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2005 Hot Health Policy Issues For State Policymakers

Background Information for . . .

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Issue: State health policymakers throughout the country continue to confront varied and complex health policy issues within the context of state budgetary pressures and probable programmatic changes at the federal level that have implications for the states. As 2005 promises to be another critical year for state-level health policymakers, national health policy and public policy research groups have outlined their priority issues for the upcoming year. How do the views and priorities of state-level health policy experts tie in with the vision, concerns and goals of New Jersey's health policy decision-makers?

Introduction

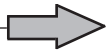
As 2005 begins, health research organizations and public policy think tank experts are weighing in on the issues for states in order to identify strategies to remediate chronic health policy issues – including increasing numbers of uninsured and underinsured, escalating health care costs and the critical need to address quality and patient safety issues – and at the same time to anticipate emerging areas of concern such as the federal government's policies regarding Medicaid reform, Medicare's long-run solvency, and the ever-growing demands on health and long-term-care programs as aging baby boomers enter their 50s and 60s.

As reported in *CongressDaily*, many policy analysts predict that "health-related issues will be front and center" on the federal agenda for two reasons: (1) President Bush plans to cut the federal deficit in half in five years, and (2) Medicare and Medicaid account for 25 percent of federal budget expenses. For the first time in years, Medicaid "is in the budget crosshairs," prompting a bipartisan group of governors to ask in a letter to congressional leaders that Medicaid be considered separately from other budget items as federal cuts are being decided upon (Rovner, 2005).

National groups engaged in tracking state-level health policy issues offer different perspectives and priorities based on the concerns of their constituent audiences. The National Governors Association (NGA) collaborates with the National Association of State Budget Officers (NASBO) each year to compile and publish the FISCAL SURVEY OF STATES (http://www.nasbo.org/Publications/fiscalsurvey/fsfall2004.pdf). NGA's Center for Best Practices identifies and researches public policy issues considered to be priority items for the nation's governors; its health section tracks state-by-state practices related to the leading issues. The National Conference of State Legislatures (NCSL) and the American Legislative Exchange Council (ALEC) work with state legislatures around the country in order to track policy issues for which legislation and laws are being proposed and promulgated. The Council on State Governments (CSG) focuses on the policy and administrative work of state governments and cuts across all branches of government – the executive, legislative and judiciary. In January 2005, the Commonwealth Fund released its first Health Care Opinion Leaders survey which included experts from four broad health care sectors: academia and research organizations; health care delivery services; business, insurance and other health industries; and government and advocacy. Also in mid-January 2005, a new post-election survey of consumer attitudes towards health care policy priorities was conducted by the Harvard School of Public Health and the Kaiser Family Foundation. There is much to be learned when findings from these perspectives are presented for comparative purposes regarding states' health policy and programmatic strategies, planning, administration and regulatory responses.

The View From New Jersey

As New Jersey's public policymakers begin 2005 the budget once again raises questions about state programs and policies. Analysts project an estimated $4 to $5 billion budget shortfall in the FY 2006 budget, which is one of the highest in the country[1]. Acting governor Richard Codey has pledged that there will



be no new tax increases. In his January 11, 2005 State of the State address, Codey outlined his goals for New Jersey, which included several goals related to health and mental health care:

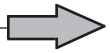
- Improving mental health services by creating a $200 million fund to build 10,000 affordable housing units for those with mental illness and other developmental disabilities
- Forgiving up to $20,000 in student loans for college graduates who work in a mental health institution
- Providing free mental health screenings for uninsured new mothers
- Opening 10 new community health centers that will serve an additional 30,000 residents
- Opening pharmacies at health centers for low-cost prescription drugs
- Proposing funding for the Stem Cell Institute of New Jersey to promote medical research[2]

The acting Governor's mental health initiative was developed based on findings from a task force appointed to offer recommendations to overhaul the state's mental health system. Both advocates and parents of mentally ill patients testified that housing is their most urgent need (Livio and Whelan, 2005). Fifty percent of adults with severe mental illness live with parents over age 55. Although many mentally ill patients reside in boarding homes in the state, there is little oversight regarding their care and treatment. Under Codey's plan, the types of housing would range from specialized group homes to larger rooming houses that would provide a full range of services.

State Senator Joseph Vitale (D-Middlesex) and Assemblyman Robert Morgan (D-Monmouth) recently announced plans to address the state' large numbers of uninsured by proposing changes to the state's FamilyCare insurance program to increase coverage and health care access for the state's children, as well as their parents. The two legislators announced their reform plans after months of working with various stakeholders – including the New Jersey Council of Teaching Hospitals, the Office of the Child Advocate, Legal Services of New Jersey, the Association for Children of New Jersey, the New Jersey Hospital Association and the New Jersey Association of Health Plans. At present, the FamilyCare program – which provides medical, pharmaceutical and dental coverage through HMOs to the working poor – has enrollment of 106,000 children and 108,000 adults. Overall, there are currently an estimated 1.4 million uninsured residents in the state, including an estimated 264,000 children. Under the proposed plan, FamilyCare would be expanded to enroll 101,000 more children over the next three years, and would be re-opened to parents of eligible children. In 2002, the state froze enrollment for adults as a result of rising program costs. Projected enrollment for parents is estimated at 103,000, and an estimated "35,250 childless adults could be enrolled if the federal government agrees to share the costs" (Livio, 2005).

The proposed FamilyCare reforms call for streamlining administrative processes in an effort to reduce costs, and include strategies to secure additional matching funds from the federal government to expand both FamilyCare and Medicaid.[3] The plan also calls for better negotiated FamilyCare contracts with managed care and pharmaceutical companies. The proposal promotes access to preventive care – e.g., coverage for routine doctors' visits as covered under FamilyCare – versus inappropriate, episodic care, such as emergency room visits by the uninsured which then fall to coverage under the hospital charity care system.[4] The reforms will cost the state an additional $23 million, in addition to the $400 million in state and federal funds currently allocated to it. Cost savings are expected in terms of fewer emergency room visits, better preventive care and less of a charity care burden on New Jersey's hospitals that are providing care for the uninsured.

Policy Implication: *Will state budget shortfall pressures affect the integrity of New Jersey's public programs? The New Jersey Legislature passed a 2004 law that revised the formula for distribution of hospital charity care subsidies and created a $202 million increase in charity care funding to hospitals for fiscal year 2005. How will state policymakers balance the realities of budget shortfalls and the need for continued sustainability and expansion of our health care programs?*



National Governors Association (NGA) And The National Association Of State Budget Officers (NASBO)

Through its Center for Best Practices, NGA staff analyzes and prioritizes various aspects of health and medical care policies and programs, with a focus on issues pertinent to the nation's governors. In addition to Medicaid and state budget issues, specific topics of critical concern for 2005 include:

- Medicaid, SCHIP and HIFA
- Children's Health
- Medicare
- Aging and Long-Term Care
- Chronic Disease Management and Prevention
- The Uninsured
- Public Health
- Mental Health and Substance Abuse

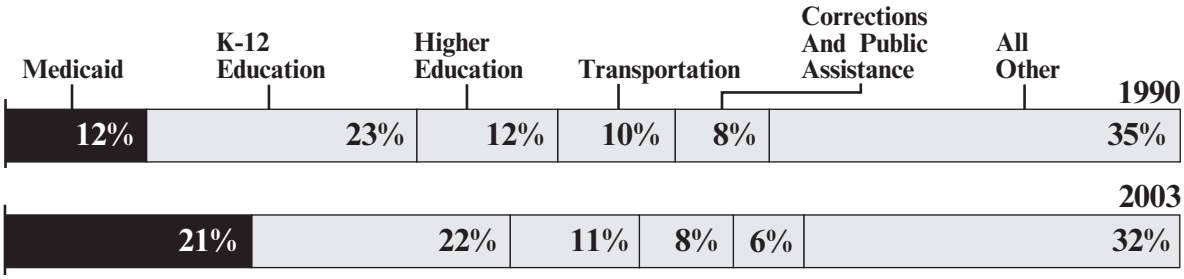
The Fiscal Survey Of States: December 2004

Each year the National Governors Association (NGA) and the National Association of State Budget Officers (NASBO) collaborate on producing The Fiscal Survey of States. According to the most recent survey – released in December 2004 – a gradual improvement in the economy has been seen in fiscal 2004, with revenue collections narrowly exceeding budget projections in nearly all states. The trend in improved revenue collection is expected to continue in fiscal 2005, with collection of sales, personal income, and corporate income taxes projected to increase on average 7.1 percent over the prior year, based on enacted budgets. In fiscal 2005, the largest tax and fee increases occurred in cigarette and tobacco taxes ($888.4 million), sales taxes ($710.6 million), and other taxes ($707.7 million) (*The Fiscal Survey of States:* December 2004, ix).

Although a slight economic improvement was reported in FY 2004, the survey also indicates a continued pressure on state spending. While state expenditures have begun to increase on a small scale, they still remain below the 27-year average.

Medicaid – Federal And State Agendas

Total State Expenditures By Category



Source: National Association of State Budget Officers, 2004, and *The New York Times*, January 23, 2005.

After years of representing the second largest category of state spending, Medicaid is now overall the largest component of the total state spending – surpassing spending for elementary and secondary edu-

cation combined. On average, Medicaid currently encompasses 22 percent of states' budgets, compared to 10 percent in 1987. The Medicaid program provides health care to over 50 million low-income children and adults nationally and to approximately 698,000 enrollees in New Jersey (2002). Over the past five years, total national spending for the Medicaid program has increased 63 percent at a current cost of $300 billion a year for federal and state governments. Actual fiscal year 2003 Medicaid spending in New Jersey totaled $7.458 billion, comprised of: $3.726 billion from state general funds, $3.709 billion in federal matching funds, and $23 million from other state funds. New Jersey exceeded its Medicaid budget – by 10 percent in FY 2003 – a trend experienced by over 20 other states with overages ranging from 16.4 percent in Tennessee to .3 percent in South Dakota (NASBO, 2004).

Incoming Health and Human Services Secretary Michael O. Leavitt – former governor of Utah – stated before a Senate committee reviewing his nomination that "reshaping Medicaid to slow its costs would be a theme for the administration in 2005" (Pear, 2005). A bipartisan group of governors – through NGA – is appealing to the federal government in response to anticipated federal policy changes related to the Medicaid program. Two primary issues of concern: that in its fiscal 2006 budget proposal the Bush administration may try to reduce the federal budget deficit by either scaling back federal spending on the Medicaid program or by shifting more of the program's costs to the states. As part of their efforts, the governors are working to avoid a capped federal contribution – which the Bush administration tried and failed to enact in 2003. They are also urging the federal government to assume the full health care costs of dual eligibiles – those individuals who are poor enough to qualify for Medicaid and who are also elderly and/or disabled beneficiaries of the Medicare program, which is fully financed by the federal government (Belluck, 2004). On average, 42 percent of all Medicaid dollars go to Medicare beneficiaries – primarily for long-term care.

Policy Implication: *In New Jersey, 153,000 of our 1.2 million Medicare beneficiaries fall into the category of dual eligibles.*

Medicaid program elements that are driving costs up include long-term care, prescription drugs and expanding caseloads. According to NASBO, states had to come up with an additional $7 billion to cover end-of-year gaps for fiscal years 2003 and 2004; this is a continuation of a recent trend of states failing to set aside enough funds in their budgets to cover unexpected cost increases in Medicaid (Prah, 2005).

Several states are facing critical Medicaid shortfalls, including Louisiana with an estimated $1.9 billion Medicaid budget gap; Mississippi, with a projected $266 million Medicaid shortfall and Alabama, with an estimated $127 million shortfall. Because of escalating program costs, Tennessee Governor Phil Bredesen has announced plans to cut 323,000 adults – and limit services for 400,000 others – from the state's TennCare program. The 10-year-old TennCare program for the poor and uninsured expanded coverage beyond the state's Medicaid requirements to cover working poor families who are unable to afford private insurance. "Without the cuts, the state would have to had to find an extra $650 million to cover FY 2006 program costs; even with the cutbacks, the program's costs will increase an additional $75 million for FY 2006" (Prah, 2005). The instability and vulnerability of the TennCare program carries significant implications for Medicaid programs around the country. Medicaid program advocates warn that the federal-state debate over Medicaid "constitutes, literally, the largest threat to public health coverage in the history of our country" (Pollack, 2005).

In response to escalating costs and Medicaid budget shortfalls, state-level policymakers are considering Medicaid reform strategies ranging from the incremental to broader, more radical redesigns:

- Florida – Governor Jeb Bush has proposed partially privatizing the state Medicaid program by providing each beneficiary with money from a set Medicaid budget, capped by the state Legislature, to use for private health insurance. "Bush's plan would have the state pay Medicaid premiums for health care plans offered by private insurers and HMOs and would make Florida the first state in the nation to let insurers set benefits for the poor" (Connolly, 2005).

- New York -- Governor George Pataki is proposing close to $1 billion in spending cuts for health care and Medicaid in an effort to make up a $4 billion budget deficit; New York's annual Medicaid budget is $44.5 billion.

- Georgia – Governor Sonny Perdue is proposing more than $100 million in cuts to the state's programs for uninsured children and the poor; the cuts are expected to fall primarily on hospitals in the state.

In fiscal 2005, Medicaid is estimated to increase 12.1 percent, due in part to expiring federal fiscal relief. The long-term growth of Medicaid is expected to be 8 to 9 percent, much higher than projected state revenue growth (NGA *Press Release*, dated December 16, 2004).

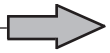
Policy Implication: *In response to escalating Medicaid program costs, states around the country have utilized various cost-controlling mechanisms, such as limiting benefit services and/or revising eligibility standards. New Jersey's Medicaid program has been historically comprehensive in scale and scope – how will the state maintain the program for its most vulnerable citizens in the face of growing program costs and federal changes?*

In recent federal/state funding news, New Jersey was one of 28 states to receive redistributed funds from unspent State Children's Health Insurance Program dollars from 2002. Outgoing Health and Human Services Secretary Tommy Thompson "ordered the redistribution after the last Congress did not pass legislation that would have given states more time to spend the money instead of returning it to the federal Treasury" (*Modern Healthcare's Daily Dose*, January 24, 2005). Thompson – who has the authority to redistribute an estimated $660 million of the total $1.1 billion in unspent funds without congressional action – stated that the money went to states with a demonstrated need.

National Conference Of State Legislatures (NCSL) And American Legislative Exchange Council (ALEC): Forecasts For 2005

One result of the 2004 elections in the state legislatures is parity in the number of seats controlled by each of the two major political parties. Nationally, the Democrats gained seats, and now hold a 10-seat advantage overall, only about 0.1 percent. The Republicans continue to hold more legislatures, but only by a one state margin – 20 Republican, 19 Democratic and 10 split. It is no longer common for one party to dominate a state legislature and party monopoly is not predicted to return any time soon ("Perpetual Parity," *State Legislatures*, December 2004).

About four years ago when the national economy stumbled, state revenues took a dramatic turn for the worse. Most states experienced huge spending gaps as revenues fell below projected levels. Collectively, states had to close a $235 billion budget gap. As a result, state government used various mechanisms to close their budget gaps, including spending cuts, raising taxes and using one-time revenue sources, such as tobacco settlement money.



Now, as the national economy begins to improve, an increase in state revenues is beginning to be seen as of fiscal 2004. The states received critical assistance from the federal government in the form of the federal Jobs and Growth Tax Relief Reconciliation Act of 2003. This act was implemented to help states protect essential programs and cover rapid growth in Medicaid expenses at a time when revenues were declining. It helped minimize program cuts and reduce the use of reserves and other one-time revenues.

Recent data on fiscal 2005 indicates that revenues will continue to recover, but it will take time to reach the levels of four years ago. At the same time, spending is expected to outpace revenue for the foreseeable future, projected into fiscal 2006 and beyond. According to the Health Policy Tracking Service (HPTS) survey of states, 23 states are experiencing higher state expenditures than predicted. Spending components that are consuming the most expenditures include: state Medicaid programs, mental health services, state employee healthcare costs and state retiree healthcare costs (HPTS, 2005). Policy experts including Sujit CanagaRetna – a tax and budget expert at the Council of State Governments – observed that health care costs are a critical problem issue for states as they consume larger and larger shares of state budgets and threaten the integrity of other programs, such as education: "Medicaid is the bear that is scaring states out of their wits" (Prah, 2005).

Health Policy Tracking Service (HPTS): 2005 State Health Care Priorities Survey Report

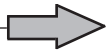
The 2005 State Health Care Priorities Survey Report is the ninth such report filed by HPTS, a communications and information organization that identifies, researches, monitors and reports on state health legislation, policies and programs that affect the private and public sectors. Results from the survey of key state health legislators indicate that the top five health care priorities for state legislatures in 2005 are:

- Medicaid
- Access to health insurance
- Prescription drugs
- Long-term care
- Health care providers

Medicaid – Forty states expect a Medicaid budget deficit in FY06, and a least 22 states are considering reducing payments rates and eligibility. At least 18 states will seek to revamp their Medicaid programs as part of a cost-controlling plan. States reported addressing Medicaid issues in several ways:

- Altering provider reimbursement rates (22 states)
- Establishing or increasing provider taxes (13 states)
- Reducing eligibility criteria (18 states)
- Applying for or amending current waiver programs (24 states)

Access to Health Insurance – By the end of 2005, it is projected that the national number of the uninsured will grow to 46 million. At the same time, employer premiums continue to increase and individual spending has escalated as a result of higher cost-sharing mechanisms. State policymakers in 30 states will address the problem of their uninsured through measures such as broadening access to health insurance programs that provide premium assistance to the working poor and giving tax credits to small employers who offer health insurance to their employees (HPTS, 2005). Twenty-six states will consider legislation to establish medical savings accounts, although "most health policymakers believe these accounts, while excellent alternatives for young and/or relatively healthy individuals, will not solve the problem of the uninsured" (ibid.). States are also considering legislative remedies regarding: purchasing alliances (24 states); employer-based reforms (23 states) and high-risk pools (21 states).



Policy Implication: *Employer-sponsored health insurance continues to be the primary source of coverage for most Americans and New Jerseyans. Employer plans cover 161 million Americans under the age of 65 and 12 million elderly persons; in New Jersey, 64 percent, or 5.3 million residents are covered through their employer's health plans. Gabel reports that four years of double-digit premium increases have taken their toll on coverage: nationally five million fewer jobs provided health insurance in 2004 than in 2001. Although premiums have risen 11.2 percent from spring 2003 to spring 2004 (compared to 13.9 percent last year), both the percentage of small firms offering health benefits has fallen (from 68 percent in 2001 to 63 percent in 2004), as well as the percentage of workers covered by their employer's health plan (from 65 percent in 2001 to 61 percent in 2004) (Gabel et al, 2004). How are New Jersey's employers and businesses addressing this trend? What impact does this trend have on the growing numbers of uninsured in the state?*

Policy Implication: *New Jersey initiated small group and individual market insurance reforms over a decade ago. Current enrollment estimates for its Small Employer Health program are 875,306, and enrollment for the Individual Health Coverage program is estimated at 83,896. With increasing premium costs across all sectors in New Jersey, what is the future sustainability of these programs which were implemented in a radically different health insurance environment?*

Mandated Benefits – The survey of state legislatures found that similar to previous years, few states enacted new benefit requirements in 2004. Most of the mandated benefit legislation amended existing coverage requirements or required state lawmakers to study the cost implications of proposed mandates. Eighteen states may consider legislation that calls for a cost study of current and/or existing mandated benefit requirements for the 2005 session.

Policy Implication: *New Jersey is one of several states which recently established a Health Care Mandates Advisory Committee to review and report upon any bill introduced in either House that requires a health insurance carrier to provide or offer coverage for certain benefits. What impact will the new Commission have on the issue of proposed mandated benefits?*

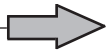
Prescription Drugs – States continue with the implementation process of the Medicare Prescription Drug, Improvement and Modernization Act (MMA). Specific MMA related priorities are:

- MMA's affect on state budgets (33 states)
- Pharmaceutical assistance programs (24 states), with three states considering discontinuing their programs (Florida, Missouri, South Carolina)
- Increase prescription drug benefits in light of the MMA (17 states)

As part of state cost-controlling efforts, several have looked at ways to regulate pharmacy benefit managers (PBMs) and establish drug importation programs. For 2005, 23 states have indicated that addressing PBMs is a priority. Drug importation strategies are reported to be a high priority for 21 states.

Policy Implication: *How will the implementation of MMA in New Jersey tie in with the PAAD program? What is the status of enrolling eligible beneficiaries in the new Medicare Prescription Drug program?*

According to a recently released Congressional Budget Office (CBO) report, spending on Medicare is estimated to reach $325 billion for fiscal 2005, up from $297 billion is fiscal 2004. The new Medicare prescription drug benefit, which begins January 1, 2006, is expected to increase spending by $47 billion in that year and reach $174 billion in 2015, when it will make up 23 percent of the $766 billion in total Medicare spending. By then, Medicare spending will increase by 57% compared to 2004 figures. The rate of spending growth on Medicare is projected at 9.8% annually from 2005-2015, while Medicaid is projected to grow at a rate of 7.8% (CBO, 2005).



The issue of the dual eligibles – those individuals who are Medicaid enrollees and who are also eligible for the Part D prescription drug benefit – is on the agenda for policymakers in all 50 states. According to the survey, at least 35 states will focus on establishing or enhancing their current prescription drug cost control measures, such as preferred drug lists, prior authorization, pharmaceutical reimbursements, and limits on prescriptions or co-payments. NCSL reports that in 2004, the first multi-state Medicaid bulk-purchasing pool was formed. The Centers for Medicare and Medicaid Services (CMS) is encouraging states to pursue this strategy to increase their negotiating power with pharmaceutical companies. Twenty states identified mutli-state bulk purchasing as a priority for 2005.

Long-term Care is a priority issue for most states as it is the single largest cost in state Medicaid budgets. At least 31 states will focus on developing an infrastructure to reduce expensive nursing home care by enhancing community-based alternatives. Thirty-eight states will focus on strengthening laws that govern the quality and safety of care in nursing homes and long-term care facilities. Twenty states will explore legislation to provide either a tax credit or tax deduction for the purchase of long-term care insurance. Currently, four states – Indiana, California, Connecticut and New York – allow for individuals to purchase long-term care partnership plans which combine private LTC insurance with Medicaid. According to NCSL, states spend an average of 38 percent of their Medicaid dollars on long-term care and more than half of that on nursing home costs (Prah, 2005).

Policy Implication: *Thirteen percent of New Jersey's population is 65 years and older, one percent greater than the national average. The fastest growing segment of the elderly population is comprised of those individuals aged 85 and over; this population is challenged by an increase in health, mental health and psycho-social needs. How are New Jersey's long-term care facilities – as well as its community-based programs such as the Community Care Program for the Elderly and Disabled – poised to handle the needs of the state's elderly? What is the adequacy of the states long-term care infrastructure – including transportation and housing services – as the number of seniors continues to grow?*

Mental Illness and Addiction – Priority issues for legislators in 2005 will be:

- Services for children and adolescents (32 states)
- Establish or expand mental health courts (23 states)
- Overcrowding in psychiatric hospitals (22 states)

The issue of providing a continuum of care, or "wrap-around" services for mentally ill children remains a priority for 26 states in 2005.

Policy Implications: *In his State of the State, New Jersey's Acting Governor Codey identified his priority to expand services to the mentally ill across the life cycle, specifically related to housing. What will be the status of such program development and implementation against the backdrop of the state budget shortfall?*

Health Care Providers – Surveyed states reported that priority issues related to health care providers include medical malpractice, medical errors and workforce shortages. Although 26 states have already enacted medical malpractice legislation, at least 26 states will introduce new or attempt to amend current legislation concerning medical malpractice in 2005. At least 31 state legislatures plan to address medical errors and patient safety issues this coming year. In response to workforce shortages, at least 41 state legislatures reported plans to address the issue, specifically in respect to nurses, dentists, pharmacists and hospital technicians.

Policy Implications: *What is the status of New Jersey's quality initiative strategies, including Leapfrog, and the impact of the 2004 New Jersey Patient Safety Act? How will New Jersey policymakers and stakeholders address the issues of medical malpractice in the upcoming year? Will the trend of workforce shortages continue to affect the health and medical care services in the state?*

Commonwealth Fund – What Do The Experts Think?

The Commonwealth Fund's Health Care Opinion Leaders survey reported findings from health industry stakeholders in the public and private sectors who represented a broad range of professional and ideological perspectives:[5] Eighty-seven percent of survey respondents ranked coverage of the uninsured as Congress' top health care priority over the next five years.

The ranking summary for the other top priorities for Congress from 2005 – 2010 were:

1. Expand coverage to the uninsured
2. Improve the quality and safety of medical care, including increased use of information technology (IT)
3. Medicare reforms to ensure long-run solvency
4. Enact reforms to moderate the rising costs of medical care for the nation
5. Medicare payment reform to reward performance on quality and efficiency
6. Control rising cost of prescription drugs
7. Address racial and ethnic disparities in care
8. Malpractice reform
9. Administrative simplification and standardization
10. Medicaid reforms to improve coverage
11. Improve the quality of nursing homes and long-term care
12. Control Medicaid costs

Overall, survey results showed broad consensus in a number of areas and divergence of opinion in others. For example, nearly half to two-thirds of respondents in all four sectors showed wide agreement on the top two policy solutions to cover the uninsured by ranking as a priority either "expanding access to group health insurance such as the federal employees' health program or Medicaid/CHIP expansion." Yet, less than one-fourth of respondents say that expanding health savings accounts (22 percent) and tax credits for the uninsured to buy into individual insurance (20 percent) are priority solutions. Another example of divergent opinion was expressed on the issue of establishing a single-payer plan through a new program or Medicare: such a solution was rated a priority by 45 percent of total respondents, but only 29 percent in the business/insurance sector ranked it so. Regarding mechanisms for improving health care quality and controlling health care costs, respondents in all groups ranked pay-for-performance methods such as rewarding efficient providers and effective disease management – and increased use of information technology (IT) – as either the first or second priority. In discussing the findings of this inaugural survey – which will be used as a benchmark for future surveys -- Commonwealth Fund president Karen Davis noted: "Our goal is not only to gauge what experts surveyed think about important health policy concerns but to stoke debate about how to address them by presenting a range of well-reasoned points of view on the issues and potential policy solutions." Detailed survey findings can be found at http://www.cmwf.org/usr_doc/CMWF_Opinion_Leaders_summary.pdf. Tables 1-4 in the Appendix list the priority rankings for the leading issues identified by survey respondents.

Kaiser Family Foundation/Harvard School Of Public Health Consumer Survey – What Does The Public Think?

When asked to rank a list of 12 health care priorities for President Bush and Congress to address in 2005, almost two-thirds (63 percent) of the 1,400 American adults surveyed cited lowering the costs of health care and health insurance as a top priority. Ranked second and third were: making Medicare more fiscally sound for the future (58 percent) and increasing the number of Americans with health insurance (57 percent). The survey – conducted by the Kaiser Family Foundation and the Harvard School of Public Health – found that overall, U.S. adults rank health care third when asked to name the single most important priority to be addressed by the President and Congress; the war in Iraq and economic issues were

ranked first and second. The issue of health care tied with terrorism and national security as the third-most cited issue. An interesting finding that provides insight into public opinion on the issue of medical malpractice: 26 percent of the public cites reducing malpractice jury awards as a top priority, ranking 11th on the list. Those surveyed placed greater emphasis on limiting the number of lawsuits than on capping awards; they also favored higher caps for non-economic damages than the $250,000 being discussed by the Bush administration. The complete survey results can be viewed at: www.kff.org/kaiserpolls/pomr011105pkg.cfm.

Policy Implication: *Although terrorism and bioterrorism ranked third in the Kaiser survey, the issues of public health and emergency preparedness did not receive the primary ranking of importance as they did during the time immediately after September 11, 2001 and the anthrax attacks during the fall of 2001. Public health experts acknowledge that New Jersey is a vulnerable state regarding threats from bioterrorism, domestic security and public health outbreaks such as SARS. What is the status of New Jersey's surveillance and monitoring infrastructure and its emergency response systems? What have we learned from this fall's flu vaccine shortage and the state's response to it? How will the state be affected with cutbacks in its federal preparedness funding?*

Concluding Remarks

The challenges facing state health policymakers in 2005 and beyond continue to grow ever more varied and complex. Ongoing reforms and strategies at the federal level appear to bear out the administration's "ownership society" theme at both the state and individual level as the trend continues to place more responsibility on the states to administer, fund and oversee health care programs. In New Jersey, a number of public and private workgroups are examining health policy issues and devising strategies to address the critical issues of costs, access, coverage and quality across all sectors. Although each stakeholder may hold different sets of priorities, there is a growing consensus that we are at a critical moment in state health policy history to address these issues if New Jersey is to maintain its role as an innovator in state health policy reforms, programs and initiatives.

Endnotes

[1] The state of California reports the highest budget deficit at an estimated $9 billion; New York follows with a projected $4 billion deficit (Prah, 2005). Other states with the largest budget deficits for FY 2006 include: Connecticut ($1.2 billion); Illinois ($1.4 billion); Ohio ($1.4 billion-$2 billion – two-year budget); Oregon ($1 billion – 2-year budget); Washington ($1.8 billion – two-year budget); and Wisconsin ($1.6 billion – two-year budget).

[2] Under the proposal for the Stem Cell Institute of New Jersey, voters would need to approve $230 million in bond issues to fund the Institute and the state would need to spend $150 million to build it (Hester, 2005).

[3] New Jersey's cap for Medicaid reimbursement is 41 percent of the Federal Poverty Level (FPL), compared to our neighboring states of New York (with a 150 percent cap), Pennsylvania (with a 200 percent cap) and Delaware (which has a 117 percent cap). Increasing the cap for Medicaid reimbursement would potentially increase federal matching funds.

[4] According to Dr. Richard Goldstein, head of the New Jersey Council of Teaching Hospitals, "last year, New Jersey hospitals delivered over $800 million in charity care services for uninsured patients, and an additional $400 million in unpaid care for patients whose income was slightly over charity care limits ($56,550 annual income for a family of four) but were unable to pay their bill. The state reimburses hospitals almost $500 million of that overall cost. . .If we do nothing, in the next four years we can expect the cost for charity care alone to rise to over $1.3 billion" (*News Release,* "Vitale-Morgan introduce reforms to fulfill promise of FamilyCare," January 2005).

[5] The four broad health sectors were: academia and research organizations; health care delivery services; business, insurance and other health industries; and government and advocacy.

REFERENCES

Belluck, Pam. "Governors Unite in Medicaid Fight." *The New York Times*. December 26, 2004.

The Commonwealth Fund. "New Health Care Opinion Leaders Survey: Covering Uninsured, Improving Quality and Safety of Care Should be Congress' Top Health Priorities." *Newsroom*. January 7, 2005. www.cmwf.org

Congressional Budget Office. THE BUDGET AND ECONOMIC OUTLOOK. FISCAL YEARS 2006 TO 2015. January 2005.

Gabel, Jon, G. Claxton, I. Gil, J. Pickreign, H. Whitmore, E. Holve, B. Finder, S. Hawkins and D. Rowland. "Health Benefits in 2004: Four Years of Double-Digit Premium Increases Take Their Toll on Coverage." *Health Affairs*. V. 23, no. 5 . September/October 2004.

Health Policy Tracking Service. *2005 State Health Care Priorities Survey Report*. January 2005. www.hpts.org/HPTS2005/

Hester, Tom. "Codey outlines goals for N.J." January 12, 2005. www.nj.com.

Kaiser Family Foundation. "Americans Favor Malpractice Reform and Drug Importation, but Rank Them Low on Health Priority List for the Congress and President. Lowering Health Care Costs Overall Seen as Top U.S. Health Priority." *News Release*. January 11, 2005.

Livio, Susan K. "Two Legislators craft plan for expansion of FamilyCare." *The Star-Ledger*," January 6, 2005.

Livio, Susan K. and J. Whelan. "Codey plan would aid mentally ill." *The Star-Ledger* January 9, 2005.

Lyman, Rick. "Florida Offers a Bold Stroke to Fight Medicaid Cost." *The New York Times*. January 23, 2005.

Modern Healthcare's Daily Dose. "HHS returns $643 million in SCHIP funds to states." January 24, 2005.

National Governors Association and National Association of State Budget Officers. FISCAL SURVEY OF STATES. December 2004. http://www.nasbo.org/Publications/fiscalsurvey/fsfall2004.pdf

Pear, Robert. "Bush Nominee Wants States to Get Medicaid Flexibility." *The New York Times*. January 19, 2005.

Prah, Pamela M. "Billion-dollar deficits greet several states." *Stateline*.org. January 18, 2005. www.stateline.org

Prah, Pamela M. "Long-term care on states' short-list of priorities. *Stateline.org*. January 13, 2005.

Rovner, Julie. "Medicare and Medicaid account for 25 percent of federal budget expenses." *CongressDaily*. January 6, 2005.

APPENDIX

TABLE 1a
WAYS TO CONTROL RISING COSTS AND IMPROVE QUALITY

"Below is a list of ways that have been proposed to control the rising costs of health care and improve the quality of care. Which of the following should be the top priorities for action?"
(Multiple Response)

Base: 318 Respondents

	Total	Academic/ Research Institution	Health Care Delivery	Business/ Insurance/ Other Health Care Industry	Government/ Labor/ Consumer Advocacy
	%	%	%	%	%
Reward more efficient medical care providers and effective disease management	69	61	63	83	80
Increased and more effective use of information technology	67	64	74	72	69
Make information on comparative quality and costs of care of hospitals and physicians available to the public	56	52	41	70	49
Reduce administrative costs of insurers and providers	42	50	56	29	34
Consolidate purchasing power by public and private insurers working together to moderate rising costs of care	36	39	27	28	51
Encourage small employers to join larger group purchasing pools to buy health insurance for their employees	34	34	44	28	31
Create a national agency to set quality standards and practice guidelines	32	36	33	21	43
Malpractice reform	31	25	54	47	9
Reduce inappropriate medical care and fraud	27	24	17	29	34
Legalize the importation of brand name prescription drugs from Canada or other countries	18	21	26	10	23
Encourage competition among insurers and providers	18	19	9	25	6
Require consumers to pay a substantially higher share of their health-care costs	13	11	9	15	6
National health plan/Universal health plan/Single payer system	3	5	3	2	6
Other	4	5	4	3	9

Source: The Commonwealth Fund Health Care Opinion Leaders Survey. November/December 2004.
http://www.cmwf.org/usr_doc/CMWF_Opinion_Leaders_summary.pdf

TABLE 1b
WAYS TO CONTROL RISING COSTS AND IMPROVE QUALITY
Ranking Summary

Base: 318 Respondents

	Total	Academic/ Research Institution	Health Care Delivery	Business/ Insurance/ Other Health Care Industry	Government/ Labor/ Consumer Advocacy
	Rank	Rank	Rank	Rank	Rank
Reward more efficient medical care providers and effective disease management	1	2	2	1	1
Increased and more effective use of information technology	2	1	1	2	2
Make information on comparative quality and costs of care of hospitals and physicians available to the public	3	3	5	3	4
Reduce administrative costs of insurers and providers	4	4	3	5 (tie)	
Consolidate purchasing power by public and private insurers working together to moderate rising costs of care	5	5			3
Encourage small employers to join larger group purchasing pools to buy health insurance for their employees	6				
Create a national agency to set quality standards and practice guidelines	7				5
Malpractice reform	8		4	4	
Reduce inappropriate medical care and fraud	9			5 (tie)	

Source: The Commonwealth Fund Health Care Opinion Leaders Survey. November/December 2004. http://www.cmwf.org/usr_doc/CMWF_Opinion_Leaders_summary.pdf

TABLE 2
NEXT STEPS IN MEDICARE REFORM
Ranking Summary

Base: 318 Respondents

	Total	Academic/ Research Institution	Health Care Delivery	Business/ Insurance/ Other Health Care Industry	Government/ Labor/ Consumer Advocacy
	Rank	Rank	Rank	Rank	Rank
Use Medicare's purchasing power to negotiate lower prescription drug prices	1	1	1	2	1
Link increases in Medicare physician payments to quality performance	2	2	2	1	2 (tie)
Have higher-income Medicare beneficiaries pay higher premiums	3	4	3	3	3
Eliminate the "donut hole" in the Medicare drug benefit	4	3	5	4	2 (tie)
Raise taxes to ensure Medicare's long-term solvency	5	5 (tie)	4	5 (tie)	
Eliminate extra payments for private health plans	6	5 (tie)			4
Improve Medicare's benefit package other than prescription drugs	7				5
Raise age of Medicare eligibility	8				
Encourage more enrollment in Medicare Advantage or private plans	9			5 (tie)	

TABLE 3
EXPANDED COVERAGE FOR THE UNINSURED
Ranking Summary

Base: 318 Respondents

	Total	Academic/ Research Institution	Health Care Delivery	Business/ Insurance/ Other Health Care Industry	Government/ Labor/ Consumer Advocacy
	Rank	Rank	Rank	Rank	Rank
Allow individuals and small businesses to buy into the Federal Employees Health Benefits program or similar federal group option	1	1	1	1	3
Expand existing state-based public insurance programs, Medicaid and SCHIP	2	2	2	3	1 (tie)
Let near-elderly adults buy into Medicare	3	4	3 (tie)	4	1 (tie)
Single-payer system of health insurance through a new program or Medicare-for-all	4	3	3 (tie)		2
Incentives or requirements to expand employer-based health insurance	5	5	4	2	5
Reinsurance for small business insurance plans	6		5	5	4

Source: The Commonwealth Fund Health Care Opinion Leaders Survey. November/December 2004. http://www.cmwf.org/usr_doc/CMWF_Opinion_Leaders_summary.pdf