HOT TOPIC: Health Care

Cutting Costs In Medicaid

Health Care Reform 101

Affordable Care Act: A Tale of 3 States

What to Do About Cost Drivers

“I’ll know we’ve made the best decision for Arizona based on the overall wellness of our citizens and the health care system in our state.”

Arizona Gov. Jan Brewer
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ON THE COVER
Arizona Gov. Jan Brewer has made no secret of her opposition to the Affordable Care Act. But after the U.S. Supreme Court ruled the law constitutional, she and her team carefully considered the options to expand Medicaid and to operate a state-based health insurance exchange. She ultimately decided to support the first, but forgo the latter.

Photo by Lance Eldert Photography

MAY/JUNE 2013

12 HOT TOPIC—CONTAINING COSTS
With estimated U.S. health care spending expected to be about $2.8 trillion this year, states are doing what they can to contain costs. That’s partly because of the costs of Medicaid, which totaled—between state and federal spending—$407.7 billion in 2011.

22 HOT TOPIC—GUIDE TO HEALTH REFORM
Here’s what you need to know as the Affordable Care Act speeds toward full implementation in 2014.

30 HOT TOPIC—COMMUNITY HEALTH CENTERS
Many Americans who will join the ranks of the insured next year likely will be looking at federally qualified community health centers for care. Find out how four health centers are preparing for health insurance expansion.

42 HOT TOPIC—GUN LEGISLATION
After last year’s deadly shooting at a Connecticut elementary school, 22 state legislatures considered new assault weapons bans; 23 states introduced bills on magazine capacity; and 23 states sought to expand mandatory background checks.
CONTAINING COSTS
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GUIDE TO HEALTH REFORM
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ACA CHOICES FOR STATES
Two of the most visible parts of the Affordable Care Act—expansion of Medicaid programs to 138 percent of the federal poverty level and implementation of health insurance exchanges—have drawn mixed responses from the states.

COMMUNITY HEALTH CENTERS
Many Americans who will join the ranks of the insured next year likely will be looking at federally qualified community health centers for care. Find out how four health centers have been affected by the Great Recession and how prepared they are for health insurance expansion.

FEDERALISM
Stephen McAllister, the solicitor general of Kansas, discusses what happens when states object to federal law. He points out that the basic issues of pre-emption apply when state and federal law both operate on the same subject matter.

GUN LEGISLATION
After last year’s deadly shooting at a Connecticut elementary school, 22 state legislatures considered a new ban on, or restricted access to, assault weapons; 23 states introduced bills on firearm magazine capacity; and 23 states sought to expand mandatory background checks.

HEALTH CARE REFORM
Matt Salo, executive director of the National Association of Medicaid Directors, says states are saving money by moving away from the traditional fee-for-service, both as a delivery model and as a payment incentive.

MEDICAID SAVINGS
An estimated 443,000 people die each year from smoking-related illnesses, and smoking costs the U.S. $96 billion in direct medical costs and $97 billion in productivity each year. States have raised taxes on cigarettes in an effort to cut smoking rates.

GOV. JOHN KITZHABER
Oregon Gov. John Kitzhaber says for the Affordable Care Act to be successful, states must change the delivery model for health care.

EXPERTS SHARE THEIR THOUGHTS ON THE BIGGEST HEALTH CARE COST DRIVERS IN THE COUNTRY AND WHAT STATES CAN DO TO ADDRESS THEM.

MAINTAIN A WORK-LIFE BALANCE
Kentucky Rep. David Watkins, a physician, has seen health care up close and personal. He sees some positive steps toward cutting costs in the Affordable Care Act, but is left scratching his head on other parts of the law.
Leadership is the Best Medicine

While health care is an important part of determining a nation’s health, it is only one factor and not the most important. While the U.S. ranks first globally in per capita expenditures on health, we rank 38th in the world for health outcomes. As I see it, leadership is the single most important resource needed to improve the health of our nation. In state after state, leadership is being marshaled to create change and enhance health—by focusing on more than just health care.

Our genes and biology account for 10 to 15 percent of an individual’s health, health care accounts for about another 15 to 20 percent with the balance being determined by many social conditions and life experiences. These social determinants help dictate health outcomes and today’s leaders are beginning to understand that addressing these circumstances is necessary to enhance the health of Americans.

Research has demonstrated that the longer people live in disadvantaged circumstances, the more likely they are to suffer from a range of health problems, particularly cardiovascular disease. Poor social and economic circumstances affect health throughout life. People further down the social ladder usually run at least twice the risk of serious illness and premature death as those near the top. Poverty and social exclusion increase the risks of divorce and separation, disability, illness, addiction and social isolation, and vice versa, forming vicious circles that deepen the predicament people face.

A good diet, a steady and safe food supply, and physical activity also are central to promoting health and well-being. Cycling, walking and the use of public transport promote health in four ways. They provide exercise, reduce fatal accidents, increase social contact and reduce air pollution.

Education also contributes to health. The statistics that document this fact are compelling. College graduates can expect to live at least five years longer than individuals who have not finished high school. The infant mortality rate among children born to women who never graduated from high school is nearly double that of women with college degrees. These are troubling outcomes considering 46 percent of adults over age 25 have either not completed or pursued education beyond high school.

You can see why leadership is needed if we want to improve the health of our nation.

When state leaders work to create jobs, eliminate poverty and enhance access to educational opportunities, healthful food, early childhood education and public transportation, they are health care leaders. By creating healthy places to live, work and play, they are positively impacting the social determinants of health in their states.

Much of the political debate in health care over the last generation has focused on reforms to the health care system. While most of us would agree the status quo is not sustainable or desirable, many would disagree on the path of reform. But if we look at health in a broader context and consider what truly must be done to improve the health of our states and nation—areas of consensus quickly emerge. The Council of State Governments works with our members—the states and territories of the United States—to discover promising approaches and identify best practices in public policy. Our wide-ranging expertise at both the regional and national level allows us to serve as a trusted convener of state leaders. We believe a robust dialogue among state leaders has and will continue to provide pathways for effective change. We are committed to energizing such discussions and working with state leaders to find solutions to the health challenges facing the states.

In this issue of Capitol Ideas, we feature the stories of many state leaders who are dedicated to improving the health of their state. I particularly like the innovations occurring in Oregon under the leadership of Gov. John Kitzhaber. He is featured in our 10 Questions interview. Prior to becoming a politician in Oregon, he was a practicing physician. First elected to the Oregon House of Representatives, Kitzhaber served in the Oregon state Senate for 12 years, eight of them as Senate president. In 1994, Kitzhaber ran for governor, winning comfortably. He was re-elected in 1998 by a wide margin. After completing his second term, Kitzhaber returned to medicine and campaigned for better public access to health care. Kitzhaber successfully ran for a third term in 2010. He is a health leader and a public servant who is making a difference.

Quality health care is important, but education, transportation, economic status, social integration and good nutrition are even more essential to our health. Yet, in the absence of leadership, the U.S. will continue to lag behind many other nations in the world when it comes to health. If we want to improve the health of our nation, leadership is just what the doctor ordered.
“Individuals, families and small businesses will be able to get **quality, affordable health coverage** that saves them money and fits their budget.”

—Minnesota **Rep. Joe Atkins** about the launch of the state-based health insurance exchange known as MNsure, in a March press release on the website of Gov. Mark Dayton

“They definitely did not envision this many **federally run exchanges**. It was considered a **fallback**.”

—**Caroline Pearson**, vice president at Avalere Health LLC, a health care research company, as quoted in *The Washington Post* in March

“They said it

"**Medicaid expansion** is a misguided, and ultimately doomed, attempt to **mask the shortcomings** of Obamacare.”

—Texas **Gov. Rick Perry**, on the portion of the Affordable Care Act that allows states to expand Medicaid up to 138 percent of federal poverty level, as quoted on *CNN.com*

“It’s pretty much around the uncertainty or the unknown of **what’s to come**.”

—Maryland **Lt. Gov. Anthony G. Brown**, discussing the public’s feeling of general anxiety over the Affordable Care Act, as quoted in *The Baltimore Sun*

“We are taking full advantage of this historic opportunity to increase **access to health care** and create thousands of **good-paying jobs**.”

—**Illinois Gov. Pat Quinn**, in a March press release on his website announcing progress on the Affordable Care Act

“I’ve been yelling like Paul Revere for three years around this place. You’re going to see an **increase in taxes**. You’re going to see an **increase in premiums**. You’re going to see **costs go up**.”

—Oklahoma **Rep. Mike Ritze**, a physician, discussing a March report from the Society of Actuaries that predicted the Affordable Care Act will raise medical claims costs, as quoted by KJRH, the NBC affiliate in Tulsa, Okla.
**ELECTIONS DIRECTOR**
Will Senning is Vermont’s new state elections director, the Burlington Free Press reported in March. Senning will oversee state and local elections, coordinate campaign finance report filings and gather election results in his new position. One priority for the director will be to make information more accessible to the public via online measures. He replaces Kathy Scheele, who retired after 13 years as director.

**CHILD ABUSE**
A bipartisan group of Pennsylvania’s lawmakers in March announced a 16-bill package aimed at overhauling the state’s child abuse reporting system, according to the Philadelphia Inquirer. The bills tackle many of the recommendations made by the Pennsylvania Task Force on Child Protection. Proposals include expanding the definition of child abuse, as well as expanding the list of people legally required to report child abuse.

**BUDGET FORECAST**
The Delaware Economic and Financial Advisory Council in March increased estimates for the 2014 fiscal year personal and corporate income tax receipts, The News Journal of Dover reported. The council raised projections by $37.6 million compared to figures released in December. Based on new figures, the state will have an additional $11.1 million to spend in fiscal year 2014.

**VANDALISM PENALTIES**
Rhode Island Sen. Frank Lombardi in March introduced a bill to increase penalties for those found guilty of certain acts of vandalism, according to The Associated Press. Vandals doing more than $1,500 worth of property damage would be guilty of a felony under the bill. The legislation was introduced in response to a 2011 incident in a Newport cemetery where vandals did more than $100,000 worth of damage. Vandalism is a misdemeanor under current state law.

**BOND PROPOSAL**
Maine Gov. Paul LePage in March proposed a $100 million bond package to fund transportation projects, including road and bridge upgrades. The proposal, sponsored by Sen. Patrick Flood, would require passage by two-thirds of the legislature and voter approval via referendum, the Portland Press Herald reported. Included in the proposal is $46 million for highway projects and $30 million for bridge repairs.

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**New Jersey Becomes Third State to Legalize Online Gambling**

New Jersey Gov. Chris Christie in February signed a bill legalizing online gambling in Atlantic City. New Jersey joins Nevada and Delaware as the third state to allow Internet gambling, Bloomberg reported.

“This was a critical decision and one that I did not make lightly,” Christie said. “I am confident that we are offering a responsible yet exciting option that will make Atlantic City more competitive while also bringing financial benefits to New Jersey as a whole.”

Under the law, any game played in Atlantic City’s 12 casinos can be played on the Internet, initially only within the state. This will be expanded later to third parties who want to partner with the state, according to The Star-Ledger of Newark. Casinos must apply for an online gambling permit.

Christie initially vetoed the bill in early February and the legislature came back with a new version containing his recommendations. Those recommendations included increased funds for gambling addiction services, a casino tax rate of 15 percent rather that the originally proposed 10 percent and a provision allowing the law to expire after 10 years, The Star-Ledger reported.

State casino revenue is expected to nearly double next fiscal year thanks to online gambling, additional advertising and Hurricane Sandy recovery, according to The Star-Ledger. The governor’s office has projected casino tax revenue of $435.8 million in the 2014 fiscal year, compared to the 2013 fiscal year revenue of $235.4 million.

The measure also is expected to save a few of Atlantic City’s casinos that were in danger of closing, according the bill’s sponsor, Sen. Raymond Lesniak. He has indicated the online gambling operation should be up and running by September.
South Carolina Expects to See Boost in Job Creation

South Carolina could see an increase in manufacturing jobs in 2013, the Greenville News reported in March. In the past year, manufacturing companies bolstered the state’s employment rate and economists speculate that health care and construction industries also will provide momentum this year.

South Carolina’s unemployment rate saw an uptick in January, the same as the national average. The state’s Department of Employment and Workforce said the unemployment rate rose from 8.6 percent in December to 8.7 percent in January. Employers in the state added 26,840 jobs within the past year. The agency reported that nonfarm jobs in the state were up 31,100 in 2012, with leisure and hospitality, trade, transportation and utilities, and government sectors leading the way with 9,800, 6,900 and 6,500 additional jobs respectively.

According to Department of Employment and Workforce officials, the leading sectors of economic activity include professional and business services, trade, health care, education, government and tourism.

Job creation is expected to grow 1.2 percent in 2013, according to forecasts presented in December by Doug Woodward and Joseph Von Nessen, economists with the Moore School’s Division of Research at the University of South Carolina.

“Though manufacturing has largely been responsible for South Carolina’s economic recovery, we’ve started to see other industries expand this year and we expect more diverse growth in 2013,” Von Nessen said.

BACKGROUND CHECKS

The West Virginia state police recently implemented a policy to permit organizations serving as providers for children, elderly and disabled individuals to directly receive results of FBI background checks. This update to the state background check system will streamline the process and reduce the potential security risk of individuals tampering with the results, the Charleston Daily Mail reported. The state’s previous background check contractor, MorphoTrust, could only run background checks through the state police system.

TRANSPORTATION

The Virginia General Assembly ended its annual session with the passage of a comprehensive transportation measure. The new law replaces the 17.5 cents-per-gallon tax on gasoline with a new 3.5 percent wholesale tax on motor fuels. The measure will raise the sales tax on nonfood merchandise from 5 percent to 5.3 percent and allocate more revenue to transportation instead of other services, according to The Washington Post.

PRISON PHONES

Two prisons in south Texas—the 2,800-convict Stiles Unit and the 2,700-inmate McConnell Unit—are using new technology to block the use of contraband cell phones by inmates, according to the Austin-American Statesman. The newly installed systems intercept all phone calls made to and from the facilities, and only allow a connection for preselected numbers. The private firm that operates the pay phones in state prisons paid the $1 million installation costs, officials said.

ASIAN TRADE

During a weeklong tour of Asia, Missouri Gov. Jay Nixon signed trade agreements worth $1.9 billion with the nations of Taiwan and South Korea, according to The Missourian. In Taiwan, the agreements comprised $500 million with the Taiwan External Trade Development Council and $200 million with the Taiwan Feed Industry Association. In Korea, the Korea International Trade Association, the Korea-U.S. Economic Council and the Korea Importers Association will partner with Missouri companies to bring their products overseas.

GOVERNMENT EFFICIENCY

Alabama Gov. Robert Bentley in March signed legislation to consolidate several law enforcement agencies to bring greater efficiency, coordination and economies of scale to the system, The Montgomery Advertiser reported. The bill, sponsored by Senate President Pro Tem Del Marsh, created an Alabama State Law Enforcement Agency directed by a cabinet-level secretary and divided into the Department of Public Safety and State Bureau of Investigations. The investigation units and law enforcement divisions of several state departments will be moved into the new agency.
**The Midwest**

**TRANSPORTATION SAFETY**
The Iowa Senate in March passed a bill that would require rest periods for drivers of vehicles transporting railroad crews, *The Des Moines Register* reported. The bill would apply to drivers of vehicles intended to transport crews of seven to 15 people and would be comparable to current restrictions for commercial vehicle drivers.

**UNION PAY DEDUCTIONS**
The Kansas House in March approved a bill that will no longer allow public employee unions to deduct money from members’ paychecks to help finance political activity, according to *The Kansas City Star*. Those in favor of the bill contend it will protect union members from having part of their pay directed toward candidates or issues they oppose. Gov. Sam Brownback is expected to sign the bill into law.

**SEX OFFENDER REGISTRY**
Michigan Gov. Rick Snyder in March signed a bill that will add more people to the state’s public sex offender registry, *The Lansing State Journal* reported. People convicted of a single Tier I offense for certain crimes involving minors, such as possession of child pornography and surveillance of a minor, will now be placed on the public registry. Previously, those convicted of Tier I offenses had to register with the state, but were not placed on the public registry.

**WOLF HUNTING**
The Minnesota Senate Environment and Energy Committee voted in March for a five-year moratorium on wolf hunting seasons, according to *The Associated Press*. During the state’s first wolf season, which ended in January, hunters and trappers killed 413 wolves. The legislature authorized wolf hunting in 2011, a move that moratorium opponents argue came too soon after wolves were removed from the endangered species list.

**DEATH PENALTY**
The Nebraska Legislature’s Judiciary Committee in March advanced a bill to abolish the state’s death penalty, the *Lincoln Journal Star* reported. LB542, sponsored by Sen. Ernie Chambers, would change the death penalty to life in prison without the possibility of parole. Chambers has introduced a similar bill every year of his legislative service.

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**Illinois Governor Launches Creative Economy Initiative**

Illinois Gov. Pat Quinn in March announced the Illinois Creative Economy Initiative, an effort to generate more jobs in the state’s creative economy sector. Through the initiative, the state will explore innovative approaches to expand Illinois’ $2.7 billion creative economy, according to a governor’s office press release.

“Culture means business in Illinois,” Quinn said. “This initiative will strengthen our creative economy in Illinois, which will create more economic growth and make Illinois an even more vibrant place to live and raise a family.”

Quinn appointed Ra Joy, executive director of the Illinois Arts Alliance, to lead the Creative Economy Initiative. In this role, Joy will work to identify and implement methods to strengthen the role of the arts within the state’s economy.

The arts contribute at least $2.75 billion annually to the state’s economy, create more than $300 million in state and local tax revenue and employ 78,000 full-time equivalent jobs, according to the Illinois Arts Alliance.

Studies show areas offering museums, theaters, orchestras and other cultural outlets are very attractive to business looking for high-skilled employees. Those cultural outlets are also major tourism drivers for Illinois. “Cultural tourists” spend more than twice as much on event-related expenses than local residents, the governor’s office reported. In 2011, Illinois hosted a record 93.3 million out-of-state visitors.

The creation of the Illinois Creative Economy Initiative is an example of Quinn’s recognition of the importance of the arts to the state. Quinn was recognized with the 2012 Public Leadership in the Arts by Americans for the Arts, supports the Illinois Film Tax Credit and the Live Theater Tax Credit, and has funded several arts programs through his Illinois Jobs Now! program.

To learn more about these and other developments in the Midwestern Region, visit: [capitolideas.csg.org](http://capitolideas.csg.org) and [www.csomidwest.org](http://www.csomidwest.org).
Wyoming Governor Signs Lottery Bill

Wyoming Gov. Matt Mead in March signed House Bill 77 into law, allowing the creation of a state lottery corporation, the Casper Star Tribune reported.

“This is a way to keep Wyoming money in Wyoming,” Mead said. “Right now we are seeing many people cross the border and spending their dollars in out-of-state businesses. I want to keep those dollars here.”

After the law takes effect July 1, Mead will appoint a nine-member board to oversee the lottery corporation, according to a press release issued by his office. The board will be responsible for hiring the corporation’s CEO, who will be responsible for recommending budget items and personnel.

While the state is facing budget cuts and the loss of Abandoned Mine Lands reclamation money, a lottery would bring much-needed revenue to the state, Mead said.

The lottery is expected to generate profits up to $6 million. Those funds will be distributed to cities, towns and counties. Anything beyond that amount will be put toward education, according to the Casper Star Tribune. After six years, the legislature will assess how the money is being spent.

Mead has publicly stated his hesitation to create a state lottery and has promised to observe the social impacts of the lottery.

“This is a form of gambling and I commit to keeping a close eye on any social impacts of the lottery when it gets up and running to see if there are ways to address those,” Mead said.

It is expected to take up to one year before Wyoming residents will be able to purchase lottery tickets. The lottery board will determine whether the state will set up its own game, participate in a multistate lottery or choose both options.
The question of how to produce savings in Medicaid is almost as old as the program itself. While Medicaid traditionally has sought cost savings via cutting eligibility, benefits or reimbursement rates, state Medicaid directors are recognizing that we cannot continue to cut our way out of this problem. In fact, there is growing awareness that the solutions lie along a different path, that of a broader delivery system and payment reforms.

In this context, Medicaid agencies across the country are examining all their possible levers to affect change, including collaborative efforts with other stakeholders. And other stakeholders in reform likewise must look to Medicaid. Medicaid has become—in many states—an important player and powerful tool in multipayer initiatives that bear the promise of improving not just Medicaid, but also the entirety of the U.S. health care market.

While these changes will take on different aspects depending on the state, the core themes stress moving away from traditional uncoordinated fee-for-service, both as a delivery model and as a payment incentive. The acute, behavioral, pharmaceutical and long-term care needs of the Medicaid population are not, and cannot, be met in the current siloed system where no individual provider or entity is responsible for holistically treating the patient. This is especially true for the seniors and individuals with disabilities that comprise the bulk of the program's spending. Better integrating or coordinating the care for these populations—hand-in-hand with changes in how we pay for their care—is clearly a huge part of the solution and has the potential to reduce costs, as well as dramatically improve the health care outcomes of our most vulnerable citizens.

The National Association of Medicaid Directors works with states to share best practices and lessons learned in these areas. Here are some examples of these types of efforts.

- **Payment reform.** As an incentive for quality and efficient service delivery or as a disincentive for uncontrolled costs and ineffective care, states are examining a range of payment models that will give a competitive advantage to groups offering better outcomes to Medicaid and its beneficiaries. Some examples include bundling payments for episodes of care or specific diagnoses and reduced payments for undesirable outcomes such as hospital readmissions or early elective induction of labor. These payments can be specific to provider or beneficiary, or based on benchmarks of performance generalized across a population.

- **Quality oversight.** Value-based purchasing is the watchword of modern Medicaid. As such, it is imperative that agencies have the capacity to assess value and track progress in quality improvement. Monitoring performance of providers allows Medicaid to identify problem areas and reward quality. Public release of quality data and analytical tools to support competitive contracting and benchmarking among plans and providers are also a more frequent tool.

- **System accountability.** Managed care and other sub-capitated arrangements such as shared savings are a few of the models designed to promote and enhance coordination and holistic care. Rather than working to improve quality in a particular service type or provider, these arrangements can leverage a broad group of providers in a way that improves outcomes of care generally and creates accountability for individual outcomes.

- **Targeted care coordination.** Medicaid agencies across the country recognize the majority of costs are for a relatively small number of individual program beneficiaries. Medicaid agencies have begun to implement health homes and similar efforts for these populations, including those who are dually eligible for Medicaid and Medicare, those who are seriously mentally ill and other beneficiaries with multiple chronic conditions. Medicaid agencies have found effective care coordination often involves different professionals working together to help a beneficiary navigate a range of health and health-related issues.

- **Multipayer initiatives.** Medicaid is a major player in the health care marketplace, but it is far from the only one. A number of states are working to fit Medicaid into a broader strategy that includes private and other public payers in coherent cross-market value purchasing programs. [4]
A New Day Dawning

The Affordable Care Act will begin to take its full shape in 2014, as more Americans gain health insurance coverage through expanded Medicaid and health insurance exchanges operated by the state, the federal government or a joint effort between the two. States will continue to face challenges in implementation as the new law takes shape. Meanwhile, states already are working to try to contain costs, specifically in their Medicaid programs, but with the hopes those changes will rein in spending throughout the health care system.
Massachusetts is widely acknowledged as a pioneer in state health care reform—it’s 2006 reforms are credited for the fact that 97 percent of the state’s residents now have health insurance. The Massachusetts model for expanding health insurance coverage is often cited as the blueprint for much of the Patient Protection and Affordable Care Act, and the Commonwealth Connector is the precursor of the state health insurance exchanges.

But the state didn’t stop there. It’s also tackled health care costs.

“We have been working toward it (cost containment) since the original reform that expanded access in 2006,” said Sen. Richard Moore, a principal architect of the 2006 and subsequent health reform laws. “We are certainly confronting it head-on with the most recent legislation passed in 2012.”

This time, lawmakers tied the rise in health care costs to the growth of the state’s economy. Moore said the goal is to keep the rise in health care costs to something like 3.5 percent per year, about half the current growth in health care expenditures.

The bill holds the annual increase in total health care spending to the rate of growth of the state’s gross state product for the first five years. For the next five years, the rate of growth will be cut to half a percentage point below GSP growth, and then back to GSP growth thereafter. The estimated savings over 15 years totals $200 billion.

In signing the bill, Gov. Deval Patrick said the savings translated to an additional $10,000 in take-home pay, per worker, and a savings of $40,000 in health insurance premiums, per family, over 15 years.

Even while the state is trying to cut health care spending, officials are mindful that it can have a downside.

“We are trying to be careful not to impact quality or our economy since health care is such an important part of the economy,” Moore said.

“The economy is on a rebound and we don’t want to throw it back into recession.”

But Moore said bending the cost curve is definitely doable.

“Experts suggest elimination of waste and
The $42 million Arkansas just received from the federal government under the State Innovation Models Initiative is certainly welcome, but officials say they were already well on their way to totally changing the state’s health care payment methods.

Arkansas is implementing a system of episode-based payments for treatment of certain time-limited acute care conditions. An episode is defined as a collection of care provided to treat a particular condition for a given length of time.

“It is definitely a two- even three-year effort, that was down the road even before the Affordable Care Act,” said Rhonda Hill, director of health care finance at the Arkansas Center for Health Improvement. “A multi-payer group—Medicaid and private insurers Blue Cross Blue Shield and QualChoice of Arkansas—were looking at unsustainable growth rates in health care costs and realized they have a problem they needed a joint solution to fix.”

Before, Hill said, providers tried to see as many patients and perform as many procedures as possible in an eight-hour day.

“Looking at value of care was not a priority,” she said. “We are shifting from volume to value.”

Arkansas has been covering three episodes—upper respiratory infections, perinatal care and attention deficit hyperactivity disorder—under this payment method since Oct. 1, 2012, and two others—congestive heart failure and total hip or knee replacement—since Feb. 1. Two more groups of episodes are slated for implementation this summer and fall.

A patient’s principal provider is responsible for providing all the care related to the episode, from diagnosis through treatment. The provider bills Medicaid or the two private insurers and also collects certain data to ascertain quality.

Providers in Arkansas are still paid fees for their services, but at the end of the year their billings are reviewed, unusually costly cases are subtracted, and their average billings are compared to a state threshold. Medicaid goes through a public process to set those thresholds and private insurers do so through their contracting process with medical providers.

The provider’s data allow calculation of an average cost per episode, which is compared to what the state deems “acceptable” and “commendable” levels of cost. If a provider’s cost is above the acceptable level, the provider could have to pay back a portion of the cost reimbursement. If the provider’s average cost is below commendable and meet quality standards, he or she will share in the savings. Costs between acceptable and commendable are neither rewarded nor penalized.

The major providers in the state reached agreement around the definition of the episodes and the care to be provided, but each payer sets its own payment thresholds. Hill said this retrospective method of sharing risk and savings with providers was developed with considerable provider input.

“The steps we have taken are based on evidence where we can find it and then based on faith too.”

—Massachusetts Sen. Richard Moore
In its annual survey of state Medicaid programs, the Kaiser Foundation asks states about their use of managed care. In its October 2012 release, “Medicaid Today: Preparing for Tomorrow,” Kaiser reported that only Alaska, New Hampshire and Wyoming do not operate managed care programs. In 1991, 9 percent of Medicaid beneficiaries were in managed care, increasing to 51 percent in 2000, and to about two-thirds today.

As states have moved to managed care, especially contracting with managed care organizations, they are looking for immediate savings from increased coordination inherent in managed care.

“Generally speaking, based on WellCare’s experience, a state converting from Medicaid fee-for-service to a new managed care program can expect to see an initial cost savings of up to 5 percent in the first year,” said Dan Paquin, president of national health plans for WellCare Health Plans.

Paquin maintains, however, “the real benefit to managed care is not only cost savings, but the increased value delivered by the Medicaid program when it utilizes managed care. State governments who use (managed care organizations) enhance the quality of care while keeping costs predictable.”

The budgeting benefit of using managed care organizations and providing predictable capitated rates cannot be underestimated. Medicaid programs, like all other health insurance programs, face inflationary increases in cost that are nearly impossible to predict and can be much larger than overall inflation.

Paquin said Georgia has achieved such budget predictability with managed care. The state has kept Medicaid expense growth below national averages without benefit reductions or provider reimbursement reductions. The result is a cost savings of 7.8 percent four years into the program. The so-called dual eligible—people who are eligible for both Medicare and Medicaid—is the next frontier for managed care. The nation’s 9 million dual eligibles account for 15 percent of states’ Medicaid enrollment but nearly 40 percent of the spending. Those numbers explain states’ interest in achieving savings. The federal government is in for its matching share for Medicaid as well as for all Medicare spending.

The federal government has issued a number of planning grants for states to tackle better coordination of care and lower costs, and has awarded major grants to California, Illinois, Massachusetts, Ohio and Washington. All except Washington will use managed care organizations. California will be the largest test.

Connecticut purposely has veered off the managed care course, using the principles of care coordination and monitoring quality indicators, but bypassing contracts with managed care organizations. When the state moved to managed care in 1995, it expected to save money. Connecticut started with 14 managed care organizations and initially granted rate increases in line with medical inflation rates.

Ellen Andrews, a health consultant for CSG East and a member of the medical advisory committee for Connecticut Medicaid, said a secret shopper survey was the beginning of the end for Connecticut managed care.

Only one of every four doctors on plans’ provider lists would make a patient appointment. The others said they were not seeing Medicaid patients. At the same time, the number of participating plans fell to three and they asked for larger rate increases, leaving the state little negotiating room. A 2009 audit by actuarial firm Milliman found the rate increases for Connecticut managed care organizations were higher than those for similar Medicaid populations in other states. The audit also found that the organizations were not held accountable for care management standards designed to lower costs.

Connecticut now contracts with one of its old managed care organizations—the nonprofit Community Health Network—to provide care coordination, including intensive case management for the aged, blind and disabled population. Connecticut is participating in the federal dual eligible grant program and expects a large implementation grant soon.

The transition, which began in 2012, has been smooth and provider networks have remained robust.

“The fear that providers only participated in Medicaid because the (managed care organizations) brought them other business didn’t turn
Minnesota will use a $45 million federal grant over the next 42 months to transform its health care delivery systems through payment and other reforms, with overall savings forecast to be $111 million over three years.

The next steps in health care reform feature real coordination—at the state level, within providers’ offices and within communities—not just lip service to the ideas of coordination and collaboration.

“The grant is an amazing opportunity at core to change not only the conversation about health reform but to change fundamentally how we do that in some ways that are grounded in common sense and lay language and community ownership and leadership. That’s why I’m particularly excited our department (of health) and the department of human services jointly pursued this,” said Ellen Benavides, assistant commissioner of the Minnesota Department of Health.

The Department of Human Services Medicaid accountable care organizations will link with the Department of Health’s public health—or population health—frame and workforce development. She said Minnesota is looking to broaden the more traditional health care frame and include an array of services including mental health, long-term care, human services, social services and dental health.

Minnesota is taking the patient-centered health care home model and broadening it to address such an array of services.

The state will create 15 accountable communities for health, which will integrate services at a local level, depending on the needs and health priorities of the community, Benavides said. Like health care homes, these communities will be responsible to coordinating care across agencies and organizations and improving health outcomes.

“The beauty of this innovation grant is to shift the locus of control,” she said.

Minnesota is also working to innovate in another high-need area—the health care labor force. It’s the first state after Alaska to have dental therapists.

“They live in the space between a dental hygienist and a dentist and have a scope of practice much more advanced than a dental hygienist,” Benavides said.

The state also has developed the role of a community health worker, Benavides said, “a paraprofessional who is certified Medicaid reimbursable and who acts as a key member of the health team in kind of both translation and trafficking—an ally support for a patient.”

The state will expand its statewide health improvement program, where a community-led set of initiatives links schools, clinics, employer settings and other community resources to help build a healthier community. Employee wellness programs, community weight loss programs and farm to school food programs have been parts the improvement programs.

Benavides said the state wants to build on these programs “so that health services and other supports get woven together to really change some behaviors in really significant ways.”

Like health homes, these “accountable communities for health” will be responsible to coordinating care across agencies and organizations and improving health outcomes.

“It’s really about what do we need to do collectively to improve the health of the population so that we collectively can bend the cost curve,” Benevides said. “When we focus on the 10 percent slice of the pie, we’re focusing on the patients in the old-style health care system instead of moving upstream to address population health.”

Savings from the move from managed care were budgeted at $41 million in 2012. In 2013, the move is expected to slice $80 million off the state’s $4.6 billion Medicaid budget. Andrews said it is too early to verify all the savings, but in the last six months of 2012, the Children’s Health Insurance Program for low-income children has documented 23 percent annualized savings. Connecticut learned a lot with its move to, and from, managed care, Andrews said.

“States must monitor everything—the network, access, provider panels, utilization rates, but especially the money,” she said. “Don’t make assumptions, monitor.”

Finally, in what may be universal advice to policymakers, Andrews said, “If you do this (managed care), make a commitment to do it right.”
A grim reaper, dressed in a black cloak and carrying a scythe, walked the hallways of the Oklahoma Capitol in February. A Senate Committee had just rejected Gov. Mary Fallin’s proposal to repeal a 1987 law that restricted cities and towns from enacting tobacco control measures more restrictive than state law.

Fallin had thrown down the gauntlet in her State of the State address: “Any plan to improve the health of Oklahomans must address the state’s number one killer: tobacco.”

She ticked off the costs to the state: more than $2 billion in health care costs and lost workforce productivity annually; nearly 6,000 deaths to smoking-related illnesses, including both her parents.

Convinced that smoking costs the state money and lives, Fallin will lead a ballot initiative for 2014.

“It’s time to let voters decide whether or not they want clean air in public places like bars and restaurants. I believe the answer will be ‘yes,’” the governor said in a press release posted on her Facebook page.

She needs only to look at Massachusetts to see the success of an aggressive campaign against smoking.

As part of its health reform efforts in 2005, Massachusetts legislators established a two-year smoking cessation pilot aimed at the Medicaid population. They allocated $7 million per year for the program and ordered evaluation.

Research found the program returned $2.12 for each dollar spent on the program.

“We looked at smoking data from CDC and documented drops in smoking rates among Medicaid enrollees. Then we looked at (Medicaid) claims data and saw much lower rates of hospitalization for heart attacks. Rates of heart attacks fell by about a half;” said Leighton Ku, professor of Health Policy at George Washington University, one of the researchers.

“State legislators care about what you can do to save me money this year,” Ku said. “The good news is the reduction in hospitalizations is fairly rapid and savings accrued within a year. You save the money relatively quickly.”

The other good news, according to Ku, is that tobacco abstinence doesn’t have to be permanent to show these savings. “Even with short-term abstinence, there are these dramatic improvements in cardiovascular hospitalizations and health.”

In Massachusetts, these savings amount to $14.7 million each year.

Components of the Massachusetts program include individual and group counseling and the full range of FDA-approved prescription and over-the-counter medications, with copayments ranging from $1 to $3. Massachusetts also invested in a statewide tobacco quitline, health provider education and a public education campaign. Massachusetts continues the Medicaid cessation program and is investing state funds to target veterans and those purchasing insurance through the state health insurance exchange.

Cessation is permitted under the federal Medicaid program. No other states have programs as comprehensive as Massachusetts, according to the American Lung Association’s 2013 State of Tobacco Control report.

—Debra Miller
443,000 DEATHS EACH YEAR

The Centers for Disease Control and Prevention estimates the number of deaths due to cigarette smoking at about 443,000 each year. The numbers are based on a survey from 2000 to 2004 and are the latest data available on smoking deaths. The CDC also broke down the deaths to specific causes:

- Lung cancer: 128,900 deaths
- Other cancers: 35,300 deaths
- Ischemic Heart Disease: 126,000 deaths
- Chronic Obstructive Pulmonary Disease: 92,900 deaths
- Stroke: 15,900 deaths
- Other diagnoses: 44,000 deaths

Source: CDC—Smoking-Attributable Mortality, Morbidity, and Economic Costs

SMOKEFREE LAWS

24 STATES PROHIBIT SMOKING IN WORKPLACES, RESTAURANTS AND BARS

12 STATES PROHIBIT SMOKING IN ONE OR TWO OF THE THREE

14 STATES DO NOT PROHIBIT SMOKING IN ANY OF THE THREE

Source: American Nonsmokers’ Rights Foundation, Summary of 100% Smokefree State Laws and Population Protected by 100% U.S. Smokefree Laws

COVERAGE YOU CAN count on from coast to coast

Healthcare is changing and it’s more important than ever to have a health plan that will change with it. In every state and every ZIP code in America, Blue Cross and Blue Shield companies are partnering with doctors, community leaders and policymakers to build an innovative healthcare system that is stronger and more secure for tomorrow. As they have for more than 80 years, The Blues® will continue to lead in bringing the next generation of healthcare coverage to the communities they serve.

An estimated 443,000 people die from smoking-related illnesses each year, U.S. Health and Human Services Secretary Kathleen Sebelius wrote in her message in the 2012 Surgeon General’s report on smoking. Besides those premature, and preventable deaths, cigarette smoking costs the U.S. $96 billion in direct medical costs and $97 billion in lost productivity each year, Sebelius wrote.

States have long worked to address these issues—many of them have raised the taxes on a pack of cigarettes in an effort to price them out of reach of potential new smokers. In fact, four of the states with the lowest taxes per pack of cigarettes also have among the highest rates of smoking and highest mortality rates. Utah, which has the lowest mortality rate from smoking and the lowest prevalence of smoking among adults, has the 36th highest tax rate. New York, which has the highest tax rate per pack of cigarettes, has the ninth lowest smoking prevalence rate and the 14th lowest smoking-attributable death rate. Kentucky has the highest smoking prevalence rate and smoking-attributable death rate, but the 11th lowest tax rate on a pack of cigarettes.

**HEALTH PROBLEMS RELATED TO SMOKING**

- Cancer
- Heart Disease
- Stroke
- Lung Diseases
  - Including Emphysema, Bronchitis and Chronic Airway Obstruction

**FOR EVERY PERSON WHO DIES FROM A SMOKING-RELATED DISEASE, 20 MORE PEOPLE SUFFER AT LEAST ONE SERIOUS ILLNESS FROM SMOKING.**


**3,800** THE NUMBER OF PEOPLE UNDER AGE 18 WHO SMOKE THEIR FIRST CIGARETTE EACH DAY IN THE U.S.

**> 1,000** OF THOSE YOUTH BECOME DAILY CIGARETTE SMOKERS.

Source: Society of Actuaries: Economic Effects of Environmental Tobacco Smoke

**> $10 BILLION** THE ANNUAL COST IN HEALTH CARE EXPENDITURES, MORBIDITY AND MORTALITY OF SECONDHAND SMOKE.

Source: Society of Actuaries: Economic Effects of Environmental Tobacco Smoke
### Cigarette Excise Tax ($ per pack)

<table>
<thead>
<tr>
<th>State</th>
<th>Tax Rate</th>
</tr>
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<tbody>
<tr>
<td>Kentucky</td>
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<tr>
<td>West Virginia</td>
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</tr>
<tr>
<td>Arkansas</td>
<td>26.9%</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>26.1%</td>
</tr>
<tr>
<td>Mississippi</td>
<td>25.9%</td>
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### Smoking Prevalence Rate

<table>
<thead>
<tr>
<th>State</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Jersey</td>
<td>16.9%</td>
</tr>
<tr>
<td>Hawaii</td>
<td>16.9%</td>
</tr>
<tr>
<td>Puerto Rico</td>
<td>14.8%</td>
</tr>
<tr>
<td>California</td>
<td>13.6%</td>
</tr>
<tr>
<td>Utah</td>
<td>11.8%</td>
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</tbody>
</table>

**New York has the highest cigarette excise tax at $4.35 per pack.**

**Crackdown on Tax Evaders**

NEW YORK—Queens District Attorney Richard Brown announcing a crackdown on cigarette smugglers and tax evaders in the Queens borough of New York. The state has the highest tax on cigarettes in the country. © AP Photo/Frank Franklin II

**THE BOOK OF THE STATES**

Since 1935, The Council of State Governments’ The Book of the States has been the leading authority on information about the 50 states and territories.

» [www.csg.org/bookofthestates](http://www.csg.org/bookofthestates)
What is it about this new plan that gives you confidence it will work?
“"The traditional way states have dealt with increased costs in the Medicaid program is to either drop people from coverage, which just swells the ranks of the uninsured and sends those folks into the ER, or cut provider reimbursement—doctor payments, hospital payments to the point that doctors won’t participate—or cut benefits. None of those addresses the real underlying driver of medical inflation, which is the business model essentially around which health care is organized.”

What is Oregon doing differently?
“What we’ve done is redesigned the way health care is organized and delivered with a focus on patient-centered medical homes, care coordination, integration of dental, mental, physical health services, (creating) a direct link to the community to make sure people with chronic conditions that account for the vast majority of costs in the system are managed when they are out of the hospital rather than just bouncing in and out of the hospital. It’s really a coordinated delivery model and we’ve got 15 coordinated care organizations up and running in Oregon, covering over 93 percent of our Medicaid population.”

With those changes in reimbursement, what are you doing to get the necessary buy-in from providers?
“I think most physicians and a lot of hospitals recognize that the current system is simply not sustainable. Medical inflation is growing way faster than revenue growth in both the public and private sector. ... The opportunity to test out a new delivery model on a portion of the population—Medicaid is about 16 percent of our population—was very appealing to a lot of physicians. We actually got strong endorsement of this from the Oregon Medical Association, as well as the Oregon Hospital Association.”

How will this affect other areas of health care?
“The fact is that we’re expecting to save about $5 billion over the next decade, … but that’s money that comes out of the health care economy. Now, step 2 is to take this care model and list it on our health insurance exchange as a high-quality, low-cost option for public employees and public school teachers, which begins to move it into the private sector. We’re also having conversations with private employers about aligning their purchasing power with that of the state to make this care model available to private employers as well.”

What markers will you be looking for to determine success?
“The first three markers we’ve already passed. We opened applications last year and as I said, we’ve had 15 certified coordinated care organizations up and running around the state that are covering over 93 percent of our Medicaid population. We get the leadership of those coordinated care organizations together every month in a learning collaborative. Their attitudes are extremely positive. They’re very excited about the work. People are really leaning into it, learning from each other, committing to make it work. From an organizational and delivery standpoint, I think it’s working very well. Later this month (April), we’ll actually have our first empirical data on health outcomes. We’re expecting those to show that we’re actually improving health outcomes through this new model.”

Will success lay the groundwork for more adoption?
“I think it already has laid the groundwork. We’ve had very productive conversations with the State Employees International Union, which is one of our larger public employee unions. They’re very interested in moving in this direction. The cost of health care is squeezing out, at the bargaining table, wage increases and all these other things. They are very supportive of this move.”
Oregon Gov. John Kitzhaber, a physician, says his state’s new approach to Medicaid under a federal waiver has fundamentally changed the way health care is organized and delivered. It established coordinated care organizations, which are moving away from a fee-for-service model. The state expects to save about $7 billion in the program over the next decade.

As a physician and governor, what do you see as the biggest benefit of this plan?

“I think there’s a number of them. First of all, there’s a lot of things that doctors do today that could be done equally as well, if not better, by a nurse practitioner or a physician assistant, so this will allow doctors to practice at the top of their license, essentially doing things that only they can do. … It will give them a very predictable, stable revenue stream instead of wondering what the government is going to reimburse them from one year to the next. … The care coordination allows them to become part of the larger team so they’re not out there all by themselves. They’re working with primary care specialty, other community health workers, social workers, so it’s a much more collaborative approach. Finally—and I think this is very important to most doctors, particularly when you’re dealing with complicated situations with multiple chronic illnesses—this actually is going to help improve the care and quality of life of those individuals.”

What advice would you offer other states?

“We’ve got a real-life example of an approach that really gets to the underlying issues rather than just moving the deck chairs around. I had the opportunity to make a brief presentation at the end of January at the National Governors Association in Washington, D.C., about this care model. … We are currently trying to develop a six or seven state collaborative to try to work together with the Obama administration to see if we can bring this care model to other states as well.”

What would be involved with that effort?

“We’ve got to identify willing governors and we’re interested in getting three or four Democratic governors and three or four Republican governors. We want states that have decided to expand under the Affordable Care Act because that’s a very important part of this. … I think every state might develop something that looks a little bit different but the three significant components are: one, federal flexibility and how we use those dollars; second, an upfront investment in federal resources to get the program started; and third, a commitment by the states that they will deliver on a set of health outcome metrics on cost and quality and patient satisfaction.”

How important was the Affordable Care Act in being able to make the changes?

“We were moving in this direction anyway, and we actually had passed legislation to establish the health insurance exchange and these coordinated care organizations even before Supreme Court ruled on the constitutionality of ACA. Particularly, the expansion under ACA will be very, very helpful to us. With the insurance exchange and with that expansion, we will be able to reduce the number of people without insurance in Oregon to about 5 percent in about two years, which is quite remarkable. That wouldn’t happen without the federal government financing the expansion of Medicaid under the ACA and also the series of tax credits available to individuals and small businesses to come out of the exchange. We think that what’s necessary for the ACA to work is a delivery model like the one we’ve set up here that grows at a fixed rate so state budgets don’t get overwhelmed by the increased number of people who are now covered.”
The Patient Protection and Affordable Care Act, sometimes referred to as "Obamacare," has been taking effect slowly since its passage in February 2010. Changes have been made to state Medicaid programs and requirements for insurance companies.

The Medicare-Medicaid Coordination Office is working to improve access, coordination and cost of care by focusing on three major areas—program alignment, data and analytics, and models and demonstrations. The office is creating a technical assistance center to help all states meet the needs of these dual eligibles. It also has launched an initiative to align the two programs to eliminate unnecessary and inefficient conflicts in the requirements for the two programs.

The CMS in 2010 selected 14 other states—California, Colorado, Connecticut, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington and Wisconsin—to receive contracts for up to $1 million each to design new integrated care models.

LAW UPHELD
WASHINGTON, D.C.—Holding a sign saying "We Love Obamacare," supporters of health care reform rallied in front of the U.S. Supreme Court in March 2012 as the court continued hearing arguments on the health care law signed by President Barack Obama. The Supreme Court upheld the constitutionality of the law—except for the requirement for states to expand Medicaid—June 28, 2012. © AP Photo/Charles Dharapak

DUAL ELIGIBLES ARE PEOPLE WHO ARE ELIGIBLE FOR MEDICAL COVERAGE UNDER BOTH MEDICARE AND MEDICAID. THE AFFORDABLE CARE ACT CREATED THE FEDERAL COORDINATED HEALTH CARE OFFICE—ESTABLISHED IN SEPTEMBER 2010—TO IMPROVE CARE COORDINATION FOR PEOPLE ELIGIBLE FOR BOTH PROGRAMS.

IMPACT ON MEDICAID

DUAL ELIGIBLES

The Centers for Medicare and Medicaid Services announced in August 2012 that Massachusetts was the first state to partner in a project to test a new model for providing dual eligibles with a more coordinated, person-centered care experience.

The Medicare-Medicaid Coordination Office is working to improve access, coordination and cost of care by focusing on three major areas—program alignment, data and analytics, and models and demonstrations. The office is creating a technical assistance center to help all states meet the needs of these dual eligibles. It also has launched an initiative to align the two programs to eliminate unnecessary and inefficient conflicts in the requirements for the two programs.

Under the Financial Alignment Demonstration, the state and the CMS contracted with integrated care organizations to coordinate the delivery of services for all covered Medicare, Medicaid and expanded services.

The CMS in 2010 selected 14 other states—California, Colorado, Connecticut, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington and Wisconsin—to receive contracts for up to $1 million each to design new integrated care models.
CUTTING COSTS  The Affordable Care Act included several provisions aimed at cutting the cost of providing health care to those who qualify for Medicaid.

It established the Center for Medicare and Medicaid Innovation in 2010 to test new payment and delivery system models that reduce costs while maintaining or improving quality. The center has organized Innovation Models into seven categories—accountable care; bundled payments for care improvement; primary care transformation; initiatives focused on Medicaid and the Children’s Health Insurance Program, or CHIP; initiatives focused on Medicare–Medicaid enrollees; initiatives to accelerate the development and testing of new payment and service delivery models; and initiatives to speed the adoption of best practices.

Ten states—California, Connecticut, Hawaii, Minnesota, Montana, Nevada, New Hampshire, New York, Texas and Wisconsin—are participating in an initiative to offer incentives to Medicaid beneficiaries who participate in prevention programs and demonstrate improvements in health risk and outcomes. The Centers for Medicare and Medicaid Services offered $100 million in grants to states that targeted chronic disease prevention through the program. The grants are for three years.

POINTS OF SERVICE  The Affordable Care Act includes several provisions that allow states to give Medicaid enrollees options about where they can obtain services.

Home and Community-Based Services

Starting Oct. 1, 2010, states could offer home and community-based services to certain elderly and disabled populations through a Medicaid state plan amendment; they also could extend full Medicaid benefits to individuals receiving home and community-based services under a state plan.

The Centers for Medicare and Medicaid Services on Feb. 22, 2011 issued a proposed rule to allow states to provide home and community-based attendant services and supports through the Community First Choice Medicaid state plan option.

In its final rule issued April 26, 2012, the U.S. Department of Health and Human Services announced states choosing to participate in the Community First Choice option would receive a six percentage point increase in federal Medicaid matching funds for providing community-based attendant services and supports to enrollees who would otherwise be confined to a nursing home or other institution.

“Prior to passage of the Affordable Care Act, many families had few choices beyond nursing homes or other institutions for their loved ones,” Health and Human Services Secretary Kathleen Sebelius said in announcing the rule.

Health Homes

According to the Kaiser Commission on Medicaid and the Uninsured, about half of the 9 million people who qualify for Medicaid based on disability suffer from mental illness; 45 percent have three or more diagnosed chronic conditions.

The Affordable Care Act gave states the option to permit certain Medicaid enrollees to designate a provider as a health home; states taking the option received 90 percent federal matching payments for two years for health home-related services.

Health homes coordinate care for people on Medicaid who have chronic conditions. To be eligible for a health home, Medicaid enrollees must have two or more chronic conditions—defined as mental health, substance abuse, asthma, diabetes, heart disease and being overweight; have one chronic condition and be at risk for a second; or have one serious and persistent mental health condition.

Health home services include comprehensive care management; care coordination, health promotion, comprehensive transitional care/follow-up, patient and family support, and referral to community and social support services.

Health Home Providers can be a designated provider, such as a physician, clinic or mental health provider; a team of health professionals, including nurse care coordinators, social workers and behavioral health professionals; or a health team, which may include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral health providers, chiropractors, and licensed complementary and alternative practitioners.
TWO KEY PROVISIONS OF THE AFFORDABLE CARE ACT AFFECTING STATES DEAL WITH EXPANDING STATE MEDICAID PROGRAMS AND THE MANAGEMENT OF HEALTH INSURANCE EXCHANGES. SEVENTEEN STATES HAVE DECLARED THEY WILL OPERATE AN EXCHANGE WHILE SEVEN ARE PLANNING FOR A PARTNERSHIP EXCHANGE. TWENTY-SIX STATES WILL DEFAULT TO THE FEDERAL EXCHANGE. AS FOR EXPANDING MEDICAID BEGINNING JAN. 1, 2014, GOVERNORS IN 26 STATES SAY THEY WILL SUPPORT EXPANSION, 19 OPPOSE EXPANSION AND FIVE ARE WEIGHING THEIR OPTIONS.

The Iowa and Maine legislatures are considering bills to expand Medicaid despite the governors’ opposition. In Florida, Montana and Ohio, the governors supported expansion but the legislatures voted it down. House Democrats in Ohio offered an amendment to reinstate the governor’s expansion proposal April 16. At press time, the Missouri legislature appeared poised to reject expansion as well.

KEY

Governors’ Positions on Expanding Medicaid
- Supports
- Opposed
- Undecided

Health Exchanges
- State
- Partnership
GUIDE TO HEALTH REFORM | hot topic

MINNESOTA

Gov. Mark Dayton signed legislation in February authorizing expansion of Medicaid in the state. The state is participating in two projects with the federal government to cut costs and improve outcomes—one to design a new integrated care model for dual eligibles, people who receive both Medicare and Medicaid, and one to offer incentives to Medicaid patients to participate in prevention programs.

MAINE

Although the state received a federal Exchange Planning grant of $1 million and a $36 million Early Innovator Grant, Gov. Paul LePage wrote a letter to federal officials that Maine would not operate a state-based exchange. Legislation to establish a state exchange failed to pass in 2011 and 2012.

CONNECTICUT

The state will receive up to $1 million to design new integrated care models for those people who are eligible for both Medicare and Medicaid. The state also is participating in an initiative to offer incentives to Medicaid recipients to participate in prevention programs and improve their health risks and outcomes.

MISSISSIPPI

Commissioner of Insurance Mike Chaney, who is elected, submitted a blueprint application to the Department of Health and Human Services in November 2012 indicating the state would establish a health insurance exchange. Gov. Phil Bryant opposes a state-based exchange, and HHS rejected the state’s application Feb. 7, 2013.

VIRGINIA

Legislators in the 2013 session decided to create a bicameral commission to work on reforming Medicaid before considering expansion. Gov. Bob McDonnell said he could not support Medicaid expansion without program reforms.

ABOUT HEALTH INSURANCE EXCHANGES

Individuals and small businesses will shop for health insurance through health insurance exchanges established by the Affordable Care Act. Consumers will start enrolling for coverage Oct. 1, 2013; coverage begins Jan. 1, 2014.

ABOUT MEDICAID EXPANSION

Medicaid expansion was one of the tenets of the Patient Protection and Affordable Care Act. The Supreme Court, in declaring the act constitutional in June 2012, ruled that states could opt out of the expansion of Medicaid eligibility to people at or below 138 percent of the federal poverty line in 2014. Thus far, there is action in 27 states to expand the program.

The federal government will fund 100 percent of these newly eligible people the first few years, then drop the funding to 95 percent in 2017 and to 90 percent after 2020.
CHANGES FOR EMPLOYEES

Jan. 1, 2014: Employers with more than 50 employees can be charged a $2,000 fee per full-time employee if they don’t offer coverage and have at least one full-time employee who receives a premium tax credit. The first 30 employees are excluded from the fee.

Jan. 1, 2014: Employers can offer employees rewards of up to 30 percent, potentially increasing to 50 percent, of the cost of coverage for participating in a wellness program and meeting certain health-related standards; the law established 10 state pilot programs that permit participating states to apply similar rewards for participating in wellness programs in the individual market.

ENFORCEMENT

The federal government will oversee the health care law in Missouri, Oklahoma, Texas and Wyoming after those states told the U.S. Department of Health and Human Services they couldn’t or wouldn’t implement the new rules.

Source: Politico

INDIVIDUAL MANDATE

IF YOU CAN AFFORD TO BUY HEALTH INSURANCE—that is, if it wouldn’t cost more than 8 percent of your monthly income and if you earn above the federal poverty line—the Affordable Care Act requires you to do so. If you don’t, you could owe a tax, administered by the IRS. The penalty wouldn’t be enforced until 2016.

DID YOU KNOW?

HEALTHCARE.GOV

The ACA required the Department of Health and Human Services to set up a website—healthcare.gov—to help consumers identify health coverage options.

HELP FOR COVERAGE

Everyone has to buy health insurance or face a penalty. Medicaid expansion in some states will help to cover those up to 138 percent of the federal poverty level.

U.S. citizens and legal immigrants who buy coverage in the exchange and who have incomes up to 400 percent of the federal poverty level are eligible for tax credits. They can’t get the credits if they are eligible for public coverage or have access to health insurance through an employer.

FEDERAL POVERTY LEVEL

The federal poverty level—approximately $14,000 for an individual and $29,000 for a family of four—is used to determine who is eligible for Medicaid and subsidies to buy health insurance.

COSTS AND SAVINGS

The Congressional Budget Office says implementing the health care law will cost $938 billion over the next 10 years. But it also says the law will cut the federal deficit about $124 billion over that same time period.

KID STUFF

The health reform law allows parents to keep their children on their insurance policies until the age of 26.

DENIED—NOT

The law does not allow insurers to deny coverage to people with pre-existing conditions starting Jan. 1, 2014, and eliminates the lifetime limits on health care coverage.

AN OUNCE OF PREVENTION

The law requires private health insurers to cover recommended preventive services without any copays or deductibles for the patient. This includes screenings for such things as diabetes, obesity, cholesterol and various types of cancers.

WOMEN

The law requires private insurance companies to cover a range of preventive service, including Pap tests, cancer screenings, diabetes screening and prenatal care without copays. It also requires coverage of some brands and methods of birth control.

FUNDING FOR EXCHANGE

FRANKFORT, KY.—Kentucky Health Benefits Exchange Executive Director Carrie Banahan is leading the effort to implement federal health care reforms in the Bluegrass State. She said in February the state will seek less revenue for its health benefit exchange than federally operated exchanges that some other states are relying on. © AP Photo/Roger Alford
AHEAD OF THE GAME
PORTLAND, ORE.—Physician assistant Anna Streuli, left, examines Maria Guzman at the Multnomah County's Midcounty Health Center. Oregon started working on health care reform before President Barack Obama's initiative in 2010 and has worked aggressively to implement the requirements.  © AP Photo/Rick Bowmer

KEY DATES

Starting Jan. 1, 2013: The federal government increased by one percentage point federal matching payments for preventive services in Medicaid for states that offer Medicaid coverage with no patient cost sharing for services recommended (rated A or B) by the U.S. Preventive Services Task Force and recommended immunizations.

Jan. 13, 2013—Dec. 31, 2014: Medicaid payments for primary care services provided by primary care doctors will be increased to 100 percent of the Medicare payment rate for 2013 and 2014—with the federal government paying 100 percent of this increase. States are expected to receive more than $11 billion in new funds for their Medicaid primary care systems because of an increase in rates paid for primary care services, according to the Centers for Medicare and Medicaid Services.

Fiscal Year 2013: Authorization and funding for CHIP was extended through 2015. Previous authorization was through 2013.

Oct. 1, 2013: States’ Medicaid Disproportionate Share Hospital allotments will be reduced. The secretary of the Health and Human Services cabinet will be charged with developing a methodology for distributing the reductions.

Jan. 1, 2014: States have the option to expand Medicaid to individuals not eligible for Medicare under age 65—children, pregnant women, parents and adults without dependent children—with incomes up to 138 percent of the federal poverty level. The federal government will fully cover those who are newly eligible for Medicaid through 2016; after that, federal funding will cover 90 percent of the costs. States had the option to expand coverage to childless adults beginning April 1, 2010.

Jan. 1, 2014: All hospitals participating in Medicaid can make presumptive eligibility determinations for Medicaid-eligible populations.

Oct. 1, 2015: The federal match rate in CHIP will increase 23 percentage points, up to a cap of 100 percent.

KEY DATES IN ACA HISTORY

2009

2010
» Feb. 22, 2010: President Obama lays out his legislative proposal for health care reform, similar to the Senate bill.
» March 21, 2010: The U.S. House of Representatives passes the Senate health care bill.
» March 23, 2010: President Obama signs the Patient Protection and Affordable Care Act
» March 23, 2010: Florida files a lawsuit in federal district court challenging the constitutionality of the individual mandate. Florida is joined by 25 other states in the lawsuit.

2012
» June 28, 2012: Supreme Court upholds constitutionality of the act.

2013

2014

2015

Source: New York Times

© AP Photo/Rick Bowmer

CAPITOL IDEAS » MAY / JUN 2013
For Arizona Gov. Jan Brewer, the decision to take the federal government up on expanding Medicaid just made sense.

“By expanding Medicaid just slightly beyond what Arizona voters have twice mandated at the polls, we can draw down nearly $8 billion of our own tax dollars from the federal government,” she said.

Since the federal government will cover individuals earning up to 138 percent of federal poverty level, Brewer said that influx of money will cover costs the state was incurring as people without health insurance sought care in emergency rooms—the least affordable option.

She wasn’t as accepting of establishing a state-based exchange.

Brewer’s consideration of two of the Affordable Care Act’s most visible pieces for states—expanding Medicaid and setting up health insurance exchanges—illustrates the decisions with which policymakers around the country have wrestled.

Fourteen states—and the District of Columbia—that will be operating a state-based insurance exchange, and six states that have committed to a partnership exchange with the federal government, also are expanding Medicaid. On the flipside, only six states that are deferring to the federal government for an exchange support expanding the joint federal-state health insurance program for low-income people. That leaves 17 states rejecting, outright, two major parts of the act. Four states are still mulling whether to expand Medicaid.

**Medicaid Expansion**

South Carolina is one of those states saying thanks, but no thanks, to Medicaid expansion and the exchange. And it’s doing so with confidence.

Tony Keck, director of Health and Human Services for South Carolina Gov. Nikki R. Haley, said expansion of Medicaid—and expansion of insurance coverage in general—doesn’t address the real question the country faces. That is, “How do you get as many people as healthy as possible,” he said.

“The debate has made the universal assumption that everybody should have health insurance,” he said, “that health insurance is the path to healthiness.”

But if the state or federal government isn’t focusing on real problems, improving health outcomes and lowering costs, the value of health care isn’t getting better, he said.

South Carolina has been focusing on reducing costs and improving outcomes for several years. It’s changed the way it pays providers to encourage them to consider outcomes as opposed to volume. It’s also worked with providers to better integrate clinical care “to view the patient as a whole.”

The state this year introduced the next phase of its strategy, focusing on hot spots to figure out the issues in areas that have particularly high health care needs.

“There’s a real question about putting all this money into a system before you get the system to actually show that it can produce results,” said Keck. “We think if you just expand with asking nothing in return, you expand without reforming the health system, that is just making false promises. It’s just wasting money.”

Arizona, too, has been working with its health care system to lower costs. Its prepaid, capitated-care model contracts through public and private health plans to pay a predetermined amount per patient for care each month. Brewer said that model keeps costs down and makes coverage affordable.
But people without coverage often use the hospital emergency room for care. “Those costs are threatening our hospitals, weighing down our economy and hitting every Arizonan with what I call the hidden health care tax,” she said.

Brewer estimates that’s nearly $2,000 more in health premiums the average Arizona family pays to cover those uncompensated care costs.

In Minnesota—a state that has continually worked to improve health outcomes while lowering costs—a report from the Minnesota Budget Project found covering the additional 87,000 people under Medicaid expansion would improve health outcomes and reduce state costs.

The state took advantage of the early option to expand in 2011 to help very low-income people access health insurance. Medicaid previously covered those individuals fully under a state-financed program; now the federal government is picking up half the tab.

Ellen Benevides, assistant commissioner in the Minnesota Department of Health, said the Medicaid expansion will help the state continue its efforts in reforming the state’s health care system.

State-based Insurance Exchanges

She said the same thing about the state-based health insurance exchange, as well as other components in the Affordable Care Act.

“All of that reform around us feeds into what we’ll be doing with the state innovation model grant,” she said of federal funding that allows a state to reform its health care system through payment reform and other state-led initiatives.

Benevides will be involved with regulating the qualified health plans available through the exchange. “I think about what kind of quality measures are the qualified health plans providing that people can purchase on an exchange and how do they align with what might be available to somebody in an accountable community for health,” she said of a plan in Minnesota to develop 15 areas in the state to improve the health of residents there.

But the appetite across the country for states to operate their own health exchange isn’t as hearty as the federal government had hoped, for several reasons.

Brewer, for instance, said she and her health policy team determined it would be a state health exchange in name only. “Our actual authority would have been very limited and we would have needed federal approval for many of the things required to meet the unique needs of Arizonans,” she said.

In addition, she and her team saw too many unknowns about how the exchange would actually function.

South Carolina had those same concerns, Keck said.

The state did put together a group to study the exchange option, even though the governor intuitively was opposed to it. The group came to two conclusions.

“One, that there was so little guidance in terms of what would be required of the states—what the cost would be, how the federal government would be regulating it—that it was very risky for a state to implement,” he said. “The other reason it would be risky for a state to implement it was that the timelines were completely unreasonable.”

So South Carolina rejected the idea of operating its own exchange, but is keeping its options open.

The federal government will operate the exchange in both Arizona and South Carolina, and Keck said that means residents in his state still will get access to those benefits.

Plus, he said, the federal government is leaving open the option for states to take over operation of the exchange down the road. “If it’s a train wreck and it’s hurting the people of South Carolina, we’ll have to step in,” Keck said.

Assessing Decisions

While Jan. 1, 2014, is a date to watch as states and the federal government begin full implementation of the Affordable Care Act, state officials will be watching the results to determine if they’ve made the right decision on these two key elements.

“I’ll know we’ve made the best decision for Arizona based on the overall wellness of our citizens and the health care system in our state,” Brewer said. “The key will be to keep costs down and government interference to a minimum.”

As for Minnesota, one of the few states embracing both Medicaid expansion and a state-based exchange, the key for Benevides will be when the discussion changes.

“What I will look for is if we stop talking about health care reform and start talking about health,” she said. “We need a different conversation about health.”
When Jan. 1, 2014, rolls around, one of the most significant parts of the Affordable Care Acts takes effect. That’s when all U.S. citizens and legal residents are required to have health insurance coverage.

While tens of millions of Americans will join the rolls of the insured, one thing is not so clear: Where will those millions of people get their primary care?

Many of the newly insured probably will find themselves at a federally qualified community health center. These centers, created in 1965, are designed to ensure everyone has access to basic primary care and preventive services regardless of insurance coverage or ability to pay.

“They provide basic primary health care services … and also provide oral and mental health services,” said Dan Hawkins, senior vice president of public policy and research at the National Association of Community Health Centers.

Health centers must meet several standards to be considered federally qualified, which allows them to receive federal grants that help subsidize care for the uninsured and under-served. The centers must:

» Be located in a medically underserved area or serve a high-need population;

» Be governed by a community board whose majority is made up of patients;

» Provide comprehensive primary care;

» Provide services to all regardless of a patient’s ability to pay; and

» Meet certain performance and accountability measures.

More than 22 million Americans get their primary care from one of 8,500 health centers across the country.

Hawkins said the Affordable Care Act provided $11 billion over five years to expand health centers to increase patient capacity up to 40 million people. Due to the federal fight over the budget, only about $22 million of that $11 billion has been appropriated and distributed to community health centers. The sequester—which cut $120 million in health center funding—hasn’t helped, Hawkins said.

Health centers are being stretched thin due to increased demands for their services during the Great Recession, and Hawkins is worried about their ability to take on new patients Jan. 1, especially in the area of primary care.

“We have such a shortage of primary care, nurse practitioners and physician assistants,” he said. “Every one of them is worked to the nub. … I think, in the broader health care community, it’s really questionable where we can expand to accommodate the new folks who gain coverage.”

Here’s how various health centers across the country have been affected by the Great Recession and how prepared they think they are for the health insurance expansion in 2014.
In 2006, only 21 percent of children in low-income families in Wisconsin received any kind of dental care. That was a real problem, said Greg Nycz, executive director of the Family Health Center of Marshfield Inc. Only Florida had fewer low-income children visiting a dentist at the time.

“It’s because our state has many underpaid private dentists and they feel they just can’t serve that population,” Nycz said. “Many of them (low-income children) have that benefit, but they just don’t have anywhere to go to get that realized.”

So in late 2006, the secretary of the state Department of Health Services called Nycz and asked for help from Wisconsin health centers. Nycz devised a 10-year plan to increase low-income children’s access to dental services.

“Collectively, our state community health centers have gone from serving about 24,000 largely low-income people for dental in 2003,” said Nycz, “and right now we’re serving over 124,000. That’s in 2011. … We have eight dental centers now with 45 dentists. Our ninth dental center is being built in collaboration with the Ho-Chunk Nation.”

The five sites of the Yakima Neighborhood Health Services in Washington state see a high number of patients who are migrant workers or uninsured. When the Great Recession hit, it saw a rapid increase in the uninsured, according to CEO Anita Monoian.

Yakima received a federal grant to expand to a new location in the Sunnyside community.

“That’s going to be a dramatic expansion, which of course we’re doing to get ready for Medicaid expansion. … We want to be sure our facilities are ready,” Monoian said.

One of the biggest challenges she faces is finding enough doctors to serve the new patients they expect to see. Monoian said 300,000 people are expected to gain insurance coverage just in Washington with the Medicaid expansion.

“It won’t surprise you to know that we’ve been recruiting for this for several months now, knowing it was coming,” she said. “There’s a huge need in this country and a shortage of primary care physicians. We have for years had a very nice mix of physicians to nurse practitioners to physician’s assistants that, of course, has really helped us expand our services.

“It (recruiting) is the biggest challenge. There’s no getting around it.”

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When states started feeling the bite of the Great Recession in 2008, Nycz said his health centers began seeing a lot more people coming through its doors. When more people become insured Jan. 1, Nycz said it will be a mixed bag on whether patients can get the care they need.

“Where we are in our service area now, the single biggest need used to be dental,” he said. “We’re kind of meeting that need now. The single-biggest need now is in the behavioral health area. This is an area of growing concern for us. When we meet with tribal folks up north, they tell us they’re going to lose a generation of children because they don’t have access to child psychologists.”
Growing, Again, To Care for More People

The East Boston Neighborhood Center is one of the limited groups of professionals in the country that can say, “been there, done that” regarding Medicaid expansion. Massachusetts enacted its own law in 2006 requiring most state residents to get health insurance. “We saw an increase in demand soon after the law was passed,” said CEO Manny Lopes. “We increased our hours, we brought on as many (employees) as we could afford and had space for. … All of our buildings, we had taken up just about every corner closet … to see patients.”

Lopes thinks the center will once again see more patients after the Affordable Care Act is implemented because it “changes people’s mindset once they feel like they have less concern about going to the doctor, less concern about how to pay for that.”

To prepare, the East Boston Neighborhood Center has been expanding. It received $12 million from the American Recovery and Reinvestment Act, which helped it build a new 50,000 square foot building.

Lopes said state policymakers should pay close attention to an often-overlooked piece of health insurance reform—patient navigators. “Massachusetts made the investment and helped pay for folks who worked at the health centers and helped the patients understand what options they had,” he said. “At least for us, that was a very important piece, making sure people who were signing up were signing up for a program that met their needs.”

Lopes said policymakers also need to remember to bring health centers, not just the big insurance companies, to the table when discussing health care reform. “We have a consumer board that really gives us direction,” Lopes said. “We have ears on the street to know what’s going on. We’re really in tune with the community that we’re serving and we can really help. “Understand us, understand what we do and bring us to the table. I think you’ll find we’ll be good partners.”

| Name: East Boston Neighborhood Health Center | Location: One main campus located in East Boston | Number of Patients: 60,000 | Poverty: 69 percent of patients have incomes less than 200 percent of the federal poverty level. | 2012 Total Patient Contacts: More than 300,000 | 2012 Budget: $96.4 million | Funding Sources: 37.4 percent Medicaid and other state low-income insurance programs; 25.4 percent nonfederal grants/contracts; 21.2 percent federal government grants; 13.6 percent private insurance/other; and 2.4 percent self-pay |

TREMENDOUS GROWTH
FRANKLIN, LA.—Dr. Mayra S. Bustillo, a pediatrician with Teche Action Clinic, talks about the importance of a healthy lifestyle to second-graders at LaGrange Elementary School in 2012. Teche Action Board has had to expand rapidly—building three new clinics in the past eight years—due to the Great Recession and a large number of former residents of New Orleans who flocked to the area after Hurricane Katrina. Doctors there expect another surge of patients in January.

Name: Teche Action Board Inc. | Location: Eight clinics located in rural southern Louisiana | Number of Patients: 18,000 | Poverty: 78 percent of patients have incomes less than 200 percent of the federal poverty level. | 2012 Total Patient Contacts: 65,000 | 2012 Budget: $11 million | Funding Sources: 40 percent Medicaid; 33 percent federal government grants; 20 percent Medicare; 6 percent private insurance; and 1 percent state funding
MORE THAN PRIMARY CARE

BOSTON, MASS.—The East Boston Neighborhood Health Center maintains its own emergency department, top, which gets 45,000 visits annually. Kristen White, left, a fourth-year student from the New England College of Optometry, gives Concetta Cunningham a vision exam earlier this year at East Boston’s new Vision Care Department. Community health centers provide primary care, dental, mental health and sometimes vision services, as well as assistance with transportation issues. Photo by Steven Snyder

“...We had a double whammy,” Wiltz said. “We had both natural and man-made disasters hitting us. I had 19 relatives come live with us in Franklin after Katrina. We saw a great influx of community health center patients come out of New Orleans.

"Then as the recession hit, people became unemployed. Between 2005 and 2012, … we went from having two sites to eight sites. We had a tremendous increase in access.”

Wiltz said the board secured federal funding to build three new clinic sites. There now are six doctors and 10 nurse practitioners spread over those eight sites. Wiltz credits President Obama with being systematic in how the Affordable Care Act has rolled out, but he is concerned about the federal budget cuts that already have hit and what the future may hold.

“I think we’ve positioned ourselves well,” he said. “I’m saying that community health centers, if we got adequate funding, we could increase to capacity and serve those folks.

“There just aren’t enough of us. We have plans to expand to six days a week, 12 hours a day to keep it convenient and keep people from going to the emergency room. This country has got to get away from that cost of care. We’ve got to invest in primary preventive care.”

Wiltz said health centers have learned to be nimble out of necessity. Local uninsured women, for example, needed mammograms and a local hospital didn’t have enough mammogram patients to keep its certification. Wiltz said he helped put together a plan benefitting both sides where patients only had to pay half of the cost of the test and the hospital got enough patients to keep its certification.

“That’s the great thing about community health centers,” he said. “Fifty-one percent of the board are users of the clinic. I always make the comment: It’s local problems with local solutions by local people using state or federal money. When people talk about states’ rights, you can’t get any more local than community health centers.”
WHAT IS THE BIGGEST HEALTH CARE COST DRIVER AND WHAT CAN STATES DO ABOUT IT?

EXCHANGES, REGULATIONS POSSIBLE

“States don’t control the biggest health care cost drivers, like advances in medical technologies. … The big levers for states to control health care spending right now are, first of all, Medicaid programs. States are doing pretty much what they can to control Medicaid costs. … States, if they choose to, can use (health insurance) exchanges to set up active purchasing, which means … they will only allow plans to compete for people’s business in exchange for meeting certain criteria, like they will not allow plans to compete … that hit people with very large premium increases. … The third level some states use but many do not, is the ability states have to regulate insurance premiums. States do that to varying degrees.”

REWARD PATIENT OUTCOMES

“Reining in health care costs requires a shift from a system that rewards volume of care to one that rewards better patient outcomes. With the largest networks of alternative payment and delivery models like patient-centered medical homes and accountable care organizations in the country, the Blues® are leading efforts to transform the way care is managed, financed and delivered in nearly every state. By rewarding quality, enhancing coordination and encouraging more informed patient decisions, these innovative models are yielding healthier patients and lower costs. States are vital partners in these reform efforts and we must continue to work together to advance initiatives that promote better, more cost-effective health care for patients.”
WHAT IS THE BIGGEST HEALTH CARE COST DRIVER AND WHAT CAN STATES DO ABOUT IT?

LEGISLATORS PLAY A KEY ROLE

“The key drivers of health spending growth are interconnected and include how health care is organized, delivered and paid for. Similarly, the solutions are multifaceted and inexorably linked. What’s more is that many of the drivers and the solutions are local; therefore, states (and state leaders) not only can make a difference, they must, using their influence as the most reliable convener of all stakeholders, and their power as a major purchaser of health care (Medicaid and state employees). And then they promote experimentation with every credible innovation in health care delivery and financing. Evaluate, implement, spread, convene and repeat.”

ANDREW HYMAN, J.D.
Coverage Team Director and Senior Program Officer
Robert Wood Johnson Foundation

EMERGENCY COSTS INCREASING

“As the un- and underinsured population grows, emergency rooms shoulder increased costs, particularly from those who have not been able to afford primary and preventive care. These uncompensated costs to hospitals are eventually shifted to the state, privately paying patients and those with insurance. With the highest rate of uninsured in the nation and a population growing twice as fast as the national average, Texas can no longer avoid this issue. Uncompensated care in our state is already unsustainable and is expected to increase drastically over the next 10 years. The time is ripe for our state to develop, negotiate and implement a Texas-shaped solution that benefits patients, providers, our economy and taxpayers.”

JOHN ZERWAS, M.D.
Texas State Representative

BETTER COORDINATION NEEDED

“We believe that excessive utilization of services is the main cause of higher health care costs. Excessive utilization is mostly due to duplication of services or unnecessary services because no one is helping patients and doctors to coordinate care. In fee-for-service Medicaid programs, health care services are fragmented and coordination of care is lacking. This creates a particularly challenging situation for Medicaid patients who suffer from behavioral health issues, language barriers and lack of transportation. States can lower costs and ensure better care and outcomes by enrolling these patients in care management programs.”

J. MARIO MOLINA, M.D.
President and CEO
Molina Healthcare
WESTRAIN Completes Pilot Project in Five States

WESTRAIN—a pilot program of CSG West that provides professional development training directly to state capitols—completed its initial five-state test run in March. California, Colorado, Idaho, Montana, and Nevada were selected by CSG West officers as the pilot states.

Each pilot state chose one topic and speaker from a short list of options—such as communications, ethics, stress management and time management—to provide training to legislative staff and/or legislators. The trainings were well attended and received positive feedback. CSG West officers will review the evaluations of the pilot program and will decide on a possible expansion and continuation of the program for the next fiscal year.

CSG East Hosts Health Care Panel for Legislators

CSG East hosted a panel on insurance exchanges in the Connecticut Legislative Office Building March 19. The panel, “Health Insurance Exchanges: How Connecticut Can Benefit,” informed legislators about the Affordable Care Act and the role insurance exchanges will play in the state.

Speakers included Dave Chandra, senior policy analyst for the Center on Budget and Policy Priorities; Christie Hager, regional director for the U.S. Department of Health and Human Services; and Vicki Veltri, Connecticut state health care advocate. Connecticut State Comptroller Kevin Lembo moderated the panel.

In addition, the Northeast States Association for Agricultural Stewardship hosted a lunch with the Connecticut Rural Caucus March 20.

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The Book of the States 2013

Learn more on CSG’s Knowledge Center.
2013 NAST Legislative Conference

The National Association of State Treasurers held its 2013 legislative conference March 18-20 in Washington, DC. The event drew 174 attendees, including 52 state treasurers. Attendees discussed a wide range of financial topics, including the future of tax-exempt municipal bonds, the impact of federal budget cuts on the economy and the global economy. Treasurers also visited with White House officials and congressional leaders.

—from left—Vermont State Treasurer Beth Pearce, Idaho State Treasurer Dan Himel, Illinois State Treasurer Mike Fitzpatrick, 2013 NAST President and Virginia State Treasurer Mark Obenshain and West Virginia State Treasurer John Purcell attended the 2013 NAST Legislative Conference.

ICJ Members Make Presentations

Rose Ann Bisch, commissioner of Minnesota’s Interstate Commission for Juveniles, participated in the annual conference for the Association of Administrators of the Interstate Compact on the Placement of Children in Denver May 3-6. Bisch is in her second year as co-chair of the work group promoting cooperation, collaboration and communication between the two compacts.

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While health care reform gained a lot of attention in the past year, states are facing other issues related to federalism. Kansas Solicitor General Stephen R. McAllister says when state and federal laws both operate on the same subject matter, basic issues of pre-emption apply. Following the Newtown, Conn., shootings last December, President Obama and Congress began a new push regarding gun control issues. Many states responded by considering their own legislation on guns, ranging from bans on assault weapons to a bill in Texas to remove any law enforcement officer who refuses to enforce state or federal law.
In recent years, states with some frequency have disagreed with and objected to a variety of federal laws. Sometimes the objectionable federal law has been in the form of federal statute. Sometimes the federal law is constitutional law, in the form of U.S. Supreme Court decisions interpreting the scope of the federal government’s power and federal constitutional rights.

Prominent examples in recent years include state objections to the federal health care law, in particular the individual mandate that requires people to purchase health insurance, and the federal government’s decision not to exempt certain employers with religious objections from mandatory contraceptive coverage as part of employee health plans. Other prominent examples include state-sponsored personhood amendments or laws that would declare life to begin at conception, an objection to the current abortion jurisprudence under federal law.

No matter the source of federal law, however, basic issues of pre-emption apply when state and federal law both operate on the same subject matter.

The starting point for any discussion of the relationship between the U.S. and state constitutions is the Supremacy Clause of Article VI of the federal constitution, which says, “This Constitution, and the Laws of the United States which shall be made in pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme law of the land; and the Judges in every State shall be bound thereby, anything in the Constitution or laws of any state to the contrary notwithstanding.” (Emphasis added.)

As stated in “State Constitutional Law: The Modern Experience,” this clause “makes clear—in explicit terms—that federal law has primacy over state law, including state constitutions, when there is a conflict between any federal law (constitutional, statutory, or even regulatory) and state law.”

There are numerous examples of the U.S. Supreme Court invalidating state laws and provisions in state constitutions that are pre-empted by contrary federal
law. So if there is a true conflict between federal and state law, longstanding legal doctrine leaves no doubt as to which law prevails—the federal law trumps contrary state law.

For example, a state law prohibiting any state resident from being required to buy health insurance cannot block a federal law requiring such purchases. A state law exempting employers from covering contraceptives in their employee health insurance plans on religious grounds cannot block or supersede valid federal law that, to the contrary, requires employers to provide such coverage.

It is, of course, also true that state law can express a preference for drawing the balance differently in such cases than does federal law. So a state may adopt a state constitutional amendment or enact a statute that expressed disagreement with the holdings of Roe v. Wade and related abortion cases, or that objects to the imposition of particular requirements under the federal health care law.

Such a state law may serve the useful and important purpose of permitting a particular state’s residents to express publicly and collectively their strong and fundamental disagreement with federal law in controversial areas. Indeed, on some very important and potentially controversial issues, state law—including state constitutions—may enshrine very different value judgments than those found in the U.S. Constitution, as interpreted by the U.S. Supreme Court.

But there should be no illusion that state laws contrary to federal laws can somehow exempt an objecting state and its residents from such federal laws, or provide some sort of legal immunity from the application of federal law. That simply cannot happen in light of the Supremacy Clause of the U.S. Constitution and longstanding U.S. Supreme Court precedent.

Nor do state laws purporting to preclude the application of federal law to state residents give the state—usually in the person of the attorney general or governor—legal standing to challenge objectionable federal law. Instead, the affected people would have to bring their own lawsuit challenging federal law. For example, a person objecting to a requirement to buy health insurance would bring the lawsuit. That person’s challenge would not be that state law immunizes him or her from compliance with federal law, an argument that would necessarily fail as a legal matter. The argument would be that the federal law is invalid, either because it exceeds the power of Congress—the argument made in the health care cases—or because applying the federal law will violate individual rights protected in the U.S. Constitution.

Only if the Supreme Court were, for example, to overrule Roe v. Wade and declare that the U.S. Constitution does not recognize any individual right to decide whether to terminate a pregnancy could states ban or limit abortions beyond what current federal law allows. And, of course, if in the recent health care cases the Supreme Court had ruled that Congress lacked the constitutional power to impose the individual mandate in the health care law, then no citizens would be subject to that requirement. That result would be because the federal government never had the power to impose the mandate, not because the states passed laws or constitutional amendments contradicting federal law.

Ultimately, state legislatures certainly may, in given instances, prefer a very different recognition of rights than what is provided by the federal constitution, and those state preferences may go in either direction—in favor of greater protection or in favor of less protection than federal law provides.

But what state legislatures and states cannot do in our system of dual sovereignty is simply opt out of federal law with which they disagree on policy, moral, ethical or religious grounds. If that proposition was not settled when the U.S. Constitution was ratified in 1789, then the Civil War certainly resolved the question in favor of federal supremacy over state law. At least in the sense that when federal and state laws conflict, federal law always prevails so long as the federal law is otherwise valid in the first place, i.e., the federal government had power to enact the law and the law does not violate any provision of the U.S. Constitution.

Stephen R. McAllister is a law professor at the University of Kansas School of Law and solicitor general of Kansas. For a more extensive discussion of these issues, see McAllister’s “Individual Rights Under A System of Dual Sovereignty: The Right to Keep and Bear Arms,” available online at http://www.law.ku.edu/sites/law.drupal.ku.edu/files/docs/law_review/v59/07-McAllister_Final.pdf.

FEDERALISM ISSUES

While the federal Affordable Care Act has garnered much attention with regard to state-federal relations, other issues are coming to the forefront. For instance, some states are legalizing marijuana, both medical and other, and are making gay marriage legal. Far left, Oregon state Rep. Sal Esquivel, R-Medford, left, and others have objected to federal raids on medical marijuana grow sites in Oregon, saying the states should be left to regulate them. Troy Morris of M-Research, right, explains how the active ingredients are concentrated in the buds of the plant on a farm outside Jacksonville, Ore. At left, Colorado Gov. John Hickenlooper gave a thumbs up as he celebrated with members of the legislature in March after signing the Civil Unions Act into law at the Colorado History Museum in Denver. The U.S. Supreme Court is considering several cases with regard to gay marriage.
After Two High-Profile Mass Shootings, States Considering Variety of Gun Laws

by John Mountjoy

Connecticut Deputy House Speaker Bob Godfrey lives just 10 miles from Sandy Hook Elementary School, the scene of the deadly December 2012 shooting that left 20 first-graders and six adults at the school dead.

Godfrey has advocated for reasonable gun laws for more than 24 years. But this time, he believes, it’s different.

“The horror of the massacre of innocents at an elementary school has motivated an extraordinary response,” he said.

In fact, the shooting at Sandy Hook, like the one at the Aurora, Colo., movie theater last July, has brought renewed focus on gun laws across the country.

An analysis by The Council of State Governments shows that, as of mid-March, 22 states had introduced legislation seeking a new ban on assault weapons or strengthening existing laws restricting access to or ownership of such weapons; 23 states had introduced bills seeking restrictions on firearm magazine capacity; and 23 states—not necessarily the same states—had introduced legislation seeking to expand or make mandatory, background checks for all firearms purchases.

Congress and the Obama administration acted quickly to explore reforms to the nation’s gun laws. Federal legislation focused on banning the future sale of assault weapons, restricting firearm magazine capacity to 10 rounds and calling for background checks on all gun purchases—including private face-to-face sales. The national debate over these proposed measures has been anything but civil and, as a result, the future of proposals at the national level is uncertain.

State laws, too, are anything but certain.

New York’s SAFE Act—Secure Ammunition and Firearms Enforcement Act of 2013—not only bans the sale of assault weapons and restricts the sale of covered rifles already in circulation, but also further limits the legal capacity of ammunition magazines to seven rounds, down from New York’s already restricted 10 rounds. It’s already being challenged in a state supreme court.

Still, states are pressing ahead.

Connecticut policymakers have joined forces through its Bipartisan Task Force on Gun Violence Prevention and Children’s Safety, which examined gun violence, school security and mental health.

While agreement exists on issues such as straw purchases of firearms, ammunition purchases and a statewide deadly weapons offender registry, differences are pronounced when it comes to further restricting assault weapons, magazine capacity and background checks.

Godfrey hopes progress can be made by “expanding the definition of military-assault weapons, outlawing oversize magazines, enhancing safe storage requirements and..."
extending Connecticut’s permit-to-carry a handgun to more firearms.”

The legislature in April passed a package of new gun laws, including immediate bans on the sale of assault weapons and magazines capable of holding more than 10 rounds of ammunition. It also passed a bill to require uniform background check for all firearms purchasers.

The Economic Impact

But Connecticut’s actions could have an adverse effect on the state’s economy. Colt’s Manufacturing, one of America’s oldest firearms makers, has signaled its willingness to move out of its 175-year-old home in the state with the adoption of stricter firearms legislation.

Colt’s has launched a statewide ad campaign along with other Connecticut-based firearms manufacturers to educate the public on the gun industry, which contributes $1.7 billion annually to the state’s economy.

Gunmaker PTR Industries announced in April that it will leave Connecticut because of the new laws. The potential economic impact is one reason Colorado Sen. Greg Brophy, an outspoken advocate for gun rights, is disappointed in the legislation that was ultimately adopted in his state.

While the Centennial State has not considered an assault weapons ban this year, Gov. John Hickenlooper in March signed bills to restrict magazine capacity, require background checks for all firearms purchases and pass background check costs on to the consumer. Additional gun control measures are still active in the legislature.

The ‘AR’ in AR-15

Assault rifle? Automatic rifle? The AR in AR-15 actually stands for Armalite Rifle. Armalite, a division of Fairchild Aviation, was created in 1954 as a design shop to license firearm concepts to other companies. Eugene Stoner, the designer of the AR platform, initially began his work to produce a larger caliber battle rifle for the U.S. and NATO partner countries during the Cold War. His AR-10 design, though revolutionary for its day, never caught on. Subsequent designs led to the development of the smaller caliber AR-15, its licensing to Colt’s Manufacturing and the mid-1960s adoption of the weapon by the U.S. military as the M-16. The military still uses that weapon and its variations, making it the longest serving military rifle in American history.
HISTORY OF FEDERAL FIREARMS

1791
SECOND AMENDMENT TO THE U.S. CONSTITUTION RATIFIED

“A well-regulated Militia, being necessary to the security of a free State, the right of the people to keep and bear Arms, shall not be infringed.”

1934
NATIONAL FIREARMS ACT

Created as a result of gangster violence in the 1920s and early 1930s; restricted the sale of automatic weapons, short-barreled rifles and shotguns, as well as silencers. The act also placed a $200 tax—$3,400 adjusted to 2012 dollars—on any new restricted weapons bought and subjected them to approval through the U.S. Treasury Department. The $200 tax and federal approval are still in place.

1938
FEDERAL FIREARMS ACT

Designed to cut down on interstate and offshore trafficking of firearms and required the licensing of firearms dealers via the Federal Firearms License. Dealers also were required to record the names and contact information for buyers and were prohibited from selling guns to people convicted of certain crimes.

1968
GUN CONTROL ACT

Following President John F. Kennedy’s assassination by Lee Harvey Oswald, who used a rifle bought via mail order, and the subsequent assassinations of Martin Luther King and Robert Kennedy, the Gun Control Act expanded dealer licensing requirements, restricted handgun sales across state lines, enlarged the list of people who could not buy a gun, and outlawed direct sales of rifles and shotguns by mail order.

1986
FIREARM OWNERS’ PROTECTION ACT

Loosened several previous restrictions, including limited sales of long guns across state lines, legalized ammunition sales via mail and the transportation of firearms through states where such possession is legal. The law also placed restrictions on how the ATF can inspect firearms dealers. The law outright banned the sale of automatic weapons to civilians; the 1934 National Firearms Act merely restricted their sale.

1990
CRIME CONTROL ACT

Established drug-free school zones, including the prohibition of firearms in designated school zones. The law also outlawed the domestic manufacture of certain semiautomatic rifles or shotguns using legally obtained imported parts.

1994
VIOLENT CRIME CONTROL AND LAW ENFORCEMENT ACT

Commonly known as the Assault Weapons Ban, the law banned the manufacture, possession and importation of certain semiautomatic rifles and shotguns and restricted the manufacture and sale of firearm magazines with a capacity over 10 rounds. The law established criteria for defining an assault weapon and banned 19 firearms specifically, including the AK-47.

2004
FEDERAL ASSAULT WEAPONS BAN EXPIRES

A 10-year sunset clause was included in the 1994 law and Congress did not reinstate the law.

SHOOTING AFTERMATH

AURORA, COLO.—Jeanine Anderson, left, and U.S. Air Force Staff Sgt. Ryan Eanes visited the memorial across from the Century 16 theater, the site of a deadly shooting in July 2012. Twelve people were killed and more than 50 wounded in a shooting attack early Friday, July 20, at the theater during a showing of the Batman movie, “The Dark Knight Rises.” © AP Photo/Alex Brandon

The gun control debate in Colorado, the scene of 2012’s other high-profile mass shooting, was seemingly as much about the economy as it was about public safety. Magpul, the popular Colorado-based manufacturer of 10-, 20- and 30-round rifle magazines, publicly stated its intent to leave the state if more restrictive gun laws were adopted.

With Hickenlooper’s signature, Magpul is making good on that promise, stating in a press release on the company’s website that it will shift operations out of Colorado and will resume magazine production elsewhere within 30 days. It is likely goes Magpul’s 200 workers and its estimated $85 million annual contribution to the local and state economies.

“IT’s not just Magpul leaving, but all of Magpul’s suppliers. They have a super-short supply chain and, in the end, we’re going to end up losing nearly 1,000 jobs overall,” Brophy said.

“Two-thirds of Coloradans were paying close attention to this debate and, unlike a lot of legislation we consider, people were very aware of the secondary and unintended consequences of these actions,” Brophy said. “My colleagues in favor of more gun control are now emboldened and don’t appear to be willing to compromise. With an election 18 months away—and anything can happen in 18 months—I’m hopeful that this will be dealt with by the voters.”

The economic impact of firearms and firearms-related products is not just limited to Connecticut and Colorado.

In Maryland, Beretta, the nearly 500-year-old Italian firearms maker, is exploring pulling up stakes there and relocating some of its North American manufacturing if the state adopts more restrictive firearms laws.
Bolstering Gun Rights

While gun control advocates have made quick advances this session and may see more progress before the year is out, some states are considering firearms bills to bolster gun rights. In fact, 21 states are considering both gun control and gun rights legislation.

CSG research shows that 30 states have introduced legislation seeking to pre-empt federal gun control efforts and define penalties for those caught enforcing federal gun control measures within a state’s borders.

Pre-emption laws related to guns are not new. Many states with concealed carry laws pre-empt local governments from adopting ordinances that are more restrictive of open or concealed carry laws than those defined by the state—with an eye toward limiting confusion and contradictory practice. But the idea that states can prohibit the enforcement of federal gun laws is new.

“I’m not sure that a state law pre-empting new federal gun laws will ultimately pass muster, but they certainly send a strong signal … that the states take their role in regulating firearms seriously,” said Kentucky Rep. Bob Damron.

In addition, the Firearms Freedom Act has gained modest acceptance in traditionally pro-gun states. Before this year, eight states had adopted such legislation, which seeks to pre-empt the enforcement of certain federal gun laws within a state on the grounds that firearms and ammunition manufactured, sold and possessed within a single jurisdiction are not subject to federal interstate commerce authority. Fifteen states have introduced the act or some variation this year.

Some local officials—particularly sheriffs—are taking it a step further. Many of those who have been critical of state and federal efforts to restrict access to certain firearms, reduce magazine limits and enhance background checks have gone on record that they will refuse to enforce any new gun laws.

In response, Texas Rep. Yvonne Davis has introduced legislation that would remove from office any sheriff or law enforcement officer who refuses to enforce state or federal law.

In Missouri, Rep. Mike Leara has introduced legislation making it a class D felony for any state legislator to introduce legislation restricting the rights of residents to keep and bear arms.

Uptick in Legislation

The past several years have seen an uptick in firearms-related legislation, mainly focused on concealed carry and firearms on college campuses.

- 40 states have “shall issue” concealed carry laws on the books, meaning that the burden is on the issuing jurisdiction to prove that an applicant shouldn’t have a permit.
- 14 states and territories have “may issue” provisions in their laws; that means the burden is on the applicant to prove a need for a concealed carry permit, such as personal safety arising from a domestic dispute.
- 21 states ban carry on college campus, while 23 states permit colleges and universities to determine their own policies.
Oregon Rep. Phil Barnhart was a practicing psychologist for 18 years before being elected to the state legislature 12 years ago. He said it’s increasingly difficult for people to balance their work and home lives in our connected culture, but it’s vitally important for legislators to remember where their priorities lay. Here are his tips on how to keep it all together, even during the heat of a legislative session.

MORE ISN’T ALWAYS BETTER.
The constant presence of technology in most people’s lives makes it harder than ever to get away from your job, Barnhart said. But working 24 hours a day isn’t necessarily going to make you better at your job. “People in the public eye, it’s even a little more difficult because it is really easy to get completely absorbed in the public process and ignore your personal life and personal responsibility,” he said. “My view is if you do that, eventually you become ineffective. You can’t function … if you don’t take care of your personal health and you have to take care of your personal relationships.”

TAKE CARE OF YOURSELF.
Although legislators often worry about taking care of their constituents, the first person they need to take care of, Barnhart said, is themselves. “You have to attend to your own health,” he said, “getting enough sleep, eating properly, getting enough exercise and those kinds of things. You can skimp on it now and then when push comes to shove, but basically if you don’t do that (take care of yourself), you’ll get sick and you won’t be able to handle any of your other priorities.”

TAKE CARE OF YOUR CHILDREN.
Barnhart said you have to take care of yourself first to be able to take care of others. “If you have young children, they come second, they have to,” Barnhart said. “There’s no other way around that.”

TAKE CARE OF YOUR SIGNIFICANT OTHER.
Barnhart said too often, spouses take a back seat when things get tough for a legislator. That’s not a good thing. “You can’t put it off all the time,” Barnhart said. “You have to get back to that relationship and do what it takes, actually do the good things that allow you to renew that relationship, keep it fresh and interesting and vital. … Too many colleagues have gone through divorces because of the difficulty they face here. It’s devastating. It’s a horror. Most of them don’t stay, they can’t because they’re personally too devastated to function.”

MAKE A LIST OF YOUR PRIORITIES.
“I try to keep it simple because I need it simple for myself,” Barnhart said. “In the middle of a crisis you’ve got four things pulling at you and you have to figure out which thing you’re going to attend to. Having this very simple priority list in my head makes it easier for me to make the right choices.”
National and Regional Meetings

Registration and application deadlines may apply. Visit www.csg.org/events for complete details.

Csg Affiliates
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NLGA (National Lieutenant Governors Association) | www.nlga.us
NASTD (National Association of State Technology Directors) | www.nastd.org

Western Legislative Academy

CSG West will hold its 2013 Western Legislative Academy Nov. 13–16, in Colorado Springs, Colo. The intensive three-and-a-half-day professional development program for Western state legislators in their first four years of service is designed to assist legislators become more effective leaders and strengthen legislative institutions. The WLA focuses on communications, time management, governing, ethics and consensus building.

Admission to WLA is highly competitive, as space is limited to 39 legislators from the 13 Western states.

For more information, visit csgwest.org/LegislativeAcademy or call (916) 553-4423

Nate Silver to Keynote CSG National Conference

Nate Silver, founder of FiveThirtyEight.com who gained national attention during the 2008 presidential election by accurately predicting results of the primaries in 49 states and the general election, will give a keynote address during The Council of State Governments 2013 National Conference in Kansas City, Mo. Silver will speak during the luncheon Sept. 21.

Visit www.csg.org/2013nationalconference for more information.
Kentucky Rep. David Watkins has the inside track to health care reform—he’s seen it up close and personal as a physician in the small city of Henderson for nearly 40 years. Watkins sees some positive steps toward cutting health care costs in the Affordable Care Act, but is left scratching his head about some other things. He likes the focus on preventive care. “I just believe if you can prevent things, you’re better off doing it,” he said. In fact, Watkins, 69, entered politics just eight years ago to gain a wider reach on the health care messages he was giving daily in his office—on smoking, diabetes and weight. “I just felt like I could brush with a little wider stroke and affect a larger number of people by being in the legislature,” he said. Watkins thinks getting more people covered by health insurance is a good thing—it could cut the number of people who use emergency rooms for primary care. But he worries about access to care. “Basically the biggest flaw in the Affordable Care Act is that we don’t really have enough providers to absorb all these new people that will be coming on board in the next three or four years,” he said. “That’s one area we have to work on.”
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Keynote Speaker

Nate Silver
Founder, FiveThirtyEight.com;
Author of The Signal and The Noise
Saturday, Sept. 21, Noon

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