Applications available in January!
Applications are due by April 15.

If you have any questions concerning the application process or need additional information please contact Krista Rinehart, Toll Fellows Program Manager, at (859) 244-8249 or krinehart@csg.org.

WWW.CSG.ORG/toll
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A look back in time
A lot of attention is being focused on the proposed federal stimulus package aimed at helping states rebuild infrastructure. But transportation issues will be big for another reason this year: SAFETEA-LU—or the Safe, Accountable, Flexible, Efficient Transportation Equity Act: A Legacy for Users—is up for reauthorization. Read about what states can expect from the federal infrastructure stimulus package as well as plans for the reauthorization of the federal transportation law on Page 8, then check out Capitol Comments for information about The Council of State Governments resolution on transportation, which was adopted at the December annual meeting in Omaha.

When Maryland became the first state to pass comprehensive laws regulating pharmacy benefit managers, that state effectively compromised with an Industry that’s known as the middleman of the pharmacy benefit world. Check out the story on page 21, then read Capitol Comments to see if any other states are jumping on the bandwagon by considering similar laws. Capitol Comments will also feature updates on a court case that is challenging one such law regulating pharmacy benefit managers—the 2004 Washington, D.C., AccessRx Act, which is still being litigated.

Look for the Capitol Comments indicator throughout the magazine to find Web extras on the CSG blog.

Question:
Which state has the highest average age of employees, as of 2007, according to the 2008 Book of the States? Which state has the lowest average age?

To find the answer, log onto CSG’s Web site at www.csg.org!
CDC Report: Teenage Pregnancy Increases, Especially in the South

The national teen birth rate in the United States has risen for the first time in 14 years. That’s according to a report released in January by The National Center for Health Statistics, a division of the U.S. Department of Health and Human Services’ Centers for Disease Control and Prevention.

Of the 4.3 million births in the United States in 2006, which are the latest figures available, approximately 435,000 of them were to teenage mothers, a 21,000 or 3 percent increase from 2005. This represents a break in the steady 14-year decline in teenage births from 1991 to 2005 and reflects the highest overall teen birth rate since 1971.

Also, the report indicated that only three states—New York, North Dakota and Rhode Island—and the District of Columbia saw decreases in teen births from women ages 15 to 19. In 26 states and territories, the percentage change was not considered to be significant.

Overall, the South experienced the most dramatic increases in births to teenage mothers, according to the report, while the lowest rates are in the Northeast where three states saw rates at approximately half the national average.

Mississippi had the highest teen pregnancy rate in the country, with approximately 68 of every 1,000 births to teenage mothers, a rate 60 percent higher than the national average of 42 of every 1,000 births.

High teenage birth rates can be attributed to several factors, including poverty, racial demographics and increasing cost or unavailability of birth control in certain communities, experts say. While there is general consensus among experts regarding the influences of these factors, there is more debate regarding the influence of other issues, such as the advent of abstinence-only education or greater cultural acceptance of unwed mothers.

Also, since 2007 statistics are currently unavailable, it is impossible to discern if this sudden increase in teen pregnancy in 2006 was an anomaly or an indication of a changing trend in America.

Please visit http://www.cdc.gov/nchs/data/nvsr/nvsr57/nvsr57_07.pdf to view the final report.

CSG Justice Center Releases Guide on Re-entry Partnerships

The Council of State Governments Justice Center recently published a guide to improving prisoner re-entry collaborations among state governments and faith-based and community organizations. “Reentry Partnerships: A Guide for States & Faith-Based and Community Organizations” offers recommendations for how state governments and faith-based and community organizations can improve state re-entry grant programs, tailor responses to local conditions as well as ensure accountability for use of state funds. Implementation strategies from across the country are also included.

According to the report, reduced recidivism, increased public safety and better outcomes for people released from prisons and jails are contingent on the availability of both treatment and programming in correctional facilities and services in the community. Faith-based and community organizations provide re-entry services in prisons and jails and have networks to link people to the resources they need. But these groups cannot always connect with state government agencies. The guide works to break down those barriers.

“As the number of people released from prisons and jails grows, state governments must find fiscally sound ways to meet the rising demand for re-entry services,” said New York State Assemblyman Jeffrion Aubry, an advisory board member. “We need these concrete strategies to more effectively leverage community resources.”

This new report is funded by the Bureau of Justice Assistance, U.S. Department of Justice, and the Center for Faith-Based and Community Initiatives, U.S. Department of Labor. Please visit www.reentrypolicy.org/reentry_partnerships_pubs_tools to download the report. Hard copies of the report can be ordered through the National Criminal Justice Reference Service at www.ncjrs.gov.
States Offer Expanded Sex Offender Registries

Four states—Arizona, Utah, Wisconsin and Texas—are among more than two dozen that are quietly expanding their online registries of convicted sexual offenders, Stateline.org reports. Interestingly, it seems at least for this handful of states, the data is available in a variety of new, advanced ways.

The new features come as states approach the July deadline to comply with the 2006 Federal Adam Walsh Act, according to Stateline.org.

Want to check and see if you or your child has gotten an e-mail from a registered sex offender? Folks in Arizona can use their state’s registry to check the sender’s e-mail address against the state’s database of convicted molesters, according to Stateline.org.

And perhaps a little like signing up for a Google alert, Utah residents can now sign up for e-mail alerts that notifies them when a sex offender moves into their neighborhood, Stateline.org reports.

Wisconsin's online registry even provides maps to let users know exactly where the closest sex offender lives, according to Stateline.org.

Texas' sex offender registry now includes all kinds of information available to users—information from sex offenders’ work addresses to nicknames and even their shoe sizes, Stateline.org reports. The Texas sex offender registry includes more than 54,000 people, according to Stateline.org.

All 50 states have publicly searchable sex offender registries, which are accessible through a national database kept by the U.S. Justice Department. That Web site is available at http://www.nsopw.gov/Core/Conditions.aspx.

A December Stateline.org analysis of all 50 state sex offender registries, found:

- All states include information about the crime committed by each sex offender or, in some cases, general information about the victim.
- At least 29 states provide mapping to show exactly where sex offenders live.
- At least 19 states allow users to sign up for e-mail or other alerts telling them when sex offenders change their status or location.
- At least 18 states list information about where registered sex offenders are employed and those details vary by state.
- At least 12 states post information about the type of cars sex offenders drive.
- At least five states—Arizona, Colorado, Florida, Michigan and West Virginia—allow users to search for sex offenders using an e-mail address or instant messenger screen name.

Arkansas Still Looking At Cigarette Tax Increase

Lawmakers in Arkansas are planning to bring back a bill that would fund a much-needed state trauma network that links hospitals. Arkansas is the only state in the nation without a state-designated trauma center and one of just three states in the country without an organized trauma system, according to the Associated Press.

Right now, lawmakers may propose increases in the state’s cigarette tax to pay for the trauma system, which Arkansas Gov. Mike Beebe estimates could cost $28 million in its first year, the AP reports.

Beebe says he supports an increase in the cigarette tax—possibly increasing the tax by 50 cents per pack or more, according to the AP.

Arkansas Rep. Gene Shelby, also an emergency room doctor, authored a bill in 2007 that would have increased the cigarette tax by 50 cents. The bill would have allocated some of those funds to building a state trauma system. Although that bill didn’t make it, Shelby told State News in October that he’d most likely be authoring a similar bill this year.

“The number one thing and my motivation is the really good studies that show that if you increase the cost on cigarettes, there is a reduction in the use—(and) that’s more pronounced for younger smokers,” Shelby told State News. “From a public health standpoint it’s probably one of the best things we can do.”

Not only that, it could help pay for the state’s trauma network—“it does generate a fair amount of revenue,” Shelby said.

But passing a tax increase during a not-so-great economy may be tough this session, the AP reports.

“It’s a big hurdle,” Shelby said.

Passing the tax measure requires a three-fourths majority in both the Arkansas House and Senate.
## State Emergency Management: Agency, Budget and Staffing

<table>
<thead>
<tr>
<th>State or Other Jurisdiction</th>
<th>Position Appointed</th>
<th>Appointed/Selected By</th>
<th>Organizational Structure</th>
<th>Agency Operating Budget FY 2009</th>
<th>Full-time Employee Positions</th>
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**Key:**
- *—Yes
- —No
-  G—Governor
- ADJ—Adjutant General
- ED—Executive Director, Dept. of Local Affairs
- M—Mayor
- HSEMC—Homeland Security/Emergency Management Commissioner
- PSS—Public Safety Secretary/Commissioner/Director
- (a) Not a member of NEMA, and therefore is not represented in the survey data
- (b) Includes homeland security, emergency management and other positions
- (c) Includes both homeland security and emergency management positions

FORK IN THE ROAD
Economic Stimulus Plan Could Cloud Already Murky Future for Federal Transportation Programs

A lot of attention is being focused on the proposed federal stimulus package aimed at helping states rebuild infrastructure. But, according to Arizona’s Victor Mendez, transportation issues will be big for another reason this year: SAFETEA-LU—or the Safe, Accountable, Flexible, Efficient Transportation Equity Act: A Legacy for Users—is up for reauthorization.

By Sean Slone

“Shovel-ready” road projects are getting most of the attention directed at transportation and infrastructure spending these days.

President Barack Obama is counting on those projects—more than 5,000 of them identified by state transportation departments—as a key element in his plan to jumpstart the nation’s economy and create hundreds of thousands of new jobs.

But there is another reason transportation issues will likely continue to be a part of the national discourse in 2009. The legislation that authorizes federal highway and transit programs is due to expire Sept. 30. Known by the acronym SAFETEA-LU (which stands for Safe, Accountable, Flexible, Efficient Transportation Equity Act: A Legacy for Users), the legislation has set funding levels for transportation programs since it was passed by Congress in 2005.

Replacement legislation is likely to determine not just federal funding levels for transportation, but also expected necessary funding levels for state governments to repair crumbling infrastructure and invest in the transportation systems of tomorrow. New legislation could redefine the state-federal relationship in this area and restructure federal programs to address a growing list of priorities in the transportation sector and beyond.

The debate over the replacement for SAFETEA-LU comes at time when last summer’s high gas prices contributed to an ongoing decline in U.S. driving. Fewer drivers paid gas taxes or tolls that fund transportation programs and that means funds for infrastructure were drying up.

“Clearly what needs to be considered for the future is the sustainability of the revenue source for our investments in transportation,” said Victor Mendez, director of Arizona’s Department of Transportation, a member of CSG’s Transportation Advisory Group who served on the Obama transition team.

It was already apparent last summer that revenues from current federal and state gas taxes weren’t sufficient to finance needed improvements to the nation’s infrastructure. Yet state policymakers have discovered in recent years that raising gas taxes is not a popular or politically viable option in many states. The federal gas tax has not been increased by Congress in 15 years and is not indexed to inflation, so it remains steady at 18.4 cents per gallon.

“I think a lot of people recognize the issues that we’re facing with the gas tax. The revenues have been dropping dramatically for the last year and a half,” Mendez said. Last September, Congress had to step in with an $8 billion infusion at the last minute to keep the Highway Trust Fund solvent, he said.

Declining revenues mean Congress and state governments will likely need to consider new ways to fund transportation programs. These may include leasing transportation assets to private companies, increasing tolls and even charging drivers per vehicle mile traveled.

Reauthorization, Stimulus Go Hand in Hand

Despite the attention the proposed investment in shovel-ready projects has received, Mendez said the transition team has been working on the stimulus package and the next authorization plan for federal transportation programs in tandem.

“I wouldn’t say that reauthorization has taken a back seat. I think a lot of us still are working on the reauthorization issues and ensuring that Congress understands our agendas, our interests when they do start talking about reauthorization,” Mendez said. “I think it bodes well from my standpoint that we now have a Congress and an administration that are clearly willing to invest in transportation and other infrastructure for that matter.”

But some state leaders, including Pennsylvania Gov. Ed Rendell, has expressed concern that a stimulus package that includes money for transportation projects may full Congress into thinking a replacement bill for SAFETEA-LU is not urgent. That could delay passage of legislation until after the current law expires, according to Mendez.

Competing legislative priorities and a new administration will already make meeting the deadline difficult.

“We need to be realistic and it just seems to me that here it is January already and to say that we’re going to have a reauthorization package by Sept. 30, I don’t think is realistic,” Mendez said.

For one thing, the U.S. Department of Transportation under Obama’s nominee for secretary, former Congressman Ray LaHood, probably won’t be fully staffed until midway through 2009. In addition, many elements that could be included in the next authorization are still being debated intensely in the corridors of power.

For that reason, Mendez believes a delayed authorization may not be such a bad thing.
“I think an economic recovery package may buy us time in terms of actually creating a new reauthorization scenario,” he said. “I think the recovery package may give us more time for a new administration (and) new Congress to take a good hard look at the outstanding issues here.”

The outstanding issues are many, Mendez said, but they begin and end with the long-term sustainability of the nation’s investment in transportation.

“I think we all need to, on a national basis, begin thinking about how we’re going to transition from a primarily fuel tax-based investment to some other scenario. I know a lot of people have been talking about the (charging motorists for) vehicle miles traveled approach. There may be other things that need to be researched. So I think we may buy time in trying to lay out some of those longer-term scenarios.”

Passage of a short-term extension of federal programs as they currently exist would seem a likely solution while these issues are explored. If recent history is any guide, there may be a need for more than one extension. The three previous authorization plans were two months late, nine months late and two years late respectively.

But analysts point out that current levels of revenue going into the Highway Trust Fund have already proved incapable of supporting the federal program. That means Congress would still have to find a way to get more money into the system sooner rather than later. Some predict that last September’s $8 billion emergency transfer from the general fund won’t be enough to keep the highway fund afloat through the end of the fiscal year, making another bailout necessary.

But, according to an analysis by the Government Accountability Office, the federal deficit has grown to the point that the general fund may be unable to keep bailing out the highway fund. Analysts believe if funding is not increased over current levels, cutbacks of $19 billion to the highway program and $5 billion to the transit program could be necessary in fiscal year 2011.

For those and other reasons, Mendez remains hopeful a new multi-year authori-

The Shape of the SAFETEA-LU Successor

Individuals and organizations for months have weighed in on what they’d like to see in the SAFETEA-LU successor. The American Association of State Highway and Transportation Officials issued a slate of recommendations in October. The recommendations outline national goals for transportation, put a dollar figure on hoped-for federal investment and present a number of reform proposals to redefine federal programs (see sidebar).

The association’s recommendations were among the ideas incorporated into a policy resolution passed at The Council of State Governments’ annual meeting in Omaha, Neb., in early December. The resolution calls on Congress to “pass an authorization bill that provides short-
term funding stability, long-term vision, strong federal funding and maximum flexibility to states in meeting transportation and infrastructure needs.” (see Capitol Comments)

The resolution also seeks to balance urban and rural transportation concerns, which many say will be an important juggling act for Congress in the next authorization.

South Dakota Secretary of Transportation Darin Bergquist, another member of CSG’s Transportation Advisory Group, contributed to the resolution.

“Most of the media resonates with the message regarding urban congestion primarily caused by localized commuting because most of the media is centered in those locations,” he said. “In our area of the country, the need is for preservation and maintenance of routes serving long distance, interregional, interstate and intercity traffic in and across rural areas.
AASHTO Recommendations

Among the national goals defined by the American Association of State Highway and Transportation Officials in its recommendations issued in October:

- Increasing funding for congestion relief projects and metro areas;
- Improving highway connections and transit access for rural America;
- Raising transit ridership to 20 billion by 2030, and to 50 billion by 2050;
- Trimming six to 12 months from project delivery time by expanding state environmental responsibilities and integrating planning;
- Dedicating federal funding for a fast and reliable intercity passenger rail network;
- Reducing highway traffic fatalities by half in two decades; and
- Moving as swiftly as practical from current funding methods to a distance-based user fee.

The association’s recommendations call for an overall $545 billion investment from 2010 through 2015 for highways, transit, freight movement and intercity passenger rail. That investment would be broken down as follows:

- $375 billion for highways,
- $93 billion for transit,
- $42 billion for freight improvements, and
- $35 billion for intercity passenger rail.

Its proposed system reforms include:

- Streamlining the federal programs and concentrating 90 percent of federal dollars on core programs distributed to the states;
- Capping earmarks at no more than 5 percent of the federal program;
- Expanding the current congestion air quality program to include climate change initiatives; and
- Boosting transit funding and ridership while streamlining the federal program structure and grant processes.

The association also identified a number of possible funding options for Congress to consider.

Read the recommendations at http://www.transportation.org/?siteid=98.
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The rising cost of health care has prompted many states to offer wellness programs to their employees. Supporters believe these programs and incentives are well worth the investment.

By Mary Branham Dusenberry
The average person makes about 250 food decisions a day, and Linda Feltes wants those choices to be healthy ones. Feltes is part of a wellness movement across the country as states try to help their employees live healthier lives.

“You can only tweak the health care system so much,” said Feltes, the coordinator for a worksite wellness program in Minnesota’s Department of Health. “Now it’s time to really look at behavior and how we can influence employees’ behavior and make it healthier.”

Minnesota, like many other states, is trying to figure out just what it will take. Some states have developed full-blown worksite wellness programs, while others have developed such programs within various agencies. Still others are tweaking the healthy programs and incentives they offer.

**Rising Costs of Health Care**

Part of the impetus for incorporating worksite wellness programs for state employees has been the rising cost of health care. Texas Sen. Eddie Lucio, who serves on his state’s Senate Finance Committee, said experts predict by 2020, $2 of every $10 spent in the U.S. will be spent on health care. But only 5 percent of health care dollars are used for prevention, Lucio said. He wants to see that changed.

Lucio proposed legislation in 2007 that would have established a worksite wellness program for Texas state employees. His bill didn’t pass, but many provisions were incorporated into a House bill only on a voluntary basis. While disappointed, Lucio believes the new law could have some effect on employee health, as well as costs to the state.

“The goal of the worksite wellness legislation was to reduce the long-term health costs associated with state employees to improve their productivity and reduce absenteeism by encouraging healthy behaviors,” Lucio said.

Those who work closely with such programs can tell anecdotally that the efforts pay off, which is important in these tough economic times as legislators struggle to make budget decisions.

“We know intrinsically that there is definitely a connection to reducing our health insurance costs,” said Kim Wells, director of statewide wellness for Dela-
ware’s DelaWELL program, which was recognized as an innovative and successful state program with a CSG Innovations Award last year. “In Delaware, we are seeing that our health insurance costs are not increasing at the rate that we are seeing nationally.”

That’s important, not just for the states but also for employees. Health care premiums are likely to face steep increases, said Tammy Till, Wyoming’s wellness coordinator.

“There is no decrease,” she said. “We want to keep it affordable for the state and employee, but there could come a time where it could be out of control, that the costs could be so outrageous, that we would have to pick and choose what we could do for health care.”

Wyoming picks up 85 percent of the cost of state employee health care, but rising costs may force the state to change that policy, Till said.

That’s why Wyoming, like other states, is looking at prevention—trying to keep employees healthy.

Designing a Program

Many states with worksite wellness programs begin with a health risk assessment and go from there. A basic health risk assessment typically measures an employee’s blood pressure, cholesterol and glucose levels, as well as personal wellness activities, such as exercise and diet. That gives employees some idea of the condition of their health. From there, the programs vary widely, and many states are trying some innovative approaches.

In Minnesota, for example, Feltes is working with her state’s health insurance provider, Health Partners, on a pilot project with four state agencies that operate in four large buildings in St. Paul in which Community Supported Agriculture farms will deliver fresh produce on site.

A Community Supported Agriculture farm is one in which consumers buy a share of the farm in the spring. In exchange for sharing the risk, the consumer gets a variety of fresh fruits and vegetables weekly during the harvest season.

“Health Partners is thinking when you go to the grocery store or farmers market, you always buy the same kinds of things,” Feltes said. They’re wondering if being exposed to a variety will encourage people to eat more and different fruits and vegetables, “which we know will have health benefits for them.”

In addition, Feltes is working on state policy that will cover everything from what foods can be provided at state-sponsored meetings and building management support for healthy behaviors, such as setting an example for exercise by taking the stairs.

She’s also working with a team in the Department of Health to write facilities guidelines. That team is looking at such things as the ideal number of bike racks per employee or building dual-use spaces into new buildings that could also be used for exercise or yoga.

Another innovative program is one in West Virginia, which has long had a problem with obesity. The state offers a weight management program for those people with a body mass index of 30 or more, or a BMI of 25 with a related condition. Qualifying employees can get free individualized services from a dietitian and a personal trainer when they visit a fitness facility, according to Nidia Henderson, health promotions director for the West Virginia Public Employees Insurance Agency.

“What we have found is that people want face-to-face, hands-on interactions,” Henderson said. “They go to a fitness facility, meet with a dietician to get an individual nutrition plan (and) meet with an exercise physiologist.”

They are expected to visit the participating fitness center at least three times a week. Employees can participate in the program at one of 50 sites across the state. As long as employees are making progress, they can stay in the program for up to two years, Henderson said.

She said the program—the first of its kind in the nation—is a very cost-effective way to offer such a benefit to employees. And employees get the benefit of having the program designed for them. “It’s really hard for, even a professional, to figure out what’s appropriate based on their condition,” Henderson said.

Another area that receives special focus is often chronic disease management. In North Carolina, the State Health Plan for Teachers and State Employees reaches out to members who need help with chronic disease management. The plan’s NC HealthSmart health coaching program targets those members most at risk for complications from chronic disease, according to Anne Rogers, director of Integrated Health Management for the State Health Plan.

“The engagement rates (talking with a health coach and making changes) have been up to 88 and 90 percent of people targeted for outreach and reached by telephone,” Rogers said.

The health coach—a nurse or dietician, for example—talks with an at-risk person to discuss the management of their health. The coach offers suggestions to improve their lifestyle or manage medication, and provides education about their condition, which includes diabetes, asthma, chronic obstructive pulmonary disease, congestive heart failure and coronary artery disease.
Rogers said the State Health Plan expanded the program in July 2008 to target more members with conditions such as hypertension, chronic pain and chronic fatigue, among others.

“The health coach really is a strong resource for our members,” said Rogers.

Members also have access to the health coaches for around-the-clock telephone advice for acute situations, according to Rogers.

Other state programs involve Web-based personal health assessments and participation.

Healthier Wyoming, for instance, is an interactive online program that promotes simple steps for daily life changes. It accepts both e-mail and postal mail contact information to get people involved, and involves three components employees must complete by September.

A health assessment is the first step. Then employees are asked to get an annual physical exam, including bloodwork which is covered by the state, as well as age-and gender-specific screenings. They’re also asked to participate in two of seven planned behavioral change programs that can range from brushing your teeth to laughter for a day, to weight maintenance programs, according to Till.

They had one year, from October, 2008, to this September to participate in these programs.

Dangling a Carrot

In many states, better health isn’t the only incentive employees have to participate in such programs.

DelaWELL, for instance, has in the past offered a $100 pre-tax bonus for employees who participate in a health risk assessment and biometric screening.

Employees who participate in the Healthier Wyoming program offered by the state’s insurance carrier can get a $480 discount—$40 a month—on health insurance premiums in 2010, if they complete three components of the program, Till said. She said the programs thus far have attracted about 30 percent of the 14,000 eligible employees and retirees. Employees can also get $50 cash incentive to take a health risk assessment online.

A West Virginia program called “Improve Your Score” offers incentives based on a grading system. Employees receive a score based on BMI, blood pressure, blood sugar and cholesterol levels.

They get a color-coded report card with detailed information about their health. The green card indicates a healthy range; yellow is moderate risk; and red is high risk. Employees who get a green report card receive a $50 check, and those who receive a yellow get a $25 check.

“We’re trying to get their attention,” Henderson said. “The doctor does get a copy of their report, and the next phase will be to add an intervention component for the reds and yellows.”

She said state officials weren’t sure that small amount of money would attract participants, but more than 10,000 people participated in 2007, and another 2,300 joined in the second year. And only about 25 percent of the participants fall in the green category, which means the state reached more than just healthy people. “We were a little surprised because programs like worksite wellness tend to be self-selecting,” she said.

In Texas, employees who receive an annual physical exam and complete an online or in-person health risk assessment can earn up to eight hours additional leave time once a year, Lucio said.

“Your reward is better health,” Till said. “But when it comes down to basics, if you’re trying do a wellness program, an incentive will increase the participation level.”

Dealing with Hard Economic Times

But in these hard economic times, it’s difficult to make the case for spending money up front when results are still not in. But Wells of Delaware and others believe these programs make sense in the long run.

“One of the fiscal impacts that states are really feeling is health insurance costs for states are growing astronomically,” said Wells. “Year after year we’re seeing double digit increases in health insurance costs. We have to keep up with that. The way to do that is to keep people healthy.”

North Carolina has some hard data to support that theory. Rogers said Health Dialog, the company that provides the health coaching for the state’s wellness program, NC HealthSmart, has reported a 2-to-1 return on investment in the program that helps workers manage chronic conditions.

Actuaries compared members with a chronic illness who had engaged with a health coach to members who had a similar illness but had not engaged with a health coach. Rogers said. “They looked at cost trends across the program and validated what our disease management contractor has been telling us about the return on investment,” she explained.

Rogers said the State Health Plan has conducted several worksite wellness pilot programs over the past several years, currently focusing on the Department of Transportation, Department of Health and Human Services and a subset of public school systems, and hopes to have some strong supportive data on the impact of the program in North Carolina over time.

Worksite wellness program advocates say states can still offer programs if money is tight.

DelaWELL offers “lunch and learns,” where a program employee presents an educational seminar at various worksites in state government, Wells said.

DelaWELL has also held volunteer-coordinated run/walks during the workday.

“There are lots of things you can do inexpensively during a tight fiscal time,” Wells said.

And, Henderson from West Virginia said, state policies can go a long way in meeting the goal of healthier individuals. She advocates for menu labeling, policies on nutrition in school foods, and incentives for people who use food stamps to buy healthier foods.

“We didn’t get into this mess by ourselves and we’re not going to get out of it by ourselves,” Henderson said. “We really need help from other entities in state government.”

State government efforts to create a healthier environment can be a model for business and industry, Lucio believes.

“The state of Texas is working hard to create a public health message that stresses the value of certain behaviors such as regular exercise and stress management,” he said. “If we do not invest in the wellness of our employees, the message gets extremely diluted.”

—Mary Branham Dusenberry is managing editor of State News magazine.
Tobacco Users Face Surcharges for State Employee Health Insurance

In at least eight states, state employees who smoke or use tobacco must pay more for their health insurance premiums. While some states take the stick approach and call it a surcharge, some states prefer the carrot approach and give nonsmokers a special discount on health insurance premiums. Either way, smokers pay.

By Mikel Chavers
Two things are going on when a state starts charging its employees who smoke or use tobacco more for their health insurance — trying to control costs and trying to control behavior.

That’s according to Nidia Henderson, who supports West Virginia’s more than nine-year-old smoking surcharge. This July, single employees who use tobacco will have to pay $25 extra per month in health insurance premiums, an increase over the previous surcharge of $15 for singles. Families with tobacco users will have to pay a surcharge of $50 a month, an increase from $30 a month.

“It would be nice if we could say people were motivated simply by health,” Henderson, who is the health promotions director with West Virginia’s health plan, said. “But in our experience, finance gets people’s attention.”

At least eight states now charge extra for tobacco users who have state health insurance. That group of states — mostly Southern states — includes Alabama, which prefers to call its version of the idea a discount, not a surcharge. Alabama gives nonsmokers a monthly discount on health insurance premiums but smokers and other tobacco users aren’t eligible for the discount.

Indiana and Kansas work much the same way, giving nonsmokers and nonusers of tobacco with state health insurance a discount. Indiana gives nonusers of tobacco a $500 incentive per year to offset employees’ health insurance deductibles.

South Carolina, the latest state to join the group, will begin charging smokers an extra $25 each month for health insurance premiums beginning in January 2010. The state, which has the lowest cigarette tax in the country, got serious about the idea after it was initiated by Gov. Mark Sanford last summer at a Budget and Control Board meeting.

Rob Tester, the director of the employee insurance program in South Carolina, said the surcharge doesn’t really cover the total cost of health insurance claims for smokers, but is more “to discourage people from smoking.”

And a growing number of states are trying to get the attention of smokers, who create an estimated $193 billion cost burden on the nation a year, a figure that includes health care costs as well as lost productivity, according to the Centers for Disease Control and Prevention’s latest numbers.

Attention-grabbing surcharges range from around $20 a month to the $60 per month smoking surcharge in South Dakota.

‘The Right Thing to Do’

When West Virginia began charging smokers more for the state’s employee health insurance plan in 2000, the state was believed to be the first state to adopt the approach. And although the initial reasons may have been mainly financial — to cover the additional health costs for smokers — Henderson thinks extending people’s lives by giving them an incentive to quit smoking is enough of a reason for the surcharge.

“You can make the argument that disease management saves money, and I think that sounds terrific,” Henderson said. “But when you look at it over the long-term, I’m not sure that argument holds up.”

That really remains to be seen, she said. “If people live longer lives, they cost more.”

In fact, she said her state conducted a study of people who use tobacco and what they cost the state in comparison to nonsmokers. The difference was negligible, she said.

“We’re doing it because we think it’s the right thing to do,” Henderson said.

And, since the state has been charging smokers extra for health insurance, the number of employees who pay the surcharge has decreased — pointing to a decrease in the number of smokers.

In the seven years the state has collected data on the number of tobacco users paying the surcharge (please see the chart), the percentage of policies with employees or family members using tobacco decreased from 33 percent in 2002 to 26 percent in 2008, according to Henderson. Data was not collected until 2002, although West Virginia first began the tobacco surcharge in 2000, according to Henderson.

“We’re going to continue to try to encourage people to stop using (tobacco) and trying to improve the quality of life,” Henderson said. “And if you want productive, healthy workers, this makes sense.”

More of a Deterrent

In South Dakota, the $60 per month surcharge for a smoker is perhaps the highest in the nation. That charge is doubled per month if the employee’s spouse also smokes, but the surcharge doesn’t apply to dependents yet.

The $60 smoking surcharge was recently increased from $40 a month in June, according to Mary Weischedel, assistant director of benefits in South Dakota.

“As premiums increase, the tobacco user fee is reviewed as well,” Weischedel said.

Like many states, South Dakota is self-insured. And for basic health care coverage, employees don’t have to pay anything in premiums. So unless an employee is a smoker, he or she won’t have to pay anything in health insurance premiums.

And, like Henderson from West Virginia, Weischedel agrees that the tobacco surcharge is more of a deterrent than a fiscal responsibility move.

A Dangerous Precedent?

But charging extra for employees’ personal behaviors may be a slippery slope where states could eventually go the way of charging people extra on health insurance premiums for eating too much junk food, for instance, said Lewis Maltby, president of the National Workrights Institute.

“Surcharges aren’t inherently wrong, but they are a very dangerous precedent,” Maltby said. “The problem is that smoking is far from the only bad habit that people have.” There’s also alcohol, caffeine and junk food — and the list goes on, he said.
Although West Virginia began charging tobacco users extra on their monthly premiums in 2000, data were not collected until 2002. In the seven years that data were collected, the number of tobacco users paying the surcharge has decreased.

West Virginia's Tobacco Surcharge

Alabama ran into some bad press last summer when the state announced its new wellness premium discount program. The first phase of the program will go into effect Jan. 1, 2010, and gives employees a $25 discount per month for taking a worksite wellness screening. Like the discount for not smoking, if employees voluntarily get their blood pressure, cholesterol, glucose and body mass index checked through the wellness screening, they can get the discount.

That program initially got attention because the state incorporates the BMI levels of employees—but it’s not a fat tax, said William Ashmore, CEO of the Alabama State Employees Insurance Board.
“The focus of the program is we want to encourage all employees to go through these screenings and identify any health risks that they have,” Ashmore said.

If an employee has any risk factors for obesity, diabetes, high cholesterol or hypertension, for example, they are identified through the wellness screening and are given a special voucher that waives the co-pay for their first visit to the doctor—intended to kickstart the management of a health condition or to manage risk factors.

Risk factors include high glucose, high cholesterol and a BMI of 35 or greater.

Employees will need to certify each year that they are managing the condition by consulting with a doctor, participating in Alabama’s Wellness Management Program or by reducing their own risks through self-management, according to the State Employees’ Insurance Board.

Alabama prefers to give employees discounts both for not smoking and for participating in the health screenings, he said. “We firmly agree with the carrot approach.”

But Maltby believes it’s all the same. “Calling it a discount instead of a penalty is baloney. It’s just semantics. It doesn’t change anything,” Maltby said. Anecdotally he said it seems clear that wellness programs are on the rise.

“And wellness programs don’t have to be punitive—there are lots of things that employers can do to hold down health costs that don’t penalize anyone.”

—Mikel Chavers is associate editor of State News magazine.

—Mikel Chavers

Not One Without the Other

Tobacco Cessation Programs

In 2000, West Virginia learned an important lesson.

If a state is going to charge smokers more for health insurance, then the state ought to provide the necessary tools to quit.

When West Virginia became the first state in 2000 to charge smokers and other tobacco users more for their state employees’ health insurance, the state also started a tobacco cessation program. Back then, the cessation program included a quit line, designed to give the state’s mostly rural residents access to specially trained coaches.

At that point, the medical provider community didn’t have experience in tobacco cessation, said Nidia Henderson, health promotions director of the West Virginia Public Employees Insurance Agency.

But last year, recognizing that the provider community had gotten more sophisticated in helping people quit, West Virginia discontinued the quit line.

Now the tobacco cessation program is more like a health insurance benefit where employees are able to receive the care and medications they need to help them quit. Nicotine patches are free and other medications can usually be purchased by co-pay depending on the preferred drug list for the state’s employee health plan.

Employees can participate in the tobacco cessation program and have all their services and medications covered once per year and three times per lifetime. The number of times pregnant women can participate in the program is unlimited.

There is an estimated 40 percent quit rate in the program, Henderson said, although the state is looking at better ways of collecting that data.

“My main advice, if you’re going to do (a smoking surcharge), you have to give people the tools to quit,” Henderson said. “It’s got to be the carrot and the stick.”
In the wake of recent lawsuits waged by the states against pharmacy benefit managers, some states are taking matters into their own hands and passing laws regulating the industry. Maryland’s law is being boasted as a compromise and a success while other laws have been challenged in court.

By Mikel Chavers
Maryland last year became the first state to pass a comprehensive package of laws regulating the中间men of the pharmacy drug benefit world.

And even though the state was dealing with an industry that’s been involved in recent controversies, Maryland officials managed to facilitate a compromise.

That’s because the state didn’t just propose the laws and pass them—everyone involved was at the table going through the laws page by page and word by word.

The state’s action stands as a strong example of how states interact with the middlemen of the pharmacy benefit world amid recent controversial court cases challenging how that industry does business.

Those middlemen are known as pharmacy benefit managers. The companies determine what drugs are on the preferred drug list—meaning which drugs or brands are covered—for a specific health insurance plan selected by an employer. Many of the employers using pharmacy benefit managers are state governments.

To manage drug benefits, the pharmacy benefit managers—known as PBMs for short—contract with pharmacies and pharmaceutical manufacturers and interact with consumers and health care providers on behalf of health insurers and employers.

“PBMs manage prescription drug benefits for about 210 million Americans with drug coverage provided through both large and small employers, unions, government and insurers as well,” said Charles Coté, a spokesman for the Pharmaceutical Care Management Association, the trade group representing PBMs. “PBMs typically lower costs by about 30 percent by designing benefits that (incentivize) the use of generics, of lower-cost delivery options like the mail service pharmacy with cutting edge technology like e-prescribing. And so there’s a strong track record out there.”

Since large drug companies often pay large rebates for having their drugs on the preferred drug list or formulary, the PBM is in charge of passing that rebate back to the client.

Problem is, some pharmacy benefit managers have gone to court over whether they were acting in the best interest of their clients when choosing or recommending different drugs and whether they were passing on those rebate savings to customers after all.

In July, New York settled a case with Express Scripts Inc. and CIGNA Life Insurance Company recovering $27 million for the New York State Health Insurance Program. The office of New York State Attorney General Andrew Cuomo had accused the companies of a practice known as drug switching.

Drug switching occurs when a pharmacy benefit manager seeks to increase profits by contacting a patient’s doctor without the patient’s knowledge and switching to a different drug for the patient so the company can increase its profits, according to a release from Cuomo’s office.

“At a time when New Yorkers are struggling to pay rising health care premiums, (the) $27 million agreement cracks down on PBMs that put profits ahead of patients’ health,” Cuomo said in the release. “The message is clear: Companies that switch patients’ drugs without informing them will be prosecuted to the fullest.”

The settlement, he said, “forces pharmacy benefit managers to abide by a new standard of transparency.”

Other recent class-action lawsuits from last year include the similar May 2008 multi-state settlement with Express Scripts, one of the country’s largest PBMs. As part of the settlement, 29 states will receive more than $9 million related to certain switches between cholesterol-controlling drugs, according to the Pennsylvania Attorney General’s office, one of the states involved in the lawsuit.

“(The) settlement puts an end to Express Scripts’ misleading business practices and takes the necessary steps to protect health plans and patients,” Pennsylvania Attorney General Tom Corbett said in a statement.

But there’s still a fight over what kinds of laws regulating pharmacy benefit managers are fair, because some states and Washington, D.C., have tried to force PBMs to operate in what they see as a more open and transparent manner.

And there are still things that PBMs just don’t want to disclose—certain competitive information they say helps them do their job.

Maryland Laws Cut Through the Arguments

But the Maryland laws are different. In fact, Coté said, the laws could serve as a model for other states.

“We believe this represents a reasonable compromise,” he said.

For starters, the bills regulating the PBM industry had been around for years and just hadn’t passed, according to Maryland Delegate Dan Morhaim, who chairs Maryland’s Subcommittee of Health and Government Operations.

His subcommittee was in charge of going through those bills.

Morhaim and fellow lawmakers were prompted to take action by the recent string of class-action lawsuits waged by the states against PBMs.

“Solving things by litigation is expensive and not often really getting to the heart of the problem,” Morhaim said.

The state also recognized pharmaceutical costs were part of the rapidly rising costs of health care.

PBMs, Morhaim said, are quiet giants and often operate in a complex world. But that world is one in which Morhaim has insight—he’s a board-certified internal medicine physician and is on faculty at the Johns Hopkins School of Public Health.

So Maryland came up with a package of bills that basically requires PBMs to register with the state, so the state can simply know how many of these types of companies actually operate within its borders. No state will know how many are there unless they pass a PBM law, according to Morhaim. “We didn’t even know how many PBMs were in Maryland—they were virtually unlicensed,” Morhaim said. With House Bill 419, the state can “get a handle on how big the universe is” when it comes to the PBM industry.

Regulations are also part of the new laws. House Bill 120 requires the PBMs to disclose certain types of information about rebates they get from manufacturers as well as other types of basic business information.
House Bill 343 regulates the way a PBM can change from one prescription to another and prohibits the PBM from switching drugs unless certain conditions are met. The PBM must obtain authorization to make certain changes.

Altogether, the five bills—House Bill 120, House Bill 257, House Bill 343, House Bill 419 and House Bill 580—are a “balanced regulation,” Morhaim said.

That’s mostly due to how Maryland went about vetting the laws, Morhaim said.

Once the bills were filed, and the initial presentation was made—“the PBMs were against everything,” Morhaim recalls.

But then when everyone came to the table, the details were hammered out and “at the end of the day, it’s not about these abstract comments—it’s the words on the page.”

And everyone at the table—lawmakers, PBM representatives and others—went through the laws word for word.

**Litigation Can Be Lengthy**

Although the Maryland laws were not challenged in court by the PBM industry, other laws seeking to force the PBMs to act as fiduciaries for their clients by enforcing certain fiduciary-disclosure provisions have been challenged. A 2004 Washington, D.C., law is still being challenged in court and a similar Maine law was also challenged in court.

Pharmacy benefit managers say they should be allowed to operate with their competitive information in secret in order to protect their ability to do business and secure lower drug costs for clients—which include states. Therefore, the industry has typically been against these types of fiduciary-disclosure laws.

The Pharmaceutical Care Management Association is still fighting aspects of the Washington, D.C., law called the AccessRx Act.

The association is challenging the law because “we feel that its onerous fiduciary disclosure requirements would increase costs for consumers and payers without providing any upside,” Coté said.

And state governments and other employers don’t have to hire a company to manage their pharmacy benefits, Coté said. PBMs are hired because of the savings they can facilitate.

“What these PBMs do is kind of pit drug manufacturers against one another to try to get them to lower their costs because without any kind of competition, drug manufacturers kind of have free reign to charge whatever prices they would like.”

With these laws, he said, “it would be kind of like the equivalent of playing cards with all the house cards up.”

When all that information is out in the open due to requirements seeking to make PBMs act as fiduciaries in their client’s best interest, “It gives drug manufacturers the upper hand and allows them to see all the cards that are being dealt and all the cards that you’re playing with.”

The PBM industry believes that kind of information is proprietary.

PBMs don’t like the Washington, D.C., law because “it would provide (drug manufacturers) with kind of an unprecedented level of negotiating leverage over a PBM and they would know automatically what their competitors are getting and that would really kind of hobble a PBM’s ability to deliver savings to their clients and consumers,” Coté said.

Basically, “if you put all of that competitive information out in the public domain, it will really limit our ability to pit these manufacturers against one another to force them to drive down their costs,” he said.

The Pharmaceutical Care Management Association also challenged a similar 2003 law in Maine—however, that litigation is over. The Maine Unfair Prescription Drug Practices Act requires PBMs to pass on the volume-based discounts they get from the drug manufacturers to their clients. It also requires PBMs seeking to switch a patient’s drug to get physician approval, and to disclose that information to the individual.

The law also requires the PBM to notify the health insurance provider of the cost of both drugs in question and also reveal the payment the PBM is receiving to make the switch, according to an article on ModernMedicine.com, a resource Web site featuring Advanstar’s journals and other publications on medical-related issues.

Even though that sounds similar to the Washington, D.C., law being challenged, Coté said it’s always different when similar laws are drafted in different states. Although the Maine and Washington, D.C., laws are aiming at similar themes, the real concern is how it impacts different jurisdictions, Coté said.

As for Maryland’s jurisdiction, so far there haven’t been any challenges from the industry or expected tweaks from the legislature, Morhaim said.

“I think that we have a comprehensive plan. It’s strong. Copy our model and build on it,” he said.

—Mikel Chavers is associate editor of State News magazine.
ACCIDENTAL OVERDOSES FROM LEGAL DRUGS
Prescription Drugs Play Increasing Role in Overdoses

As recent tragedies shine the spotlight on accidental drug overdoses, it’s becoming increasingly clear that prescription drugs are playing an increasing role in accidental deaths. States are doing something about it.

By Ann Kelly

Drug overdose deaths are on the rise in the United States, but it’s not what you might think.

They are accidents.

Many states are reconsidering policies to combat prescription drug overdoses in light of new statistics and recent tragedies. Those tragedies include celebrities as well as teen-agers in local communities, like Ryan DePuy of Washington, a 17-year-old whose death resulted from a combination of prescription and over-the-counter medications.

Deaths from drug overdoses involving prescription medicines actually exceed deaths from heroin, cocaine and other illicit drugs combined, according to data from the Centers for Disease Control and Prevention.

Deaths from drug overdoses involving prescription medicines actually exceed deaths from heroin, cocaine and other illicit drugs combined, according to data from the Centers for Disease Control and Prevention.

Most of these deaths are unintentional—not suicides and homicides. In fact, the unintentional drug overdose death rate today is more than twice the rate during the early 1990s, the era of crack cocaine deaths, primarily due to the increase in accidental prescription drug overdoses, according to CDC.

With unintentional deaths increasing, state programs to control drug misuse are becoming more important. With the help of the federal government, public health programs are identifying ways to strengthen state efforts to prevent these accidental deaths.

CDC reports trends in unintentional drug overdose deaths that can help states determine their priorities for combating prescription drug misuse. The most recent figures available showed that from 1999 to 2004, prescription drugs replaced heroin and cocaine as the primary cause of unintentional drug overdose deaths in both rural and urban areas of the country.

In West Virginia, which had the biggest increase during the five years, nearly all the accidental overdose deaths involved prescription drugs, and two-thirds of those people obtained the drugs without a prescription, CDC said. Prescription narcotic medications for pain and psychotherapeutic drugs were involved more frequently than other types of drugs.

The highest death rates from prescription drug overdoses are among white men, but young people are increasingly likely to die accidentally from prescription drug overdoses. In 2005, death rates for accidental drug overdoses were highest in rural Appalachian states, southwestern states and New England. And researchers, public health and law enforcement experts indicate deaths have continued to increase since 2005.

Controlling Misuse, Abuse

Thirty-eight states have implemented or approved legislation to develop a prescription drug monitoring program to identify patients who are doctor shopping—when an individual visits several different doctors to obtain prescriptions for the same medications—and patients who are misusing prescriptions. As of November 2008, 32 states had monitoring programs for prescriptions filled within their borders. Since 2002, the Department of Justice’s Harold Rogers Prescription Drug Monitoring has supported program development, and the number of states operating programs has more than doubled—from 14 to 32.

But the programs are costly: The Department of Justice estimates it costs $350,000 to start a state prescription drug monitoring program, and the states operate the programs with annual budgets ranging from $100,000 to $1 million. As state programs become operational, they face financial challenges. As a result, states use a variety of sources to fund operations—federal grants, state tax revenues, portions of professional license fees, donations and grants to fund ongoing operating expenses.
All prescription drug monitoring programs are designed to protect patient privacy and specify who has access to the information. Physicians and pharmacists are educated on how they can request information from the program to better manage a patient’s drug regimen, refer patients for addiction treatment and reduce the availability of drugs for overuse.

Law enforcement officials can request prescription information when gathering evidence of prescription drug diversion, enabling them to act more efficiently and quickly by identifying the pharmacies where prescriptions were filled.

States estimate prescription programs can save at least 80 percent of the time spent on investigations because pharmacies don’t have to investigate every pharmacy where prescriptions may have been filled. A 2006 study by Simone Associates also found that monitoring programs reduce the per capita supply of prescription pain medications in a state.

States are also working together to strengthen efforts to prevent diversion of prescription drugs. Prescription drug diversion is “the illegal removal of a prescription drug anywhere along its path from the manufacturer to the patient,” said John Burke, president of the National Association of Drug Diversion Investigators.

Some state public health agencies, such as Massachusetts, exchange bulk prescription data—without patient identifiers—with neighboring states to determine how many people are crossing state lines to fill prescriptions. The results are used to educate in-state physicians on these trends.

State prescription programs are also working together to evaluate program costs and benefits by developing performance standards and monitoring expected outcomes.

Information Sharing and Doctor Shopping

Even with the advances in prescription tracking programs, only a few states are working to develop a system to share information among states. Information sharing could be important, especially when it comes to doctor shoppers—those patients who shop for prescriptions from multiple doctors, often in bordering states where no prescription program exists, according to the U.S. Drug Enforcement Administration.

Danna Droz, administrator for the Ohio State Board of Pharmacy’s prescription drug monitoring program, believes out-of-state information is vital to a complete picture of controlled drug use or misuse in a particular community or state. Droz reviewed prescription data from six states—Virginia, New York, California, Ohio, Kentucky and Nevada—and found up to 15 percent of prescriptions in each state are written by out-of-state prescribers and up to 7 percent of patients are from out of state.

“As prescription drug abuse continues to expand, pharmacists and prescribers have a greater need to monitor the prescriptions that their patients receive,” said Droz.

She said medical professionals can sign up for multiple state prescription drug monitoring programs to obtain prescription history information, but it is an inefficient and time-consuming process.

“A much better approach would be to create a system where a prescriber or pharmacist could make one request to access prescription data from more than one (prescription monitoring program),” Droz said.

The Kentucky legislature authorized sharing prescription monitoring information with other states in 2005, and Kentucky and Ohio plan to begin sharing information this year. Working with the Department of Justice-funded Integrated Justice Information Systems Institute to develop the technological solution, the two state systems expect to exchange test data by early this year.

The pilot project uses a secure hub server that communicates only with state prescription management program databases. The monitoring programs encrypt all prescription data for privacy reasons when it is passed through the secure hub.

For example, an Ohio physician who wants information on his patient’s prescriptions filled in Kentucky makes the request to the Ohio program. The Ohio program then encrypts the request and passes it through the secure hub to Kentucky. The Kentucky program would open the request and send an encrypted response back through the hub to Ohio. The Ohio program then opens the response and transmits it to the requesting Ohio physician.

Dave Hopkins manages the Kentucky Cabinet for Health and Family Services prescription drug monitoring program known as KASPER and is vice-chair of the Department of Justice steering committee of eight states and six technology vendors working on sharing prescription data between states.

Hopkins said the Kentucky program has worked to develop standards, agreements and software to enable data sharing with other state drug monitoring programs since early 2008. Kentucky expects to be able to share data with Ohio and one other state this year.

“We have had strong direction from the state legislature and Secretary Janie Miller to implement this system and by late 2009 we expect to be able to share data to support patient treatment by health care providers and to expedite our investigation of Kentucky residents involved in illicit prescription drug use across our borders,” Hopkins said.

But sharing this kind of information also comes at a cost. The Integrated Justice Information Systems Institute estimates it could cost from $100,000 to $200,000 for...
state prescription monitoring systems to participate in this kind of hub-based data-sharing among states, depending on the existing capabilities of the state system.

**Drug Courts**

Drug courts are another way states are trying to decrease prescription drug misuse and the unintentional deaths associated with it. When it comes to nonviolent drug offenders, according to the National Drug Court Institute, researchers deem drug courts a solution that works. The institute found drug courts to “work better than jail or prison, better than probation and better than treatment alone. Drug courts significantly reduce drug abuse and crime and do so at less expense than any other justice strategy.”

The Department of Justice has funded drug courts since 1995, and courts are operating in all 50 states, U.S. territories and more than 70 tribal locations. Federal funding for developing state drug courts has historically attracted state and local funding at seven times the federal investment, once the drug courts started to realize savings.

Drug courts exist in fewer than half of U.S. counties and only serve a fraction of the drug offenders who could benefit from the services, according to the National Association of Drug Court Professionals.

In his experience, Judge Lewis Nicholls, a retired Kentucky senior judge, found 80 percent of defendants in the criminal justice system were addicted or drug dependent, and two-thirds of them were taking prescription medication.

He credits the combined supervision and drug treatment available through the state drug court program to reducing the drug court recidivism rates to 20 percent compared to 57 percent among those who received prison and parole.

“Drug courts work exceptionally well for clients whose crimes are motivated by an addiction to prescription drugs,” Nicholls said.

For more information and resources, go to [http://www.healthstates.csg.org/Public+Health+Issues/Injury+Prevention/](http://www.healthstates.csg.org/Public+Health+Issues/Injury+Prevention/)

—Ann Kelly is assistant director of health policy for The Council of State Governments.

**Unintentional Prescription Drug Overdoses**

State efforts to reduce prescription drug abuse have become the line of attack for the crisis in unintentional deaths from prescription drug overdoses—when a person takes a drug without intending to die.

Unintentional deaths are not suicides or homicides and usually occur when individuals take excessive amounts of prescribed drugs or mix prescriptions with illegal drugs. Unintentional overdoses can also occur when people use narcotic pain medications in their family medicine cabinet recreationally, unaware of the dangers involved or trusting that FDA-approved prescription drugs are safe for anyone to use. But the consequences can be tragic. Still many times, unintentional overdose deaths involve individuals who obtain the drugs through fraudulent means.

To shine the light on promising state strategies to reduce unintentional drug overdose deaths, the CDC brought together state, local and national public health experts and other interested parties during the course of two meetings in December and January. Experts at the meetings discussed the strengths and challenges related to state efforts and the results to date in reducing drug overdoses caused by prescription drugs.

Attendees at the December meeting reviewed state legal efforts to address prescription drug overdoses, including prescription drug monitoring programs, drug courts, state-issued prescription forms, laws to control doctor shopping and pain clinic regulations.

The second meeting in mid-January was oriented to state public health departments. It focused on additional programmatic strategies to address prescription drug abuse issues. Topics included prescription drug dosing guidelines, the epidemiologist’s role, the use of medical examiner data and review of prescription drug use by Medicaid recipients.

Meeting materials will be available on the Web sites of CDC’s National Center for Injury Prevention and Control and Public Health Law Program.
Safe Haven Laws Aimed at Saving Abandoned Children

After Nebraska became the final state to pass a safe haven law to protect abandoned infants, the state learned some hard lessons when older children were instead dropped off. That’s prompted a deeper look into the effectiveness of states’ safe haven laws.

By Jennifer Horne Boyter

An overwhelmed widower dropped off his nine children at an Omaha hospital Sept. 24. He just couldn’t care for the children—ranging in age from 1 to 17—after his wife died.

A Nebraska woman dropped off her bipolar 11-year-old son because she could no longer cope with his violent outbursts without help. Other desperate parents drove to Nebraska from as far away as Florida, Michigan and California to take advantage of a new Nebraska law that was really designed to protect infants from harm.

In July, Nebraska became the 50th state to pass a so-called safe haven law. Such laws designate specific locations, like hos-
pitals, where parents can drop off an infant without fear of criminal prosecution for child abandonment. The goal is to reduce the number of newborns abandoned in unsafe places, such as dumpsters.

Nebraska lawmakers were under significant pressure to pass a safe haven bill at the beginning of the 2008 legislative session. Three babies had recently been abandoned, and lawmakers did not want the state to be the only one in the country without such a law.

But some legislators opposed such a law because it did not offer protections for older children. The legislature eventually passed a compromise bill that offered protection from prosecution for leaving a child at a hospital, offering a safe haven to children of all ages.

The law took effect in July with little fanfare, and in September, the first child was dropped off at a hospital. To everyone’s surprise, it was an 11-year-old boy, not an infant. Other children quickly followed, including a 15-year-old boy and a 13-year-old girl. On Sept. 24 alone, 11 children were dropped off at Nebraska hospitals, including the nine siblings. These parents said they were overwhelmed by their children’s behavioral problems or were not able to care for them.

As the number of abandoned children grew, lawmakers scrambled to amend the legislation to restrict its provisions to infants. However, in the time between the call for a special session to change the law and its eventual enactment, six more children were abandoned by parents trying to beat the deadline.

In less than three months, 36 children were surrendered; none of them were infants. According to the Nebraska Department of Health and Human Services, the vast majority of the children were 13 or older, and only two were under 10 and were dropped off with older siblings. All but two of the children had a history of being treated for mental health issues and 34 of 36 were from single parent homes. Six of the children were from out-of-state.

Nebraska Gov. Dave Heineman was forced to plead with out-of-state parents on CNN: “Please don’t bring your teenagers to Nebraska.”

Lawmakers amended the state’s safe haven law during a special session Nov. 21; it now applies only to infants 30-days-old or younger.

Todd Landry, director of the state’s Department of Health and Human Services, said the safe haven law was not meant to allow parents to abandon older children. The legislation, he said, “was intended to protect helpless children who are in immediate danger, such as an infant who is left outside or unattended. It was not intended for those having difficulty parenting older youth who may be defiant, unruly or who have behavior problems.”

No Two Laws Are Alike

Safe haven laws to encourage desperate mothers to surrender unwanted babies anonymously, instead of abandoning them in unsafe places, began in Texas in 1999, after 13 infants were abandoned in the Houston area within 10 months. These laws typically allow a parent, or an agent of the parent, to remain anonymous and to be shielded from prosecution for abandonment or neglect in exchange for surrendering the baby to a safe haven.

New Jersey makes that promise explicit in the tagline of its safe haven law: “No Shame. No Blame. No Names.” Immunity is provided either by a guarantee of non-prosecution or as an affirmative defense—an explanation for a defendant’s actions that excuses or justifies the behavior—in any prosecution.

While all 50 states now have safe haven laws on the books, no two are the same, but they all share similar characteristics. The most common age limitations range from infants no older than 72 hours to 30 days, although North Dakota’s law covers children up to 1-year-old.

The laws all specify locations where an infant can be dropped off safely. For example, all states allow babies to be dropped off at hospitals. Other common locations include police and fire stations or to an emergency 911 responder. In most states, either parent may surrender the infant, but some states permit only the mother to do so, while others allow an agent of a parent.

Once a baby is relinquished to a safe haven, the provider is generally required to accept emergency protective custody of the infant and provide any immediate medical care the infant may require. The infant is then transferred to a medical facility and the local child welfare department is notified.

The effects of safe haven laws are mixed. Imperfect record keeping makes it difficult to determine the number of babies surrendered to a “safe haven.” However, the National Safe Haven Alliance estimates that such laws have “saved well over 1,000 infants.”

Although many newborns have been left at hospitals or other safe haven locations, other infants continue to be left in unsafe places or killed by their mothers. For example, since New Jersey passed its safe haven law in 2001, 38 babies have been safely surrendered. However, in the same time period, 28 infants have been abandoned in an unsafe location.

Proponents of safe haven laws, including the National Safe Haven Alliance, argue that this is due, in part, to inadequate publicity of safe haven locations and programs, as many states do not have any guaranteed funding mechanism to promote the law to at-risk mothers.

“Safe haven laws are appealing to people who want to leave their babies in a safe place. But we need to worry about the people who are willing to leave their babies in unsafe places, such as dumpsters.”

—Adam Pertman, executive director
Evan B. Donaldson Adoption Institute
But even with excellent and well-funded public relations campaigns, many women do not exercise the safe haven option. New Jersey is considered to have one of the best campaigns in the country, but at least half as many babies have been abandoned in unsafe places as those in safe havens in the state. One baby was abandoned in full view of a billboard advertising the safe haven option.

Adam Pertman, executive director of the Evan B. Donaldson Adoption Institute, a national nonprofit organization devoted to improving adoption policy and practice, believes safe haven laws are simply not reaching the women they are designed to reach.

“Safe haven laws are appealing to people who want to leave their babies in a safe place,” Pertman said. “But we need to worry about the people who are willing to leave their babies in unsafe places, such as dumpsters.”

He said women who abandon their babies in such unsafe places are often suffering from post-partum depression, extreme denial, fear or mental illness.

“We are talking about a woman who is so disturbed that she leaves her newborn in a toilet,” he said. “Would she really have taken the baby to a safe haven location if only she had seen a billboard?”

Pertman believes the danger is now that all 50 states have safe haven laws, policymakers will declare the problem of abandoned babies solved and move on. Yet there is little research-based evidence that shows that safe haven laws work.

“It is nearly impossible to gauge the efficacy of these laws,” Pertman said. “We assume they must be working because some children are being dropped off at safe havens. But there is no research to show that these women who utilize safe havens would have left their babies somewhere unsafe were it not for the safe haven laws.”

Lessons Learned

The process of surrendering an infant to a safe haven does have several negative consequences. Those surrendering a baby do not have to provide family and medical history information, although many states require the safe haven provider to request it. In addition, the father may not be aware of the birth and would be deprived of his legal right to care for the child.

Also, unlike the process of giving a child up for adoption, the mother receives no counseling and has little time to reflect on the choice, and the child will not have access to family and medical information.

Kathy Moore, executive director of Voice for Children in Nebraska, said her organization, which advocates for children’s issues in the state, opposed the safe haven law saying it did not serve the interests of children, birth parents or the adoptive family.

“Safe haven laws circumvent the established best practices in adoption services, especially the lack of medical and family history and the ongoing opportunities for contact that open adoptions provide,” Moore said.

Critics say safe haven laws cannot serve as a replacement for a more comprehensive strategy to enhance services for women at risk of abandoning infants. Similarly, lawmakers in Nebraska say the state’s brief experience with a safe haven law with no age restrictions revealed serious problems with the way it cares for children with mental and behavioral problems, as well as a shortage of resources to help troubled families or those struggling to raise troubled youth.

Legislators vowed to address that shortage in their 2009 regular session, despite a growing state budget deficit.

In December, the legislature convened a task force, and in three meetings, heard from dozens of experts from across the state, including hospital executives, juvenile judges, children’s advocates and social workers. The group said it plans to recommend comprehensive legislation to protect at-risk children in a way that the safe haven law never did. Sen. Amanda McGill, chair of the task force, told reporters that “there’s a political will now that maybe didn’t exist before.”

But Moore worries that lawmakers have not learned any meaningful lessons from Nebraska’s safe haven experience, and believes significant reforms of the state’s behavioral health system, specifically for children and struggling families, are not likely to happen.

“It is unlikely that the state will find the money in these difficult economic times to fund and fully implement the array of behavioral health services that the state is sorely lacking,” she said.

—Jennifer Horne Boyter is a senior public safety and justice policy analyst for The Council of State Governments.
In the coming months, CSG will release several more issue briefs and reports, including:

- **Early Childhood Education**—a Trends in America Special Report that focuses on financing and structure of pre-kindergarten programs in the U.S.

- **Middle Class Issues**—an issue brief examining exactly how the current financial crisis affects the average Joe

- **Identity Crime**—a Trends in America Special Report that educates state lawmakers about the types of identity crime as well as solutions to the growing problem

- **Renewable Portfolio Standards**—a look at the effects on states of laws that require renewable energy sources supply a certain percentage of retail electricity

- **Health Disparities**—an issue brief that focuses on how health outcomes differ for people in different socioeconomic and racial groups in the U.S.

To read the Trends in America publications, please visit [www.trendsinamerica.org](http://www.trendsinamerica.org).
Czarnecki Joins National Association of State Technology Directors

Paul Czarnecki has joined the staff of the National Association of State Technology Directors, formerly the National Association of State Telecommunications Directors, as a technology analyst.

Czarnecki previously served for more than eight years as the public information manager and associate to the CIO at the University of Cincinnati’s Office of Information Technologies. He has also worked for the City of Chicago and Unitrin Inc., the parent organization of the United Insurance Company of America.

Czarnecki, a graduate of the University of Notre Dame, lives in Georgetown, Ky.

Toll Fellow Hilda Solis Tapped for Secretary of Labor

President Barack Obama has nominated U.S. Rep. Hilda Solis of California, a 1998 Toll Fellow, to be his secretary of labor.

Solis, the daughter of immigrants, has dedicated her career to forwarding fair labor practices. As a California state senator, Solis fought to increase the state minimum wage from $4.25 to $5.75 an hour in 1996.

“I am humbled and honored to be nominated by President Barack Obama to serve as Secretary of Labor,” said Solis. “I look forward to working with President Obama to reinvest in work force training, build effective pipelines to provide at-risk youth and underserved communities with sustainable skills, and support high-growth industries by training the workers they need. This includes promoting green collar jobs.”

In addition to forwarding labor causes, since 2000, Solis has worked actively in the U.S. House of Representatives on various environmental and health issues while serving on the Committee on Energy and Commerce and the Committee on Natural Resources. In 2007 she was named to the House Select Committee on Energy Independence and Global Warming. In 2000, Solis was the first woman awarded the John F. Kennedy Profile in Courage Award for her work in California on environmental justice issues.

CSG-WEST Announces 2009 Leadership

New Mexico Rep. Jose Campos will chair The Council of State Governments-WEST for 2009. Campos has moved up in the officer corps of the organization, first serving as vice chair and then chair-elect. He will join with his New Mexico legislative colleagues to host the 2009 CSG-WEST annual meeting Oct. 5-8 in Santa Fe.

In 2004, legislative colleagues from throughout the West selected Campos as class president of CSG-WEST’s prestigious Western Legislative Academy. A quintessential citizen legislator, the New Mexico representative also serves as mayor of his hometown of Santa Rosa and owns and manages a local restaurant.

Other members of this year’s CSG-WEST leadership team are Idaho Rep. Rich Wills, chair-elect, Hawaii Rep. Marcus Oshiro, vice chair, and Alaska Sen. Lesil McGuire, immediate past chair. These officers guide all policy and program decisions of CSG-WEST.

The Western region of CSG serves state legislators from Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington and Wyoming. The association promotes excellence in Western state legislatures through regional problem-solving and professional development. Each year the region holds forums and collaborates with other governmental associations on policy matters affecting the West.

For information about how to get involved with CSG-WEST, call Sacramento headquarters at (916) 553-4423.
With a faltering economy, it’s becoming harder and harder for low- and middle-income families to afford their heating bills and pay their home mortgages.

The Council of State Governments’ Eastern Regional Conference is trying to change that.

CSG/ERC officials are working on a program, called the ENERGY STAR Mortgage Program, which strives to help eligible homeowners afford weatherization methods to lower their energy bills, and in some cases refinance their high interest-rate mortgages as well.

Typically, steep energy bills and high-interest mortgages and have made it tough for low- and middle-income families to upgrade and weatherize their homes. Many do not have the ready funds to pay for home improvement costs that can lower energy bills and increase their home’s value.

The ENERGY STAR Mortgage Program will incorporate the cost of energy-efficiency investments into their total lending package. These investments can reduce a home’s energy use by up to 30 percent.

Rona Cohen, CSG/ERC’s senior policy analyst for energy and environment, is developing outreach materials, including project summaries and issue briefs, for the program. She is also editing and writing press releases and interviewing marketing companies to help publicize the program.

The Energy Programs Consortium in Washington, D.C., created the program in collaboration with the U.S. Department of Energy, the U.S. Environmental Protection Agency, as well as energy and housing agencies and foundation grants. Mark Wolfe, a CSG/ERC energy consultant, is the Energy Programs Consortium executive director.

The consortium plans to launch the program in Maine, New York and Massachusetts this year. CSG/ERC is being paid by the Energy Programs Consortium for its services.

NEMA Secures $4 Million Mutual Aid Grant

The National Emergency Management Association has received a $4 million grant from the Federal Emergency Management Agency to support mutual aid activities between states and territories.

NEMA administers the Emergency Management Assistance Compact, which is the nation’s interstate mutual aid system. EMAC allows states to provide assistance to each other during times of disaster and emergency. And a primary objective of the grant project will help states do just that. The grant will go to providing education and training for state and local emergency response personnel who may provide mutual aid assistance through EMAC.

During the response to Hurricane Katrina in 2005, more than 65,000 personnel were deployed to the Gulf Coast through EMAC. This was the largest utilization of mutual aid in U.S. history. All 50 states, Washington, D.C., Puerto Rico, the Virgin Islands and Guam are members of the compact. For more information on EMAC, visit www.emacweb.org.

NEMA is an affiliate organization of CSG.

Midwest Group Pushes Rail in Federal Stimulus Plans

Passenger-rail advocates from around the Midwest gathered in Omaha, Neb., in December to consider issues related to federal and state support for this transportation mode.

The Midwest Interstate Passenger Rail Commission, a group of legislators and passenger-rail leaders from around the region, held its fall meeting Dec. 3 and 4 in conjunction with CSG’s Annual Conference.

Commission Director Laura Kliewer presented an overview of the new federal Passenger Rail Investment and Improvement Act, which reauthorizes Amtrak and provides the first 80 percent-20 percent federal-to-state match for passenger rail development.

The legislation also provides funding for the development of high-speed corridors and congestion grants for heavily traveled routes.

Also at the December meeting, Midwest Interstate Passenger Rail Commission members discussed ways to ensure passenger rail is part of any new federal economic stimulus plan. Based on a proposal made by its Federal Relations Committee, the commission developed a recommendation for including passenger rail in the stimulus package and sent it to congressional leaders. A contingent of commissioners and staff then traveled to Washington, D.C., Jan. 7-8 to meet with Midwestern members of Congress and discuss both short- and long-term passenger rail-related stimulus requests.

The Midwest Interstate Passenger Rail Commission is a 10-state interstate compact commission that promotes improvements to passenger rail in the Midwest and the nation. CSG Midwest provides secretariat services for the nonprofit organization. Member states are Illinois, Indiana, Iowa, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio and Wisconsin.

This calendar lists meetings as designated by CSG’s Annual Meeting Committee. For details of a meeting, call the number listed. “CSG/” denotes affiliate organizations of CSG. Visit www.csg.org for updates and more extensive listings.

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<tr>
<td>Feb. 8–11</td>
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<tr>
<td>CSG/American Probation and Parole Association (APPA) Winter Training Institute—Myrtle Beach, SC—Embassy Suites Hotel at Kingston Plantation. Contact registration at (859) 244-8204 or <a href="mailto:kchappell@csg.org">kchappell@csg.org</a>. Visit <a href="http://www.appa-net.org">www.appa-net.org</a>.</td>
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<td>March 6–8</td>
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<tr>
<td>CSG/ERC Executive Committee Meeting—Burlington, VT—The Hilton Burlington Hotel. Contact Michelle Shiwamber at (646) 383-5728 or <a href="mailto:mshiwamber@csg.org">mshiwamber@csg.org</a>.</td>
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<td>March 7–10</td>
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<td>March 8–11</td>
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<tr>
<td>National Association of State Treasurers (NAST) Legislative Conference—Washington, DC—Willard InterContinental Hotel. Contact Adnée Hamilton at (859) 244-8174 or <a href="mailto:ahamilton@csg.org">ahamilton@csg.org</a>.</td>
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<td>May 3–6</td>
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<td>National Association of State Technology Directors (NASTD) Midwestern Region Seminar—Madison, WI—the Madison Concourse Hotel. Contact Pamela Johnson at (859) 244-8184 or <a href="mailto:pjohnson@csg.org">pjohnson@csg.org</a>. Visit <a href="http://www.nastd.org">www.nastd.org</a>.</td>
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<td>May 8–10</td>
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<td>CSG/SLC Legislative Service Agency Directors Group 2009 Spring Meeting—Miami, FL—The Hilton Bentley Hotel. Contact Elizabeth Lewis at (404) 633-1866 or <a href="mailto:elewis@csg.org">elewis@csg.org</a>.</td>
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<td>May 12–15</td>
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<td>National Association of State Treasurers (NAST) Treasury Management Conference &amp; Exposition—Atlanta, GA—Marriott Marquis Hotel. Contact Adnée Hamilton at (859) 244-8174 or <a href="mailto:ahamilton@csg.org">ahamilton@csg.org</a>.</td>
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<td>May 16–19</td>
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<td>CSG 2009 Spring Conference—Coeur d’Alene, ID. Contact registration at (800) 800-1910 or <a href="mailto:registration@csg.org">registration@csg.org</a>.</td>
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<td>June 6–9</td>
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<td>National Association of State Technology Directors (NASTD) Western Region Seminar—Whitefish, MT—Grouse Mountain Lodge. Contact Pamela Johnson at (859) 244-8184 or <a href="mailto:pjohnson@csg.org">pjohnson@csg.org</a>. Visit <a href="http://www.nastd.org">www.nastd.org</a>.</td>
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<td>June 27–July 1</td>
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<td>National Association of State Technology Directors (NASTD) Southern Region Summer Seminar—Louisville, KY—The Brown Hotel. Contact Pamela Johnson at (859) 244-8184 or <a href="mailto:pjohnson@csg.org">pjohnson@csg.org</a>. Visit <a href="http://www.nastd.org">www.nastd.org</a>.</td>
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<td>July 10–14</td>
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<td>CSG/Midwestern Legislative Conference—15th Annual Bowhay Institute for Legislative Leadership Development (BILLD)—Madison, WI—Fluno Center of Executive Education—Contact Laura Tomaka at (630) 925-1922 or <a href="mailto:ltomaka@csg.org">ltomaka@csg.org</a>.</td>
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<td>July 11–15</td>
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<td>National Association of State Personnel Executives Annual Meeting—Park City, UT—Park City Marriott. Contact Jessica Ruble at (859) 244-8179 or <a href="mailto:jruble@csg.org">jruble@csg.org</a>.</td>
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<th>August 2009</th>
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<td>Aug. 2–5</td>
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<td>CSG/ERC Annual Meeting—Burlington, VT—The Hilton Burlington Hotel. Private sector contact is Michelle Shiwamber at (646) 383-5728 or <a href="mailto:mshiwamber@csg.org">mshiwamber@csg.org</a>. Public sector contact is Cynthia Valle at (646) 383-5726 or <a href="mailto:cvalle@csg.org">cvalle@csg.org</a>.</td>
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<td>Aug. 5–8</td>
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<td>CSG/WEST Western Legislative Academy—Colorado Springs, CO. Contact Mary Lou Cooper or Cheryl Duvachelle at (916) 553-4423 or <a href="mailto:csw@csg.org">csw@csg.org</a>.</td>
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<td>Aug. 9–12</td>
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<td>CSG/Midwestern Legislative Conference—64th Annual Meeting—Overland Park, KS. Contact Cindy Andrews at (630) 925-1922 or <a href="mailto:candrews@csg.org">candrews@csg.org</a>. Visit <a href="http://www.csgmidwest.org">www.csgmidwest.org</a> for more information.</td>
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<td>Aug. 15–19</td>
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<td>National Association of State Technology Directors (NASTD) 32nd Annual Conference &amp; Technology Showcase—Montgomery, AL—Renaissance Montgomery Hotel &amp; Spa at the Convention Center. Contact Pamela Johnson at (859) 244-8184 or <a href="mailto:pjohnson@csg.org">pjohnson@csg.org</a>. Visit <a href="http://www.nastd.org">www.nastd.org</a>.</td>
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<td>Aug. 15–19</td>
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<tr>
<td>CSG/Southern Legislative Conference—63rd Annual Meeting—Winston-Salem, NC. Contact Elizabeth Lewis at (404) 633-1866 or visit <a href="http://www.slcatlanta.org">www.slcatlanta.org</a> for additional information.</td>
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Although the federal government tends to get more attention, state officials are often on the front lines of cutting-edge trends and issues. On the other hand, sometimes in the community of state governments, the more things change, the more they stay the same.

In print since 1958, State News (formerly State Government News) has chronicled many of the changes … and continuities.

Here’s what we reported on:

40 years ago—February 1969

The Role of Lieutenant Governors

Florida Gov. Claude R. Kirk Jr. appointed former state Rep. Ray C. Osborne as the state’s first lieutenant governor in early 1969, according to a brief article in the February 1969 State Government News. The appointment came as part of the new constitution ratified by voters in November 1968, the article reported.

The new constitution provided that the lieutenant governor is a member of the executive branch with duties assigned by the governor or the legislature, according to the magazine. The lieutenant governor would not preside over the Senate under provisions of the constitution.

Update

By November 2009, 45 states will have an official with the title lieutenant governor. New Jersey will elect its first in November. Only five states do not have lieutenant governor. Two have the senate president first in line of succession, while in three the secretary of state holds that position. The new Arizona governor indicated she may consider creating the office of lieutenant governor.

25 years ago—February 1984

Education, Jobs Dominate Governors’ Messages

Education was listed as the top priority for governors who gave their state of the state addresses in January, according to a February 1984 State Government News article. Jobs and economic development were also gubernatorial priorities.

Twelve governors called for pay raises for teachers; three called for higher taxes for education while six called for tax hikes or extension of higher rates to balance budgets. Four governors proposed tax relief.

Also on the list of priorities for the 24 governors covered in the February article were jobs and economic development, including tourism, exports, infrastructure improvements, job training, industrial development and high technology centers at universities.

Update

Governors across the country have started giving their State of the State addresses last month. A tight economy will limit any new initiatives, and governors who have addressed their states have indicated education will remain a top priority. In addition, addressing the nation’s energy crisis and attracting new jobs will likely be at the top of the list of many governors. Read an analysis of the governors’ addresses in the March State News.

10 years ago—February 1999

Technology in Education

Technology is quickly becoming a major part of classrooms across the country, and has been on that ride for the past 10 years. In 1999, students at a high school in Pennsylvania made history by producing the nation’s first live Internet webcast of the governor’s budget address, according to an article in the February 1999 State Government News. Governors and state legislators indicated support for funding education technology.

“They recognize that technology is increasingly important in preparing students and they want to be leaders in this arena,” Melanie Griffith George, state policy manager with the Software Publishers Association, told the magazine.

Update

States are still striving to be leaders in technology in the classroom and have made great strides over the years. One new area drawing attention is Internet2, which can link high school classrooms to universities with the right networking, according to David Jent, associate vice president for networks at Indiana University. Jent discussed Internet2 at The Council of State Governments annual meeting in Omaha in December 2008.

More than 200 U.S. research universities collaborate with partners in industry and business for Internet2. The network allows universities and research partners to safely and efficiently share large amounts of data for projects, Jent said. In addition, he said the advanced applications available on Internet2 make it a perfect fit for connecting K–12 classrooms to college campuses.

For instance, high schools can tap into college classes if they have the same advanced features available on networks, Jent said.

“Where higher education and K–12 have a disconnect is services it can run,” he said. “I may not be able to have a class in high school collaborate with a class in college because of a mismatch of advanced features.”

The possibility of competition for the commercial Internet presents challenges for the growth of Internet2, according to Jent. He said private sector providers are resisting expansion of connections to Internet2 for K–12 education. He believes the benefits for K–12 education would be great.