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CONGRESSIONAL TESTIMONY

Enhancing Federalism to Address Medicaid and the Uninsured

Testimony before
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Summary of Testimony

- Potential savings in Medicaid should be considered within the general goal of increasing coverage. And the key to achieving that goal is to explore new ways of using our system of federalism.

- Political polarization in Washington requires us to think of achieving legislative progress less in terms of building out from the center and more in terms of building in from each flank. An enhanced federalism strategy, such as that developed by Stuart Butler of Heritage and Henry Aaron of the Brookings Institution, recognizes this.

- Utilizing this approach involves the following core elements:

    - Congress establishes broad and measurable goals for increasing coverage while using funds more effectively, and protections or policy boundaries for vulnerable populations.

    - Congress enacts a "policy toolbox" federal reforms or programs that would be available to states, not required. The aim would be a "logrolled" toolbox package of federal initiatives and legislated waivers that represented the preferred options of liberals and conservatives as well as centrists in Congress.

    - States could offer innovative proposals to achieve the goals, utilizing selected federal toolbox items and state initiatives. An independent commission would select a slate of proposals that would be implemented, subject to an up-or-down vote in Congress for the entire slate.

    - Using the principle of pay for performance, states would receive funding according to an agreed timeline for achieving the agreed goals in the proposal.

- In the context of the current debate over Medicaid, the uninsured, and the federal budget, Congress should consider the following:

    - To the extent that there might be additional federal funds for increases in coverage, this money should be focused on a small number of creative federal-state initiatives rather than spread thinly over the entire nation.

    - Whatever changes Congress finally makes in the Medicaid program to comply with the Medicaid budget target, states should have the opportunity to propose creative ways of achieving those targets within the goal of generally

increasing coverage. Enhanced federalism offers a procedure to do that. The 1996 welfare reform legislation contained a similar structure – there was a "default" federal reform but states could propose alternative ways of achieving their intent of the federal reforms.

- There will be buy-in by the governors and the minority only if they believe the process for selecting state initiatives will be fair and balanced. That is why selections should be undertaken by a commission, not by the Secretary of HHS. But using a commission to choose a slate of state initiatives to reduce uninsurance, or to propose savings in Medicaid, requires the commission to be truly bipartisan – with voting representatives selected by governors, and by the congressional minority and majority.

- Large-scale demonstrations are often seen as the means of attracting "outlier" votes to win passage of legislation. The enhanced federalism approach uses large demonstrations as the centerpiece of legislation in order to test a range of innovative proposals.

- Rather than trying to establish a formula for how states would be rewarded, state proposals to the commission should include a "bid" regarding federal funds. If new federal funds were available for increasing coverage, then a federal funding request would be included as the bid. If the national funding goal were only to reduce federal costs in Medicaid, then the bid would involve net federal savings expected from restructuring programs within the proposal. The commission would engage in rounds of negotiation so that the final slate of proposals was in line with budget requirements.

- "Outlier" proposals from states, such as approaches based on a form of single payer model or a strong consumer-choice model, could be undertaken within a limited geographic area of for only certain categories of state resident.

Mr. Chairman, the states face a daunting budget challenge in maintaining existing service levels under Medicaid and other health programs, especially as education and other state obligations compete for limited resources. But it is also the states that face the immediate pressure to address the health needs of working-age Americans who lack insurance coverage. Yet budgets are also strained at the federal level. The result: states find themselves in a financial shell game with the federal government rather than involved in a process of constructively searching for a resolution. Meanwhile promising ideas that might lead to ways of organizing and delivering care more effectively and efficiently remain bottled up in Congress.

The current tension over Medicaid underscores the need to introduce a more creative and comprehensive approach; one that encourages both states and the federal government to seek ways of delivering the Medicaid promise at less cost while launching approaches that would reduce the general level of uninsurance. This can be done only by considering changes in Medicaid not in isolation but within the context of the goal of reducing uninsurance. And the key to achieving that goal is to explore new ways of using our system of federalism. If we were to do that we might trigger more creativity in the search for effective and efficient ways of reaching our health care goals and "unlock" promising approaches now bottled up in Congress. Yet even if the immediate goal is narrower – achieving net savings for the federal government – the same approach would achieve that goal with less disruption to those currently covered by Medicaid, and perhaps in some states an increase in Medicaid or equivalent coverage.

The Environment for Improving State-Based Coverage

There are several reasons why the prospects today are generally considered to be unfavorable for bold and fresh initiatives on health care for working age Americans. Among the most important:

1) Absence of Political Enthusiasm

Wile many Republican lawmakers and leaders have offered health proposals with great enthusiasm, it is still fair to say that health care does not rank as highly with Republicans as it does with Democrats, in terms of budget priorities or political urgency. There is also reluctance among Americans to the idea of significant new health programs. Survey analysis by Robert Blendon[1] and Daniel Yankelovich, among others, indicates this ambivalence among the public. While Americans express the desire to address uninsurance and related health care problems for working-age households, and they are concerned about the continuity of their own coverage, they not yet willing to accept what experts see as the necessary tradeoffs. In particular, Americans today are unwilling to accept the argument that major additional resources are needed to address the goal of reducing uninsurance.

[1] Robert J. Blendon, John M. Benson, and Catherine M. DesRoches, "Americans' Views of the Uninsured: An Era for Hybrid Proposals," *Heath Affairs*, Web Exclusive, August 27, 2003

2) Political Polarization

Polarization in Congress is another obstacle. The heightened political partisanship in recent years makes the prospects seem especially bleak for progress on health care. In particular, the traditional vision of "build-out-from-the-center" bipartisanship is far less tenable today. The cadre of conservative Democrats and liberal Republicans that once led on health care has shrunk considerably. Today's partisanship means that many congressional health initiatives have a more pronounced ideological aspect to them. But these tend to languish in Congress. Partly this is because of partisan opposition. But partly it is because proponents of more ideological proposals are less open to winning passage by accepting "watered-down" versions that lack key but controversial component, because they fear these might fail and cast doubt on the original idea. So all too often today, congressional "debate" consists of presenting dueling computer simulations of ideal proposals rather than crafting compromise bipartisan legislation.

Reasons for Optimism

Despite these obstacles to broad action on health, there are some trends that suggest there may be possible ways of achieving progress in this environment.

1) Republican interest in state experimentation

Republican support for state experimentation, through waivers, does mean that diverse approaches could be tried if these are proposed by the states – albeit within the limitations of statutes and Administration political priorities. Such openness to state experimentation means that proposals that would not make it through a polarized Congress if they were advocated for the whole country could perhaps be tested in the field within one state.

2) Bipartisan support for individual health care subsidies

While debate continues about the design and eligibility for refundable tax credits for health insurance, there is still broad bipartisan support for the idea. This represents an important commitment by Republicans as well as Democrats for direct subsidies to enable families to afford coverage. Since federal tax credits could be used in tandem with other approaches, including state-based initiatives for insurance pooling or Medicaid and SCHIP changes, this commitment could make possible an array of possible federal-state partnerships.

3) Wide support for insurance pooling, reinsurance and risk-adjustment

There is also broad bipartisan support for spreading the cost of high risk individuals across wider populations, meaning that there is the potential to craft an insurance infrastructure that makes coverage affordable (with some subsidies) to all income and risk groups. Such ideas range from Senator Kerry's federal reinsurance proposal, to state-sponsored high-risk pools, to risk-adjustment system systems, to Bush-supported health associations for small businesses and non-business associations. To be sure, there are intense policy disputes about which approach is best, and what the practical consequences of rival proposals would be, but these are "engineering design" arguments rather than a dispute about the principle of spreading risk beyond merely employment-based pools.

4) Some openness to modifications of low-income support programs

There is also an increasing willingness to contemplate a variety of novel ways of fulfilling the purposes of Medicaid/SCHIP – providing the eligibility of individuals is maintained or widened and equivalent services are provided in a manner that assures quality and continuity. One way to do this, for example, might be to use a portion of the existing Medicaid budget for an individual, in combination with a federal refundable tax credit, to enable that individual to enroll in employment-based coverage instead of Medicaid. This would free up the remaining Medicaid money to fund part of the cost of the coverage for another individual. Or a federal tax credit might be used by a family to "buy into" Medicaid, or in combination with some Medicaid funds to purchase private coverage through a state-sponsored pooling arrangement. Proposals from the National Governors Association argue that we should consider giving at least some individuals on Medicaid the option of using a federal refundable credit for private insurance.

Using Enhanced Federalism to Achieve Progress With Limited Dollars

An enhanced approach to federalism is likely to be the most effective way of moving forward in this checkered environment, by circumventing political obstacles at the national level and enabling creative and potentially more efficient proposals to be tried. While the idea of state demonstrations and waivers is of course not new, permitting more sweeping state initiatives – particularly federal legislation that would also make new and modified federal programs available in state experiments – could break the political logjam that impedes action today.

A version of enhanced federalism has been laid out by this author and Henry Aaron of the Brookings Institution.[2] To summarize the Aaron-Butler approach:

> "We propose that Congress provide financial assistance and a legal framework to trigger a diverse set of federal-state initiatives. To help break the impasse in

[2] Henry J. Aaron and Stuart M. Butler, "How Federalism Could Spur Bipartisan Action on the Uninsured," *Health Affairs* Web Exclusive, March 31, 2004

> Congress over most national approaches, we propose steps designed to enable "first choice" political ideas to be tried in limited areas, with the support of states and through the enactment of a federal "policy toolbox" of legislated approaches that would be available to states but not imposed on them. Our view is that elected officials would be prepared to authorize some approaches now bottled up in Congress if they knew that the approach would not be imposed on their states."[3]

The Aaron-Butler vision of enhanced federalism contains the following core elements:

Goals and protections: Congress would establish broad and measurable goals for federal-state initiatives, such as reducing the percentage of uninsured in a state. Goals could incorporate quality as well as quantity: many lawmakers and organizations, as well as the National Governors Association, advocate initiatives to improve the quality of health services and coverage as well as broadening coverage. Congress would also place some protections or boundaries on what would constitute success. These boundaries would include some definition of what constitutes adequate "coverage" and specify any groups of Americans that should in general be held harmless by any initiative (e.g. some mandatory populations currently covered by Medicaid or some categories of workers covered by employer-based insurance).

A "policy toolbox" of federal policies and programs: A major reason for gridlock today is that a Member of Congress who opposes introducing a certain approach in his/her state will block a national initiative that would have that result. This tendency is accentuated by the increased partisanship in Congress (where ideological opposition becomes more of a factor). Ironically, since many states have developed their own initiatives to improve coverage, there is also the fear in some states that Washington's 'heavy helping hand' would disrupt these initiatives.

The idea of a "policy toolbox" is that instead of imposing new or changed programs on the entire nation, a package of congressional measures that would be blocked if designed to apply nationwide is instead made available only to states wishing to utilize the measures within a federal-state initiative. Items in the toolbox would be available to states, but not required in any state without its permission. Politically this encourages a productive form of what one might call "ideological logrolling", with left-right partisans agreeing to support each other's policy tools in order to achieve the chance to field-test a reasonably pure version of their own proposal. An important political feature of this approach is that these ideological lawmakers in both parties would be a countervailing pressure against the general tendency of Congress to micromanage bipartisan health care agreements.

Examples of proposals that might be legislatively unlocked in this way include some form of health association (perhaps with agreed exemptions from state mandates rather than federal preemption); permitting new populations to be covered by the FEHBP and VA programs or some equivalent arrangement; providing a large tax credit for

[3] Op. cit.

coverage; expansions of permitted Medicaid populations or utilizing Medicaid funds to enroll individuals in other forms of coverage to achieve net savings; insurance reform to create statewide, risk-adjusted pools; and extending tax benefits to employees picking certain plans not sponsored by their employer.

State proposals with federal approval: A state wishing to take part in this enhanced federalism would prepare a formal proposal to make progress towards the goals established by Congress. Such proposals would select some items from the federal policy toolbox in tandem with state initiatives designed to make progress towards the proposal's goals. A procedure would be established by the federal legislation for choosing proposals to implement, negotiating necessary administrative waivers to 'fine-tune' each proposal, collecting data, and monitoring performance. Proposals would be approved for a specific and standard period, say five years – although proposals might be approved for longer periods if they involved large changes in programs or health arrangements in a state.

Funding linked to goals: The principle for rewarding success would be "pay for performance." To the extent that new funds were made available, states would receive money if they succeeded in extending coverage or meeting related goals, and nothing if they did not. If the proposal were to require the use of federal funds from other programs to achieve improved coverage while meeting a goal for federal savings in, say, Medicaid, then federal funds would be released in line with the achievement of agreed milestones in expanding coverage.

Crafting A Viable Legislative Proposal

The devil of any approach to build momentum for health care legislation lies of course in the political and technical details. Within the general framework of enhanced federalism there are several key design issues that would have to be resolved. How one does resolve them depends as much if not more on political judgments as on technical considerations.

1) Federal funding goals – net savings or net increases

The Aaron-Butler approach envisioned a pool of new federal money for reducing uninsurance. Hence the assumption was that state proposals would vie for available new funds. But the same approach is adaptable where the federal funding objective is to achieve reductions in the growth of a program, such as Medicaid. In that case the state proposals would be designed to meet the reduced federal budget allocation for the state in a manner that had the least impact on state residents currently with insurance or Medicaid coverage – and perhaps even achieved net savings in innovative ways that actually increased coverage.

2) The number and scale of state initiatives – the need for focus and ideology

Budget and political trade-offs are inextricably linked in determining the ideal number and scale of the state initiatives. In today's environment it is wiser to assume that the available budget for health initiatives (likely to be modest) will determine the technical and political design of the approach rather than assuming the design will determine the federal budget. The presumption here is that pool of available resources would include some existing funds or proposals already on the budget table. The pool thus might include part of any reserve fund created to finance President Bush's initiative on the uninsured, a portion of projected savings from Medicaid, perhaps some portion of federal funds for uncompensated care (matched with additional federal funds), as well as some new funds.

Whatever the available funds, there are political tradeoffs in selecting the number and size of state proposals. Proposing to spread funds broadly but thinly over many states might seem attractive to gain the support of more states, but then each individual state would see less of a funding incentive to support the idea. However the flexibility and availability of new federal programs would be powerful incentives to support the approach even without the prospect of major new federal funding. The critical test for a state would be whether the combination of flexibility in using existing and new federal funds, combined with the opportunity to undertake launch a creative initiative with the federal government to expand coverage, proved sufficient to warrant the political and other risks involved. That is an empirical rather than theoretical question.

The ideological dimension of possible initiatives plays into the possible calculation at both the congressional and – perhaps to a lesser degree – at the state level. The opportunity for congressional partisan supporters of what one might call "paradigm" ideas to see them truly tested in the field likely would make supporters inclined to focus new federal funds on a small number of state initiatives – although there could be other initiatives primarily using existing program funds in creative new ways. To be sure, there might seem to be little incentive for states as a whole to support an approach that concentrates new federal money on a few states. But a governor who supports a paradigm approach (such as a significant expansion of Medicaid, or large tax-based subsidies to individuals) might well be open to another state receiving federal funds if that could lead to a convincing demonstration of the approach and its subsequent availability to all states.

Initiatives and modest new federal funds could also be focused on proposals to cover less than an entire state, assuming the scale of the experiment reached a critical mass. This option could build political support among states. For instance, for a certain level of funds, several large states could have funded proposals limited to certain counties, rather than using the funds for only one statewide proposal. Moreover, cross-border joint proposals covering metropolitan or rural areas could generate broader state support.

3) Selecting successful state initiatives – a bipartisan, full-voting "base closing commission"

An approach that involves selecting a limited number of federal-state initiatives from competing state proposals raises obvious political challenges, especially where there is an ideological dimension to some proposals and there is new federal money. In particular, how could we secure broad political support for the approach – especially from the minority party in Congress?

It seems very unlikely that many minority party Members of Congress or states could be persuaded to support legislation that allowed the Secretary of Health and Human Services (HHS) to choose among competing state proposals that could mean large changes in state health systems – including perhaps Medicaid and SCHIP. The reluctance of Democrats and governors to join the recently enacted Medicaid Commission underscores the political dangers of making the HHS Secretary in any administration the gatekeeper for recommendations.

The key to generating wide political support is a process for selecting initiatives that is considered fair and balanced by everyone. This cannot be achieved if the Secretary of HHS makes the final selection. In the article authored last year by Aaron and Butler, we emphasized that these decisions had to be made by an independent body that was truly bipartisan, with the decisions certified by Congress. We recommended a newly created commission with full voting members selected by Congress, the Administration and the states, perhaps with technical advice from the General Accountability Office. States would submit formal draft proposals to the commission to evaluate. These proposals would include federal toolbox items as discussed below. The commission would discuss and negotiate the elements of the proposal with the state, to assure that it met the congressional guidelines and complemented other state proposals. The commission would then present a recommended "slate" of proposals to Congress for an up-or-down vote without amendment. The HHS Secretary's role would be restricted to negotiating final administrative details with the successful states. This is essentially a "base-closing commission" solution.

The legislation setting up this procedure would essentially instruct the commission to come back with a slate that complied with certain guidelines. The legislation would set the total federal budget limits for the slate. Rather than giving the commission *carte blanche* to select the slate, the legislation might require the commission to include certain categories of paradigm state proposals envisioned in the federal policy toolbox and reflecting the ideas favored by congressional constituencies that were key to bipartisan support. So the commission might be directed to include at least one proposal to expand Medicaid and/or SCHIP, and an equivalent of large individual tax credits or vouchers and purchasing pools, among other proposals. While any directions from Congress can easily degenerate into micromanagement and the inclusion of pet demonstration projects, the political need for strong advocates of paradigm proposals to be assured of seeing a valid, "clean" demonstration of their proposal could mean a degree of *détente* when it came to adding excessive requirements.

A variant of the Aaron-Butler commission idea would be for the commission to propose a slate to the Secretary. But in this case, governors and Members of Congress from both parties would have to feel confident that the members of the commission had such political stature and bipartisanship that, politically, the Secretary could not ignore the slate of recommendations. The 1982 Social Security commission and the recent 9-11 commission are examples of how a politically powerful commission can build momentum for its recommendations.

4) Designing the federal policy toolbox – symmetry and logrolling

The federal "policy toolbox" described earlier is a key part of an enhanced federalism approach, both politically and technically. From a policy perspective, the toolbox is important because it provides a major federal policy dimension to complement state initiatives to improve coverage. Items in the toolbox can be seen in some cases as new or expanded federal programs that would be available in selected states, and in some cases as statutory waivers – or 'super-waivers' – to permit significant variations in existing programs and the use of their funds.

Today is it fairly common to include a limited demonstration program in a larger piece of legislation when the political support of a group of lawmakers is necessary for passage but others would balk if the program were applied nationwide. For example, when it was clear that introducing vigorous competition into Medicare as part of the recent drug legislation could cost critical Republican votes and doom the bill, the leadership included it instead as a demonstration program. This was enough to retain conservative supporters but left Republican as well as Democratic opponents secure in the knowledge that the competition initiative would not apply to their states.

The toolbox idea converts such demonstrations from a minor political necessity to retain lawmakers in a coalition to a core logrolling strategy to build a bipartisan majority for radical state-based initiatives.

To accomplish logrolling there has to be symmetry so that ideological members of each party could support the package. Thus it would be important to assemble pairs or groups of proposals that would appeal to a broad ideological spectrum, balancing philosophy and the allocation of funds. For instance, costly expansions of Medicaid or SCHIP might be balanced in the toolbox with a similarly funded refundable tax credit or voucher (designed to mimic a tax credit); a health association program might be balanced with a government-led health alliance; opening up the FEHBP in some way might be balanced with a VA-like single-payer option. The federal toolbox would be hammered out in Congress and enacted before the states and the commission considered proposals.

5) Protections and boundaries – guidelines with flexibility

Creating a bipartisan coalition necessitates assuring key constituencies and lawmakers that they can acquiesce in radical changes they do not support because they can be sure that certain principles will be protected and certain lines will not be crossed.

Like other requirements of a bipartisan agreement, it would not be easy to agree on these protections and boundaries. But supporters of innovative and ideological initiatives would know their own ideas would be blocked if they were unreasonable about demanding detailed protections for other proposals.

One such protection or boundary issue concerns the very definition of "coverage," or the meaning of "insurance." The amount of family financial exposure before comprehensive insurance reimbursement (or government provision) kicks in is one area that would need to be resolved satisfactorily for all sides, as would the nature of benefits that constitutes "insurance." The Aaron-Butler proposal recommended setting an actuarial minimum and allowing wide variations in state-required benefits. States would be free to design plans with different benefits at or above that minimum, including high deductible insurance plans with perhaps partly funded health savings accounts.

Some level of protection for individuals already covered would also have to be resolved (particularly those in Medicaid or state programs, and those in most employer-sponsored plans). Achieving the goal of a decrease in uninsurance by dropping high-cost individuals and replacing them with a larger number of healthier people probably would not pass muster. Aaron-Butler proposed no reduction in the degree of coverage for currently insured populations, most notably those in Medicaid – though it would not rule out major changes in Medicaid. A state could provide the functional equivalent of Medicaid, for instance, by utilizing a tax credit in combination with a federal tax credit or voucher to enable some currently on Medicaid to enroll in an employer-based plan or individual coverage (perhaps within a statewide pool). But even with reductions enacted in the growth of Medicaid, there could be protections included for certain populations covered by the program. However the coverage protection issue was resolved, it is critical for the overall political and policy success of enhanced federalism that Congress set only broad guidelines.

6) Determining and rewarding success – trust but verify

Another difficult issue is how to determine what constituted success in a state initiative and how success should be rewarded.

Rather than setting out detailed objectives for proposals, the essence of enhanced federalism is for Congress to establish only broad goals for the improving the degree and quality of coverage. How a state envisioned the goal and sought to reach it would have to be agreed with the federal government within the guidance of the statute. The state proposal would need to contain a timeline of targets and outcome measures. If a commission were to select a "slate" of proposals for federal approval, that would be an additional assurance that the state's interpretation of the goal was reasonable, and its plan and timeline realistic.

But how to agree on and verify success, particularly if that triggered a federal financial bonus for a state? On the other hand, what if the funding objective of the

federal government involved achieving a reduction in the baseline cost of Medicaid? What elements would have to be in the equation?

One element is an agreement on information. To the extent that certain base information on coverage was needed to confirm progress, Congress would be wise to include funding for appropriate surveys and data collection. Standard data collection methods across state lines would be essential, especially with some funding contingent on success in reaching goals, to avoid disputes between states and with the federal government. A state's willingness to assist in the collection of data could be a factor in selecting proposals for implementation.

Another element is an agreement on who decides success or failure. One of the lessons of the experience with state welfare reform demonstrations prior to the 1996 reform legislation was that the state and the federal authorities agreed to third party measurements of results. Similar "arbitration", conducted rigorously by an independent body, would be critical to the willingness of states and the federal government to agree on a plan and on whether there was adequate progress. Third-party assessment also would reduce the need for detailed and standardized measures to be agreed nationally or placed in legislation; instead the details would be agreed between the three parties. The state and the federal government would jointly select the third party assessing progress for each proposal. This might be a private analytical organization. It might also be a federal agency, such as the GAO, or even a state body if the selection was agreeable to both parties.

A third element is an agreement on the allocation of federal funding or the use of some portion of savings. New federal funding is not the heart of the enhanced federalism approach – the most important feature is freedom and flexibility in design and use of existing funds to reach agreed goals, which might include savings in a program such as Medicaid. But some federal funding to offset evaluation and design costs and provide bonuses for success likely would be needed to induce states to offer major proposals. And federal funds would be appropriate where a proposal hinged on creating or expanding a program that had a federal component (such as Medicaid) or that incorporated a federal initiative (such as a refundable federal tax credit). On the other hand, elements of the state proposal could be designed to save federal funds, with some portion of the savings reprogrammed into initiatives intended to increase coverage.

Bidding for federal dollars. Perhaps the least attractive way of allocating any new federal funding would be through a strict allocation formula tied to congressionally determined performance standards. That would invite damaging formula fights. But can that be avoided? A way to do so might be through the selection process for the commission's slate of proposals. Let's say the individual states put in an initial public "bid" to the commission, indicating the degree of federal funding it felt was needed and fair to accomplish the proposed goal, bearing in mind the total funding available under the program and the congressional guidelines. The proposal would perhaps focus on reducing uninsurance among particular groups, such as children or older workers, and the financing bid would reflect the targeted population. With a set of proposals containing

bids for federal funding before it, the commission could engage in successive rounds of discussions or negotiations with states to produce a final set of recommended proposals within the total budget. Through such a bidding procedure and negotiating rounds, the process would produce funding formulas agreeable to the chosen states.

A successful bidding "market" of this form could be an alternative to the daunting task of trying to develop a federal funding formula adjusted for regional differences, categories of individuals newly covered etc. And even if it were thought that a nationwide funding formula would ultimately have to be created, a bidding market of this kind would produce a "market-tested" outline for such a formula.

This is actually less radical than it may seem. In reality most large federal grant programs operate a little like a bidding market – just not one as structured as proposed here. For example, when a city develops a proposal for a federally supported mass transit system, it requests a certain level of federal dollars to achieve a certain result – much as recommended here for a set of state proposals. Moreover, the city typically structures the transit proposal not just in the context of the program's budget allocation but also based on its knowledge of other city's bids under the program.

Would states propose only initiatives that involved large infusions of federal money under such an arrangement, to maximize out-of-state funding? Would states avoid initiatives that expanded coverage primarily by using existing funds more creatively? Perhaps. But the federal government would have the opposite incentive and so a balanced commission would have an inclination to give strong consideration to proposals that did not require heavy federal funding. Indeed a state might include a larger bonus within its bid as "profit" for a proposal that sought to reduce uninsurance at relatively low federal cost.

Perhaps the additional bonuses for reaching or exceeding goals – as opposed to the release of federal funds associated with direct costs – could be linked to a congressional formula based on goals for particular political groups. But those bonuses would be relatively small and less likely to spark the level of congressional heat that accompanies major federal commitments to programs like Medicaid.

Bidding for savings. The same bidding model can be adapted for a situation in which the federal funding objective is a reduction in projected outlays for Medicaid or another program. The aim in that case would be to craft a proposal to meet a federal funding target for the state in ways that kept reductions in coverage to a minimum or actually increased coverage. The analog is the welfare reform legislation of 1996. Whatever "default" changes are put into place, the state would be able to propose an alternative method of reaching the same goals. Thus a state could propose changes, including utilizing items from the federal toolbox that achieved the same savings in a number of ways – for example, by inducing employers to enroll workers or dependents who might otherwise be eligible for traditional Medicaid. In some instances those methods of reducing Medicaid costs might include new federal outlays for other forms of coverage (e.g. refundable tax credits), such that the net federal outlays for the state met

the target for Medicaid. In this case the bid would involve a request for increased funding elsewhere to achieve larger Medicaid savings (with the net federal outlays meeting the goal for Medicaid).

7) Designing outlier proposals – the art of the possible

The more radical the proposal being considered by a state, the more disruptive it would be to existing arrangements and thus the more politically challenging. A statewide single-payer initiative, for instance, would mean closing down all employer-sponsored plans. A pure consumer-choice individual market initiative would mean suspending Medicare and the VA system within state borders. Clearly this is not likely to be accepted in the foreseeable future in Congress or in any state.

But the objective of testing the more radical ideas favored by the left and the right could in some instances be achieved by limiting the population involved and so reducing disruption and political opposition. The critical thing is to have an initiative that is seen by supporters as a true test of the idea, not necessarily a statewide initiative covering everyone. So a state might design an initiative approximating a single-payer system while exempting ERISA plans, perhaps with a proposal to make Medicaid or VA coverage the only state-approved coverage for the non-ERISA population in some counties. Or another state might propose federal-state vouchers for all the non-elderly and non-ERISA population in a few counties or statewide in order to test the functional equivalent of a refundable tax credit.

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