The Reforming States Group and the Promotion of Federalism

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SINCE 1991, LEADERS IN HEALTH POLICY FROM THE legislative and executive branches of state government have come together, with financial support and staff collaboration from the Milbank Memorial Fund, to share their experiences and to work on practical solutions to pressing health care problems. What began with a handful of states at the forefront of health reform is now the Reforming States Group (RSG), a bipartisan, voluntary association that includes leaders from over 40 states. This article describes the origins, history, and future prospects of the RSG.

Prelude to the RSG: Hard Choices in Hard Times

In 1990 and 1991, most state and local governments faced serious budget deficits as a result of economic recession and reductions in federal aid. Unfunded federal mandates, increases in the number of low-income people qualifying for assistance, and a growing elderly population all contributed to an explosive growth in state Medicaid expenditures. The number of persons without health insurance coverage was also grow-

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ing rapidly, placing an additional burden on strained public budgets. Moreover, health programs had to compete with other programs within each state for limited funds. In order to balance their budgets, government leaders had to choose between cutting programs and raising taxes.

Early in 1991, Michigan state representative David Hollister asked the Milbank Memorial Fund for help in clarifying the principles that should guide the retrenchment of state programs in health and social services. As chair of the House Appropriations Subcommittee for Health and Social Services during a time of deep budget cuts, he was confronted daily with difficult decisions about programs affecting the health and well-being of many people. He thought his colleagues in similar positions would welcome a position paper that offered guidance. The Fund agreed to assist Representative Hollister, but only if the paper presented the best bipartisan thinking and had the endorsement of people like himself—decision makers who are accountable to the electorate.

In March 1991, 20 current and former senior state legislative and executive branch officials assembled with experts in state law and politics in Rensselaerville, New York, to try to define the guiding principles for budget cutting. The group produced a pamphlet designed to assist their colleagues in making these decisions (Milbank Memorial Fund 1991).

In June 1991, New York state senator Michael Tully, chair of the State Council on Health Care Financing, asked for the Fund's assistance in organizing a symposium on health care spending and hospital efficiency for senior legislators and executive branch officials from 11 states in the Northeast. The symposium, titled "State Strategies for Controlling Health Care Costs," attracted over 100 persons from the public and private sectors. Among the speakers they came to hear were legislators from Minnesota, Massachusetts, and Maine—states that were exploring ways to expand access for the uninsured and to reduce the impact of Medicaid expenditures on state budgets.

Impressed by the Albany symposium, state representative Bob Foster of New Hampshire asked for the Fund's assistance in planning and sponsoring a workshop on access to care for the uninsured for another group of officials from the six New England states. During the months preceding the New Hampshire workshop, several persons who had participated in both the Rensselaerville meeting and the Albany workshop met with Fund staff to discuss the possibility of a meeting where officials from states that were moving ahead with health insurance reform

could share their experiences with each other. In the spring of 1992, Mark Gibson, legislative staff director to the president of the Oregon state senate, Minnesota state representative Lee Greenfield, Maine state representative Charlene Rydell, and Robert Fordham, a program officer of the Fund, began planning the meeting. They reasoned that, with most states trying to find ways to cut health care expenditures while increasing access to care, there was likely to be an audience eager to learn more about the process of reform as well as the results.

The New Hampshire workshop on access to health care for the uninsured, which was held in May 1992, provided an opportunity for a face-to-face meeting of some members of this informal planning group, which was joined for the first time by a legislator from Vermont. The group agreed that the proposed meeting should also include representatives from Hawaii, the first state to mandate that employers provide health insurance coverage for their employees. A representative from Florida later joined the group following the passage in July of legislation creating the Florida Agency for Health Care Administration. Representative Rydell, who had twice served as chair of the Health Committee of the National Conference of State Legislatures (NCSL), was asked to serve as chair.

A session at the workshop on Minnesota's recently enacted health reform legislation focused not only on what state leaders did to expand coverage and contain costs but also on how they did it. Lee Greenfield, the Democratic chair of the House Health and Human Resources Appropriations Subcommittee, and Curtis Johnson, senior advisor to the state's Republican governor, described in detail the bipartisan coalition that succeeded in getting the reform legislation passed in the face of strong opposition from provider groups. The audience's enthusiastic reaction to the session confirmed the planning group's notion that state officials looked to their peers less for ideas about how to address urgent and growing problems than for information or analysis of their experiences.

By the end of May, planning for what was now a project on health insurance reform, supported by the Fund, was well under way. The aim of the project was "to develop a practical guide to organizing successful legislative action at the state level" (M. Gibson: memorandum to R. Fordham, May 1, 1992). The Fund agreed to support a meeting in November of officials from the five states, a report describing recommended approaches to health care reform, and a short book of commis-

sioned papers that would describe in more detail the process of reform in the five states.

The States That Could Not Wait

On November 19, 1992, 19 senior decision makers from Florida, Hawaii, Minnesota, Oregon, and Vermont met at Timberline Lodge on Mount Hood in Oregon. Each state was represented at the meeting by a bipartisan group of three or four legislators and executive branch officials who had been active in health reform. They met over a period of three days, in general sessions and in informal groups at meals, keeping their focus on the process—and the politics—of reform rather than debating the relative merits of each state's plan. The participants shared with each other their experiences and worked together to draft lessons for health reform derived from these experiences. At the meeting's conclusion, they agreed to come together again the following year and to make themselves available to speak to their colleagues in other states contemplating reform.

To help the Timberline meeting participants prepare their practical guide to the process of legislating reform, the Fund commissioned Harry Nelson, a long-time medical journalist recently retired from the *Los Angeles Times*, to attend the meeting and write a report based on discussion there and on subsequent interviews with the participants (Nelson 1993). Each participant reviewed several drafts of the report, which the Fund distributed to state officials and others across the country.

Soon after the Fund's report was published, the commissioned papers appeared in *Health Affairs* as part of a special section on state models (Brown 1993; Fox and Leichter 1993; Leichter 1993a,b; Neubauer 1993). The articles were also published in a book (Fox and Iglehart 1994).

In January 1993, a new administration came to Washington, D.C., with promises to address the health care problem. Yet the prospect of a national solution did not deter state officials from continuing their reform efforts. On January 5th, *The New York Times* reported that Florida was moving ahead with health insurance reform because, Governor Lawton Chiles said, "We just can't wait, given what the costs are." His comment was the inspiration for the title of the report from the Timberline group, *The States That Could Not Wait: Lessons for Health Reform from Florida, Hawaii, Minnesota, Oregon, and Vermont* (Nelson 1993).

During much of 1993, representatives of the Timberline group responded to invitations from their peers in other states to provide technical assistance in briefing sessions on health reform. The ground rule for each session was that the invitation had to come from the speaker of the house, the presiding officer of the senate, or the governor, and from two of these if they were of different parties. The group and the Fund insisted on this rule in order to ensure that the audience would be the peers of the presenters—legislators and executive branch decision makers, not their staffs—and that it would be bipartisan. In planning each briefing, the Fund required that the roster of speakers from the Timberline group include Republicans and Democrats.

The first of these sessions, which was cosponsored by the Eastern Regional Conference of the Council of State Governments, was held in Maine in May 1993. State representatives Greenfield (Minnesota) and Harrington (Vermont), joined by Oregon senate staff member Gibson, described the process of reform in their states to an audience of state legislators who were considering whether Maine should enact universal health care coverage. The speakers urged their colleagues not to wait for Congress to act. In a letter to the president of the Fund after the meeting, the house and senate chairs of the Committee on Banking and Insurance described "the visit by the three health policy leaders . . . [as] the catalyst for beginning discussions with the Governor about the direction of future health care reform."

Other briefings were held in Vermont, Connecticut, Idaho, North Dakota, and Delaware. There were two sessions in Vermont in October. Interest in other states' reform efforts was high, as Vermont's Health Care Authority, charged with writing proposals for single- and multipayer plans, was due to release a report in November and legislative deliberations were scheduled to begin in January. A briefing for members of the Delaware Health Care Commission and public and private leaders in health care was titled "Lessons from the States That Could Not Wait: A Focus on the Process of Reform."

The Timberline group's recommendations also reached legislators through two of their membership organizations. In July and August 1993, Representative Rydell and Fund staff gave presentations at sessions on health reform at the annual meetings of the National Conference of State Legislatures and the Eastern Regional Conference of the Council of State Governments.

Throughout 1993 other states joined Florida, Hawaii, Minnesota, Oregon, and Vermont in legislating health care reform. At the same time, however, the concern about how a national plan would affect the states' accomplishments or evolving plans was heightened by the secrecy surrounding the deliberations of the federal health reform task force.

On July 16th, Fund staff and four members of the Timberline group met with a small group of state officials: William Richardson, chair of the newly appointed Maryland Health Care Access and Cost Commission (MHCACC) and president of the Johns Hopkins University; John Colmers, acting executive director of MHCACC; Hal Cohen, an MHCACC member; and Nelson Sabatini, secretary of the Maryland Department of Health and Mental Hygiene.

The meeting focused on how the states could retain flexibility within federal health care reform. Participants agreed that the states wanted to be assured that any federal legislation would allow them to retain the compromises and coalitions that led to their success in legislating reform. At Richardson's suggestion, they agreed to collaborate on proposals to make legislation for health care reform flexible enough to allow states to build on the reforms they had begun. Following the meeting, the Fund approved an expansion of the project on health insurance reform in the states to support technical assistance in the form of a second meeting of state leaders, scheduled for later in 1993, and a report that would address the issue of federalism in health reform.

Federalism in Health Reform: The Reforming States Group

A committee composed of the Timberline planning group members and new recruits from Maryland and Washington (states that had enacted health reform legislation during 1993) planned a meeting at which leaders of the reforming states would develop an agenda for state participation in national health reform. Committee members agreed that the meeting on federalism should include representatives from states considering health care reform as well as from those that had already acted. Like Timberline, the meeting would offer participants opportunities to learn more about their colleagues' experiences

and to discuss a constructive federal–state partnership in health care reform.

To provide a starting point for the discussion, Mark Gibson, who had left the staff of the Oregon legislature and temporarily joined the staff of the Fund, interviewed many of the officials who would participate in the meeting and then outlined the issues of concern to them (Gibson 1993). A number of the state policy makers he interviewed were ambivalent about the prospect of federal health reform. Although they welcomed a federal plan that would enhance the efforts already under way in the states, these leaders were worried that federal action might instead cause the states to lose the ground they had gained by enacting their own reforms. The states hoped for a federal initiative that would provide them with the flexibility to take advantage of their unique demographic, economic, and institutional bases.

To guide the states' efforts in advocating for flexibility, the discussion draft listed the general principles that would form the basis of their argument. It also offered specific recommendations for flexibility within the Medicare and Medicaid programs and under the Employee Retirement and Income Security Act (ERISA), which exempted self-insured companies from state health insurance regulation.

In December 1993, legislators and executive branch officials from 14 states met at a conference center outside of Washington, D.C. The group reached a consensus at the meeting about their recommendations for an effective federal–state partnership in health care reform. These recommendations, as well as an update on state activity, were published as a Fund report (Nelson 1994).

At the meeting's conclusion, the participants named themselves the Reforming States Group (RSG) and established a formal steering committee, whose members represented eight of the reforming states. They agreed to undertake a series of activities in the states and in Washington, D.C., to inform other policy makers about state concerns. Following the meeting, participants sent the steering committee lists of what they thought were the major federal roadblocks to state reform. Several participants sent their lists to the congressional delegations from their respective states. The newly formed RSG recognized that if the states were to influence federal action on health reform, they would have to move quickly while Congress was preparing to consider legislative proposals.

The RSG Goes to Washington

During the 1994 debates about health care reform, the RSG became known to White House staff, interest groups, members of Congress and their staffs, and the press as a reliable source of balanced information. By February the group was receiving invitations to share its knowledge about health reform at the state level.

Because the report on federalism would not be published until the summer, the members of the steering committee prepared a summary of their recommendations that could be distributed at the meetings they attended. "Federalism in Health Reform: Recommendations from the States That Could Not Wait" stated that leaders from 14 states, both Democrats and Republicans, wanted a partnership for health reform with the federal government, and it proposed five elements that these leaders considered essential to the success of such a partnership:

- The federal government should establish a timetable for action, standard core benefits, and standards for access to and quality of care, cost containment, administrative efficiency, and portability of coverage between states.
- The federal government should grant the states the flexibility to implement reforms that meet federal requirements and that equitably and efficiently address access, coverage, and cost containment.
- Federal subsidies should be equitable among states and should neither penalize nor give advantages to states that have already enacted health reforms.
- Federal health care reform should continue to respect the historical rights of states to regulate insurance.
- States should have the authority to regulate the solvency, claims practices, and the market conduct of all health care risk-bearing entities and to collect a uniform health data set.
- During a transition period the federal government should require all states to maintain at least their current level of fiscal commitment to health care or be subject to federal penalties. (Reforming States Group 1994)

The committee also specified accommodations with self-insured employers under which such businesses would make information available

to the states while continuing to be afforded protections under ERISA from state regulation and premium taxes.

Throughout the spring of 1994, groups of steering committee and other RSG members met with members of Congress of both parties, senior White House officials, and representatives of business groups. In May, RSG members first met with representatives of the Corporate Health Care Coalition (CHCC), which represents major corporations that self-insure.

By July 1994 the steering committee had reached agreement with the Corporate Health Care Coalition on several issues central to federal health reform legislation. Through face-to-face meetings and conference calls during May, June, and July, the two groups developed a consensus document, which they titled "White Paper on State and Federal Responsibilities under Comprehensive National Health Care Reform." The CHCC's interest in working with the RSG stemmed from its members' concern that federal legislation might exempt individual states from ERISA rather than imposing general standards on all states. Although the large employers represented by CHCC supported federal health care reform, they did not want to lose the ERISA preemption, which could result in their being subject to a different set of regulations in each state. Instead, they favored national standards that would apply to every state and were eager to work with the RSG in developing them.

At the request of Senator Mitchell's office, the two groups provided information about their agreement on state flexibility and ERISA preemption. Language from the groups' consensus appeared in the health care reform legislation that Senator Mitchell, with bipartisan support from Senator Chafee, introduced at the beginning of August.

On September 21st, the RSG, now grown to include 29 representatives of 24 states, returned to Timberline Lodge in Oregon for two days of talks about the implications for the states of federal action or inaction on health reform and updates on state health reform. After debating the nuances of almost every word, the group refined its recommendations, which were published in a Fund report (Nelson 1994) and in an article that also described an action plan (Reforming States Group 1994; Rydell 1994). Concern about how to implement state reforms already enacted in the absence of federal exemptions from ERISA preemption remained, and the group sought ways to address the problem.

For the first time, a reforming states meeting was followed by a press conference, which the committee agreed to hold after considerable dis-

cussion. *The New York Times* reported on September 24th that the RSG "has been brainstorming for two years about overhauling the health care system. But today, with national health care reform nearly dead in the Senate, there is a heightened sense of urgency among the group's members."

After Senator Mitchell withdrew his bill on September 26, 1994, several other bills remained for consideration. Portions of the RSG–CHCC document were included in the markups of bills introduced by Senators Graham, Hatfield, and Kennedy, and by Congressman Fazio.

During November and December, RSG steering committee members presented the group's revised recommendations, especially on ERISA, to organizations that sought their views: the National Conference of State Legislatures (NCSL); the Physician Payment Review Commission; the New York State AFL–CIO and the national AFL–CIO; the National Conference of Insurance Legislators; and the Corporate Health Care Coalition. They also continued their discussions with White House and congressional staff, and with representatives of NCSL, the National Governors' Association, the American Association of Retired Persons, and the U.S. Department of Labor in order to advance the reforming states' interest in federal action that would facilitate state health reform efforts.

New Issues, New Partners

Although federal roadblocks to state reform continued to occupy the RSG, by the end of 1994 the group began to examine other topics of interest to the states. Public officials brought these issues to the attention of the Fund and the RSG because they thought that convening decision makers in the style of previous RSG meetings could yield practical recommendations for action. The result was several large projects that expanded the RSG's scope of interest and its constituency.

State Oversight of Integrated Health Systems

In January 1995 the RSG steering committee, in response to a suggestion from two state leaders, decided to develop a new project to address issues raised by the rapid growth of large, integrated insurer–provider

organizations. State representative Carmen Buell of Massachusetts, vice chair of the committee, volunteered to lead the project and to draft a list of controversial issues as background information for a planning meeting of state health officers, Medicaid directors, insurance commissioners, and members of the RSG steering committee to plan the project.

Participants in the meeting agreed that large, integrated health systems—combinations of physicians, hospitals, and insurers—presented new problems for state regulation and oversight. They wanted to know how states are responding to concerns about public safety, fairness, quality of care, and financial solvency, and they recommended that a survey be conducted of oversight activities in each of the 50 states. Members of the RSG, the Association of State and Territorial Health Officials, the Association of State Medicaid Directors, and the National Association of Insurance Commissioners (NAIC) offered to supply names of legislators and executive branch officials in each state to participate in telephone interviews with Fund staff. The RSG steering committee appointed several of its members as a planning committee for the project and also invited state insurance, health, and Medicaid officials holding leadership positions in their national organizations to join the planning committee.

More than 250 state officials participated in interviews and reviewed successive drafts of summaries of their state's oversight activities. RSG steering committee and oversight project committee members also reviewed the drafts and offered their views on what the members of the RSG wanted to say to their colleagues about oversight, which became the introduction to the published report (Buell 1997; Milbank Memorial Fund and Reforming States Group 1997).

Health Information Policy

Mark Legnini, deputy director of the California Office of Statewide Health Planning and Development, and Mary Jo O'Brien, Minnesota's health commissioner, convened a meeting in December 1994 to discuss how to develop model legislation for the collection and use of health data based on the experience of the states, especially of California, Maryland, and Minnesota. At that meeting, the legislators, state and federal executive branch officials, and state officials responsible for collecting and analyzing information advised that, before making any recommen-

dations, the RSG should build a consensus among private- and public-sector purchasers of care on common solutions to practical issues. Their view was that purchasers should reach agreement on policy—public and corporate—before addressing the concerns of providers.

In January 1995 the RSG steering committee developed a project whose goal was to create a consensus on the appropriate use of information to enhance the accountability of providers to purchasers and of purchasers to consumers. The project began with meetings of RSG leaders and their colleagues in business to discuss the common interests of major purchasers of health care in health information.

The result of these meetings was a consensus paper, "Information for Accountability in Health Care Purchasing," which was issued after extensive review by the meeting participants (Reforming States Group 1996). Some of them then used the document as the starting point for building coalitions in their home states. The first of these formal efforts took place in Kansas in March 1996, when private- and public-sector purchasers met to develop a coordinated health care data collection and accountability plan under the leadership of William McKee, executive director for human resources of Western Resources, and state senator Sandy Praeger. By the end of 1996, the group had moved forward in its efforts to develop uniform performance standards and outcomes measures, for which it received notice in the national press (Moore 1997). Several similar meetings were also held in 1996, in Maine and Oregon.

The health information project changed the RSG from an organization focused only on state and federal policy to one also concerned about the shared interests of government and business. This expansion followed logically on the collaboration of the RSG with the Corporate Health Care Coalition in 1994.

Federalism in Health Reform

By the time the federal reform initiative died in the fall of 1994, the RSG had established good relations with congressional staff who were interested in proposals for incremental reform and with lobbyists for Fortune 100 companies. These companies were eager to protect the freedom from federal and state regulation accorded them by ERISA. They also knew that, unlike many smaller firms, they already offered their employers and dependents many of the same insurance benefits

that advocates of incremental reform believed should be made available to people nationwide. Supporting modest insurance reform that applied to self-insured companies might be an inexpensive way to protect their exemption from state taxes on premiums or to ward off federal mandates that would cost them money.

In this context, staff of Senator Nancy Kassebaum, chair of the Senate Committee on Labor and Human Resources, invited Lee Greenfield to testify on proposed health insurance reform legislation in March 1995. In his testimony, Greenfield articulated what had become the RSG's approach to collaborative federalism:

> The Reforming States Group proposes a solution which will allow states to move ahead and at the same time allow large interstate business to stay covered by ERISA and not be under different rules in each state. We are proposing what we see as the essential elements of federal–state partnership. The federal government should establish the standard for health care reform by setting a timetable for action, standard care benefits, standards for access to and quality of care, cost containment, administrative efficiency, and portability of coverage between states. Further, the federal government should grant states the flexibility to implement reforms that meet these federal standards.

Three regional meetings were held each year in 1995, 1996, and 1997 to introduce a new group of officials to the work of the RSG and to give both new and returning participants opportunities to relate their experiences in health reform, to learn more about RSG projects, and to discuss how the RSG might respond to federal health reform proposals. In 1996, the groups discussed the Health Insurance Portability and Accountability Act (HIPAA) (Atchinson and Fox 1997); in 1997, the newly enacted State Children's Insurance Program was on the agenda.

Federalism and health reform has been the most prominent issue for the RSG since 1992. In April 1997, Senator Jeffords, chair of the Committee on Labor and Human Resources of the U.S. Senate, invited the Fund and the RSG to provide "information concerning the analysis, study and research conducted by the Fund and the RSG" that could assist his efforts to obtain "a clear and comprehensive understanding of an appropriate Federal and State framework" for the allocation of health care oversight responsibilities between the states and the federal government (J.M. Jeffords 1997: letter to D.M. Fox, April 15). In response to his letter, members of the steering committee drafted a position

paper, which participants in the regional meetings reviewed, that offers the RSG's "colleagues in government and the private sector both principles and practical examples of their implications to help guide future deliberations on reforming the health care system and holding it more accountable." The paper argues that "the complexity and interrelationship of the elements in the American health care system require a balanced federalism [that] . . . accords preeminence to neither the federal government nor the states" (Reforming States Group 1997).

As this article went to press, the RSG's position paper and the wording of the principles of balanced federalism were evolving in discussions with other state leaders, members of the congressional staff, persons in the federal executive branch, and representatives of multistate employers. In early December 1997, the issues the principles address included national standards, accountability, market forces and oversight, ERISA, joint public and private sector purchasing strategies, and clinical decisions (Reforming States Group 1997). The paper also identifies issues that represent the overlapping interests of the state and federal government in a complex health care system:

- standards for the oversight of multistate plans and providers
- oversight of new forms of risk-bearing entities
- fraud and abuse
- quality improvement and performance measurement
- efforts to expand insurance coverage
- conversion and mergers of nonprofit plans and providers
- antitrust laws and regulations
- grievance procedures and consumer protection
- health data collection and confidentiality

Children's Health Insurance

In June 1997, the Fund and the RSG called a meeting of officials from 10 states to discuss what could be learned from existing state children's health programs and to explore the policy and fiscal implications of federal proposals to expand coverage for children. Kay Johnson, a policy analyst and advocate on children's issues, and Massachusetts representative John McDonough, who had successfully sponsored children's health insurance legislation in his state, wrote a background paper describing what states have done. Following the meeting, they expanded the report

to include the provisions of the State Children's Health Insurance Program (SCHIP), which was enacted by Congress in July (Johnson and McDonough 1998).

In early July, the RSG developed recommendations to send to the members of Congress as they deliberated on the legislation creating SCHIP. The leadership of the steering committee wrote to every member of the cognizant committees in both houses of Congress. There is evidence in the final bill that the committee's recommendations were discussed in the conference committee. The RSG urged, among other points, that the states "should have the flexibility to choose between Medicaid expansion and insurance subsidy programs or to blend these two main approaches." They also recommended that funds "be distributed equitably among states, without penalizing those that have already implemented child health coverage expansions."

The RSG is now responding to requests from states for technical assistance in implementing SCHIP. The first requests were from legislative leaders in Kansas, Maryland, and New York.

Conclusion

The RSG is an unprecedented organization. It is a voluntary, bipartisan association of state leaders who have assisted each other in informing national policy as well as policy in other states. Practical solutions based on the experience of decision makers, not rhetoric, characterize the RSG's approach to health policy. The group agrees to undertake projects that meet the following criteria: having a direct relation to health policy needs in the states; having a broad application; holding the potential for direct application to policy; yielding practical results that are available for use in the real world on a timely basis; and being consistent with the RSG style of bipartisanship and informal collegiality.

Participants in the RSG have gained national visibility and greater effectiveness through their unified efforts to inform leaders in the states, the federal government, and business. The group's strict adherence to a principle of nonpartisanship has enhanced its credibility as a source of good information, beginning in 1994 with federal health care reform and continuing in 1997 with requests for assistance from congressional committees and federal agencies on issues like health insurance coverage for children.

The leaders of professional organizations of elected and appointed officials cannot easily cross the boundaries separating the branches of government in different states. Nevertheless, the RSG and the National Association of State Budget Officers are jointly conducting a national survey of state spending for all health care and public health. This project expands the RSG constituency to include state officials, who have historically had limited relations with legislators or executive branch officials outside their states while maintaining highly formalized relations within state boundaries. By 1996 the president of the National Association of Insurance Commissioners (NAIC) and the chair of the Health Committee of the National Conference of State Legislatures (NCSL) were ex officio members of the RSG Steering Committee. Following passage of the Health Insurance Portability and Accountability Act of 1996, leaders of NAIC and NCSL collaborated with the Fund on a report to provide information to state legislators on the act's provisions (Milbank Memorial Fund, National Association of Insurance Commissioners, National Conference of State Legislatures 1997).

Members of the business community, as well as government representatives, are now participating in RSG projects. The information policy project has brought together health care purchasers from government and business in several states to work out agreements about common goals. By the end of 1997, ten states had such groups, a number of them initiated by the RSG.

The Milbank Memorial Fund and the RSG have been partners. Ideas meeting both the Fund's and the RSG's criteria for action receive staff support from the foundation as well as funds for travel and meetings. Because most state officials have no public funds to do this kind of work, it is of some consequence that the Fund pays travel and meeting costs for RSG activities, all of which adhere rigorously to federal prohibitions against lobbying by foundations.

The role of the states in health care reform has shifted since the early 1990s, when states confronting rising health care costs and reduced access to services began to explore solutions to the problem in the absence of a federal plan. Cutting across the dividing lines of individual states, political parties, and professions, the RSG offers a vehicle for expanding communication among disparate groups and defining a productive relation between the states and the federal government.

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