. Regulatory and legislative flexibility would trigger widespread state action. Whether one thinks that ensuring coverage requires a unified national approach or that diverse conditions require different methods in different states, the likelihood of progress will be advanced if states test out various ways to expand coverage. We describe a practical way by which the federal government can promote state action to expand health insurance coverage. [*Health Affairs* 27, no. 3 (2008): 725–735; 10.1377/hlthaff.27.3.725]

HISTORIAN SHELBY FOOTE REMARKED THAT before the Civil War, people commonly wrote, “the United States are...” but that after the war they wrote, “the United States is...” As far as health care delivery is concerned, the United States remains very much in the “are” phase. Whether and when it will move to the “is” phase remains highly uncertain. County and state differences in the organization, financing, and use of health care are vast. The proportion of uninsured people varies across states by nearly three to one. Expenditures per person in the highest-spending state exceed those in the lowest by 70 percent. Use of various services differs among Hospital Referral Regions (HRRs) by five or ten to one and sometimes more.<sup>1</sup> Some of the differences arise from explicit state policies or income differentials. Some result from historical accident. The simple fact is that for whatever reason, quality of and access to care are better on average in some states than in others.

These differences should not be ignored as the nation strives to reform its health care system. Some people argue that national legislation is imperative to achieve consistent, comprehensive coverage throughout the country. Others hold

---

Henry Aaron ([haaron@brookings.edu](mailto:haaron@brookings.edu)) is the Bruce and Virginia MacLaury Senior Fellow at the Brookings Institution, Economic Studies, in Washington, D.C. Stuart Butler is vice president, Domestic and Economic Policy Studies, at the Heritage Foundation, also in Washington.

that separate action by individual states is the wiser course, given the U.S. political system and disagreements on the best way forward, even among experts of the same philosophical persuasion. This disagreement is important, but adherents of both positions should recognize that encouraging state action to expand coverage at this time will advance both agendas. We argued some time ago in *Health Affairs* that measures to energize state experimentation within a federal-state framework based on clear national goals will achieve two objectives: it will extend coverage in the near term, and it will advance the date at which coordinated national action is possible.<sup>2</sup> Our view has not changed, and it is unlikely to do so, no matter who wins the next presidential election.

### **State Reform: The Best Way To Trigger National Action**

Each of us continues to favor national action. We both feel that Americans have come to a consensus that access to adequate basic health care is part of what it means to be a resident of the United States. That consensus involves important values and goals, and it requires key legislative actions at the federal level to set the nation on course to realize those goals. But for three reasons we believe that a strategy based on state initiatives is likely to be the best way to trigger national action.

■ **Breaks political deadlocks.** First, there are deep disagreements among reasonable and committed people—including between us—about what the best practical approach is. That makes it very difficult to get political support for coherent, workable action even among those who broadly agree on goals. Our strategy is designed as a political device to break that deadlock by making it possible to launch a variety of bold approaches quickly, with the more successful initiatives helping to build consensus for more sweeping action.

■ **Allows for glitches in a limited arena.** Second, given the complexity of current U.S. health care financing, it is likely that well-intentioned reformers will make mistakes. Eventual national action will emerge with fewer glitches if those mistakes are made on the limited stage of individual states than if a full-blown national plan must be designed in advance.

■ **Can accommodate states' variations.** And third, we believe that any national system would have to accommodate considerable state-to-state variation, at least for many years. If that is so, then why not begin with a system that incorporates state variation as an instrument to spur continuous improvement amid uncertainty and disagreement about the ideal solution?

### **Federal Encouragement Of State Action**

Federal encouragement of state action makes political as well as programmatic sense for several reasons. The first is the enduring, palpable failure of efforts to turn plans for a national health system reform into law. Whether one dates the first of these nonachievements with Franklin or Theodore Roosevelt, the biparti-

san roster of presidential failure is too glaring to ignore. Those yearning for national action have repeatedly believed that “the time is now! Political tides have shifted.” Democrats, in particular, are now disposed to think that a big 2008 victory would make national reform a reality. But all should recall how often in the past others discovered that the successes they saw as within grasp were mirages.

The second reason is that the U.S. health care sector is remarkably complex, and knowledge about what will work best in the diverse political and health system environments of the fifty states is remarkably incomplete. So whether one believes that the ideal reform would be national or federalist, the ability to move ahead in the near future will be advanced by learning from state initiatives now—and from initiatives that are not marginal refinements, where the results are minor and the lessons open to dispute, but bold initiatives that test very different approaches. Moreover, any national reform will be enhanced by allowing states to improve it at the margin, both to adjust the reform to local circumstances and to adapt it to new knowledge. It should also be kept in mind that other federalist nations—notably Canada and Switzerland—extended health insurance to all while allowing provinces and cantons some flexibility in how to do it.

The third reason for encouraging state action is the abundant evidence that states are eager and poised to take the lead in health system reform.<sup>3</sup> The Massachusetts plan is the most widely known. It mandates that every person have insurance or pay a tax penalty, and it subsidizes low- and moderate-income families to help them buy health insurance. It also creates a state-operated insurance exchange, known as the “Connector,” that enables individuals and employees of small businesses—indeed, anyone—to buy insurance at regulated rates and take it from job to job.

■ **Examples of state reform plans.** No other state has yet implemented quite so sweeping a plan, but some have them on the drawing boards, and many are moving aggressively to extend coverage. For example, several states are considering reforms that include an insurance exchange similar to that in Massachusetts. Mississippi’s Gov. Haley Barbour and Louisiana’s Gov. Bobby Jindal, for example, back an exchange. State legislatures in Kansas, New Mexico, and Utah, among others, have also been exploring insurance exchanges.

A number of states are pressing forward with steps to achieve coverage expansions mainly through private insurance. Maine’s Gov. John Baldacci has proposed an individual mandate, for instance. And California’s Gov. Arnold Schwarzenegger has proposed a plan that would establish an agency to create a pool for individuals and small businesses. The plan also would provide universal coverage free to low-income adults and children, financed by a combination of payroll taxes and surcharges levied on physicians and hospitals.

Other states have proposed expansions based more on public programs. Illinois, for instance, has implemented a program to offer insurance to all children under either Medicaid or the State Children’s Health Insurance Program (SCHIP)

with a sliding premium scale. Gov. Rod Blagojevich has also proposed to make insurance available to all residents and free of charge to low-income residents.

Meanwhile, Pennsylvania has instituted a Cover-All-Kids program that provides insurance at no cost to children in families with incomes below 200 percent of the federal poverty threshold and on a sliding-scale premium to those from families with incomes of 200–300 percent of poverty. Insurance would be available at pooled cost to all other children. Tennessee has converted SCHIP into a CoverKids program that is available to all children from families with incomes below 250 percent of poverty. It also has a CoverTN program to make health insurance practical and affordable to employees of small businesses. New York's former governor Eliot Spitzer proposed to extend free or subsidized coverage to all children with family incomes below four times official poverty thresholds. Indiana has received a waiver that includes a high-deductible plan with state-funded accounts.

■ **Obstacles to state reform.** This extensive list excludes many other state initiatives. Our point is not that all will or even should pass and be implemented, but that states are clearly taking the lead in trying to find ways to expand coverage. Yet this creativity is happening while the states face financial, statutory, and regulatory obstacles in their efforts. Although major changes can be made within individual programs, it is not possible, in general, to combine funds from various programs. The design of federal programs and laws often gives limited authority for states, or the administration, to try novel approaches to improve coverage. If the federal government were to encourage states in tangible ways—in particular, by a process that would allow states to apply for major alterations in existing federal law and programs within their borders and perhaps that offered modest financial assistance—we believe that there would be many more creative state proposals. We think that this approach would improve understanding of what works and what does not and would accelerate the search for the best way forward. Moreover, a process in which statutory changes apply only to a particular state would reduce the concerns of lawmakers from other states who are skeptical or opposed in principle to an approach. So, in our view, even advocates of national action should welcome these state actions as the best way to show what could work nationally.

Thus, even if one wants to gamble on the possible success of national reform, it is prudent for health care reformers to support federal legislation to encourage state action to extend health insurance coverage, limit the growth of spending, and improve the quality of care within a framework of national goals. But what form should this encouragement take? And how should we address the problems that this approach to health care reform would encounter?

## **Prospects For National Action**

Wishful thinking abounds about what the next presidential election will mean for health care. To be sure, the leading candidates have provided more details than

presidential campaigns usually generate. A presidential election offers the electorate the best chance to choose between the clear-cut philosophical differences of the two parties. Republicans emphasize the promotion of market competition, empowerment of the consumer as a force to police health care quality and price, limits on financial commitments by the federal government, and reform of the tax treatment of health spending. Democrats emphasize universal coverage, with large increases in federal funding and a mix of private and expanded public coverage.

Unfortunately for advocates of any position, even a decisive electoral victory will not ensure legislative realization—to say nothing of implementation and survival—of the winner’s vision. The electorate will likely base its vote on general statements of principle and intent. Accordingly, it cannot give a green light to clearly defined policies. Moreover, the “lions and lambs” rapprochement between business and labor on the desirability of health reform, which is sometimes cited as evidence that national action is now possible, also floats high on abstract principles with few agreed-upon details. However clear the embrace of generalities, the real debate on health care reform will not begin until a president introduces a specific bill. At that point, any seeming national consensus or apparent electoral support for specific policies will be sorely tested.

When a national reform bill is introduced, every think tank and interest group in the nation can—and will—analyze it. Only then will the impact of reform on every powerful interest group snap into sharp focus. At that point, key constituencies—including the demographically and economically diverse groups among the currently insured and uninsured, doctors, hospitals, drug companies, device manufacturers, large corporations, small businesses, unions, and the hundreds of nonprofit organizations and foundations that constitute “civil society”—will examine how the proposed bill affects them. U.S. health care is a \$2.4 trillion behemoth, an industry whose revenue exceeds the gross domestic product of the United Kingdom or France.<sup>4</sup> Transforming so hefty an entity over a span as brief as one or even two presidential terms, and doing so from the center of the political system, is not something that normally happens during peacetime in any democracy. It is virtually unthinkable in the United States, whose political system is exquisitely calibrated to frustrate action on large matters unless there is overwhelming consensus. Reform means gainers and losers. Losers will have vast resources and the determination to fight a plan; they can be counted on to do so. Against this gloomy vision of the national prospects for action, the energy and forward movement in states to reform health care financing that we summarized earlier is all the more striking.

### **A Proposal For Federal-State Action**

What we propose is that the federal government should concentrate on reaching agreement on the goals of coverage and the values that should be incorporated in any method of providing coverage in any part of the United States. The federal

government should then solicit state plans to extend adequate health insurance to an increased proportion of state residents, offering specific assistance—including changes or suspensions of existing federal laws—to at least a representative sample of those states to enable them to implement their plans. Three bills have been introduced each with bipartisan sponsorship, two in the Senate and one in the House, to implement this approach to health system reform.

■ **Step 1: define adequate coverage.** The first step for the federal government is to define *adequate coverage* for any U.S. resident. One way to do so would be to enumerate in detail those services that must be covered, along with allowable premiums and cost sharing. A better way might be to specify the actuarial value of insurance deemed as adequate, together with just a few specific requirements that the vast majority of Americans would understand as part of any definition of *coverage*. Some cap on out-of-pocket costs for individuals and families as a share of income would be necessary. So would specification of some loosely defined menu of services (such as emergency services, basic hospital care, normal physician services, prescription drugs, and a few other items).

Consistent with this approach to state action, Congress should, in our view, specify goals and values of the health care system that should prevail throughout the nation and which aspects of health care and the coverage system could differ. These details would reflect different visions and opinions of how to achieve the agreed-upon goals.

■ **Step 2: states propose their plans.** The second step is for states to come forward with plans on how they propose to reshape insurance to cover more people. A wide range of approaches should be allowed, including the favorite reforms of both conservatives and liberals. Legislation could specify particular reforms that would be presumed to be acceptable, but others could be approved as part of a complete plan.<sup>5</sup> For instance, they could build on the current employment-based system; enable their residents to enroll in the Federal Employees Health Benefits (FEHB) program; create a state-run clearinghouse for the organization and sale of insurance (such as the Massachusetts Connector), with federal tax relief available for those choosing such plans; or institute single-payer plans, individual mandates, tax-based incentives for individual or group purchase of insurance, association health plans, or other approaches that hold reasonable promise of expanding coverage. We believe that it is important to allow some flexibility in how benefits for the Medicaid population are structured and delivered, but essential to ensure that the overall value of services to currently covered groups is not diminished.

Our approach differs from the existing Section 1115 or Health Insurance Flexibility and Accountability (HIFA) waivers because it is based on a package of legislative changes and not on waivers granted by the administration. Thus, our approach would lead to state-specific changes in federal law and to programs that would allow funding to flow between as well as within programs. The result would be initiatives that are not only larger in scale but also potentially more dra-

matic in terms of their political implications. The “legislative waiver” approach would also make bold state initiatives more likely by avoiding the frustrating by-product of the existing waiver system that can require states and the federal government to go through convoluted regulatory hoops to achieve the desired result. For instance, Massachusetts had to classify its innovative Connector as an employer-sponsored “employee welfare benefit plan” to assure that enrollees in plans offered through the Connector would qualify for tax relief.

■ **Step 3: design a federal approval process.** The third step is to design a federal process for approving such state plans. This step is necessary because these state plans would call for relaxing current federal regulations or overriding current federal law governing the operation of programs the states might wish to merge. Some approvals could be done, as now, by the executive under waiver authority. But the more sweeping proposals we contemplate typically would require legislation, because any state plan would entail amending or suspending operative federal regulations or laws for an experimental period of some years. How would such legislation be decided? In our earlier *Health Affairs* paper we proposed that states offer proposals to a bipartisan commission assembled from federal and state officials, which would select a diverse “slate” of proposals for an expedited up-or-down vote in Congress.<sup>6</sup> It remains our view that such a commission would reassure states and reform advocates from both the left and the right that their favorite initiative would have a fair chance of being selected, and by so doing generate wide support for the entire federalism approach. From a political standpoint, members of Congress must be confident that states will undertake diverse approaches to extending coverage if they are to be any more willing to support these efforts than they would be to support federal action.

The bipartisan sponsorship and cosponsorship of the three bills submitted in 2007 reflect this awareness.<sup>7</sup> Those bills all would create bodies charged to approve state proposals structured to ensure that reforms appealing to both parties are tested. Various methods exist to produce the result we envision from a commission. Those serving on such a body could be designated by leadership from both parties. Approval of state plans could be contingent on a supermajority vote, thereby requiring appointees of both parties to sign on. Congressional action to approve a roster of state plans could be subject to rules prohibiting amendments, similar to those used for trade legislation and closure of military bases, thereby forcing Congress to accept the full range of plans or none at all. Only by assuring members of both parties that plans congenial to each will be among those to be field-tested could support for the entire approach be sustained.

■ **The question of federal funding.** Whether state action needs to be backed by added federal funding is open to debate, and the answer largely depends on a political calculation. Each of the three bipartisan bills introduced in the last Congress to support state action to extend health insurance coverage took different positions on this critical issue.<sup>8</sup> The principal argument against such funding—articulated by

*“Legislative waivers are the key to encouraging states to consider more far-reaching reforms.”*

.....

some Democratic sponsors, not just Republicans—is that there is already enough money in the current U.S. health care system to cover everyone and that the task is to spend that money more efficiently and fairly. Indeed, the United States spends enormous sums on health, with often questionable outcomes. So, better program design and improvements in efficiency might free up resources to cover all of the currently uninsured. Moreover, to the extent that public outlays would still have to go up to cover subsidies for the poor, these outlays could be offset from savings elsewhere in the federal budget, as two of the federalism bills envision (HR 506 and S 1169).

But new funding might nevertheless be necessary, for programmatic as well as political reasons. For one thing, systemwide spending will almost certainly increase, at least for a while, because savings from increased efficiencies are likely to be slow in coming. States are more likely to accept the political and financial burden of increased front-end spending if the federal government shoulders some of those costs.<sup>9</sup> In addition, financial support that increases during recessions would improve prospects that states could sustain a costly health coverage program during hard financial times. Still, claims that savings “by and by” will offset added spending “here and now” will evoke cynical reactions along the lines of “we’ve heard that one before.”

### **Challenges To A State-Led Approach**

A state-based strategy must surmount a number of formidable obstacles if it is to produce sustainable prototypes that might guide future national legislation.

■ **Stimulating initial enactment.** The first obstacle is stimulating the initial enactment of major reforms by the states. Although the states have demonstrated a greater willingness than the federal government to move forward, local politics and finances often prevent reform. But our system of federalism can help spur state action. Sometimes Washington can provide the spur. The one state, Massachusetts, that has enacted a state-based universal coverage plan did so in no small measure because it was threatened with the loss of about \$300 million in federal revenues if it did not have a viable plan to justify a continued federal waiver.<sup>10</sup> Federal encouragement of this kind will often be important to push state initiatives over the line when an interest group threatens to scuttle a deal. Federal encouragement can also be positive, and generally should be. The waiver process does provide for a degree of state flexibility within the boundaries of existing law. But such flexibility is limited and often requires states to take circuitous routes to reach their reform goals, as was the case in Massachusetts. That is why we have recommended legislative waivers that would increase states’ range of action, even if they entail major changes in federal law. We believe that this is the key to encouraging states to consider more far-

reaching reforms.

■ **Legislative logjams.** The second obstacle is the possibility of legislative logjams in Congress over the approval of state plans. Given the huge interests, ideological divisions, and political stakes in health reform, the possibility of such logjams cannot be dismissed. But we believe that they can be avoided. The bipartisan co-sponsors of the three major bills already introduced devoted much of the language in those bills to specifying procedures to avoid procedural delay. Each bill was designed to assure advocates of pet options of both the political left and right that their favorite options would be tested if they allowed other options also to be tested.

■ **Implementation problems.** A third threat is that, once enacted, a state plan might not be implemented or sustained. Experience to date in Massachusetts indicates that, with good will, the problems of implementing an individual mandate, an insurance clearinghouse, and subsidies to low-income households can be surmounted, although the generosity of coverage has had to be cut to fit within cost limits. Not all states are likely to succeed in implementing or sustaining their plans, however. Some states may encounter problems they cannot solve. The lessons of state failure as well as of success will guide future federal legislation. Still, the risk of failure will be greatly reduced if the federal government has a process that permits legislative waivers and the reprogramming of existing federal funds to complement the state initiative.

■ **Deeply entrenched counterlegislation.** The fourth obstacle is that some of the impediments to state action are to be found in deeply entrenched and popular federal legislation that is supported by powerful constituencies. The leading example is the Employee Retirement and Income Security Act (ERISA) of 1974, which has strong business support. ERISA explicitly exempts self-insured employer-sponsored health insurance plans from state regulation. This exemption is extremely popular with businesses, not least because it enables multistate corporations to run uniform cross-state plans, but of course it rules out some state initiatives, including any that would regulate self-insured plans, which now cover 55 percent of workers insured through the workplace.<sup>11</sup> Business determination to “hold the line” on ERISA makes it unlikely that Congress would consider a legislative waiver even for a state in which ERISA-covered employers supported a state initiative. So, in practice, states will for the foreseeable future have to consider other instruments to encourage these employers to follow state rules, or they will have to exempt such employers from their initiative. Massachusetts sought to skirt the issue. Although that state’s reform legislation does include some provisions that conflict with the ERISA preemption, it has only a minor impact on employers and makes it easy for them to comply or avoid those provisions. Indeed, if states were to pioneer approaches aimed at non-ERISA workers and were to further provide that employer participation in any new arrangement would be voluntary for ERISA-covered employers, they would likely avoid a challenge. Over time, the attractiveness to employers of successful state initiatives could gradually reduce business opposition to limited

changes in ERISA. The determination of many liberals and many moderates to avoid any erosion of protections Medicaid offers to the poor also stands as a barrier to state reforms. We believe that this concern can be relieved if any federal authorizing legislation provides that the actuarial value of Medicaid for currently covered populations will be maintained.

■ **Incorrect expectations.** A fifth obstacle to drawing useful lessons from state health insurance programs is one of incorrect expectations. State programs to extend coverage are not likely to produce fine-grained evidence on such matters as the impact of state plans on health outcomes, on what financing methods produce the lowest rates of medical error, or on how different financing methods affect use of health care services. These are all important questions, but evidence on them would not come from state health insurance reforms. It would be neither possible nor desirable in statewide plans to use control groups. Thus, forcing all states to collect the same data in the same way and controlling adequately for the huge number of confounding variables would prove impossible. In this sense, a series of state demonstrations of how to extend health insurance coverage would not resemble the much-celebrated welfare demonstrations of the 1980s and 1990s. Those demonstrations were confined to specific localities, used control groups, and dealt with a far simpler question than those just listed—how work requirements and job counseling would affect welfare enrollment, earnings, and income.

### **Potential Gains From Both Failure And Success**

The output of state programs to extend health insurance would be rather different but nevertheless extremely useful. Did the states meet specific targets for coverage? How much did the program cost at all levels of government? It would also be possible and desirable to examine data on broad medical indicators. But unless the impact of increased coverage on these latter indicators was huge, it would be undetectable and easily attributable to adventitious factors. To be sure, the states can be laboratories for testing policy instruments, but primarily in the special sense that they would face implementation problems certain to arise in any national program. Some promising approaches will fail, of course. But it is better that failure be limited to a state or group of states than that it be experienced throughout the nation. Indeed, we are more likely to detect failure, and at an earlier stage, if we have the opportunity to compare one state with another.

Other state initiatives would succeed, however. And success in a few states, most probably within “market leaders,” would produce a number of palpable benefits and examples that would be copied by “follower” states. Some proportion of the forty-seven million people currently without insurance coverage would gain it. That gain is an important end in itself and should not be minimized. If the multiyear climb in the count of the uninsured could be reversed, some millions who lack financial access to coverage and care would have it. Even more important, success by several states in significantly extending insurance coverage would

transform the national debate. Imagine what the debate on reform of health care would be like if, say, four states—Oregon, Illinois, Massachusetts, and Tennessee—had successfully extended coverage to, perhaps, 97 percent of their non-elderly residents (no state now covers more than 90 percent, and two cover 75 percent or fewer).<sup>12</sup> We think that in such a situation, the debate would be about how to mix and match the elements of what those states had done to extend coverage to all Americans, not whether to do so.

.....  
*The views expressed here are not necessarily those of the trustees, officers, or other staff of the Brookings Institution or the Heritage Foundation. The authors thank Alan Weil for many constructive exchanges on state involvement in health care reform. Henry Aaron thanks Patrick Healy for research assistance.*

## NOTES

1. On the proportion of the population uninsured by state, see U.S. Census Bureau, *Current Population Survey, 2005 to 2007 Annual Social and Economic Supplements*, “Percentage of People without Health Insurance Coverage by State Using 2- and 3-Year Averages: 2004 to 2006,” [http://www.census.gov/hhes/www/hlthins/hlthin06/percent\\_uninsured\\_state.xls](http://www.census.gov/hhes/www/hlthins/hlthin06/percent_uninsured_state.xls) (accessed 27 February 2008). On per capita expenditures by state, see A.B. Martin et al., “Health Spending by State of Residence, 1991–2004,” *Health Affairs* 26, no. 6 (2007): w651–w663 (published online 18 September 2007; 10.1377/hlthaff.26.6.w651). On regional variation in use of services, see *Dartmouth Atlas of Health Care*, <http://www.dartmouthatlas.org> (accessed 27 February 2008).
2. H.J. Aaron and S.M. Butler, “How Federalism Could Spur Bipartisan Action on the Uninsured,” *Health Affairs* 23 (2004): w168–w178 (published online 31 March 2004, 10.1377/hlthaff.w4.168).
3. The descriptions of state initiatives are drawn from recent developments and from M. Voris, “Leading the Way: State Health Reform Initiatives,” NGA Issue Brief (Washington: National Governors Association Center for Best Practices, 11 July 2007).
4. For an estimate of U.S. health expenditures, see S. Keehan et al., “Health Spending Projections through 2017: The Baby-Boom Generation Is Coming to Medicare,” *Health Affairs* 27, no. 2 (2008): w145–w155 (published online 26 February 2008; 10.1377/hlthaff.27.2.w145). For an estimate of the GDP of the United Kingdom and France, see Organization for Economic Cooperation and Development, *OECD in Figures: 2007 Edition*, [http://titania.sourceoecd.org/pdf/figures\\_2007/en/oif.pdf](http://titania.sourceoecd.org/pdf/figures_2007/en/oif.pdf) (accessed 27 February 2008).
5. For more details on how state plans could be constructed and approved, see Aaron and Butler, “How Federalism Could Spur Bipartisan Action.”
6. Each of the three draft bills introduced in Congress proposes such procedures. See, for example, S 325, the *Health Partnership Act*, cosponsored by Sen. Jeff Bingaman (D-NM), Sen. George Voinovich (R-OH), and Sen. Sherrod Brown (D-OH).
7. In addition to the bill cited above, the two other bills are HR 506, sponsored by Rep. Tammy Baldwin (D-WI) with twenty-seven cosponsors; and S 1169, sponsored by Sen. Russell Feingold (D-WI), Sen. Lindsey Graham (R-SC), and Senator Brown.
8. One bill, cosponsored by Senators Feingold and Graham, would have appropriated \$3 billion a year to assist states whose plans were approved. Another bill, cosponsored by Representatives Baldwin and Price, stipulated that state plans should not increase federal spending. And a third, cosponsored by Senators Bingaman, Voinovich, and Brown was silent on this issue.
9. The Baldwin legislation allows some averaging over time, as it requires budget-neutrality over five years rather than annually.
10. E.F. Haislmaier and N. Owcharenko, “The Massachusetts Approach: A New Way to Restructure State Health Insurance Markets and Public Programs,” *Health Affairs* 25, no. 6 (2006): 1580–1590.
11. Henry J. Kaiser Family Foundation/Health Research and Educational Trust, *Employer Health Benefits: 2007 Annual Survey*, Exhibit 10.1, p. 164, September 2007, <http://www.kff.org/insurance/7672/index.cfm> (accessed 31 January 2008).
12. The data refer to the average for the two years 2005–2006. Kaiser Family Foundation, StateHealthFacts.Org, “Health Insurance Coverage of Nonelderly 0–64, states (2005–2006), U.S. (2006),” <http://www.statehealthfacts.org/comparebar.jsp?ind=126&cat=3> (accessed 30 January 2008).