HOT TOPIC: Health Care

States Brace for Federal Action

10 States on Opposite Ends of Insurance Coverage Spectrum

Secretary Kathleen Sebelius On Health Care Reform, Health IT and Medicaid

Prevention: A Way to Bend Cost Curve?

4 Ways to Address Cost, Coverage

“Governors and state legislatures are struggling under the weight of escalating health care costs …”

—Kathleen Sebelius
Intuit Tax Freedom Project

Working in public, private and not-for-profit partnership for over 10 years

Intuit Tax Freedom Project
donates free online federal and state tax preparation and electronic filing through the IRS and state revenue agency Free File programs.

Helping low and middle income tax filers
accurately prepare their returns so they can claim all the deductions and credits they deserve.

Over 20 million returns
have been donated to qualifying taxpayers since the Intuit Tax Freedom Project began in 1998.

Learn how you can help your lower income constituents at
IntuitEmpowers.com
ON THE COVER
U.S. Health and Human Services Secretary Kathleen Sebelius is pictured in the Kansas State Capitol. Sebelius served as a governor, a state legislator and commissioner of insurance in Kansas before being appointed by President Obama to her current post. Learn how the positions Sebelius held in state government are helping her deal with the current health care reform debate on page 18.

COVER PHOTO BY SCOTT INDERMAUR

HOT TOPIC—HEALTH CARE
States will undoubtedly face some major hurdles with reform of the nation’s health care system.

2010 SESSION PREVIEW
As legislators prepare to enter the 2010 session, most are facing unprecedented budget problems. The discussions likely will focus on the practical as well as the philosophical.

SERVING THOSE WHO SERVE
While 26 states have adopted the Interstate Compact on Educational Opportunity for Military Children, the need now is training school personnel to ensure the rules are applied equitably.

HOW TO
Former TV journalist Lindsay Strand, now a coach for political officials, offers advice on how to deal with the media.
## Contents

<table>
<thead>
<tr>
<th>Page</th>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>THEY SAID IT</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>REGIONAL ROUNUP—EAST</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>REGIONAL ROUNUP—SOUTH</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>REGIONAL ROUNUP—MIDWEST</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>REGIONAL ROUNUP—WEST</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>BY THE BOOK</td>
<td>A look at health insurance coverage in the states.</td>
</tr>
<tr>
<td>12</td>
<td>IN THE KNOW</td>
<td>CSG’s health policy director shares her predictions of how states will be impacted by reform.</td>
</tr>
<tr>
<td>13</td>
<td>HOT TOPIC</td>
<td>The impact of health care reform on states will be more than just money.</td>
</tr>
<tr>
<td>18</td>
<td>10 QUESTIONS</td>
<td>Kathleen Sebelius talks about health care reform, Medicaid and children’s insurance programs, and H1N1 preparedness.</td>
</tr>
<tr>
<td>20</td>
<td>TIMELINE OF REFORM</td>
<td>States have taken action to supplement federal efforts at health care reform.</td>
</tr>
<tr>
<td>21</td>
<td>CASE STUDY</td>
<td>Four states have found ways to deal with coverage and care issues.</td>
</tr>
<tr>
<td>25</td>
<td>HEALTH CARE COST DRIVERS</td>
<td>Chronic disease and technology contribute to the rising cost of health care.</td>
</tr>
<tr>
<td>27</td>
<td>FOCUS ON PREVENTION</td>
<td>Various state programs focus on keeping people healthy.</td>
</tr>
<tr>
<td>31</td>
<td>THE LANGUAGE OF REFORM</td>
<td>Dr. Frank Luntz shares insights into the debate about reform.</td>
</tr>
<tr>
<td>32</td>
<td>HEALTH INFORMATION TECHNOLOGY</td>
<td>Recovery Act dollars will help states incentivize progress in health IT.</td>
</tr>
<tr>
<td>34</td>
<td>STRAIGHT TALK</td>
<td>Stakeholders share their opinions on important issues in reform.</td>
</tr>
<tr>
<td>36</td>
<td>SESSION PREVIEW</td>
<td>Money, or the lack thereof, will drive practical as well as philosophical debate during this legislative session.</td>
</tr>
<tr>
<td>38</td>
<td>CAPITOLS GUIDE</td>
<td>Fast facts and party control in the state capitols.</td>
</tr>
<tr>
<td>40</td>
<td>STATED BRIEFLY</td>
<td>News from The Council of State Governments and its affiliates.</td>
</tr>
<tr>
<td>42</td>
<td>SERVING THOSE WHO SERVE</td>
<td>A new compact ensures children of military parents have a smooth transition when the families move. Training for school personnel is the next step.</td>
</tr>
<tr>
<td>45</td>
<td>COMPACT ON JUVENILES</td>
<td>New compact keeps tabs on runaways, juvenile offenders.</td>
</tr>
<tr>
<td>46</td>
<td>HOW TO</td>
<td>Former TV journalist Lindsay Strand shares tips on dealing with the media.</td>
</tr>
<tr>
<td>47</td>
<td>ON THE ROAD</td>
<td>Upcoming meetings of interest.</td>
</tr>
<tr>
<td>48</td>
<td>SHOUT OUT</td>
<td>Meet Julian Carroll, a former Kentucky governor who now serves as a state senator.</td>
</tr>
</tbody>
</table>
Sharing Capitol Ideas

With this issue we unveil *Capitol Ideas*, the newest publication from The Council of State Governments. Since 1933 we have been committed to sharing capitol ideas and this new magazine honors that tradition. Please let us know what you would like to see on these pages. Submit an essay, share a tip, suggest a story idea, and let us know what you liked and what you think could be improved. This is your magazine.

It wasn’t hard to decide on what the hot topic should be for this first issue. For the last two years the national campaigns and the federal domestic policy agenda have been dominated in large part by health care reform. Rapidly escalating health care costs are a drag on economic growth and the inability of many Americans to obtain or retain health insurance has led to economic instability for many families. While most Americans are uncertain or opposed to many specific reform proposals, most also agree that key aspects of the current system are broken.

Anyone who has spent time around a legislative body is familiar with the old adage that laws are like sausage. It is better not to see them being made. Forging consensus and compromise on such a complex issue as health care has certainly resulted in a fair share of sausage making. But passage of bills by both the U.S. House and Senate marks a historic legislative milestone. Making sense out of it all and finding a way to implement the millions of words on thousands of pages of legislation will soon shift to the states.

Policy choices now pending in the reconciliation of the House and Senate versions of reform pose a potentially significant, long-term threat to the financial stability of states at a time of unprecedented budget gaps. One Democratic governor labeled the Senate bill the “mother of all unfunded mandates.” State leaders know that without proper financial support, the promise of reform will be elusive and unsustainable.

We are prepared to work with state leaders to first help them understand the intricacies of the federal legislation and specifically how it will impact their state. Second, we will provide state leaders with meaningful opportunities to learn from each other as they seek to make federal reforms work. And on behalf of state leaders we will continue our dialogue with federal officials to make certain the realities and costs of implementing the federal reforms in the states are known in Washington, D.C.

There has never been a more exciting or challenging time to be a state leader. History teaches us that often the greatest leaps forward spring from adversity. While it is clear state leaders will confront some of the most difficult choices ever in the coming year, I believe that from that experience new seeds of change will be planted and from those seeds new solutions and transformative innovations will emerge and grow.

The Council of State Governments stands ready to help empower state leaders to achieve more than they might have ever dreamed was possible. We are honored to share this journey with you.

Very truly yours,

David Adkins
“Access to health care **saves lives** and **money**! It improves quality of life and helps contain costs.”

—Massachusetts **Sen. Richard T. Moore**, president-elect, National Conference of State Legislatures, in a commentary from his Web site

“Regardless of whether the ‘payer’ is the government or private insurance, we are all going to **pay more**—in **increased** taxes, **increased** premiums, or **both**—unless we can get a handle on spiraling health care costs.”

—Vermont **Gov. Jim Douglas**, 2010 chair of the National Governors Association, 2006 CSG president

“(The proposed Medicaid expansion may be) the **mother** of all unfunded mandates.”

—Tennessee **Gov. Phil Bredesen**, at National Governors Association meeting in July, according to the **New York Times**

“... if it takes doctors six visits to get their patients straightened out, they will be **rewarded** six times for failing five.”

—Former Arkansas **Gov. Mike Huckabee**, 2003 CSG president, in September, 2009, interview in the *Arkadelphia Daily Siftings Herald* on reforming health care

“This is the last thing we need, another $3 billion of (state) spending when we already have a $20 billion deficit.”

—California **Gov. Arnold Schwarzenegger**, commenting on ABC's “Good Morning America,” Dec. 15
The East

FLU SHOTS
New Jersey last year suspended a requirement that preschool children should get a seasonal flu shot by Dec. 31 because of a shortage in seasonal flu vaccine. The New Jersey Department of Health and Senior Services said the change applied to the 2009–10 school year for preschool and day care children.

NO SALES TAX CUT
When Connecticut tax collection fell more than 1 percent behind projections, a scheduled Jan. 1 plan to cut the sales tax cut from 6 percent to 5.5 percent was nixed, according to The Hartford Courant. The tax cut’s approval was contingent on tax revenues staying within 1 percent of projections, the newspaper reports.

MAMMOGRAMS COVERED
After the U.S. Preventive Services Task Force recommended women get mammograms in their 50s and not in their 40s as recommended for years by the American Cancer Society, Maine is reassuring residents new advice won’t affect insurance coverage for mammograms. “Maine law is not contingent upon advisories from commissions or other groups,” state Insurance Superintendent Mila Kofman told the Bangor Daily News.

STUDENT FINANCIAL AID
Delaware State University didn’t ask the state for a budget increase last year but warns it will have a hard time providing financial aid to an increasingly needy pool of students, according to The News Journal in Wilmington. More than 80 percent of its students need financial assistance, the newspaper reports.

CSG EAST LEADERS

Eastern States Push Higher Payroll Taxes

Maryland, New Jersey and Rhode Island are Eastern states among those expected to push higher payroll taxes next year, according to the Reuters news agency.

Florida and Hawaii may also do so, Reuters reports.

“Raising payroll taxes is going to be the approach that a lot of states start following,” Sujit CanagaRetna, senior fiscal analyst with The Council of State Governments Southern office, told Reuters. “But this is the worst possible time to go ask employers to pay more money. It is a very unfortunate double-edged sword ... a jobless recovery.”

In New Jersey, business owners face nearly doubling taxes in 2010, according to Reuters.

But there’s something else simultaneously happening in addition to increased payroll taxes. States are also considering proposals to cut or limit unemployment benefits, according to Reuters.

As the national unemployment average reached just more than 10 percent last year, states are increasingly turning to the federal government for help in the form of loans to cover jobless benefits, Reuters reports.

The news agency also reports that state unemployment trust funds, which pay an estimated $200 to $400 a week to laid-off workers were so strapped by mid-November that 24 states and the Virgin Islands borrowed $21 billion from the federal government, according to the U.S. Department of Labor.
TRAFFIC CAMERAS
A Tennessee lawmaker wants the legislature to explore requiring cities with traffic-enforcement cameras to put some generated revenue back into public safety, according to The Chattanooga Times Free Press. The high-tech cameras have drawn attacks from some who question their fairness and money generated for local governments and private vendors maintaining them, the newspaper reports.

ONLINE HUNTING LICENSES
Buying hunting licenses online is growing in popularity in West Virginia, according to the Charleston Gazette. By mid-November, about 9,000 hunting licenses were purchased online, bringing the state more than $570,000 in revenue—that’s up from the same time last year, when 8,200 licenses were processed electronically, the newspaper reports.

RACE TO THE TOP
Texas Gov. Rick Perry directed the state’s education commissioner not to commit the state to adopting national standards and assessments in its application for Race to the Top stimulus funding, according to Perry’s letter to Texas Education Commissioner Robert Scott. The U.S. Department of Education gives preference to states that adopt national standards and assessments in awarding funding.

HEALTH REFORM
The health insurance reform bill approved by the U.S. House in November could add more than 318,000 Oklahoma residents to the state’s Medicaid program, according to The Oklahoman, citing estimates from the state’s Medicaid program. That expansion could cost the state $128 million more each year, according to the estimates.

CSG SOUTH LEADERS
New 2009–10 leaders for The Council of State Governments Southern Legislative Conference are: South Carolina Speaker Robert W. Harrell, Jr., CSG SLC chair; Tennessee Senate Majority Leader Mark Norris, CSG SLC chair-elect; West Virginia Speaker Richard Thompson, CSG SLC vice chair; and Texas Sen. Jeff Wentworth, CSG SLC immediate past chair.

Medicaid is Budget Buster in North Carolina

North Carolina Gov. Beverly Perdue said North Carolina’s Medicaid program is a real budget breaker. That’s according to her announcement in December that the state’s Medicaid program is over the budget the legislature gave state officials in summer 2009, the Associated Press reports.

The state’s Medicaid program for low-income children, older adults and the disabled is at least $150 million over budget through the first quarter of the fiscal year, according to the AP. Like a lot of states, North Carolina’s budget is strained—particularly its Medicaid budget—as more people enrolled in the Medicaid program as unemployment in North Carolina hit 11 percent last year, according to the U.S. Bureau of Labor Statistics.

North Carolina Department of Health and Human Services Secretary Lanier Cansler said in October that 8,000 more people were enrolled in Medicaid than projected.

Perdue also traveled to Washington, D.C., in December to let White House officials know about her concerns that health care reform legislation approved by the House would place additional expenses on the states, the AP reports. In December, Perdue also hoped to visit with Health and Human Services Secretary Kathleen Sebelius to talk about the state’s rising Medicaid costs, according to the AP.

To learn more about these and other developments in the Southern Region, visit: capitolideas.csg.org or www.slcatlanta.org.
Like many states, Kansas may be in store for more budget cuts this session even after the state cut $259 million from the budget last year—representing its fifth round of cuts in 2009, according to the Lawrence Journal-World.

The Council of State Governments Midwest executive director Mike McCabe told the newspaper declines in state revenues have been historic, and Kansas’ problems aren’t unique.

“States really are pulling out all the stops,” McCabe told the newspaper. He said states won’t get back to 2008 revenue levels until 2013, according to the Lawrence Journal-World.

Kansas, like many states, is facing potential budget shortfalls because the state hasn’t started recovering economically and the federal stimulus money is running out and will dry up this year, the newspaper reports. Kansas Gov. Mark Parkinson’s budget director, Duane Goossen, told the newspaper the state’s decline in revenues is the worst since the Great Depression.

Goossen told the newspaper the state was beyond looking for efficiencies and was making painful cuts. That feeling may be nearly universal in the states.

In fact, many experts refer to the economic conditions the states are now dealing with as the “Great Recession.”
MEDICAID SHORTFALL

New Mexico stopped accepting individuals into the State Coverage Insurance program, which helps nearly 50,000 low-income folks and small employers afford health insurance, according to the New Mexico Independent. The step is one of many cost-cutting measures leading to next year’s possible $300 million shortfall in the state’s Medicaid budget, according to the newspaper.

PRIVATE INSURANCE

Since 2005, Utah residents with private health insurance expressed increasing satisfaction with their plans, according to the 2009 Consumer Assessment of Health Plans Survey from the Utah Department of Health. That didn’t hold true for residents enrolled in Medicaid, however.

JOB LOSSES

At 9.9 percent, Arizona has the highest percentage of job losses nationwide since the recession began in December 2007, according to the Economic Policy Institute. That’s above Nevada and Michigan. Arizona was the nation’s first or second fastest growing state for at least 25 years before the recession, according to The Arizona Republic.

PRISON RAPE

In November, Idaho convicted the first inmate in the Department of Corrections 120-year history for rape behind bars, the AP reports. Brent Reinke, director of Idaho Department of Corrections, said Idaho’s approach to ending prison rape makes the state a model for other state prison systems, according to the AP.

CSG WEST LEADERS


California Goes Cap-and-Trade

California’s Air Resources Board met in December to discuss a cap-and-trade plan as one of the main strategies the state will use to reduce its greenhouse gas emissions by 2020, according to the board.

Under the Global Warming Solutions Act of 2006, the state is now in the final phases of putting together a proposed cap-and-trade plan to be in place by next year, according to the board. After a public comment period, a final version of the cap-and-trade plan is slated for a summer 2010 release, according to the state Air Resources Board. Consistent with the Global Warming Solutions Act, that cap-and-trade program should go into effect officially by 2012.

Regulators estimate the state’s cap and trade program could cost industry as much as $8 billion a year by 2020 if businesses trade carbon allowances at the current price on the European market of $20 per ton, according to the Los Angeles Times.

California is also working with six other Western states and four Canadian provinces through the Western Climate Initiative to design a regional cap-and-trade program, according to the California Air Resources Board.

California’s Air Resources Board met in December to discuss a cap-and-trade plan as one of the main strategies the state will use to reduce its greenhouse gas emissions by 2020, according to the board.

Under the Global Warming Solutions Act of 2006, the state is now in the final phases of putting together a proposed cap-and-trade plan to be in place by next year, according to the board. After a public comment period, a final version of the cap-and-trade plan is slated for a summer 2010 release, according to the state Air Resources Board. Consistent with the Global Warming Solutions Act, that cap-and-trade program should go into effect officially by 2012.

Regulators estimate the state’s cap and trade program could cost industry as much as $8 billion a year by 2020 if businesses trade carbon allowances at the current price on the European market of $20 per ton, according to the Los Angeles Times.

California is also working with six other Western states and four Canadian provinces through the Western Climate Initiative to design a regional cap-and-trade program, according to the California Air Resources Board.

To learn more about these and other developments in the Western Region, visit: capitolideas.csg.org or www.csgwest.org.
THE STATE OF HEALTH INSURANCE COVERAGE

a glance at who’s covered where

UNITED STATES
84.7% are insured.

- 53.7% Employer
- 4.9% Individual
- 13.2% Medicaid
- 12.1% Medicare
- 1.1% Other public

REGIONAL DATA
(percent insured)

- 88.6% Midwest
- 88.5% East
- 83.9% South
- 82.8% West

PEOPLE UNDER AGE 65
17% are uninsured.
65% have private insurance.

CHILDREN UNDER AGE 18
8.9% are uninsured.
58% have private insurance.
34% have public health plan.

Regional distribution, by health plan provider

Source: Centers for Disease Control and Prevention, FastStats
THE BOOK OF THE STATES

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

TOP 5 STATES FOR NUMBER OF RESIDENTS COVERED BY INSURANCE

BOTTOM 5 STATES FOR NUMBER OF RESIDENTS COVERED BY INSURANCE


*According to the latest study conducted by the Massachusetts legislature in late 2009, 97 percent of residents have health insurance.
State policymakers, understandably, are nervous about the shape of federal health care reform. They are concerned not only with the final costs to the states, but also with the political costs if their constituents are dissatisfied with the reforms. Here are some ways reform will affect states.

MEDICAID

The federal-state matching program that already provides health care coverage for more than 60 million low-income people is sure to expand if reform passes. While the Congressional proposals include increased Medicaid matching dollars for states, they also give states no choice but to expand their programs to cover more individuals.

States likely will be prohibited from cutting Medicaid before the new expansions roll out. States may have to pick up the full cost for new enrollees who meet the old eligibility rules as they come into the program as a result of increased outreach and enrollment activities. States that face health care provider shortages—whether because of low reimbursement rates or provider reluctance to deal with Medicaid—may find that patient access to ongoing care continues to be an issue despite expanded eligibility.

All these issues are overshadowed by questions about how the federal matching share formula will change: Which states will be financial winners and losers? Will the matching program reward or punish states that have already expanded Medicaid using state funds? The Senate bill does not expand eligibility as much as the House version (133 percent of the federal poverty level versus 150 percent) but is slightly more generous to states in federal match provisions.

INSURANCE EXCHANGES

Under the House version, states will have to establish exchanges so uninsured residents can buy health insurance. In almost all states, this will require establishing a new state office to broker insurance coverage for those without access through their workplace. These offices will also, presumably, have to work with the federal government to administer the subsidies that will be available to make exchange plans affordable to low and middle-income families. The Senate bill calls for a federally run exchange.

PUBLIC PLANS AND CO-OPS

If a public plan is in the final legislation, states will be required, or have the option perhaps, to set these up and administer the program, similar to Medicaid but closer akin to private health insurance. If consumer operated co-ops are included in the final reform, state regulatory agencies will have to coordinate with federal offices that may award loans and grants.

STATE INSURANCE REGULATION

States will continue to provide oversight of health insurance plans. They will also be responsible for enforcement of the insurance reforms likely to be adopted by Congress—mandatory issue, elimination of pre-existing condition exclusions and policy cancellation prohibitions. If cross-border sale of insurance is allowed, states will have to work out interstate compacts or other cooperative agreements.
FIRST DO NO HARM

STATES BRACE FOR IMPACT OF FEDERAL HEALTH REFORM

by Mary Branham

NONPROFIT HEALTH CLINICS CARE FOR UNINSURED

LAKewood, Colo.—Physician’s assistant Erin Frazier checks Jair Castillo, 3, at a community health center for low-income patients in Lakewood, Colo. The Metro Community Provider Network—or MCPN, which has 11 health centers in the Denver area, has seen a 138 percent increase in patients during the last year of the recession. Community health centers such as MCPN could play a major role nationally if health care reform is passed, with increased subsidies from the federal government as well as millions of newly insured low-income citizens seeking care.

Photo: John Moore/Getty Images
It’s hard for state officials to get past the anticipated costs of health care reform.

The estimated $1 trillion federal price tag has some tongues wagging across the country, but for state officials it’s the impact on their own budgets that raises red flags.

“States right now are very challenged with budgets in which revenues are down and expenses for existing Medicaid populations are up,” said South Dakota Gov. Mike Rounds, the 2010 president of The Council of State Governments.

As Congress debated an overhaul of the nation’s health care system, state officials pondered the effects any action would have on them and their budgets. Policymakers on both sides of the aisle saw potential problems.

Alabama Sen. Vivian Davis Figures, a Democrat and co-chair of the CSG Health Policy Task Force, voiced the same concern about money as her Republican counterpart on the task force, Kentucky Sen. Julie Denton.

“It’s going to be a financial hardship on many states throughout the country because right now many of us are in deficits,” Figures said. “Our revenues are down more than they ever have been historically, and I find it very hard to have a new expense when we are not even taking care of current expenses.”

Denton said potential mandates for coverage would hurt an already strapped Kentucky budget. “If they were to expand Medicaid and not send dollars to cover costs … that would put us in a very bad position,” she said.

The proposals, in fact, would require states to expand Medicaid coverage. (Congress had not taken final action on health care reform by the Capitol Ideas deadline.) Alan Weil, executive director of the nonpartisan National Academy for State Health Policy based in Washington, D.C., said the federal government would pick up a large share of the cost of drastically expanded Medicaid eligibility, but not all of it.

“Even a small share may be more than (states) can bear,” he said.

“Obviously states are struggling under the burden of financing programs they already run,” Weil said. “The notion that they’re going to be able to turn all their energy into this expansion and all these new exciting things is, I think, unrealistic.”

While that additional financial burden to states is a concern, Rounds said the added number of people getting services at discounted rates could have the unintended consequence of raising costs for others.

“Medicaid pays, at least in the upper Midwest, about 50 to 52 percent of the billed charges,” he said. “Physicians and facilities, both doctors and hospitals, will pass on or cost-shift that unpaid balance onto the private sector, which will make it more difficult for the private sector to continue to pick up their costs of health care for their employees.

“That to me is a very challenging situation which in the long-term will mean more uninsured.”

**Reform Will Affect States in Other Ways**

While the cost of expanding coverage to the uninsured has drawn a lot of attention, states would be impacted heavily when it comes to how health insurance is regulated.

New provisions related to regulation of insurance will require changes at the state level, Weil said. “States do regulate insurance, but very few of them do it around some of the parameters discussed in the federal reform, so that’s a major undertaking,” he said.

Jane Cline, West Virginia’s insurance commissioner, said the sweeping reforms to improve access and equity in health insurance markets will be the most important aspects of the bills from an insurance regulation standpoint.

“Insurance market reforms, particularly in the difficult-to-regulate individual insurance market, promise to make health coverage fairer, more transparent and more available,” she said.

The proposed health insurance exchanges, where uninsured people can buy health insurance, she said, would facilitate comparison between plans and enrollment in plans. Concerns lie in how those would be structured, which was still up in the air at press time.

If the federal government operates a national exchange, a national health choices commissioner could set rules in areas states already regulate, according to Cline. She fears
The National Academy for State Health Policy surveyed its leadership of state health policymakers to determine what states are trying to accomplish and their priorities for reforming health care. According to executive director Alan Weil, states are trying to:

1. **Connect people to the services they need**
   “What good is it to have a health care system if people don’t actually get the services they need?”

2. **Bring greater coordination, integration into the health system**
   “Fragmentation is very expensive. It’s cause for medical errors, inefficiencies, things we’re trying to drive out of the system.”

3. **Improve care for people with complex needs**
   “States have primary responsibility for populations with complex health needs . . . people with traumatic brain injury, Alzheimer’s, children with autism . . .”

4. **Orient the health system toward results**
   “Instead of paying for procedures or tasks or tests, we’re trying to figure out what the health system produces and orient the system in that direction.”

5. **Promote a more efficient health care system**
   “Resources are short. Anything we can do to make the system more efficient is on the top of the agenda.”
that would create a system in which state and federal regulators would apply different standards in the marketplace.

“As you can imagine with this sort of construct, there is room for quite a bit to go wrong,” she said. If states are responsible for operating exchanges, Cline said, those pitfalls could be avoided.

Also, when it comes to health insurance issues, health reform could create other unintended consequences for states, according to Denton from Kentucky. Before Kentucky reformed its health care system in 1994, she said, there were more than 50 insurers providing coverage. Immediately after the reform legislation, only two companies remained, she said.

She’s worried national reform would create even less competition in the health insurance market. To counteract that, Denton and others believe it would be good to allow consumers to purchase health insurance across state lines. Minnesota Gov. Tim Pawlenty, in fact, is pushing legislation to allow just that. (See page 23.)

“You lower those barriers and offer more competition and more choices,” Denton said.

But Cline said while the idea sounds good on the surface, in reality, it could cause problems.

“An insurer that chooses a state with few benefit mandates and little regulation could entice the young and healthy away from a state (with more mandates) by offering bigger discounts than insurers that are following greater mandates that were required by (another state’s) individual state law,” she said.

That would leave some insurers with risk pools filled with older and sicker individuals, she said. The premiums for those people would reflect that, she said.

And it wouldn’t necessarily be good for those who buy insurance across state lines if they run into problems, Cline believes. “State insurance commissioners would be powerless to assist the individuals in their states who had purchased policies from out-of-state carriers where they were applying the lower benefit standards,” she said.

Cline said the proposal would in effect deregulate insurance markets across the country.

Proposals in Congress would allow the creation of an interstate compact for cross-state purchase of health insurance. But Cline doubts many states would participate.

“No low-cost state is going to consent to a compact with a higher cost state,” she said. “This would result in the citizens of the low-cost state subsidizing the citizens from the neighboring state that would have the higher premiums.”

But it’s not all added costs and unintended consequences, according to Weil of the National Academy for State Health Policy. Weil said the national proposals can actually help states achieve some of their goals, such as coordination and integration of the system as well as moving to a system more oriented toward results.
Weil said the reform proposals include a lot of demonstration projects. “You almost can’t count how many demos there are around coordination and integration, public health, preventive services, health IT,” he said.

While these federal demonstrations will offer opportunity for states, Weil believes states will retain ultimate responsibility to coordinate and integrate a new health care system.

“No law in Washington is going to integrate across social services and social supports and health care services,” he said. “It just can’t be done at the national level, so most of that work remains at the state.” But, he said, “the number of resources states are going to need to actually achieve the promise of health reform is astonishing.”

Weil said the federal government must not just pass the legislation, it has to stay with reform for the long haul.

“Without a major national investment in actually helping states do the implementation (of health care reform), it doesn’t matter what’s on a piece of paper,” he said.

State Officials Watch from Sidelines

While there has been much discussion on the national level, some state officials believe their concerns haven’t weighed too heavily on the minds of those in Congress.

Denton of Kentucky said she doesn’t think state concerns were taken into consideration, especially when it comes to Medicaid. “You can’t be putting any more burden on our states at this point,” she said. “That’s a recipe for disaster.”

And Figures of Alabama would like to see more programs for education about healthy lifestyles in reform, “because some people just don’t know.”

Rounds, the South Dakota governor, said although Congress is missing the boat in some areas, there are things in the bill he believes take a good step forward.

“Health care reform should focus on requiring portability, moving from one group to another,” he said. “I think the plan to require portability and renewability, many of which some states have already done, is a good thing.”

As governor of a Western state, Rounds is also happy to see health care reform address the needs of specific groups, such as the Native American population, which, he said, has been historically underserved by federal programs.

The National Academy for State Health Policy has analyzed the proposals floating around Congress and determined states will need five things to deal with health care reform. According to executive director Alan Weil, states will need:

- Information and analysis about what is in the legislation.
- Support for strategic and information planning: “They’re going to need to create a locus of authority that says this is how we’re going to get it done. This reform affects Medicaid and insurance and the departments of personnel and administration and somehow, someone has to coordinate that.”
- Topic-specific technical assistance: “We’ve made a list of issues states are going to have to grapple with. For each one of those, states are going to need to learn from each other and outside experts for their options.”
- Communication: “They’re going to need to focus on communication, both internal to their state getting input and with the federal government so that federal regulation, as they roll out, are responsive to state needs.”
- Coordination: “States will benefit if all of these efforts are coordinated, both with what they’re doing now in terms of their own health agendas and with their existing efforts that the federal government and private organizations are supporting designed to improve the health care system.”

“Without a major national investment in actually helping states do the implementation (of health care reform), it doesn’t matter what’s on a piece of paper.”

— Alan Weil, executive director
National Academy for State Health Policy
Without Health Reform,

‘It Will Only Get Tougher’

by Mary Branham

Service as a state legislator, insurance commissioner and Kansas governor has given Kathleen Sebelius a better understanding of how the U.S. Department of Health and Human Services impacts the states. That understanding has helped her in her role as the department’s director.
“Today, too many hospitals and doctor’s offices are relying on paper records—the same system used by Hippocrates. It’s time to bring medicine into the digital age.”
—Kathleen Sebelius

1 How has being a former governor, state legislator and insurance commissioner shaped your understanding of the need for health care reform with regard to state concerns?

“Governors and state legislatures are struggling under the weight of escalating health care costs and I know how high health care costs and the growing number of uninsured Americans make their already challenging jobs even harder. … It isn’t easy and I know that it will only get tougher if we do not enact health insurance reform. I also know how difficult it is to achieve real systems changes and cost containment within the borders of just one state.”

2 Why is now the time for health care reform?

“We know that states and the American people cannot afford to wait for health insurance reform. We know that if we keep the course we’re on, by 2019, the number of uninsured Americans will rise at least 10 percent in every state in the country. In over half our states, it will go up more than 30 percent. We also know from a study done by the Business Roundtable that employer-based health costs will nearly triple from around $10,000 a year to almost $30,000.”

3 How can health information technology—which was included in the 2009 economic stimulus package—help to improve care and lower costs in the health care system?

“Today, too many hospitals and doctors offices are relying on paper records—the same system used by Hippocrates. It’s time to bring medicine into the digital age. By providing incentives to doctors and hospitals that meaningfully use health information technology, the Recovery Act will help ensure this critical technology is put to good use.”

4 Why is it important for states to be involved in developing health IT?

“States will be administering the federal health IT payments to Medicaid providers and are eligible now to receive new federal funds—at a 90/10 federal matching rate—to help them develop their health IT plans. In addition, the Recovery Act included grants worth $564 million to help states create statewide health information exchanges. … State planning and programs to promote health information exchange will help to realize the full potential of health IT to improve the coordination, efficiency and quality of care.”

5 A new report from your department addresses prevention and treatment for diabetes, a major cost driver in our health care system. What role can states play in addressing diabetes control?

“States can establish quality priorities and incentivize providers to practice high quality care through mechanisms such as grant programs and educational outreach. Emphasizing that all people with diabetes should receive regular recommended preventive exams … could help keep diabetes under better control and prevent complications down the road.”

6 What is the federal government doing to enroll the 5 million children eligible for Medicaid or the state children’s health insurance programs but are not enrolled?

“Helping states reach and enroll these children and assure that all children keep their coverage for as long as they are eligible is one of our highest priorities. The Children’s Health Insurance Program Reauthorization Act fully funds CHIP over the next four years and offers states a new (performance bonus) when they boost enrollment of Medicaid-eligible children. It also devotes an unprecedented amount of federal funding to support outreach and enrollment efforts for both CHIP and Medicaid.”

7 How have states been successful in enrolling these children?

“The strategies that have proven effective vary from neighborhood-based application assistance, such as the efforts underway in rural communities in Arizona and in the twin cities in Minnesota, to developing online application and renewal capacities, such as the initiative under development in Maryland. States like New Jersey have used the new ‘express lane’ eligibility option to make it easier to identify and enroll eligible children by relying on existing data sources, and Louisiana has been successful in virtually eliminating coverage losses due to red tape and unnecessary paperwork. These types of initiatives not only help cover children, but they also streamline the process for states and localities—a double benefit for states making do with fewer staff.”

8 The Recovery Act included funding to train health professionals. Why is this important in addressing health care challenges for the country?

“We know we have a shortage of primary care providers and that those providers are not distributed to areas that need them most. The shortage makes it difficult for some Americans to get timely, quality care, especially during an economic downturn. This Recovery Act funding makes important investments in ensuring that America’s health care work force is well-distributed, diverse and has the skills to provide high quality primary health care.”

9 Funding was also made available in the Recovery Act for health centers in underserved areas. Is this segment of the health care delivery system becoming more important?

“Absolutely. Community health centers’ work has never been more important. As Americans lost their jobs and coverage and their medical bills piled up, community health centers stretched resources to plug the holes in the system. We are committed to supporting community health centers and we’ve made a historic investment of over $1.3 billion in community health centers under the American Recovery and Reinvestment Act. That funding will support the construction of new health center sites, expansion of services, and the treatment of 2 million additional patients over the next two years.”

10 What have you learned about how the federal government handles public health issues from the H1N1 flu situation this year?

“The response to the H1N1 flu has been an unprecedented vaccination campaign with federal, state and local governments, the private sector and the American people working together to protect the public health. State and local governments have been incredible partners in the preparedness and response effort. … While we have had challenges along the way, the investments we made in pandemic preparedness allowed us to develop a vaccine in record time, administer vigorous testing and clinical trials to ensure its safety and effectiveness, and get it to the American people as quickly as possible.”
Report: Savings with Tort Reform

by Jennifer Burnett

Federal medical malpractice tort reform could reduce federal budget deficits by approximately $54 billion from 2010 to 2019, according to a report the Congressional Budget Office (CBO) released in December.

Those savings would come primarily in savings for Medicaid or Medicare.

While most states have implemented some type of medical malpractice tort reform, proponents say the CBO report supports their claim that tort reform is a necessary part of health care reform—at either the state or federal level—to cut costs.

The budget office said a recommended package of tort reforms at the federal level—including damage caps on noneconomic and punitive damages—would decrease total health spending by half a percent. The cost-savings come directly from reducing medical malpractice costs and indirectly by changing the way medical providers practice.

In a speech to a joint session of Congress earlier this year, President Obama said medical malpractice reform may not be a silver bullet, but he believes the nation should experiment with a range of ideas on how to “put patient safety first and let doctors focus on practicing medicine.”

The budget office also estimates direct medical malpractice liability costs are responsible for 2 percent of total health care expenditures in 2009. That amounts to $35 billion, including insurance premiums, settlements, awards and all other costs not covered by insurance.

In an effort to reduce those costs, states are leading the way in experimenting with medical malpractice tort reform, and have developed several approaches designed to rein in the unpredictable legal costs associated with medical malpractice. Reform legislation usually falls into two primary categories: limiting who can be found liable for wrongdoing and capping the size of awards for damages.

The political debate centers on balancing patients’ rights and constitutional protections with keeping the cost of doing business as a health care provider down.

For more information on tort reform in the states, visit capitolideas.csg.org.

Health Reform Then & Now

While there have been federal steps to address health care reform in the past century, many states have strived to expand coverage and enhance issues within their borders.

Early 1900s

1912 Teddy Roosevelt and the Progressive party push social insurance, including health insurance.
1935 Social Security Act passes Congress, including grants for Maternal and Child Health.
1939 U.S. Department of Health and Human Services born, combining federal agencies dealing with health, welfare and social insurance.

1940s

1948 National Health Assembly held in Washington, D.C. The final report endorsed voluntary health insurance, but also pointed to the need for universal coverage.

1950s

1954 President Eisenhower proposes a federal reinsurance fund so private insurers could broaden the groups of people covered.
1956 Military “medicare” program is enacted, providing government health insurance for dependents of those in the military.

1960s

1960 The precursor to the Medicaid program passes. Federal funds are used to support state programs providing the poor and elderly medical care.
1965 Medicare and Medicaid programs are signed into law.

1970s

1974 Hawaii passes the Prepaid Health Care Act, requiring employers to cover employees working more than 20 hours per week.

1980s

1981 Two types of Medicaid waivers are established allowing states to mandate managed care enrollment of certain Medicaid groups and to cover home and community-based long-term care for those at risk of being institutionalized.
1986 COBRA—Consolidated Omnibus Budget Reconciliation Act—allows employees losing their jobs to continue with their health plan for 18 months.

1990s

1993 President Clinton’s proposal, the Health Security Act, is introduced. Other national health reform plans are introduced but, like Clinton’s, fail to gain support.
1996 Health Insurance Portability and Accountability Act enacted.

2000s

2002 President Bush launches the Health Center Growth Initiative expanding the number of community health centers.
2003 Medicare expanded to cover prescription drugs. Medicare legislation also creates Health Savings Accounts.
2003 Maine passes Dirigo Health Reform Act.
2006 Massachusetts and Vermont pass health care reform.
2009 The Children’s Health Insurance Program is reauthorized.
2009 Congress debates national health care reform options.

Source: The Henry J. Kaiser Family Foundation
Three years after Massachusetts health care reform, 97 percent of the state’s residents now have health insurance—the highest in the nation, according to the latest study conducted by the Massachusetts legislature in 2009.

“We noticed that access to health insurance doesn’t guarantee access to affordable primary care,” said Sen. Richard Moore, chair of the Health Care Financing Committee.

As a result, Moore and Senate President Therese Murray sponsored legislation to expand the University of Massachusetts Medical School class for students committed to primary care. The legislation provided financial aid for those who agree to practice in primary care and expand health information technology.

But it doesn’t stop there, Moore said.

“We also commissioned a study of payment reform to transition from fee for service to global payments. Implementing these study recommendations will become Health Reform III once we draft the bill,” he said.

That legislation is slated for the 2010 session.

The state’s reform also didn’t go without its legal challenges. In one case, a Massachusetts resident didn’t believe the state should require him to have health insurance. That court case, George Fountas v. Navjeet K. Bal in her capacity as The Department of Revenue of The Commonwealth of Massachusetts, was originally filed in 2008 but Massachusetts Superior Court Justice Kathe Tuttman dismissed the case in favor of the state in February 2009, according to court records obtained by Capitol Ideas. Fountas is appealing the case against the state.

“Health care reform in Massachusetts was about much more than expanding access to health insurance. It also addressed improving health care quality and containing costs.”

—Massachusetts Sen. Richard Moore chair of the Health Care Financing Committee
Hawaii has the second highest rate of health insurance coverage for its residents, behind only Massachusetts.

That’s because since 1974, the state has required that businesses provide health coverage for employees who work more than 20 hours a week.

Linda L. Smith, senior policy adviser to Hawaii Gov. Linda Lingle, said the law has some drawbacks.

“You don’t see a lot of diversification of our economy because businesses realize they have a very high entry into Hawaii’s market,” she said.

And, because the state’s Prepaid Health Care Act mandates a wide range of coverage requirements—including chiropractic care, acupuncture and massage therapy—two insurers dominate the market. Those companies—Kaiser and Hawaii Medical Service Association, a division of Blue Cross/Blue Shield—set the reimbursement rates for medical providers, Smith said.

“Hawaii has one of the lowest reimbursement rates for doctors and hospitals in the nation,” Smith said. Hospitals are reimbursed 75 cents for every $1 they spend; mainland hospitals typically receive 87 to 90 cents on the dollar, Smith said.

“That means our hospitals and doctors are eating the costs,” she said. Last year alone, hospitals in Hawaii lost $187 million, according to Smith.

That financial reality forces many medical providers to leave the state. The exodus of doctors has occurred over the last 10 years as health care costs have risen and reimbursement rates have remained stagnant, according to Smith.

She said mandating employers to provide coverage is not in itself a bad thing. The problem comes about in specifying what those plans include.

“As soon as you start doing that, then you’re going to exclude competition in the marketplace of health insurers and you’re going to make it harder for employers and individual citizens to choose a health insurer that fits their budget and their health care needs,” Smith said.

Hawaii’s Employer Mandate

» Employers must provide health care coverage to employees who work at least 20 hours a week.

» Coverage commences after four consecutive weeks of employment.

» Employers can choose from three coverage options: an approved plan in Hawaii, a plan as part of a corporate offering—if the employer has a corporate office outside Hawaii, or a self-insured plan.

» Employee contribution is capped at 50 percent of premium costs, with a maximum of 1.5 percent of their monthly salary.

“We have health care insurance but we don’t have anybody to provide the health care.”

—Linda L. Smith

senior policy adviser to Hawaii Gov. Linda Lingle
Minnesota will be the first state in the nation to allow its residents to purchase health insurance out-of-state if Gov. Tim Pawlenty’s health care reform plan is approved this session.

Like most states, Minnesota residents can’t buy health insurance in other states. Because of that, some say, three health care plans virtually dominate the major health care insurance market in the state, with a combined market share of more than 80 percent of what the state’s Department of Commerce calls the fully insured market. That’s the market most people think of when they think health insurance; it doesn’t include the self-insured, for example.

But that could all change if the law is passed.

Supporters of the law believe if residents can buy health insurance elsewhere, the increased competition could yield lower health insurance rates.

“The hope is that by providing some degree of competition … that (the rates) would be brought down,” said Manny Munson-Regala, deputy commissioner of the Minnesota Department of Commerce. “In addition it’ll provide some consumer choice of what you can and can’t buy right now.”

The plan calls for the state’s commerce commissioner to pick states that do the best job of regulating health insurance policies and that have the best health outcomes for their residents. Minnesota residents would only be able to purchase out-of-state health insurance in those states.

Choosing the states is still a work in progress, according to Munson-Regala. “It may be more than 30, it might be less than 30 states,” Munson-Regala said.

Pawlenty also hopes the proposal will spur a new Interstate Health Insurance Compact that would allow residents from member states to purchase across state lines.

“While Congress debates federal health care reform, there are important additional steps that we can take in Minnesota to provide greater choice and competition while holding down explosive health care costs,” Pawlenty said in a press release.

“State input on health insurance products is the way to go.”

—Manny Munson-Regala, deputy commissioner of the Minnesota Department of Commerce
Alabama’s Wellness Discounts

» State employees are screened for cholesterol, blood pressure, glucose and body mass index.

» Those who undergo screening and deemed not at risk can receive a $25 monthly premium discount.

» Those deemed at risk can still get the discount if they follow up with their doctor.

» State employees get a $30 monthly premium discount for not smoking.

Alabama has taken its fight for wellness to the pocketbook.

For the past year, state employees participating in the Alabama State Employee Health Insurance program can get a discount on premiums if they take a wellness screening and, if necessary, a follow-up visit to the doctor.

Nearly one-third of Alabama’s adult population is obese, according to “F as in Fat 2009,” a report from the Trust for America’s Health. Alabama is second only to Mississippi in the percentage of obese residents, according to the report.

State employees are screened for cholesterol, blood pressure, glucose and body mass index—all considered health risk factors. Those deemed at risk are encouraged to follow up with their doctor, and the $25 co-pay is waived. If they choose to not go to the doctor, they can participate in a wellness program to receive the $25 monthly premium discount.

Kelley Sides, assistant to Alabama State Employee Health Insurance Board CEO William Ashmore, said 92 percent of state employees had participated in the screenings, and 26 percent of those deemed at risk were referred to their doctors, as of mid-November.

The premium discount is similar to one offered to nonsmokers. State employees who don’t smoke get another $30 monthly discount for their health insurance under a plan adopted in 2004.

While the media has dubbed the plan—which North Carolina also adopted—a “fat tax,” Sides said the plan is an incentive to make Alabama state employees healthier. BMI level is one of the risk factors that triggers a physician referral; it’s not a criteria for the discount, she said. And, state employees who need to lose weight can get help.

“Our program is focused on improving the health of employees.”

—William Ashmore
Alabama State Employee Health Insurance Board CEO

Montgomery, Ala.—Alabama Gov. Bob Riley, pictured in his office in Montgomery, Ala., has long advocated efforts to reduce obesity in his state. He appointed the Alabama Obesity Task Force in 2005 to address the problem when Alabama was named the fattest state in the U.S. by the nonprofit Trust for America’s Health. Among the recommendations: more public education on nutrition, more paths for physical activities and encouragement of workplace wellness programs.

Photo: Dave Martin/© 2010 The Associated Press

Alabama: It’s Not a Fat Tax; It’s a Wellness Incentive
by Mary Branham

Alabama:
It’s Not a Fat Tax; It’s a Wellness Incentive
by Mary Branham
When it comes to expensive chronic diseases driving health care costs, the issue gets very personal with Alabama Sen. Vivian Davis Figures. That’s because her mother is suffering from Alzheimer’s disease and her mother-in-law died with Alzheimer’s disease.

As the co-chair of The Council of State Governments Health Policy Task Force, Figures shared her personal connection with the costly disease at CSG’s annual meeting in November. And although she said she won’t let the fear of potentially developing Alzheimer’s dictate her life, it seems the disease does dictate ever-rising health care costs, according to some experts.

But Alzheimer’s isn’t the only thing driving health care costs.

Chronic Diseases Expensive

Alzheimer’s costs $148 billion in health care every year, said Stephen Geist, regional director for the California Southland Alzheimer’s Association. That means someone will be diagnosed with the disease every 70 seconds—and that’s going to be an increasing burden for states to bear.

Geist said states—particularly in the Northwest—will experience an estimated 81 to 127 percent increase in Alzheimer’s cases in the next 15 years. Yet only 11 states have a state Alzheimer’s plan, according to Geist.

That’s not to mention the 9.9 million unpaid caregivers that often foot the bill to care for...
MAINE PROVIDES HELP WITH MEDICARE PRESCRIPTION DRUG BENEFIT
PORTLAND, MAINE—Rita Schwenk, 71, checks her blood sugar at her home. Schwenk receives medication under the Medicare prescription drug benefit program. Diabetes is one cost driver in the health care system.

Photo: Joe Raedle/Getty Images

hot topic | COST DRIVERS

loved ones with Alzheimer’s. Sixty percent of caregivers are women, he said.

Diabetes is another health care cost driver, according to Dr. Fran Kaufman, chief medical officer with Medtronic Inc., Diabetes an associate of The Council of State Governments.

Type 2 diabetes is increasing mostly due to obesity, Kaufman said. And what’s worse, it’s a disease that requires multiple interventions, making it costly to manage.

“If we can’t prevent this, then we’ve got to have better ways to effectively manage it,” Kaufman said.

The money spent on diabetes between 2006 and 2007 nearly doubled, according to Kaufman. In 2007, $174 billion was spent on diabetes in the U.S., she said.

“This is not about me alone in a room with a patient and a family,” Kaufman said. “It’s about how to manage (and) whether someone lives a healthy lifestyle and has access to good health care.”

Kaufman believes preventive measures could go a long way in reducing the complications of diabetes.

In fact, many think preventing underlying issues that lead to costly chronic diseases is the way to reduce what’s driving health care costs.

An article published in the Journal of the American Medical Association often cited to support the point that prevention is a key to cutting health care costs is, “Bending the Cost Curve: A Critical Component of Health Care Reform.” That article by Stephen M. Shortell, dean and professor of the School of Public Health at University of California Berkeley, said disease prevention initiatives aimed at nutrition, physical activity, tobacco use and lifestyle changes will have the greatest impact on bending the health care cost curve. For more on prevention, see article on page 27.

Nutrition, physical activity, tobacco use and lifestyle behaviors have the largest influence on reducing the future burden of disease, particularly when it comes to obesity and what follows: diabetes, heart disease and cancer, according to Shortell’s article.

Some Say Technology is Culprit

But not everyone believes chronic diseases are the main culprit to mounting health care costs. Some experts say expensive new medical technology is to blame for increasing health care costs and they believe technology ranks as the number one key driver of health care costs.

“I think the consensus in the research field would be the technology is the key driver of health spending,” said Brian Quinn, research & evaluation officer on the Health Care Coverage Team at the Robert Wood Johnson Foundation. The Princeton, N.J.-based foundation’s mission is to improve the health and health care for Americans.

“Chronic diseases such as obesity are a factor. So I don’t want to say that they aren’t a cause, but I think that the consensus among the research community is that technology is really the key,” Quinn said. “We are developing new and more sophisticated ways of treating our illnesses and those technologies are quite expensive.”

Quinn said states are looking at new ways to design health care delivery and health care payment options to make sure doctors are only using the most expensive medical technologies when they are essential.

Shortell’s article also said something similar. In order to bend the cost curve, the nation must address “the behavior of patients, hospitals and physicians as they use available technologies and treatments,” according to the article. A key to changing hospital and doctor behavior is taking a look at the financial incentives driving them, according to the article.

States have tried to use regulation for decades to try to rein in health care costs with mixed success, Quinn said. An example of one type of regulation used in many states is a state’s certificate of need process, where the state must authorize new services or new construction at a health care facility. That’s how some states tried to rein in health care costs, Quinn said.

But now there’s a different approach.

“What we’re seeing is a movement toward systems redesign … it’s about trying to provide the incentives to get providers and hospitals to use technology and services in the most efficient way,” Quinn said.

Doctors are largely paid under a fee for service arrangement, where a certain amount is paid for each service provided to a patient.

“And so it’s really rethinking how payment can be redesigned to be more effective,” Quinn said. For a heart attack patient, for example, instead of being paid for each step along the way in the service provided, the doctor would be paid one lump sum payment using a bundling approach. It would be up to the doctor to identify the best course of treatment for the patient, Quinn said.

“States can have more success in rein in health care costs by trying to use expensive technologies only in the most appropriate places,” Quinn said.
Maureen Fahy picks food from the salad bar in the cafeteria at the Pitney Bowes headquarters in Stamford, Conn. Due to the rising cost of health-care, Pitney Bowes, a business services company, offers on-site clinics, exercise and other wellness programs as well as low-cost or free drugs for certain types of patients who work at the company. The result is lower benefit costs for employers and the company. State governments also offer incentives to get employees on the health bandwagon. Some states, like Indiana, are working with private enterprise to get people more active and promote a healthier lifestyle.

Photo: © David Brabyn/Corbis

Colorado Rep. Sara Gagliardi, a licensed practical nurse, teaches her dermatology patients the importance of wearing sunscreen, the signs and symptoms of cancer and how to recognize a questionable mole. That’s because as a nurse she believes in the power of prevention.

And as a state legislator, she also believes preventive care has the power to keep people healthier and can improve health systems.

“It’s key to everything,” Gagliardi said. “In every age group there’s a lot of great things that we can do for prevention. But people who have chronic illness, that’s where we need to give a lot more attention and focus. If we can get them on prevention—we can totally turn our society around.”

In fact, according to the Robert Wood Johnson Foundation, a New Jersey-based nonprofit focusing on health policy, researchers believe that hundreds of thousands of lives could be saved if people just simply stopped smoking, lost weight, exercised regularly and ate a healthy diet.
Alan Weil, executive director for the National Academy for State Health Policy, sums it up like this: The big push these days is around primary care, really coordinating care “to assure you get preventive services that you need,” Weil said. “There is a huge amount of interest in prevention and engaging the public to take better care of themselves.”

Wellness Programs Show Cost Savings
Recognizing prevention’s prowess, states turned to wellness programs in recent years to help state employees better manage their health—particularly chronic diseases—in the hopes of lowering health care costs.

Oklahoma’s OK Health is one wellness program that’s reaped dividends for the state.

Of the state’s 37,000 state employees, an estimated 32 percent have heart disease and diabetes—and there’s probably another 30 percent at risk for that same diagnosis, according to Phil Kraft, director of Oklahoma’s Employee Benefits Council.

“So when we have more than 60 percent of our work force that’s not healthy—that is alarming,” Kraft said.

For the two-year period in 2006 to 2007, participants in the program reduced their health claims costs by 21 percent, according to Kraft.

“Our definition for return on investment is lowered premiums. And one way to lower the premiums is to lower health claims costs.”

Take for example, one 50-year-old employee who joined OK Health in 2005. When she entered the program, she took a health risk assessment, or special questionnaire that de-
terms of her health risks based on the how she answered the questions. From there, she met with wellness coaches to help her manage any chronic diseases or other health conditions.

As it turns out, the program worked for her. When she came into the program in 2005, her medical claims were $3,800 a year, Kraft said.

In 2007, her medical claims were $450, according to Kraft. Doctor visits also declined—from 22 in 2005 to six in 2007, according to Kraft.

He thinks the health coaching had a lot to do with it. Basically, coaches encouraged her to take her medicines like she should and encouraged her to lose weight, he said.

“This whole program sets out to do one thing and that’s to improve the health of our state employees, but also to bend the cost curve,” Kraft said. “Through the health screening process that’s required to start the program, many of our participants have learned they had serious health problems, like cancer. Because the detections were made early, the treatments were more successful. You can’t put a value on that.”

Public-Private Partnerships Involved

InShape Indiana also focuses on prevention by bringing together public and private partners across the state. In fact, it focuses on bringing the public a message centered on the three things that contribute to the majority of chronic disease and costs nationwide: good nutrition, physical activity and no smoking, according to Dr. Judy Monroe, Indiana’s health commissioner.

Since the program started in 2005, Indiana is becoming a healthier state. Monroe thinks InShape Indiana is one of the reasons for the improvement.

For example, in 2003 Indiana was the fattest state in the nation with the highest incidence of obesity. But now the state ranks 23rd, according to the rankings from the Centers for Disease Control and Prevention.

Indiana obesity rates are leveling while other states’ obesity rates are increasing.

Part of the reason for the decline in obesity is the message coming from InShape Indiana. Launched by Indiana Gov. Mitch Daniels in 2005, the program convenes health summits every year. Last year’s summit focused on healthy small and rural communities—basically promoting wellness to individual communities and those who serve them.

Another year’s summit focusing on worksite wellness programs led to the formation of a group made up of small and large employers who actually study best practices of worksite wellness programs. Some of the large companies with established wellness programs mentor the smaller companies and work to promote the idea. “They’re taking a look at their own data and return on investment for what they do on the work site,” Monroe said.

InShape also set the stage for a small employer wellness tax credit where employers can get a 50 percent tax credit on the costs to implement a worksite wellness program, according to Monroe. In 2007, the state increased its cigarette tax, with portions of that funding going to health and to underwrite the wellness tax credit.

In the first year, 54 small employers took advantage of the tax credit, Monroe said. The state anticipated more than 100 employers would take advantage of the tax credit in 2009, she said.

Since the state started InShape Indiana, there’s also been a decline in youth smoking, according to Monroe. Smoking among high school students dropped from 23.2 percent smokers in 2006 to 18.3 percent in 2008, according to Monroe. Among middle school students, smokers declined from 7.7 percent to 4.1 in the same time period.

Still, a large part of InShape Indiana focuses on getting people healthier by focusing on individual behaviors—and a large part of prevention comes down to how people take care of themselves.

That’s why InShape Indiana uses social networking applications such as Twitter, Facebook and the program’s own dedicated social networking platform at http://iminshape.indiana.com to get the word out about healthy lifestyles.

InShape Indiana has 1,200 to 1,300 followers on Twitter, according to Josh Gonzales, communications coordinator for InShape Indiana. That’s increased from the 1,000 followers they had when they started using Twitter in April 2009. The program tweets daily on healthy habits and physical activity information, he said.

The program also features healthy recipes and promotes healthy events in the state through social networking platforms, Gonzales said.

So whether the message is tweeted, on Facebook or through a state’s wellness program, it seems states are pretty interested in prevention. “There is tremendous interest in the public and the public policy sector to try to do more around prevention,” Weil of the National Academy for State Health Policy said.

“There is a growing understanding of the burdens of things that are preventable.”
Obesity in the U.S. is growing. In fact, according to the Centers for Disease Control and Prevention, the percentage of obese children has grown more than 10 percentage points since 1976 for children ages 6 to 19. And now, two-thirds of adults are either obese or overweight.

Obesity will continue to drive the cost of health care in the U.S. Kenneth Thorpe, chairman of Emory University’s department of health and policy management, analyzed the future medical costs of obesity for America’s Health Rankings, released in November 2009. The report found obesity will cost the U.S. about $344 billion in medical-related expenses by 2018—about 21 percent of health care spending.

States are working on ways to drive the obesity epidemic—and associated costs—down. A Council of State Governments project, the Southern Collaborative on Obesity Reduction Efforts, nicknamed SCORE, funded pilot projects in six Southern states with some of the highest rates of childhood obesity. Those states chose projects that fit into categories the CDC highlighted as effective policies.

The project is funded by Leadership for Healthy Communities, a Washington, D.C.-based program of the Robert Wood Johnson Foundation.

In Tennessee, policymakers used the $10,000 grant to create a wellness center on the campus of Lewis County Intermediate and Middle schools. The school district provided a room and the $10,000 grant helped purchase child-sized equipment for the new Lewis County Wellness Center, which opened in early February 2009. The district had been meeting the state-required 90 minutes of physical activity each week, but with the new center, an additional 30 minutes a week was added for third through sixth graders.

The change has gone well beyond the school house walls.

“It’s provoked a mindset change, not only within our school system, but in our community,” Lewis County Superintendent Benny Pace said. “This has been a great thing for our school, but it’s also made us realize that we can not only change the lives of our children as far as health and nutrition goes, but we can also affect our community.”

In Kentucky, SCORE funded an effort by policymakers and a grassroots organization, Partnership for a Fit Kentucky, to release a 58-page report that addresses eight policy recommendations. Legislation addressing several of those proposals were introduced in the 2009 session of the Kentucky General Assembly.

The report, “Shaping Kentucky’s Future: Policies to Reduce Obesity,” suggests the following measures for attacking the state’s obesity epidemic:

- Increasing physical activity and physical education in schools;
- Establishing a Body Mass Index surveillance system for youth;
- Supporting breastfeeding in the work place;
- Requiring standards for nutrition and physical activity in licensed child care centers;
- Establishing complete streets policies;
- Requiring menu labeling at fast food and chain restaurants;
- Requiring healthy food at all state agencies; and
- Providing work place wellness tax credits to businesses.

For more information, visit: www.csg.org.
Political pollster Dr. Frank Luntz doesn’t practice medicine, but when it comes to the public perception of health reform, he’s got a powerful diagnosis.

“(Health care reform) has to be good for people in cities, suburbs and rural areas. It has to be good from Maine to California,” Luntz, who holds a doctorate in politics from Oxford University, said. “It has to work for conservatives and for liberals.”

The fact that public support for the reform efforts in Congress had plummeted to 36 percent by mid-December, according to a CNN poll, can be attributed to the way Democrats in Congress have handled the debate, he said.

“It actually has less support than Bill Clinton’s reform effort back in 93–94,” said Luntz, a top Republican consultant on the language of politics and author of What Americans Really Want...Really and Words that Work.

Luntz traces the falling support to one word: takeover.

“The American people don’t want a government takeover of their health care,” he said. “They want to keep it individualized, personalized and humanized.”

In fact, those three words are key to Luntz’s first rule in a list of suggestions for the GOP’s “Language of Healthcare 2009” as detailed by Politico.com.

Democrats, he said, have made a case that change is needed, but have failed to make the case that it’s their change that’s needed. House Speaker Nancy Pelosi focuses on control, choice and accountability in her speeches and press conferences, Luntz said.

“Those are the three attributes Americans want, but they don’t believe the language matches the policy,” he said.

While Democrats promised a bipartisan approach to health care reform, Luntz said the fact that it hasn’t happened is a big mistake. To make this type of fundamental change, he said, policymakers must transcend politics, ideology, demographics and geography.

But Republicans also walk a fine line in the debate, Luntz said.

“Make no mistake, Americans want health care reform and if Republicans are seen as blocking it for the sake of blocking it they’ll be punished,” he said. “The Democrats need to understand that Americans don’t want this huge bureaucratic Washington-centered program.”
Information technology advocates believe connecting the docs might lead to lower costs and better health care for patients.

And after Congress included funding for the development of health information technology in the 2009 Recovery Act, many believe now is the time to ramp up efforts in the states. It is, after all, a lengthy process.

Just ask Delaware Health Care Commission Executive Director Paula Roy. The state legislature created the commission in 1997 with a goal of developing a statewide health information exchange where health care providers could gain information about a patient electronically. Ten years later, in March 2007, the Delaware Health Information Network, a public-private partnership, went live.

Now, more than half the doctors in Delaware receive information through the exchange and about 85 percent of lab transactions flow through the system. A recent survey found 84 percent of the participants in the network believe this flow of information will improve patient care, Roy said.

The development of health information exchanges is critical to health care reform, said Jennifer Covich, interim CEO of the eHealth Initiative, an independent, nonprofit organization whose mission is to promote health care information technology.

“We’re creating the infrastructure for the future of health care information,” she said. “We want (health information) to be connected the same way banks are connected.”

That will take time. EHealth Initiative found 193 active exchanges spotted across the country in a 2009 survey. Those exchanges in operation are concentrated in the East and West. The Midwest is home to the fewest number of operational initiatives, according to the survey.

The technology is available, but Covich said the roadblocks have been political, security and privacy issues, and funding.

“Eighty percent of the care in this country is delivered by physicians in small practices so you’ve got to get all those groups wired,” she said.

**Funding Exchanges**

That’s where stimulus money—and state governments—can help, she said. The Recovery Act set aside $19 billion for the development of health information technology across the country. It also includes Medicare and Medicaid incentives to eligible providers, such as physicians and hospitals, to increase the adoption of electronic health records.

But Covich said states must invest wisely. “We need to be thinking forward about how to sustain these systems in the long-term,” she said. “The federal government can put in a big chunk of money right now but the states and
communities are going to have to be able to pick this up in years to come.”

Some states have actively funded such exchanges and adoption for several years. Michigan, for instance, invests $10 million annually to help physicians and other health care providers convert to electronic technology, according to Denise Holmes of the Michigan Health Information Network.

The network, Holmes said, provides a state backbone that connects regional exchange efforts. But she expects there’ll be a return on the state investment through cost efficiency and quality of care. In addition, from a public health standpoint, the network will improve disease surveillance, she said.

Successful initiatives in data exchange have come about locally, she said. “If we wait for that to happen across the U.S., it will be decades for health care as an overall sector of the economy to make the transformation necessary.”

That’s why state leadership is critical, Holmes believes. According to the eHealth Initiatives survey, 43 states are actively involved with the development of health information exchanges. While there are financial payoffs, Covich of eHealth Initiatives said the technology movement will also improve system efficiency and patient care.

And, according to Holmes, the e-health movement can create new sector jobs. “Michigan is particularly sensitive to that role,” she said.

People who work in health technology in the state are beginning to look at how the state can respond to the manpower needs and transformation of the workplace. With a little retraining, Holmes said, many of the people who lost jobs over the last decade could fill the needs of this new field.

Building Banks of Health Data

But not every state is banking on health information exchanges. They’re banking on, well, banks.

Oregon, for example, has been developing a Health Record Bank for Medicaid patients as a transformation project funded in 2007, according to project director Barry Kast. The bank creates an untethered personal health record controlled by the consumer.

“It’s like a manila file in your own basement filing cabinet that you could take to your doctor or to the emergency room and you can add to it no matter who is providing you with care,” Kast said.

The patient file will include everything from claims data, lab reports and electronic medical records, he said. Kast said the state signed a contract with WebMD to provide the technology and branding and marketing tools.

The health record bank is a new concept, Kast said, and is controlled by the patient, but can be accessed by caregivers registered with the system if the patient grants access. There’s also a “break glass” provision that allows providers to access health information in an emergency, he said.

“The real problems in health care have to do with how people make decisions and how people take responsibility for those decisions and whether those decisions are based on good information or not,” Kast said.

The health record bank puts the responsibility in the hands of patients, but Kast believes the state will benefit with a reduction in duplicated medical tests and, perhaps, more involvement from patients in their own health care.

“A typical person with a normal kind of pattern of health care and illness probably knows more about changing the oil in their car than they do about their own health status,” he said.

While the Oregon bank deals strictly with Medicaid patients, Kast said the state is trying to figure out a way to expand. Those who leave the Medicaid rolls will be able to maintain their accounts.

Oregon’s health record bank is expected to go live early this year and Washington state has three pilot projects in operation. Oregon’s Health Information Infrastructure Advisory Committee in 2008 said the bank is a “fundamental building block in developing health information exchange in the state.”
REWARD PRIMARY CARE

Paula Roy
Executive Director
Delaware Health Care Commission

“While most of the reported federal discussion centers on expanding access and how to pay for those coverage expansions, perhaps THE most important discussion and effort should be on HOW we deliver health care services. … Primary care remains the foundation of a patient-centered health system, so incentives, including innovative reimbursement strategies should reward primary care. Access to care for everyone is essential, but falls short of achieving the desired outcome for individuals without supports and incentives for an adequate supply and distribution of the appropriate professionals to deliver the care.”

CUT HIGH COSTS

Sen. Kevin Coughlin
Chair of Health, Human Services and Aging Committee
Ohio

“Forget the debates over the hot button issues in the proposal. The real concern for states and all Americans is that health care has become too expensive. I’m not seeing anything out of Washington that will lower costs. Expanding coverage to the uninsured is laudable. But including more people in a dysfunctional, high cost system does not sound like reform. In the end, states will share mightily in the financial burden.”
EXPANDING MEDICAID IS BUDGET BUSTER

Casey Cagle
Lieutenant Governor
Georgia

“The excessive cost of unfunded mandates from the federal government could be the breaking point for some states. In its current form, the House Democrats’ health care bill would create a huge increase in the number of Americans eligible for government-run Medicaid health care. But these increased costs would not be covered by the federal government. Instead, they would be passed onto the states in the form of unfunded mandates … The unfortunate reality is that if health care reform in its present form passes, no amount of cutting will bring our state budget into balance.”

FOCUS ON PREVENTION, DIABETES

Dr. Francine Kaufman
Chief Medical Officer
Medtronic Inc., Diabetes

“We need opportunities for physical activity. We need a good food environment, we need access to health care and we need good preventive services. The major cost driver in diabetes (a chronic disease driving health care costs) is really treating the complications of diabetes so we need to do more effort in prevention as well as the early treatment—effective early treatment—so that we can prevent the complications … We need to have an environment in which obesity is reduced. … The environment has to allow somebody to have the least opportunity to become obese.”

CARE FOR EVERYONE

Damon Arnold
Director
Illinois Department of Public Health

“I think President Obama’s plan is really remarkable—it’s really trying to include all those people who can’t gain access to health care. … The Constitution itself really was established to take care of the people. And I think that the health care system should be in alignment with that. … And of course there are going to be resolutions and changes and you have to satisfy all the parties that are involved in the process, but I think ultimately we want to make sure a child doesn’t die tonight needlessly or a senior citizen is unable to get the kinds of lifesaving care that they need.”
Let’s Talk About the Economy … Again

By Mary Branham and Mikel Chavers
Governors: All Eyes on Budgets?

Budgets and fiscal matters will also top the charts for hot issues facing governors this session. “Clearly budget problems will be the overriding issue facing governors next year,” said Iiene Grossman, director of the Midwestern Governors Association, an affiliate organization of the Council of State Governments Midwestern Office.

“Budgets, budgets, budgets are the main factor on all governors’ minds,” said Emily Marthaler, policy analyst with the Midwestern Governors Association. “I think federal stimulus funding will help fill in budget gaps in specific areas like education and transportation and infrastructure again in 2010, but for the most part it’s going to be another tough year, and the forecasts are getting grimmer,” Grossman said.

So don’t expect any sweeping new programs in tough economic times from the governors. “Budget shortfalls will make it much more difficult for governors to create new programs, if the other option is just to keep as much as they possibly can intact,” Grossman said.

One key point is “that since the recession—and resulting declining revenues—has lasted so long, state governors, budget officers and legislators have had to cut significantly, and have used up a lot of their reserves, have certainly used the ‘low hanging fruit,’” said Scott Pattison, executive director of the National Association of State Budget Officers. Pattison said the financial picture is still really difficult and will be at least through this year. “More cuts will come and tough choices on whether to raise taxes or fees will have to be faced,” Pattison said. “It’s not a pretty picture.”

But that doesn’t mean governors won’t focus on economic development. The Midwestern Governors Association, for example, has been involved in pushing green jobs with the help of chair and Michigan Gov. Jennifer Granholm’s green jobs agenda. Green jobs are a big focus for both the Michigan and Iowa governors’ economic development efforts, Grossman said, and those efforts will continue.

“Many states see energy-related jobs, especially those in green industries, as a growing area for employment,” Grossman said.

ESPN Helps Alabama Win a More Productive Session

Two years ago, the Alabama Senate had a very unproductive session—a real loser. “We didn’t pass many bills; we just left a bad taste in the mouths of our constituents and voters,” said Alabama Sen. Wendell Mitchell, the senate deputy president pro tempore. “The newspapers in the state clobbered us … we didn’t pass good or bad (bills) and waited until the last minute to pass a budget.”

So Mitchell came up with a solution.

In a nod to sports fans, a special Alabama Senate committee—nicknamed the ESPN committee—strives to make sure the Senate has a successful session. But it has nothing to do with sports unless you consider refereeing lobbyists, special interest groups, legislators and the governor’s administration in order to frontload the Alabama Senate’s calendar with noncontroversial bills sporting.

The ESPN committee stands for Ensuring a Session that’s Productive Now, and Mitchell uses it to bring all interested parties to the table for a kind of bill prescreening party. Before each legislative session, Mitchell and the committee conduct rapid fire 15-minute interviews of people who have ideas for Senate bills.

It’s the pre-game for the session.

Mitchell screens for essential bills that will easily pass the Senate. Those are put on the fast track. (The controversial bills are saved, but not put on a fast track calendar so they can be given more attention.)

The noncontroversial prescreened bills are considered as soon as the Senate convenes. Without the presession preparation, Mitchell said, on opening day, 300-400 bills are crammed in all at once and it takes a third of the session just to weed through them and get started.

“It excludes all the opportunity to be productive,” he said.

The concept seems to be working. Last year, the committee came up with a list of 115 bills from the screenings. Of those, 87 passed the Senate. The media declared it the most productive session, according to Mitchell.

States are facing a cumulative $360 billion shortfall over the next two years, he said.

In this legislative session it’ll be mostly about money—or really, the lack of it, experts said.

Sujit CanagaRetna, senior fiscal policy analyst with The Council of State Governments’ Southern Legislative Conference, expects legislative discussion of slashing programs to be interspersed with a philosophical discussion of just what the role state government should play.

“Eventually, you’ll end up with the discussion about what exactly state government should do because we’re not going to be able to do beyond a certain area because there are just no resources,” he said.

In a more practical sense, states will be looking at things such as revamping tax systems and reconsidering a slew of corporate exemptions introduced over the years, CanagaRetna said. He also predicts legislators will look at funding services and will be looking at Internet transactions.

“In those areas, you’ll see movement and some serious discussion, even among Republican-dominated legislatures because the money is just not there,” he said.

While there is a ray of optimism that the national economy may be recovering, CanagaRetna said states generally lag such recoveries by 12 to 18 months.

And he believes legislators will consider whether a consumer-based economy is the best thing for the country. According to CanagaRetna, 70 percent of the economy is based on consumer spending.

“Is it something where we should move in a direction of where we are setting the profile for a more substantive economic profile,” he said.

“In other words, are we going to be investing in infrastructure, are we going to be investing in education … those kinds of areas making more sustainable long-term (investments), as opposed to a short-term consumer-driven economic orientation.”

While many programs will be slashed, CanagaRetna said there likely will still be some innovations at the state level, “but it’s going to be more limited because states are going to be straight-jacketed by the lack of funds.”

One area of likely investment will be in alternative energy—solar, wind and geothermal among them.

“States are getting excited about that, and there is some potential to tap into some of the federal money out there.”

“We’re looking at the Great Recession … that is unprecedented in its depth and scope requiring a very fundamental philosophical debate,” he said.

States are facing a cumulative $360 billion shortfall over the next two years, he said.

Governors: All Eyes on Budgets?

Budgets and fiscal matters will also top the charts for hot issues facing governors this session. “Clearly budget problems will be the overriding issue facing governors next year,” said Iiene Grossman, director of the Midwestern Governors Association, an affiliate organization of the Council of State Governments Midwestern Office.

“Budgets, budgets, budgets are the main factor on all governors’ minds,” said Emily Marthaler, policy analyst with the Midwestern Governors Association. “I think federal stimulus funding will help fill in budget gaps in specific areas like education and transportation and infrastructure again in 2010, but for the most part it’s going to be another tough year, and the forecasts are getting grimmer,” Grossman said.

So don’t expect any sweeping new programs in tough economic times from the governors. “Budget shortfalls will make it much more difficult for governors to create new programs, if the other option is just to keep as much as they possibly can intact,” Grossman said.

One key point is “that since the recession—and resulting declining revenues—has lasted so long, state governors, budget officers and legislators have had to cut significantly, and have used up a lot of their reserves, have certainly used the ‘low hanging fruit,’” said Scott Pattison, executive director of the National Association of State Budget Officers. Pattison said the financial picture is still really difficult and will be at least through this year. “More cuts will come and tough choices on whether to raise taxes or fees will have to be faced,” Pattison said. “It’s not a pretty picture.”

But that doesn’t mean governors won’t focus on economic development. The Midwestern Governors Association, for example, has been involved in pushing green jobs with the help of chair and Michigan Gov. Jennifer Granholm’s green jobs agenda. Green jobs are a big focus for both the Michigan and Iowa governors’ economic development efforts, Grossman said, and those efforts will continue.

“Many states see energy-related jobs, especially those in green industries, as a growing area for employment,” Grossman said.

ESPN Helps Alabama Win a More Productive Session

Two years ago, the Alabama Senate had a very unproductive session—a real loser. “We didn’t pass many bills; we just left a bad taste in the mouths of our constituents and voters,” said Alabama Sen. Wendell Mitchell, the senate deputy president pro tempore. “The newspapers in the state clobbered us … we didn’t pass good or bad (bills) and waited until the last minute to pass a budget.”

So Mitchell came up with a solution.

In a nod to sports fans, a special Alabama Senate committee—nicknamed the ESPN committee—strives to make sure the Senate has a successful session. But it has nothing to do with sports unless you consider refereeing lobbyists, special interest groups, legislators and the governor’s administration in order to frontload the Alabama Senate’s calendar with noncontroversial bills sporting.

The ESPN committee stands for Ensuring a Session that’s Productive Now, and Mitchell uses it to bring all interested parties to the table for a kind of bill prescreening party. Before each legislative session, Mitchell and the committee conduct rapid fire 15-minute interviews of people who have ideas for Senate bills.

It’s the pre-game for the session.

Mitchell screens for essential bills that will easily pass the Senate. Those are put on the fast track. (The controversial bills are saved, but not put on a fast track calendar so they can be given more attention.)

The noncontroversial prescreened bills are considered as soon as the Senate convenes. Without the presession preparation, Mitchell said, on opening day, 300-400 bills are crammed in all at once and it takes a third of the session just to weed through them and get started.

“It excludes all the opportunity to be productive,” he said.

The concept seems to be working. Last year, the committee came up with a list of 115 bills from the screenings. Of those, 87 passed the Senate. The media declared it the most productive session, according to Mitchell.

States are facing a cumulative $360 billion shortfall over the next two years, he said.

In this legislative session it’ll be mostly about money—or really, the lack of it, experts said.

Sujit CanagaRetna, senior fiscal policy analyst with The Council of State Governments’ Southern Legislative Conference, expects legislative discussion of slashing programs to be interspersed with a philosophical discussion of just what the role state government should play.

“Eventually, you’ll end up with the discussion about what exactly state government should do because we’re not going to be able to do beyond a certain area because there are just no resources,” he said.

In a more practical sense, states will be looking at things such as revamping tax systems and reconsidering a slew of corporate exemptions introduced over the years, CanagaRetna said. He also predicts legislators will look at funding services and will be looking at Internet transactions.

“In those areas, you’ll see movement and some serious discussion, even among Republican-dominated legislatures because the money is just not there,” he said.

While there is a ray of optimism that the national economy may be recovering, CanagaRetna said states generally lag such recoveries by 12 to 18 months.

And he believes legislators will consider whether a consumer-based economy is the best thing for the country. According to CanagaRetna, 70 percent of the economy is based on consumer spending.

“Is it something where we should move in a direction of where we are setting the profile for a more substantive economic profile,” he said.

“In other words, are we going to be investing in infrastructure, are we going to be investing in education … those kinds of areas making more sustainable long-term (investments), as opposed to a short-term consumer-driven economic orientation.”

While many programs will be slashed, CanagaRetna said there likely will still be some innovations at the state level, “but it’s going to be more limited because states are going to be straight-jacketed by the lack of funds.”

One area of likely investment will be in alternative energy—solar, wind and geothermal among them.

“States are getting excited about that, and there is some potential to tap into some of the federal money out there.”

“We’re looking at the Great Recession … that is unprecedented in its depth and scope requiring a very fundamental philosophical debate,” he said.

States are facing a cumulative $360 billion shortfall over the next two years, he said.
Fact Check at the Capitols

There are 26 Democrat governors and 24 Republican governors.

24 lieutenant governors serve as Senate president by virtue of their office.

New Jersey elected its very first lieutenant governor in November 2009.

There are 36 male secretaries of state and 19 female secretaries of state.

5 governors—American Samoa, New Hampshire, North Dakota, Texas and Vermont—have served 2 or more previous terms.

In 9 states, the governor and lieutenant governor are from different political parties.

2 governors have just recently taken office after the 2009 general elections.

The 3 largest state legislatures are New Hampshire with 424 total members, Pennsylvania with 253 members and Georgia with 236 members.

Senate presidents in West Virginia and Tennessee also retain the title of lieutenant governor.

19 attorneys general are Republican and 31 are Democrat.

38 governors are serving terms that end in 2011.

9 women serve as senate presidents in the states and territories.

For a complete list of state leadership, visit: capitolideas.csg.org.
2010 Party Control Maps

Governors
- Democrat
- Republican

Senate
- Democratic majority
- Republican majority
- Unicameral, nonpartisan
- Even Split

House
- Democratic majority
- Republican majority
- Unicameral, nonpartisan
- Even Split

Other Jurisdictions
- American Samoa—Democrat
- District of Columbia—Democrat, mayor
- Guam—Republican
- Northern Mariana Islands—Covenant Party
- Puerto Rico—New Progressive Party
- U.S. Virgin Islands—Democrat

Other Jurisdictions
- American Samoa—Nonpartisan
- District of Columbia—Democrat, council
- Guam—Democrat, unicameral
- Northern Mariana Islands—Republican
- Puerto Rico—New Progressive Party
- U.S. Virgin Islands—Democrat, unicameral
NEW CSG LEADERS

South Dakota Gov. Mike Rounds takes the reins as The Council of State Governments president in 2010. Kentucky Senate President David L. Williams will serve as CSG national chair.
CHECK OUT THESE REPORTS!
Managing and comparing performance data is important for states in the new fiscal reality. To help states do this, The Council of State Governments, along with the Urban Institute, created the State Comparative Performance Measurement Project. New reports are now available from the project.

A Compact for Prescription Drugs
There’s still a lack of uniformity, information-sharing and cooperation nationwide in prescription drug monitoring. The Council of State Governments, through its National Center for Interstate Compacts, created a National Advisory Panel of experts to finalize recommendations for an interstate compact to bolster state-to-state cooperation.

PROVIDENCE, RI
2010 Annual Conference Dec. 4-7

Andrews Wins NEMA Award
Richard Andrews has a long and illustrious career in the emergency management field and continues to lead and guide peers in the National Emergency Management Association, a CSG affiliate. That’s why Andrews won NEMA’s 2009 Lacy E. Suiter Distinguished Service Award.

More at capitolideas.csg.org
ON THE HOMEFRONT, STATES SERVE THOSE WHO SERVE

by Mary Branham

About the Interstate Compact on Educational Opportunity for Military Children

» 26 states—Alabama, Alaska, Arizona, California, Colorado, Connecticut, Delaware, Florida, Hawaii, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Michigan, Mississippi, Missouri, Nevada, North Carolina, Ohio, Oklahoma, Texas, Virginia and Washington—are members of the compact.

» The compact represents 80 percent of children whose parents are on active duty in the military.

» States pay $1 per military child each year to cover expenses of the compact.

» The number of children per state ranges from 182 in Iowa to 76,251 in Virginia.

» Each state must form a council that includes representatives of school districts with a large military installation and the state superintendent.

» Cheryl L. Serrano of the Fountain-Fort Carson School District in Colorado is the commission chair.
When Col. Mark Needham began studies at Army War College in Carlisle, Pa., in 2004, he left his family behind in Virginia.

It wasn’t a choice he relished, but his daughter was a senior in high school and Needham didn’t want her to face the many issues children of the military deal with in transitioning to different schools.

“So many military families split themselves in the senior year,” Needham, now retired, said.

Needham, like many others, hope the new Interstate Commission on Educational Opportunity for Military Children will keep families from yet another split because of a parent’s service in the military.

“Maybe this compact will prevent some of that because we were already being split enough at deployment,” said Needham. “The mother or father or both are away enough at deployments that we don’t need to split them because of crazy transition requirements.”

Needham is the executive director of the Kentucky Commission on Military Affairs and represents the state on the Interstate Commission on Educational Opportunity for Military Children, which governs the compact that has been implemented by 26 states in the last two years. Those 26 states cover 80 percent of the military impacted students, according to Cheryl L. Serrano, the chair of the commission from Colorado.

With 25,075 students with active duty military parents, Kentucky enthusiastically embraced the compact, and has strived to ensure it’s not just a compact on paper.

That requires training.

While more than half the states have adopted the compact, the need now is to educate school districts, principals and counselors about the compact’s requirements. Not everyone in local districts is aware of the rules. Needham, for instance, found that the director of Kentucky’s high school athletic association wasn’t aware of the rules. The compact wants to ensure students of military families who arrive at a school after tryouts get the chance to join a team. The association changed its rules to adhere to the contract after Needham explained the compact.

Athletic participation is just one aspect of the compact. It addresses things such as requirements for high school graduation, transfer of school records, participation in extracurricular activities and entrance requirements for kindergarten and first grade—all of which can create roadblocks when families move from one state to another.

“It is the commission’s goal to continue assisting those families by making the transition for students as smooth as possible,” said Crady deGolian, a policy analyst with The Council of State Governments’ National Center for Interstate Compacts, which assisted with the formation of the compact and its commission. The commission in November adopted permanent rules aimed at easing the transition for military impacted students.

But people in education need to understand those rules. Kentucky’s second to adopt the compact by only a few hours behind Kansas, also developed a video with parents and children from Fort Knox and Fort Campbell—the state’s two military bases—discussing their transition problems in an effort to spread the word about the compact. Legislators, Kentucky Gov. Steve Beshear and Needham explain what schools must do to adhere to the compact. Needham and the state’s military education liaison—Christine Powell—also are available to talk with school officials throughout the state to explain the compact.

That’s a key, say school officials of districts adjacent to the large military installations. The districts in Hardin County, home to Fort Knox, and Christian County, near Fort Campbell, have long been involved in easing the transition of military students, officials there said.

“It really hasn’t impacted us a great deal because we’ve always had a great working relationship with Fort Knox,” said Bobby Lewis, Hardin County’s assistant superintendent for student services.

But Lewis points out that Fort Knox lies within a half hour drive from many counties and school districts that may not deal with the needs of military families as often as his districts does. Compact efforts help with that.

“This informs those school districts that maybe don’t deal with the military as much, ‘hey, this is how to help them (families) out and make the transition easier,’” he said.

So many military families split themselves in the senior year,” Needham, now retired, said.

The biggest impact from the compact, Tomek said, is a provision that allows students to miss up to 10 days when parents are deployed or return from deployment. The districts don’t lose state average daily attendance—or ADA—funding for two of those days, she said. Before the compact, districts would lose all that ADA money, she said.

The compact is still in the formation process; commission officers were elected, permanent rules were adopted, and a search committee for an executive director for the compact was formed at the November meeting. But the law is in place in those 26 states, and school districts could unknowingly violate the law without proper training, said Needham.

In Kentucky, for one, school districts that are members of the Kentucky School Boards Association updated policies incorporating the compact rules in 2008, according to an article in the October 2008 Kentucky School Advocate, a publication of the association.

Needham, the state’s commissioner, believes training and education will be an ongoing process.

“Teachers change. Administrators change. And you need to remind your educational leadership in the state—and to the extent that you can, military parents—that the compact is out there, it exists and here is what it was meant to do,” he said.

“The mother or father or both are away enough at deployments that we don’t need to split them because of crazy transition requirements.”

—Mark Needham, executive director
Kentucky Commission on Military Affairs
“... it helps get (inexperienced school personnel) up to speed in a hurry about the things they can and should do for transitioning students of military families in particular.”

—Katherine Berg, Hawaii vice chair of the Interstate Commission on Educational Opportunity for Military Children

In Hawaii, that process began before lawmakers even considered legislation adopting the compact last year, said Katherine Berg, the state’s commissioner who was selected as the 2010 vice chair of the Interstate Commission on Educational Opportunity for Military Children.

Hawaii’s Joint Venture Education Forum, formed to encourage conversation between the state’s school and military communities, discussed the compact at several meetings while the legislature was formulating the state’s compact law, Berg said.

“Our concern was making sure we could accommodate it without a lot more expense in the school,” she said. “That’s always an issue.”

States pay $1 per student with active duty military parents each year, according to the rules of the compact. The number of students range from 182 in Iowa to 76,251 in Virginia.

Hawaii was also concerned about immunization provisions, since it is a crossroads of the Pacific, according to Berg.

“We wanted to make sure that kids couldn’t attend school before they had the tuberculosis clearance and that the compact didn’t obviate that because that’s a health department rule; it’s not a school thing,” she said. The compact includes a provision for Hawaii’s requirement on the TB vaccine.

Berg said Hawaii officials found that vetting the compact through impacted stakeholders essentially sped up the process and got the word out early. “We sort of greased the skids before we started,” she said.

Like Needham, Berg recognizes the need for continuous education about the compact. In fact, the Military Impacted Principals Council is developing a guidebook that will include an explanation of the compact rules to give to new principals. The council has also asked to include a report from Berg at every meeting.

“(Principals are) already embracing it and want to know what the rules are because they will be handling requests directly from parents and they want to know exactly what they have to do, what they can do and where the lines are,” Berg said.

While Hawaii has long worked to meet the needs of militarily impacted students, Berg said the compact will create consistent expectations across the country.

“If you have inexperienced principals or school people, it helps them get up to speed in a hurry about the things they can and should do for transitioning students of military families in particular,” Berg said.

At the local level, school officials who work regularly with military families see the compact as a positive.

“It’s difficult enough for children to make a move, much less have to bang their heads against a brick wall in order to get the services they had in a previous school,” said Tomek of Christian County in Kentucky.

“Moving is hard on everybody,” said Lewis of Hardin County. “This helps troops under duress and stress, and hopefully makes their move a little bit easier.”

ABOUT COMPACTS

The Council of State Governments, through its National Center for Interstate Compacts, is the place states can go to address issues they share with other states. Over the past few years, CSG has worked with various agencies to develop compacts addressing the needs of children—the Interstate Compact on Educational Opportunity for Military Children and the Interstate Commission for Juveniles.

Compacts are contracts between two or more states, and can be enacted on a regional or national level. They address a range of issues.

The U.S. Constitution authorizes states to enact compacts in areas where states have traditionally exercised control and sovereignty.

Every state, on average, has adopted between 23 and 27 compacts. There are approximately 200 compacts in effect across the country, but 38 of them are inactive or dormant, according to Rick Masters, special counsel for The Council of State Governments.
Keeping Tabs on Runaways, Juvenile Offenders

Tracking Movement of Kids Keeps Them, and Communities, Safer

When kids run away from home, there’s usually something going on.

“Kids don’t just run away because they’re mad at their parents,” said Ashley Lippert. “They run away because there’s some kind of abuse.”

A new agreement among states tries to help those children. The rules of the interstate agreement, of which 41 states are members, require an investigatory process to make sure runaways are returned to safe homes, said Lippert, who was recently named executive director of the new Interstate Compact for Juveniles.

After years in the planning stages, The Council of State Governments saw the updated compact take flight when Illinois became the 35th state to adopt it in August 2008. The compact is an affiliate of CSG.

“The main focus of it is to help the juveniles … make sure they get the help they need,” Lippert said.

But the compact also aims to ensure safety of communities and victims of juvenile offenders, according to Lippert. She said states must track what she calls “a striking number of child sex offenders” to make sure they don’t fall through the cracks.

The compact works to make sure any child placed in the juvenile system—and moves across state lines—doesn’t get lost in the administrative shuffle. “It ensures safety of the public. It ensures safety of the child,” Lippert said.

The old juvenile compact was administered through the Association of Juvenile Compact Administrators; but juvenile courts recognized problems with it. Because there was no way to enforce the compact and there was conflicting language in state laws and problematic rules for the juvenile justice system, it badly needed updating. So the Office of Juvenile Justice and Delinquency Prevention partnered with The Council of State Governments to review and rework the compact.

That new compact is in effect today.

A new electronic tracking process to make the movement of those children quicker and more efficient is now in the works. Lippert is also working to establish a training program for juvenile compact administrators and a Web site for a repository of information about the compact and its rules.

The ultimate goal is to help troubled children, Lippert said, which in turn makes communities safer and reduces ultimate costs to states.

“Especially where kids are concerned … They still have the chance to be rehabilitated. That’s the goal of the compact … to provide the best environment for (kids in the system) to succeed,” she said.

“It’s really sad,” Lippert said. “Most of the time it’s troubled kids. The goal is to make sure they don’t go into the adult system. It’s that they get the help they need to go on to lead productive lives.”

—Ashley Lippert
executive director, Interstate Commission for Juveniles
Remember Your Audience and

**BE HONEST**

Lindsay Strand has worked with companies and clients on dealing with the news media for 20 years. She spent years as a political reporter in Minnesota and Illinois. Strand spoke at the CSG-WEST meeting in Santa Fe, N.M., in October, 2009, about dealing with the media. Here are some of her tips.

**PREPARE.**
Ask for more time to respond. “I think people feel naked and like an open book and like they need to answer everything at that moment. My advice is to really think like a reporter and give yourself time to prepare,” Strand said.

**ALWAYS TELL THE TRUTH.**
Being dishonest gives your opponent an edge, Strand said, and hurts your credibility.

**REMEMBER YOUR AUDIENCE AND SPEAK TO THEM.**
Know what you want to say and have three ways of saying it, Strand advises. It’s also important to know what you don’t want to say.

**DON’T ANSWER SOMEONE ELSE’S QUESTIONS.**
“Often you feel like you need to answer everything,” Strand said. If a reporter asks about another expert’s report, for example, defer those questions to the author of the report. Use phrases such as, “that’s not my area of expertise,” she said.

**AVOID EMOTIONAL WORDS.**
Don’t use the emotion-laden words that reporters will often use when they ask a question. Here’s an example: The reporter asks, “Wasn’t it just wrong to have fired the author of this report?” Don’t say: “Was it wrong to fire that person? I don’t think so,” according to Strand. Better to say: “The appropriate steps were taken for this situation,” Strand said. “Reporters ask pointed, emotional questions to get succinct and colorful responses,” she said. “When we feel threatened, our natural instinct is to fight back and once you recognize that’s part of their strategy, you have to employ your strategy.”

**DON’T GET PERSONAL.**
Don’t make it a battle between you and the reporter. For example, don’t accuse the reporter of lying, of not understanding the question or accuse them of not listening the first time. So you wouldn’t want to say, “Let me repeat myself or let me tell you again, you’re not getting it,” Strand said. “Those are just going to insult.”

“In handling aggressive questions, know what your key message is and know what you don’t want to say.”

—Lindsay Strand
National and Regional Meetings

**CSG West Annual Conference**  
Sept. 11-14, 2010 • Sun Valley, Idaho

**CSG Midwest Annual Conference**  
Aug. 8-11, 2010 • Toronto, Ont.

**CSG East Annual Conference**  
Aug. 15-18, 2010 • Portland, Maine

**CSG’s 2010 Economic Summit of the States**  
May 20–23, 2010 • New York City, N.Y.

Mark your calendars to join us at the crossroads of technology, commerce, innovation and creativity—New York City. Under the backdrop of one of America’s most celebrated and diverse cities, state leaders from across the country will gather to exchange ideas, debate tough issues and develop creative solutions. If you can make it here—we’ll give you the tools to make it anywhere. Come be a part of it!

**CSG Annual Conference 2010**  
Dec. 4-7, 2010 • Providence, R.I.

State leaders will come together in Providence, R.I., to learn from each other and nationally recognized experts as the Ocean State plays host to CSG’s 2010 Annual Meeting. You cannot afford to miss this important opportunity to discuss solutions, enhance results, and improve accountability. This meeting is designed to empower you to be an even more effective public servant.

**NEMA Annual Conference**  
Oct. 2010 • Little Rock, Ark.

**APPN Winter Training Institute**  
Jan. 31-Feb. 3, 2010 • Austin, Texas

**CSG South Annual Conference**  
July 31-Aug. 4, 2010 • Charleston, S.C.

**Csg Affiliates**

NASPE (National Association of State Personnel Executives) | www.naspe.net

APPA (American Probation and Parole Association) | www.appa-net.org

NEMA (National Emergency Management Association) | www.nemaweb.org

NAST (National Association of State Treasurers) | www.nast.org

For more information, visit: www.csg.org.
JULIAN CARROLL
Kentucky State Senator • Former Kentucky Governor

Julian Carroll first came to Frankfort as a state representative from Paducah in 1961. He moved his family to the lieutenant governor’s mansion after the 1971 election, and then to the governor’s mansion in 1974 when then-Gov. Wendell Ford was elected to the U.S. Senate. Carroll served as governor until 1979, the year he served as CSG president. Instead of moving back to western Kentucky, Carroll stayed in Frankfort, and, a quarter century later, was elected to the state Senate representing the Capital City. Carroll believes public service is a calling, especially at the local and state levels. “The calling of public service is much more effective in local government because government, after all, is most effective when it’s closer to the people you serve,” Carroll said.
It’s the only reference book you’ll need for state information.

Order your copy today! Four easy ways to order:
call 800.800.1910 | fax 859.244.8001 | email sales@csg.org | visit www.csg.org

Thanks to our NLGA Partners!
The National Lieutenant Governors Association wishes to thank the following organizations for their membership in the NLGA Partners Program. We are grateful for their support of NLGA activities and events.