

The Forums Institute for Public Policy



**Hot Health Policy Issues
for State Policymakers –
What's New and Different for 2002**

Background Information for...

THE NEW JERSEY POLICY FORUM

Wednesday, February 13, 2002

9:00am to 1:00pm

Thomas Edison State College,
Kelsey Building – Prudence Hall
101 West State Street
Trenton, New Jersey



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INTRODUCTION

The January 2002 *Governing* magazine sets out ten leading issues for state and local policymakers. Leading the list is the issue of state budget shortfalls, followed by:

- terrorism and domestic preparedness;
- welfare issues (as related to federal social service and economic assistance block grants and increased levels of unemployment);
- Medicaid program costs; and,
- education funding.

The list also includes policy and funding issues regarding the regulation of genetic information, especially as it relates to health and life insurance regulations (Conradi and Greenblatt, 2002). Over 70 percent of the topics listed in the magazine's profile touch on some aspect of health care policy and planning.

At the beginning of each year, health care policy analysts, researchers and industry stakeholders raise their crystal balls to ascertain which issues are most pressing on the policymaking agenda. The nature and character of these issues represents a range of known and unknowns.

There are some that are long familiar to state policymakers, such as:

- Medicaid costs,
- coverage and access for the uninsured and increases in hospital costs;

and some new issues such as:

- medical privacy,
- bio-terrorism and utilization of genetic information;

and still others that demographic and health care system changes are bringing to the forefront:

- long-term-care for the elderly and disabled,
- health workforce issues and behavioral health.

This briefing package includes summary points about the issues that are likely to emerge in 2002 and beyond as key health policy concerns for policymakers at all levels based particularly on major events that are happening at the national level. The issues come from the perspectives of three different national organizations:

- the National Association of State Budget Officers (NASBO),
- the National Conference of State Legislatures (NCSL) and
- the National Governors' Association (NGA).

Each organization places the leading health policy issues facing public policymakers – focusing in on the state level – within a specific policy context, whether it be a fiscal and budgetary setting or a regulatory or programmatic one.

NATIONAL ASSOCIATION OF STATE BUDGET OFFICERS

NASBO has served as the professional membership organization for state finance officers for over 50 years. It is the instrument through which the states collectively are advancing state budget practices. NASBO and the National Governors' Association jointly publish the Fiscal Survey of States twice annually; each edition focuses on a specific state policy or budget issue.





NATIONAL CONFERENCE OF STATE LEGISLATURES

NCSL is a bipartisan organization dedicated to serving the lawmakers and staffs of the nation's 50 states, its commonwealths and territories. It is a source for research, publications, consulting assistance, meetings and seminars for legislators and staff throughout the country.

NATIONAL GOVERNORS' ASSOCIATION
NGA and its Center for Best Practices work to help governors and their key policy staff develop and implement innovative solutions to governance and policy challenges facing them in their states. The Center tracks, evaluates, and disseminates information on state innovations and best practices to assist state policymakers.

SETTING THE STAGE – SOCIO-ECONOMIC FACTORS

The state of New Jersey is facing the opportunities and challenges of 2002 with a new Governor, administration and a re-configured state legislature. In addition, it is facing tough situations that currently are affecting all of the other states and their public policy decision-making processes:

- an overall economic downturn nationwide;
- state budget shortfalls with resulting cutbacks in health, social service and education programs;
- reductions in federal and state health insurance program and initiatives, including Medicaid, which is one of the largest and most rapidly growing components of state budgets;

- increases in health insurance premiums;
- financial pressures on employers to support health benefit plans;
- escalating costs for hospital services; and
- pervasive cost and access issues related to prescription drugs.

Since September 2001, national and state-level strategies related to health and medical care programs have shifted from program expansion and new program development to identifying ways to maintain and support existing programs and initiatives. The overall numbers of uninsured and underinsured individuals and families have been affected by the overall economic downturn. For example, based on U. S. Bureau of Labor Statistics on unemployment and loss of health coverage, *Families USA* reports that just for the period between March and November 2001, close to 530,000 laid-off workers lost health coverage.

In response to this situation, states are securing national emergency grants (authorized by the federal Workforce Investment Act) that provide supplemental federal funds to assist laid-off workers. According to the NGA, since the beginning of December 2001, the U.S. Department of Labor has issued over \$30 million in grants to New Jersey and seven other states - Georgia, Illinois, Iowa, Massachusetts, Missouri, Oregon, and Texas.

Employer-based health plans – the keystone of health insurance coverage in the U.S. – are experiencing both the negative impact of the recession and increases in providing health care coverage to workers. Private health insurance premiums more than doubled in 1999 after a period of historically low





growth. According to the New Jersey Business and Industry Association, overall health care costs in New Jersey rose on average 8.8 percent in 2000 – representing the highest growth rate since 1990-1991. The trend continued in 2001 when a William M. Mercer survey of 2,800 large and small businesses around the country (*The New York Times*, December 10, 2001) found that premium rate increases rose an average of 11.2 percent – to an average of \$4,924 per worker. Small business health insurance premium rate increases were significantly higher: averaging between 12 and 16.5 percent, depending upon business size. Such increases are comparable to the growth rates of 1991-1993, when national health reform became a top priority among policymakers (Lambrew, 2001). Although a majority of insured workers are eligible for COBRA, few participate because of costs. In New Jersey, COBRA premiums exceed over \$8,000 annually.¹

SETTING THE STAGE – STATE BUDGET FACTORS

Forty-four states across the country are addressing the challenges of budget shortfalls, including New Jersey. While New Jersey's shortfall of \$2.9 billion is not as large as some other states -- such as California and New York -- its shortfall as it relates to percentage of overall budget is higher than any other state, representing 12.6 percent of the state's current \$23 billion budget (Donohue, January 29, 2002).

The state's reliance on income tax revenues – which were over \$500 million lower than expected for the month of December 2001 – is a primary

reason why the shortfall is so high. State Treasurer John McCormac projects that the potential deficit could be \$5 billion to \$6 billion for next year's state budget year beginning in July 2002. Governor James E. McGreevey confirmed that one strategy to address the shortfall would be the drawing of monies from the state's \$7 billion tobacco settlement through the sale of bonds (Donohue, January 30, 2002). A joint session of the state Legislature is scheduled for February 11, 2002, at which the Governor will announce his complete action plan regarding the state budget shortfall.

SETTING THE STAGE — NEW JERSEY AT A GLANCE

New Jersey ranks 10th among states in terms of total state health care expenditures; in 1999, expenditures were close to \$7.6 million.² Nationally, 44 million (or 16 percent of the population) Americans lack health insurance coverage and current projections estimate that this number will reach between 52 and 54 million over the next decade (Meyer et al, 2001). In New Jersey, current estimates show that over 1.2 million New Jerseyans are uninsured, or close to 15 percent of the state's population. Sixty-two percent of the state's workers are covered by health insurance provided by their employers. The tables in Appendices I – III offer a snapshot of New Jersey's general population by age, by race/ethnicity and by rates of insurance coverage.





ENDNOTES

- ¹ COBRA – The Consolidated Omnibus Reconciliation Act of 1985 – carries a provision to provide continuing coverage to certain workers. On average, families pay \$7,200 for COBRA annual premiums.
- ² This number includes state-funded health care expenditures for Medicaid, the State Children’s Health Insurance Program, state employees’ health benefits, insurance and access expansion, public health related expenditures, state facility-based services and community-based services. Sources of state expenditures include general funds, other state funds and federal funds (Kaiser State Health Facts Online, 2002).

REFERENCES

Conradi, M. and A. Greenblatt. “Ten Issues to Watch. Legislative Outlook 2002.” *Governing*. January 2002.

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APPENDIX I

New Jersey: Population Distribution by Age, 1997-1999

Population Distribution by Age, 1997-1999 				
	NJ #	NJ %	US #	US %
Children 18 and under	2,121,510	26	76,329,570	28
Adults 19-64	4,984,490	62	164,358,600	60
65+	944,600	12	32,621,390	12
65-74	517,720	6	17,796,420	7
75-84	338,120	4	11,685,090	4
85+	88,760	1	3,139,880	1
Total	8,050,610	100	273,309,560	100

Notes: Individuals are assigned their family's income and family's work status. Family is defined here in terms of "health insurance units" -- i.e., groups of related persons whose combined income would be counted in determining Medicaid eligibility in most states, which is similar to persons who would be able to jointly purchase private insurance. Percentages may not sum to 100% due to rounding effects.

The number of individuals has been rounded to the nearest 10. As a result, zeros should be interpreted as representing 'fewer than 5' people.

Sources: The Henry J. Kaiser Family Foundation. State Health Facts Online (2002). Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2000, 1999, and 1998 Current Population Surveys.

Total US numbers are based on March 2000 estimates.





APPENDIX II

New Jersey: Population Distribution by Race/Ethnicity, 1997-1999

Population Distribution by Race/Ethnicity, 1997-1999

	NJ #	NJ %	US #	US %
White	5,521,060	69	193,084,530	71
Black	1,191,350	15	34,320,670	13
Hispanic	953,740	12	32,733,030	12
Other	384,450	5	13,171,330	5
Total	8,050,610	100	273,309,560	100

Notes: Individuals are assigned their family's income and family's work status. Family is defined here in terms of "health insurance units" -- i.e., groups of related persons whose combined income would be counted in determining Medicaid eligibility in most states, which is similar to persons who would be able to jointly purchase private insurance.

The number of individuals has been rounded to the nearest 10. As a result, zeros should be interpreted as representing 'fewer than 5' people. Percentages may not sum to 100% due to rounding effects.

Definitions: "Other" includes Asian-Americans, Pacific Islanders, American Indians, Aleutians, and Eskimos. These groups have been combined due to their small populations in many states which prevent meaningful statistical analyses of the groups individually.

Sources: The Henry J. Kaiser Family Foundation. State Health Facts Online (2002). Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2000, 1999, and 1998 Current Population Surveys.

Total US numbers are based on March 2000 estimates.





APPENDIX III

New Jersey: Population Distribution by Insurance Status, 1997-1999

Population Distribution by Insurance Status, 1997-1999				
	NJ #	NJ %	US #	US %
Employer	5,001,820	62	158,527,170	58
Individual	346,550	4	12,983,140	5
Medicaid	575,300	7	27,884,880	10
Medicare	880,720	11	31,360,750	11
Uninsured	1,246,210	15	42,553,620	16
Total	8,050,610	100	273,309,560	100

Notes: Individuals are assigned their family's income and family's work status. Family is defined here in terms of "health insurance units" -- i.e., groups of related persons whose combined income would be counted in determining Medicaid eligibility in most states, which is similar to persons who would be able to jointly purchase private insurance.

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