The New Jersey Capitol Forums on Health and Medical Care

LOOK WHO'S LOOKING AT NEW JERSEY
WHY? WHAT? HOW?

Background information
for

THE CAPITOL FORUM
on Wednesday, June 11, 1997
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Trenton, New Jersey

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LOOK WHO'S LOOKING AT NEW JERSEY? WHY? WHAT? HOW?

THE ISSUE: *Since 1995, various actions (and in some cases, inactions) by the Federal government* have effected a shifting of administrative and regulatory authority to the states for several large programs, including Medicaid, welfare reform and health and insurance reform. Against the backdrop of this New Federalism, there are currently several academic and public policy research organizations engaged in studies (at various stages of completion) conceming changes in New Jersey's health care, health insurance and social service programs and their impact on families and children.

What findings are coming to light about the state of New Jersey's health from these ongoing studies? Can our state serve as an innovative model for policy and program design in other states? And what mechanisms can be put in place by New Jersey's state leadership and public policy decision-makers to insure that research findings will be utilized and applied in all stages of policy design and implementation to best benefit our citizenry?

INTRODUCTION

The presenters at this Capitol Forum will discuss their ongoing research regarding New Jersey and, depending on the status of their project, will highlight any findings significant for policy and decision makers. What is it about New Jersey that is attracting so much attention from health and social science researchers?

Chart 1 — A New Jersey Snapshot — and Chart 2 — A USA Snapshot — serve as a context to compare New Jersey to the "big picture" of national aggregate data. Information is presented on population, socio-economic characteristics, personal health care expenditures, hospital care expenditures, HMO market characteristics and types of state legislation on health care and health insurance.[1] Most significantly for researchers, New Jersey's racial and ethnic composition matches more closely than any other state that of the United States as a whole.

Regarding the breakdown along the dimension of age, New Jersey parallels the national averages for most age groups, with a slightly higher percentage of those 65 years of age and older (13.8 percent) than the national percentage of 12.8 percent. Both birth rates and fertility rates are closely parallel. New Jersey's percentage of the population comprised of AFDC (now TANF) recipients is 4.3 percent, compared to 5.5 percent for the national average; recipients of Supplemental Security Income (SSI) represent 1.8 percent of New Jersey's population, compared to 2.4 percent for the national average. Regarding total per capita income, New Jersey's amount of $27,742 stands above the national average of just under $22,000. However, when all factors are evaluated, New Jersey is viewed as a microcosm to be evaluated for cross-cutting research studies. And New Jersey's comparability is not limited to health and social service studies. In a newly published book on immigration trends and policies, the state of New Jersey was selected for examining state and local implications of U.S. immigration policy (Espenshade 1997). When compared to other states, New Jersey ranks first in the diversity of its immigrant population.

NEW JERSEY'S PLACE ON THE DEVOLUTION HIGHWAY

As a result of the Federal move to shift authority to the states from the Federal level and the efforts of New Jersey to meet the challenges of a competitive health care marketplace, the past two years have witnessed significant changes in New Jersey's public programs for health, medical and economic assistance. These changes have had an impact on New Jersey's Medicaid and Medicaid managed care programs, as well as on various health insurance subsidy programs -- including the development of Children First -- and small group and individual health insurance reform.

For the most part, New Jersey's reforms have been incremental in nature, rather than comprehensive, as in

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[1] One caveat: in the past we have described the process of trying to describe a certain aspect or component of the health care system as "taking a snapshot of a moving train"; this concept remains true, for every dimension of the health care arena is "in process" and not a static thing which can be pinned down and quantified without constant re-assessment and re-evaluation.

Chart 1: A New Jersey Snapshot

PEOPLE: POPULATION AND ECONOMIC DATA

Bureau of the Census

Population (in thousands)	
1990	7,740
1991	7,767
1992	7,813
1993	7,859
1994	7,904
Population Projection: 1995 (% of total)	
Under age 18	24.6
Ages 18-44	*40.8*
Ages 45-64	20.9
Age 65+	13.8
White	80.8
Black	14.6
Asian/Pacific Islander	4.5
American Indian and other	0.2
Hispanic Origin	11.3
Total Households, 1994 (in thousands)	2,845
Household Heads, % Age 65+, 1994	23.2

National Center for Health Statistics

Births: 1993 (US in thousands)	
All Races	15,436
White Mothers	88,852
Black Mothers	23,128
Birth Rate, 1993 (per 1,000 population)	15.0
Fertility Rate, 1993 (per 1,000 women, 15-44)	65.8

National Center For Health Statistics, contd

Births to Unmarried Women: 1993	
Total (US in thousands)	
All Races	31,949
White	15,997
Black	15,489
% of births	
All races	27.1
White	18.0
Black	67.0

Bureau of Labor Statistics

Unemployment Rate, Civilian Labor Force, 1994	6.8

Bureau of Economic Analysis

Personal Income, 1994	
Total Per Capita	27,742
Disposable Per Capita	23,622

Bureau of the Census

Population Below Poverty Level (%), 1993	10.9

Social Security Administration

AFDC Recipients: 1993	
Total (in thousands)	340
As % of total population	4.3
SSI Recipients: 1995	
Total (in thousands)	142
As % of total population	1.8

TOTAL PERSONAL HEALTH CARE EXPENDITURES

Health Care Financing Administration (HCFA), Office of the Actuary

Resident Population	
Annual % growth, 1982-1992	*0.5*
% Growth 1992-1993	0.6
Personal Health Care Expenditures	
Total, 1993 (in millions)	25,741
Annual % growth, 1982-92	11.1
% Growth 1992-1993	7.4
Total, 1993, divided by population	3,275
% Of gross state product	10.7

PROVIDERS: HOSPITAL CARE

Hospital Care Expenditures	
Total, 1993 (in millions)	10,312
Annual % growth, 1982-92	9.7
% Growth 1992-93	*9.6*
Total, 1993, divided by population	1,312

STATE LEGISLATION

As of 8/1/95 (except where noted)

Insurance Reform	
Basic Benefits Package	Yes
Guaranteed Issue	Yes
Guaranteed Renewal	Yes
High Risk Pool	-
Individual	Yes
Portability	Yes
Purchasing Alliance	-
Rating Restrictions	Yes
Coverage for Targeted Populations	
Children's health Insurance	-
Indigent Care Programs	Yes
Other Coverage for Uninsured	Yes
Medicaid	
Research and Demonstration Waivers	
Section 1115, (Status as of 9/15/95):	
• Under Development	Yes
• Submitted	-
• Approved by Federal Government	-
• Implemented Section 1915 Waivers	Yes
Managed Care	
Any Willing Provider:	
• Allied (e.g. chiropractors)	-
• *Pharmacies*	Yes
• Broad array of providers	-
• Other (e.g. ancillary services; MDs)	-
Freedom of Choice	Yes
Accountable Health Plans	-
Networks	-
Regulation of UR Companies	-
Selected Clinical Mandates	Yes
Cost Containment	
Uniform Claims Forms	Yes
Regulation of Physician Practice	
Clinical Practice Guidelines	-
Self-Referral Restrictions	Yes
Antitrust	
Antitrust Immunity	-

PAYERS: HEALTH INSURANCE

Interstudy Publications

HMO ENROLLMENT: JAN 1995	
Pure (in thousands)	
Employer groups	739.6
Federal Employee Health Benefits Program	44.0
Direct Pay	8.3
Other	63.0
Total Commercial	854.9
Medicare	*17.4*
Medicaid	29.1
Total Pure	901.5
Open (POS), Total (in thousands)	61.9
Pure & Open, Total (in thousands)	963.4
Interstudy Population Denominator: 1995 (in thousands)	7,931
HMO MARKET PENETRATION: JAN 1995	
Pure (% of Population)	
Employer groups	9.3
Federal Employee Health Benefits Program	0.6
Direct pay	0.1
Other	0.8
Total Commercial	10.8
Medicare	0.2
Medicaid	0.4
Total	11.4
Open (POS), Total (% of population)	*0.8*
Pure & Open, Total (% of population)	12.1

Chart 2: A USA Snapshot

PEOPLE: POPULATION AND ECONOMIC DATA

Bureau of the Census

Population (in thousands)	
1990	249,402
1991	252,131
1992	255,028
1993	257,783
1994	260,341
Population Projection: 1995 (% of total)	
Under age 18	26.2
Ages 18-44	41.5
Ages 45-64	19.5
Age 65+	12.8
White	82.9
Black	12.6
Asian/Pacific Islander	3.7
American Indian and other	0.9
Hispanic Origin	10.2
Total Households, 1994 (in thousands)	95,946
Household Heads, % Age 65+, 1994	21.8

National Center for Health Statistics

Births: 1993 (US in thousands)	
All Races	4,000
White Mothers	3,150
Black Mothers	659
Birth Rate, 1993 (per 1,000 population)	15.5
Fertility Rate, 1993 (per 1,000 women, 15-44)	67.6

National Center For Health Statistics, cont'd

Births to Unmarried Women: 1993	
Total (US in thousands)	
All Races	1,240
White	742
Black	452
% of births	
All races	31.0
White	23.6
Black	68.7

Bureau of Labor Statistics

Unemployment Rate, Civilian Labor Force, 1994	6.1

Bureau of Economic Analysis

Personal Income, 1994	
Total Per Capita	21,699
Disposable Per Capita	18,852

Bureau of the Census

Population Below Poverty Level (%), 1993	15.1

Social Security Administration

AFDC Recipients: 1993	
Total (in thousands)	14,061
As % of total population	5.5
SSI Recipients: 1995	
Total (in thousands)	6,430
As % of total population	2.4

STATE LEGISLATION

As of 8/1/95 (except where noted)

	Total # of States
Insurance Reform	
Basic Benefits Package	39
Guaranteed Issue	37
Guaranteed Renewal	43
High Risk Pool	27
Individual	16
Portability	44
Purchasing Alliance	23
Rating Restrictions	46
Coverage for Targeted Populations	
Children's health insurance	27
Indigent Care Programs	31
Other Coverage for Uninsured	17
Medicaid	
Research and Demonstration Waivers	
Section 1115, (Status as of 9/15/95):	
• Under Development	8
• Submitted	22
• Approved by Federal Government	12
• Implemented	7
Section 1915 Waivers	42
Provider Tax	27
Managed Care	
Any Willing Provider:	
• Allied (e.g. chiropractors)	11
• Pharmacies	23
• Broad array of providers	6
• Other (e.g. ancillary services; MDs)	4
Freedom of Choice	14
Accountable Health Plans	10
Networks	20
Regulation of UR Companies	35
Selected Clinical Mandates	9
Cost Containment	
Uniform Claims Forms	38
Regulation of Physician Practice	
Clinical Practice Guidelines	10
Self-Referral Restrictions	34
Antitrust	
Antitrust Immunity	24

PAYERS: HEALTH INSURANCE

Interstudy Publications

HMO ENROLLMENT: JAN 1995	
Pure (in thousands)	
Employer groups	36,456.9
Federal Employee Health Benefits Program	2,171.5
Direct Pay	807.6
Other	298.8
Total Commercial	39,734.8
Medicare	2,942.6
Medicaid	3,505.2
Total Pure	46,182.5
Open (POS), Total (in thousands)	4,082.0
Pure & Open, Total (in thousands)	50,264.5
Interstudy Population Denominator: 1995 (in thousands)	262,314

HMO MARKET PENETRATION: JAN 1995	
Pure (% of Population)	
Employer groups	13.9
Federal Employee Health Benefits Program	0.8
Direct pay	0.3
Other	0.1
Total Commercial	15.1
Medicare	1.1
Medicaid	1.3
Total	17.6
Open (POS), Total (% of population)	1.6
Pure & Open, Total (% of population)	19.2

states like Washington and Minnesota, which have since had to retreat from earlier, all-encompassing reforms and to proceed with scaled-down efforts. This incrementalism makes New Jersey "researchable", for both short-term and longitudinal studies of varying scales, to evaluate issues from implementation to regulation, as well as impacts on populations served. Also, unlike states like Washington, Wisconsin, and Minnesota, New Jersey's population is heterogeneous and possesses widely differing health and social service needs. This demographic diversity carries a different set of policy and program design issues when compared to states with homogenous populations and offers an environment ripe for research and evaluation.

Medicaid Managed Care - A Transition in Progress

New Jersey's transition to Medicaid managed care is an example of the state's incremental approach to policy and programmatic changes. Beginning in 1995, the state has been moving through a county-by-county phase-in process of enrolling Medicaid beneficiaries who were receiving AFDC. By August 1996, New Jersey Care 2000 had enrolled more than 340,000 Medicaid beneficiaries in 13 commercial HMOs and the state-operated Garden State Health Plan. In January 1997, enrollment increased to 405,000; the state's goal is to enroll all of its almost 450,000 Medicaid beneficiaries who receive AFDC by the end of 1997. Nationally, between 1983 and 1995 Medicaid managed care enrollment grew from 750,000 (3 percent of all enrollees) to 11.6 million (36 percent) (Kaiser Family Foundation Report, November 1996). The Health Care Financing Administration (HCFA) estimates that in 1996, 13.3 million Medicaid beneficiaries were enrolled in managed care plans — approximately 40 percent of all enrollees in the Medicaid program.

These enrollment figures, both nationally and in New Jersey, represent a massive change in the delivery and financing of health care through the Medicaid program. In New Jersey, officials believe that the enrollment has gone smoothly because they ensured that an adequate infrastructure of providers was in place (mandatory enrollment required in counties where at least two HMOs are available) before they implemented massive enrollment. However, these changes involve a fundamental shift from the state's traditional role of bill-payer (through the Medicaid fee-for-service program) to one of enrollment, monitoring, regulating and overseeing managed care providers and enrollees. Sophisticated administrative resources, strategies, monitoring and administrative oversight are required to ensure the effective and consistent operation of the programs. Are states positioned fiscally and resource-wise to meet these challenges?

Welfare Reform - An Exemplary Shift of Authority

Many analysts believe that the Federal government's move to "end welfare as we know it" represents to date the most significant example of the realities of the New Federalism and the shifting of increased authority to the states.[2] Last year, when Congress decided to replace Aid to Families with Dependent Children (AFDC) — the country's main cash assistance welfare program — with a new program entitled Temporary Assistance for Needy Families (TANF), the change capped federal welfare spending and delegated increased authority to the states (Sparer, 1996). Under the new system, welfare is no longer an entitlement program, but is instead a block grant, which provides states with a fixed amount of federal dollars, reduces the federal role and gives states significant discretion in spending those dollars and in establishing program eligibility, benefit levels, and program rules.

New Jersey's newly implemented Work First program represents its efforts to overhaul the state's welfare program and to comply with the new TANF requirement. It makes changes that include a five-year lifetime limit clock on welfare assistance benefits and the creation of unified work program and career centers to facilitate helping former AFDC recipients to find employment. Because AFDC enrollment is lower in 1997 than it was in 1994 (due primarily to a strong economy), the states will receive more Federal money under the block grant initiative than they would have received under AFDC.[3] New Jersey officials hope to use the supplemental Federal funds to expand job support initiatives and child care initiatives (Ibid).

How is New Jersey positioned to make these changes under the New Federalism; where are our strengths and where are our weak points?

THE STUDIES

The ongoing studies involving New Jersey — its health care, social welfare policy, government and health insurance reforms — are being conducted by national nonprofit and academic institutions and are in various stages of investigation.[4] They range from an in-depth analysis of one program of New Jersey's health insurance reforms, to national studies collecting the public's assessment of health and social services and evaluating the infrastructure's capacity to implement and respond to changes

[2] The Personal Responsibility and Work Opportunity Reconciliation Act was passed in 1996 by a Republican Congress and signed by a Democratic President.

[3] Under TANF's block grant structure, the amount of Federal funding a state will receive to assist low-income families with children will be fixed for the next six years on the basis of recent Federal spending in each state. As a result of this formula, almost all states will receive more Federal funding than previously for the first year of TANF (Steuerle & Mermin, 1997).

[4] This summary of ongoing research studies is by no means intended to represent an exhaustive list of national studies on health and medical care. There are many ongoing studies in which New Jersey is one of 50 states being analyzed in such areas of state health expenditures, health system changes and health care quality. The studies highlighted herein are in-depth, state-specific studies related to the state of New Jersey's health.

effected by the devolution of authority to the states. A summary of current studies follows.

Rockefeller Institute of Government
The Federalism Research Group- State Capacity Study

The Federalism Research Group at the Rockefeller Institute of Government has begun conducting a four-year, national research project on the capacities of state government to implement and manage social programs, including Medicaid, services for children and families, welfare, and employment, training and work force development (Project Profile, "Study of State Capacity," 1997). This study's particular focus is on the implementation process, or how states are putting programs into effect and what types of management problems they are facing — and what kinds of strategies they are using to resolve these problems — in program planning, integrating social services, developing electronic information systems and overseeing service delivery agencies. The study will also take into account the growing reliance by state governments on nonprofit organizations to provide social services to children and families.

The Study of State Capacity is looking at all 50 states across the country. At its core there is an intensive comparative study of ten states (of which New Jersey is one) in which a scholar with state-specific expertise will collect data, conduct interviews and make site visits to understand "where and when" problems of program implementation occur and to assess state administrative capacity and impacts on state inter-governmental infrastructure. (Ibid). An interim report is scheduled to be ready for mid-1998, and a final comprehensive report is to be completed in 2000.

Harvard School of Public Health and Brandeis University's Institute for Health Policy "Evaluation of Reforms of the Market for Individual Insurance Coverage in New Jersey"

In 1992, the New Jersey Legislature enacted health insurance reform laws to increase access to coverage for all individuals and small employers. The New Jersey Individual Health Coverage Program (IHCP) and the Small Employer Health Benefits Program (SEHP) were implemented as part of this legislation. In September 1995, the Harvard School of Public Health and Brandeis University's Institute for Health Policy announced their conducting of a study to evaluate the first three years of New Jersey's Individual Health Coverage program.

The scope of the IHCP study addresses six major questions:

- Is there evidence of adverse risk selection among the people enrolled under the IHCP?;
- Where did the enrollees obtain health insurance before enrolling in an IHCP plan?;
- Why did people choose to enroll in IHCP plans?;
- What factors influenced enrollees' choices among plans?;
- How have the insurers responded to the reforms and which regulations and incentives have had the strongest impact on behavior?; and
- Which aspects of the administration and implementation of the IHCP do private and public policy makers credit with its meeting (or not meeting) the legislation's objectives? (Swartz and Garnick, 1995).

Information has been gathered from interviews with state officials and insurance executives and from a survey of program enrollees. For comparative purposes, characteristics of the sample of enrollees surveyed will be compared with those of New Jersey's general population. Analysis of New Jersey's Health Access program, whose goal was to provide subsidies to bring payment of insurance premiums within reach of more low-income New Jerseyans, is to be included in the study.[5]

To place New Jersey's Individual Health Coverage Program in a context, as of year-end 1996, 162,986 persons were covered by standard health benefits plans, a decrease of 9 percent from the previous quarter. IHCP enrollment in pre-reform, non-standard plans stood at 16,487, a decrease of 10 percent from the previous quarter. As of April 1, 1997, the lowest price for single HMO coverage was $196 per month. Currently, there are 27 carriers in the individual market, counting HMO and indemnity affiliates separately. Through assessments of private carriers, the IHCP Board has reimbursed carriers for $215 million in losses on their individual business since 1992 (*The Issue Brief Review*, 1997 "Update on Health Insurance Reform Programs").

The Urban Institute - Assessing the New Federalism and the National Survey of America's Families.

Under its policy research project "Assessing the New Federalism," the Urban Institute is monitoring the impact on children and families of the country's decentralizing of its social programs. The three- to five-year project (announced in January 1997) is national in scope and focuses on four areas of research: health care, income and employment, social services, and the well-being of children and families.

The health care component of its New Federalism project

[5] The Health Access program, which accepted applications between April 10, 1995 and December 31, 1995, had a 1995 enrollment of 22,000. Since the funding for this program has not been renewed, enrollment has decreased steadily as people became ineligible and no more were added. As of March 1997, the enrollment figure was 15,678 for the Health Access program.

will look at several substantive areas, including:

- The transformation occurring in state Medicaid programs;
- The status of other state health programs for the needy and uninsured;
- How these policy changes relate to other health systems changes, such as managed care;
- How these policy changes affect health care access, utilization and outcomes for low-income individuals; and
- How these policy changes affect health care providers.

The study is comprised of four major components:

- Intensive case studies, with a focus on 12 states (New Jersey, Massachusetts, New York, California, Alabama, Florida, Michigan, Minnesota, Mississippi, Texas, Washington and Wisconsin) to analyze policy and budgetary changes to welfare programs, innovations in service delivery and the well-being of citizens;

- state-level surveys of approximately 2,000 households in each of the states to examine changes in family income, health care access, utilization and other social and economic characteristics (the National Survey of America's Families)[6]

- the creation of a 50-state database including available data about states such as fiscal trends and social program characteristics; this information will be incorporated into a database that will track legislative and policy changes at the federal and state levels and document how these changes are implemented at the state level; and

- secondary data analysis to analyze changes using existing surveys and data bases, such as the National Health Interview Survey.

Through meetings with policy officials, legislators, program administrators, health care providers, advocates and health policy experts, project staff are conducting interviews to understand health policies in each of the states and to ascertain strategies and the types of changes anticipated in the future.

Project goals include the provision of nonpartisan, reliable data to policy makers in order to compare information from state to state; and to help policy makers distinguish promising innovations from those less likely to improve outcomes for children and families. Project findings will be made available on an ongoing basis in written materials, via a web-site, at state-level meetings and through special outreach efforts to federal, state and local officials, community groups and national associations (The Urban Institute, Cybertext, January 1997.)

CONCLUSION

The end of the 1990s is a dynamic time, especially in regard to the changing role and autonomy of the country's 50 states. New Jersey is in a particularly interesting position to serve as a model for understanding the implications of devolution and the impacts it will have on inter-governmental infrastructure, public and private providers of health and social services and most importantly, on the health and well-being of its citizens. Researchers who are focusing on New Jersey feel there are many lessons to be learned, both for own state and for the rest of the country.

In his new book Disunited States, Harvard University public policy scholar John D. Donahue focuses on the issue of devolution and the potential social and political outcomes of state autonomy. Although he concedes that devolved government offers more opportunities for innovation, he nevertheless cautiously points out the danger that competitive fiscal pressures may force states into making the "wrong" decisions — i.e, those which may not protect and preserve the public good — with their new autonomy. In his most optimistic view about shifting what might be called "mono-authority" from the Federal government to each of the states, the author relates that: "A home run somewhere is more likely with fifty batters swinging." Perhaps here in New Jersey, with the support and technical assistance for our researchers, and the vision of our decision makers, we can come close to modeling that innovative home run.

[6] Research for the National Survey of America's Families is being carried out by the Urban Institute and Child Trends, both nonprofit, nonpartisan research centers. The survey will collect information on people's experiences with changes in health care, education and human services in their demographic area.

QUESTIONS FOR DISCUSSION

Too often the gap is wide between the researchers and their findings and the policy makers and their policies and implementation of programs. A recurring goal in many of the current research project proposals is to ensure that the information is disseminated to key decision makers so that it can be used and applied in a practical manner. Yet, barring the factor of political exigencies, which are historically a part of the decision-making process, as well as responses to crises, such as the 48-hour laws implemented for new mothers and babies, there is an innate missing link between the data collected, analyzed and interpreted and the decisions made in designing health care policies, programs, services, laws and regulations. More often than not, researchers' reports, tomes, data and recommendations are perceived not as constructive guidance, but as too far removed from the economic, political and social realities for a solution. How can the gaps between research findings and their practical application to policy and program implementation be bridged?

In his book Reality and Research, social policy researcher George Glaster found that the potential impact of research on the actual implementation of policy involved an interplay among three factors: the conception of the problem to be addressed, social research on the problem and policy implementation. His analysis also reveals that the prevailing ideology of the times is the most powerful factor underlying all the other elements in the policy making process. How can policy makers and researchers work together to ensure that viable solutions to problems such as poverty and health care access are not limited by the politics of ideology?

One artifact of devolution is that the responsibility for solving complex social problems falls squarely on the shoulders of state-level decision makers. For example, across the states, an emerging, pervasive problem in "welfare-to-work" initiatives is that of transportation: states are finding that it is no easy thing to get individuals who are going off welfare to their jobs. The reasons are both large-scale and personal: poverty areas are often clustered in rural areas or in urban, inner-city areas, while, over the past 15 years, jobs have moved to the "outer" suburbs of cities; public transportation systems are often designed to bring workers from the suburbs into the cities in a kind of "one-way" access to work; those individuals trying to find jobs off welfare often times do not have cars, licenses or insurance, nor do they have the resources to acquire these things. Several cities around the country are exploring innovative ways to get welfare recipients needed transportation services. Where does New Jersey stand in its efforts to effect these linkages?

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The Capitol Forums Group would also like to thank the June 11, 1997 Forum presenters for interview time during which they discussed their research projects.