

How Far Can States Take Health Reform?

State-based health reform will achieve much more if it occurs in the context of a national strategy.

by Alan Weil

ABSTRACT: Expectations for state leadership in health reform have never been higher. States are thought to function as “laboratories of democracy,” but they do not fulfill this role effectively because insufficient attention is paid to experimentation and knowledge translation. Congressional proposals to encourage state action cover too narrow a span of state health policy, do not provide states with sufficient authority to tackle major health policy challenges, and supply insufficient funding. This paper concludes with a description of a more robust state-federal partnership that would be more likely to yield substantial health reform. [*Health Affairs* 27, no. 3 (2008): 736–747; 10.1377/hlthaff.27.3.736]

EXPECTATIONS FOR STATE LEADERSHIP promoting health reform have reached an all-time high. Four years ago, Henry Aaron and Stuart Butler set forth a compelling vision for how states could prompt action that has been elusive at the federal level.¹ Three congressional proposals designed to support state reforms were introduced in 2007 with bipartisan sponsorship.² Before the early 2008 primaries reduced the number of candidates, the leading Republican presidential candidates, more than their Democratic counterparts, carved out a substantial role for states in their vision for health reform.³

These various initiatives reflect high hopes for what states can accomplish and how far they can lead the nation in much-needed reforms designed to expand health insurance coverage, improve access to care, and address shortcomings in the quality of services. Comprehensive reforms adopted by Massachusetts in 2006 raised the possibility that what ails the health care system can be remedied state by state. Indeed, a recent compilation by John McDonough and colleagues identifies fifteen states that are discussing or implementing major health care reforms.⁴

Yet, as many have noted, the conditions in Massachusetts were more favorable for action than is the case in almost all other states.⁵ Comprehensive reform efforts, particularly in larger states such as California, Illinois, and Pennsylvania, remain out of reach. The sum total of states that have adopted comprehensive approaches to access, cost, and quality remains at three—Maine, Vermont, and

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Massachusetts—with no states added to that list during 2007.

This paper considers the promise and limitations of state-led health reform in the current environment. It then proposes an alternative approach in which states and the federal government work together to achieve more substantial change than either states or the federal government would be able to attain on their own.

A Shared Responsibility

The size and complexity of the U.S. health care system calls for both state and federal involvement in various governmental functions, including regulation, program administration, and financing. American federalism has been dynamic since the founding of the union, with the relative roles of the states and the national government changing over time and varying by domain. That dynamism has yielded more than two centuries of thought and debate regarding when roles should be assigned to each level of government.

Basic principles of federalism suggest the need for a strong federal role in certain circumstances. National uniformity promotes efficiency, while state-by-state variation can be costly for interstate actors. National standards minimize border issues and reduce the likelihood of negative externalities—letting the problems in one state flow “downstream” to the next. Higher levels of government are better able to redistribute resources because they can reach a broader tax base and need not be as concerned that businesses and taxpayers will flee to other jurisdictions.

Federalism principles also describe situations where there is a need for state and local involvement. A state role is warranted when circumstances vary around the country and when local values and preferences need to be reflected in public policy. State government can be more responsive to local conditions and adopt policies that are more closely tailored to those circumstances.⁶

The U.S. health care system has attributes that fall into each of these categories. Patients, doctors, and other health professionals routinely cross state lines. Pharmaceutical and medical supply companies operate in national and international markets, while many hospitals, nursing homes, and other institutions are owned by multistate organizations. Employers and insurance companies operate in multiple states. And extending coverage to those without health insurance involves redistribution of resources at the individual and regional levels.⁷ Meanwhile, health care markets, practice patterns, availability of health care services, and design of delivery systems all vary around the country. Decisions regarding the role and scale of government in financing coverage, design of benefits for public insurance programs, and willingness to regulate private markets all reflect values that vary from place to place.

Can States Lead Reform Efforts?

Despite its many strengths, there is overwhelming evidence that the U.S. health care system underperforms its potential along all major dimensions: access, qual-

ity, efficiency, and equity.⁸ How, within our federal system, can we create an environment with the greatest likelihood for improvement?

Theories of federalism say little about which level of government should lead the way when policy changes are needed. Federalism analysis is largely static: a certain level of government should play a particular role because it is more efficient or effective than another. Yet one of the most compelling federalism metaphors is dynamic. When people argue that states should function as the “laboratories of democracy,” state action is not viewed as an end in itself but, rather, as a mechanism for determining effective policy, which can then be adopted or rejected by other states or the nation as a whole.⁹

This pragmatic approach to federalism is compelling—but only if it accurately describes reality. If the nation is going to rely upon state laboratories as the favored path to solve what ails the health care system, we should consider whether the metaphor is apt and, where it falls short, what could be done to make it so.

Do States Function As Laboratories?

While states have accomplished a great deal with their reform efforts targeting access and quality, there is little about state health policy that resembles the conditions of a laboratory. Scientists in laboratories develop hypotheses, conduct experiments, collect and analyze data, and reach conclusions that are then applied to real-world conditions. State health policy development, by contrast, is episodic. Sometimes the spread of ideas is based on political trends that shift much more rapidly than the knowledge base that would support a policy shift. Examples can be found in state-level adoption of managed care regulation, regulation of the small-group insurance market, the wholesale adoption of managed care in Medicaid, and the growing application of cost sharing in public programs.

■ **Limited use of experiments.** Very few state health policy changes are studied using experimental methods. Despite the fact that Medicaid Section 1115 waivers are for the purpose of “research and demonstration,” these waivers are often granted primarily to enable states to make program changes with a very small research component. Indeed, the Deficit Reduction Act (DRA) of 2006 converted options that once required a waiver into authority to act without a waiver, despite the fact that no experiments have ever been conducted regarding the likely effects of many of the changes the DRA anticipates. For example, no experiments have been conducted on the effects of providing very-low-income people with scaled-back benefit packages; carving out Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefits from overall Medicaid coverage for children; or denial of services when enrollees fail to pay a copayment at the point of service.

The state of health care experimentation stands in stark contrast to the experience prior to the adoption of national welfare reform in 1996. With much federal funding and guidance, states truly experimented with their welfare programs in the early 1990s. Starting with well-defined hypotheses about the possible effects

of various changes in welfare policy—most notably, a shift away from supporting general skill development to requiring work upon enrollment—state policies were subject to random-assignment experiments in multiple locations with extensive data on outcomes collected over a period of years. These experiments led to a change in thinking about what made for effective welfare policies, and that new thinking was embodied in the new federal welfare law.¹⁰ There is no comparable story for state health policy.

None of this is to minimize the tremendous contribution to our understanding of health policy made by the large volume of high-quality health services research—much of it supported by private foundations. However, researchers are constrained in the methods they can use when the research endeavor is not built into the program design. The continued extensive reliance upon the twenty-five-year-old RAND Health Insurance Experiment (HIE) for evidence regarding the effects of cost sharing is a sign of how infrequently critical health policy topics are subjected to formal evaluation.¹¹

■ **Limited knowledge transfer.** The laboratory metaphor also implies the transfer of knowledge learned—either to shape national policy or to shape other states' choices. Here again, the metaphor is more powerful than the reality. The diffusion of policy innovations is slow and sometimes does not occur at all.

Federal health policy certainly learns from and follows state experiences. Medicare Part D, the prescription drug benefit, was enacted only after almost half of the states had developed pharmacy assistance programs.¹² But the learning ended there. Two key features of the federal law—the doughnut hole benefit design and the instantaneous enrollment of 6.4 million dually eligible (Medicare and Medicaid) enrollees 1 January 2006—diverge sharply from the lessons states learned implementing their programs.

The current impasse over the State Children's Health Insurance Program (SCHIP) also demonstrates the limitations of federal learning from state experience. SCHIP has been evaluated through a congressionally mandated study and a number of privately funded initiatives.¹³ By every criterion set forth in the original statute, the program is a success. Yet reauthorization of the program has been held up because of major ideological disagreements regarding the program's design. Thus, even in the best case, evidence from state experience does not necessarily pave the way for prompt federal action.

States frequently look to each other when deciding on their own policies. The Centers for Medicare and Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ) Office of Communications and Knowledge Transfer support a variety of evaluation and interstate communication efforts. Private foundations and dues-paying states support a handful of organizations that devote sizeable resources to promoting transfer of knowledge from one state to another. Unfortunately, the scale of these efforts does not match the number of natural experiments that varied state policies would permit. A recent analysis of

one area ripe for interstate learning—Section 1115 waivers—found little evidence of that occurring.¹⁴

Can Federal Policy Help States Lead?

In many areas of public policy, state action has spread nationally. Workers' Compensation programs were adopted by most states between 1910 and 1920, and the federal Social Security program emerged from state-level pension programs adopted by more than half of the states in the 1930s.¹⁵ By definition, since states have been working on health reforms for years, federal action will follow state action. But chronology is not causation, and in these examples there was no intentional national strategy to have states lead—they just did so on their own.

A series of recent proposals have as their primary goal supporting state reform efforts as a mechanism for achieving broader national reform. This is the Aaron and Butler approach and the subject of the three congressional proposals mentioned earlier. This approach is not new: it was also proposed in bipartisan legislation introduced after the demise of President Bill Clinton's health reform efforts, was endorsed by the Institute of Medicine as a way to transform the U.S. health care system, and was the motivation for a series of planning grants given to states between 2000 and 2005 by the Health Resources and Services Administration (HRSA).¹⁶

The current proposals touch all the right bases. Each anticipates a well-defined plan of action by each participating state, a robust data collection and analysis effort to learn the appropriate lessons, and an entity charged with taking the lessons and assuring that they are placed in the public domain and shared broadly. The changes they embody would likely help states move forward but fall short of what is needed, because they take too limited a view of experimentation, do not provide states with sufficient authority to pursue real reforms, and fail to acknowledge the critical role of federal financing as states develop their reform proposals.

■ **Limited view of experimentation.** Current congressional proposals include serious efforts to evaluate comprehensive state reforms. Unfortunately, the multifaceted nature of these reforms makes evaluation difficult. Comprehensive reform efforts include policy changes along so many interrelated dimensions that it is impossible to reach definitive conclusions regarding the effects of any particular component. The overall effect of reform may be measurable, but the results are nearly impossible to generalize to other states. We should certainly seek to learn as much as possible from the comprehensive reforms states adopt, but we should not expect clear findings that guide the nation to the best mechanism for achieving a better health care system.

If states are to function as laboratories, we need a broader conception of the lessons to be learned from experimentation and a larger investment in evaluation and dissemination. States are currently pursuing hundreds of policy changes with respect to coverage, quality, and cost containment, many of which are amenable to evaluation.¹⁷ A serious national effort to learn lessons from state activity would re-

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quire an investment in developing Medicaid data with the same quality and availability that exists for Medicare. It would require revitalizing the research and demonstration component of Section 1115 waivers and expanding the commitment to evaluation in all program waivers. An additional helpful step would be to move away from budget-neutrality as the guiding principle of waiver approval. A commitment to experimentation would include a willingness to spend money on ideas that might yield improvements along a number of dimensions other than short-term program spending.

To provide a sense of scale, consider the Assuring Better Child Health and Development (ABCD) project supported by the Commonwealth Fund and administered by the National Academy for State Health Policy. This project has the goal of identifying children at risk for developmental delays and improving child development services at the state level. The ABCD project worked with a handful of states to develop a small number of models that other states could use and adapt. The project has been effective in changing practice in one group of states and is now attempting to spread what has been learned across about half of the states.¹⁸ This intensive effort is changing one tiny corner of health care one state at a time at a cost to date in excess of one million dollars and with a timeline that stretches to almost a decade.¹⁹ A national strategy to learn as much as possible from all domains of state health policy would involve an investment that is at least two orders of magnitude larger than what the nation makes today.

■ **Insufficient authority.** Current congressional proposals are vague regarding what authority states might be granted to integrate federal programs into their reform strategies. They do not anticipate any changes to the Employee Retirement Income Security Act (ERISA) of 1974 and the barriers that law creates for state-based reform. Although it is possible to design state reforms that fit within the boundaries of current state authority, these boundaries foreclose a series of options.

States pursuing comprehensive health reform have come to learn that sustainable coverage expansions can occur only if they are pursued in conjunction with quality and efficiency improvements. Leading states are seeking to reform the health care delivery system, not just the financing system.

If states are to lead the way, they need to be able to engage the entire health care sector within their borders. Yet about half of a typical state’s residents are completely outside the reach of state authority when it comes to health care because they are enrolled in Medicare, have coverage through an employer that self-insures, or obtain services through the Department of Veterans Affairs, Indian Health Service, or other programs.²⁰ It is neither realistic nor necessary to give states full legal jurisdiction over all health programs that operate within their bor-

ders. However, states need a way to engage these other programs in broad-based efforts.

One helpful step would be to create a series of ERISA safe harbors—policies that states can adopt that would be defined in advance as permitted under federal law. ERISA explicitly bars some state action but also, because of its vague language, creates a substantial zone of uncertainty where state action may or may not be permitted.²¹ Safe harbors would be clearly defined as allowable state acts. For example, states should have the authority to adopt uniform “play-or-pay” strategies to finance broad-based coverage initiatives. States should be able to require self-funded employers to participate in premium assistance programs. And states should be able to mandate participation of all public and private payers in state-wide data collection and health system performance improvement projects.

These safe harbors would be quite different from the idea of “ERISA waivers” that representatives of the employer community have indicated are unacceptable.²² Waivers are just another form of uncertainty—for businesses and for states—and they grant excessive authority to federal program administrators. By contrast, carefully crafted safe harbors provide clear guidance and can be designed to avoid undue burden on multistate employers while also enabling true state experimentation.

States also need to be able to engage the portion of the health care system controlled by the federal government. Indeed, in one area long identified as requiring coordination—services for dual eligibles—the federal government has consistently been unwilling to engage with states in the kinds of innovation necessary to better coordinate services for this population.²³ Much of the hope for coordination now rests with Special Needs Plans authorized in the Medicare Prescription Drug, Improvement, and Modernization Act (MMA), but these plans are subject to only limited state regulation, making them essentially a federal overlay rather than a source of true integration with Medicaid.²⁴

Proponents of state leadership should be particularly wary of legislation that would shift individuals or groups into insurance products regulated by other states or the federal government. Whatever merits these ideas may have, they would put even more of a state’s health care system out of its reach, thereby impeding comprehensive state reform efforts.

■ **Federal funding.** Current congressional proposals demonstrate an ambivalence regarding the role of federal funding. While they generally seem open to reprogramming existing dollars, they are loath to put a large price tag on their bills.

States cannot pursue comprehensive health reform without substantial and reliable financial participation by the federal government. Medicaid provides a solid platform on which states can build, but coverage expansions are generally dependent upon waiver negotiations, which are time-limited and subject to much discretion on the part of the federal government. Some grand redistributive scheme might theoretically allow for the provision of insurance coverage to every-

one for the amount of money already in the health care system; however, this is not a realistic approach when limited to a single state.

If states are to serve as laboratories, they need to be afforded the resources necessary to achieve the high hopes we have for them. All credible national proposals for health reform come with a price tag. A serious state-based effort would have to build in a long-term financial commitment proportionate to the share of the problem the states are expected to address. In addition, a serious state-based effort would need to anticipate the challenge of providing quite variable amounts of money to different states, given the tremendous variability in the scale of the problem each state faces.

The Price Of State Leadership

Relying upon states to lead comes at a price for the nation, particularly if it is encouraged through a process of selecting volunteer states to pursue a range of comprehensive reform plans. This approach is likely to increase interstate variation in health indicators, at least in the short run and probably in the long run as well. We are a large and diverse nation. We tolerate and in some instances celebrate the tremendous variability in life circumstances that people experience—some of which depends upon where they live. There is no “right” amount of interstate variation, but it is important to acknowledge what exists and make judgments about whether more or less variation is desirable.

John Wennberg and colleagues have documented tremendous regional variations in medical practice.²⁵ A recent Commonwealth Fund report describes interstate variation across dimensions such as appropriate use of antibiotics to reduce the risk of infection during surgery and the incidence of deaths amenable to health care.²⁶ Variations across states in the share of the adult population without health insurance have existed for decades; in 2004–05, these ranged from a high of 35 percent in Texas to a low of 11 percent in Minnesota.²⁷

A desirable reaction to high levels of variation in health care—whether in how medicine is practiced, how much is spent on health care, or how the population ultimately fares—is to set national goals based on best practices. Policy efforts are then focused on raising the bar for everyone and reducing the degree of variation by developing strategies that bring those farthest behind closer to the front of the pack. Yet state experiments with health reform cannot be expected to reduce variation. Indeed, it seems more likely that states will build on their own successes, pushing the leaders farther ahead and leaving others behind. This pattern is demonstrated in Medicaid, in which the wealthiest states, despite receiving the lowest matching share of funding from the federal government, tend to have the most expansive programs.²⁸

At some point, the federal government might step in and raise the floor, forcing states to adopt higher minimum standards. Indeed, this is exactly what happened when the federal government mandated higher income thresholds for Medicaid

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coverage for children and pregnant women. But until that time, or in the event the federal government never decides to act, the gap between leaders and laggards grows. With all the evidence that exists to show the high level of variability across states, policies that increase the gap move the nation in the wrong direction.

The Risks Of State Leadership

It is possible that having a few states pursue serious health reform will help catalyze federal reforms, and it is likely that a few state success stories would do so. However, the strategy of putting states out front has some risk as well.

If we rely upon states to test bold strategies for reform but fail to give them the tools or resources to implement the reforms, we may conclude that certain policies are ineffective despite the fact that under the right circumstances they would perform quite well. We could easily draw the wrong conclusions from failures—blaming the overall strategy such as play-or-pay, a tax credit approach, or an individual mandate—rather than the specific circumstances facing the state. A series of state failures could even lead to the conclusion that “nothing works,” thereby motivating the nation to adopt more radical, untested changes that involve unnecessary risk.

It is also possible that a few state successes would become an excuse for prolonged federal inaction. Pushing the nation’s most pressing domestic problem onto the states gives federal politicians permission to avoid making the difficult decisions health reform requires.

Ultimately, the weakest link of the state leadership approach is its unrealistic view of federalism. It is no easier for Congress and the president to give states the authority and resources they need to do the job right than it is to get Congress and the president to agree on a health policy course for the nation. The most likely outcome is a marginal shift in power to states combined with outsize expectations for the state response.

Taking Federalism Seriously

A successful federalist strategy must be a joint venture. It would include a national commitment to universal coverage with much flexibility in how states achieve that objective. A national commitment would eliminate concerns states might have about becoming a health care magnet. Interstate issues regarding patients, payments, and the like would not go away, but they would be negotiated within a defined context that assured equal status among the states involved. A national commitment would also avoid the spectacle of states’ competing against each other for the privilege of being one of the few with the resources and author-

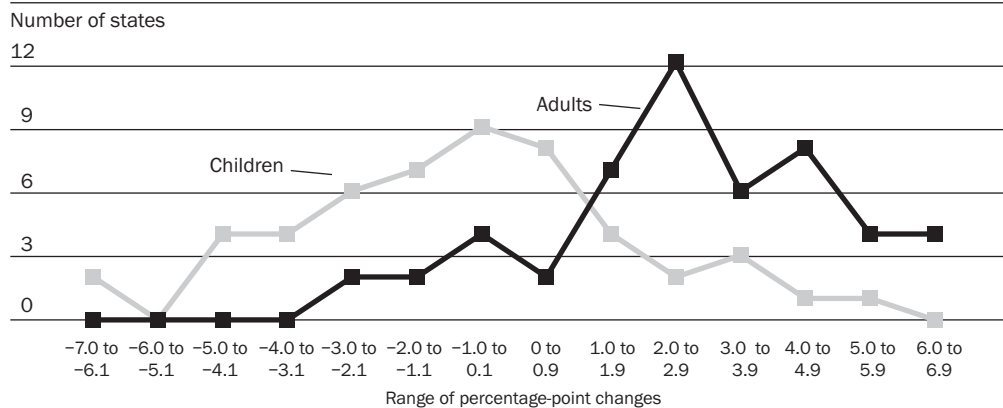
ity to meet the health needs of their residents.

The list of areas where an intentionally federalist approach could yield great results is quite long. It would include strategies to reduce medical errors, reduce unwarranted practice variation, engage consumers, develop pay-for-performance strategies, and more. For each topic, a national vision or strategy combined with a commitment to state action, evaluation, and spread could yield real progress in meeting our nation's many health system challenges.

For example, a federalist approach to comparative effectiveness research has great potential. Research on the comparative effectiveness of medical technologies, medical procedures, and drugs will yield much-needed information, but that information will not resolve the difficult policy and value choices that must be made regarding how resources should be allocated.²⁹ Examination of these choices should begin at the local and state levels, where such conversations regarding values are more likely to be fruitful.

■ **Importance of federal leadership.** There is a difference between hoping that states will solve a problem and developing a national framework within which states and the federal government each have clear roles designed to support a goal. This difference is illustrated in Exhibit 1, which compares the nation's progress (or lack thereof) in addressing the problem of uninsured adults as opposed to uninsured children. For adults, there is no national strategy. Indeed, Medicaid, which represents the nation's primary commitment to meeting the health needs of the poor, explicitly excludes adults from coverage unless they have a disability or have children living with them. For children, there is a national strategy. Despite some important exceptions and limitations, the combination of Medicaid and SCHIP extends cover-

EXHIBIT 1
Number Of States With Various Percentage-Point Changes In Uninsured Adults And Children From 1999–2000 To 2005–2006



SOURCE: Author's calculations from data supplied by the Commonwealth Fund derived from the Current Population Survey.
NOTES: The national percentage change for children was -0.8 percent; for adults, 2.8 percent. Adults are ages 18–64, and children are ages 0–17. The farther left on the spectrum, the larger the reduction in the percentage of people without health insurance; the farther right, the larger the increase.

age to almost all children living in families with incomes up to twice the federal poverty level (\$21,200 was the poverty level for a family of four in 2008). The contrast is stark: the nation has made progress covering children, while adults have lost ground.

It is one thing to provide states with a constrained set of policy tools and financial resources with the hope that states can develop and enact universal coverage proposals with greater success than Washington can. It is something else to adopt a coherent national strategy that defines state and federal roles with respect to addressing coverage, quality, access, and efficiency. The former is an act of desperation; the latter embraces the many resources states bring to the table and approaches the topic of health reform the way most people observe it—as an inter-related set of problems that must be addressed in a comprehensive way.

In the absence of federal action, states will lead, and states will accomplish as much as they can, given the constraints they face. States deserve support and encouragement in this role. But piecemeal state action will not add up to what the nation needs. A national response that honors the history of American federalism would include a series of national commitments that frame and support what states can do—indeed, what they are eager to do.

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NOTES

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