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The Health Policy Landscape: 2007 and Beyond

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EXECUTIVE SUMMARY

As Congress and state lawmakers head into a new legislative session, these are some of the more pressing health policy concerns that they and the public will confront in 2007:

- Voters will look to candidates' stances on various health issues with renewed interest as they weigh their choices for the 2008 elections.
- Although state fiscal conditions continued to improve overall and revenue streams look generally healthy for now, states including New Jersey will confront both new and recurring budget problems in the coming year.
- While New Jersey's \$42.4 billion FY 2007 budget as enacted was considered balanced, underlying fiscal problems leave the state at risk, and procuring the necessary funding to finance the promised property tax reforms will be a difficult challenge.
- Initiatives to expand health insurance coverage, including a growing number of universal health care models, face uphill battles in state legislatures as expensive propositions in a time of scarce resources and competing priorities.
- Federal policy decisions will significantly influence the success of state initiatives to expand health care coverage.
- Congress is working toward granting the government the authority to negotiate directly with drug companies on pharmaceutical pricing for Medicare beneficiaries under Part D. Not everyone is convinced such a measure would produce cost savings. Meanwhile, the funding of benefits for individuals dually eligible for both Medicare and Medicaid remains a hot topic.
- Reductions in physician payments under Medicare were avoided for this fiscal year, but cuts still may lie ahead for future years.
- States are looking to expand coverage and services for children and low-income residents as state revenue growth begins to eclipse Medicaid spending.
- SCHIP reauthorization is on Congress' plate this year, and legislation that fails to provide states with the funds needed to maintain their programs could have potentially major implications for New Jersey, a state chronically facing shortfalls.





INTRODUCTION

THE HEALTH POLICY LANDSCAPE: 2007 AND BEYOND

The year 2007 follows a dramatic election season that produced a significantly altered national legislature, and many states have seen big changes in their leadership structures as well. Given the election outcomes and the imminent 2008 presidential race, will we witness a new emphasis on health issues? How critical of a role will health issues play in the choices voters make? How will health policy developments in the states mirror – or foreshadow – events on the national stage? What are the health policy priorities taking shape during the second year of the Corzine administration?

A number of issues promise to be at the forefront of health policy debates in Congress and across state legislatures, including the expansion of health coverage; changes to Medicaid, the State Children's Health Insurance Program (SCHIP), and prescription drug benefits; reevaluating health care resources; and, above all, working to ensure the fiscal health necessary at the state level to be able to consider these competing demands.

Voter/Public Priorities

In several polls, both health care opinion leaders and the general public see extending health care coverage to the uninsured as one of the top health policy priorities for 2007, a concern that has maintained this ranking in the last several years (12)(13). Though voters staunchly back the general idea of expanding coverage, they tend to withdraw their support if they perceive it will negatively affect the cost or quality of their own care or harm the nation's economy (7). How will voters regard forthcoming universal coverage proposals if they anticipate that extending benefits to others may translate into personal sacrifices?

Opinion polls from 2006 indicate the American public considers health care to be an important issue, but less of a priority for government action than the Iraq war, the economy, and fuel/energy prices (8). However, while voters reported that issues such as the war, general economic issues, and morality/anti-corruption most prominently influenced their choices in the recent elections, health care ranks high on the list of issues the public most wants Washington to tackle in 2007, and it is an issue to which voters expect candidates for the 2008 Presidential election to devote considerable attention (22). Americans consider expanding health insurance coverage and reducing health care costs the top health care priorities Congress and the President should address in the current legislative session (22).

Looking ahead to the 2008 Presidential election, after the Iraq war and the economy, health care is the issue voters most want candidates to discuss. Health care is more important to them than deliberations over immigration, national security, taxes, energy/gas prices, non-Iraq foreign affairs, Social Security, the national budget, morality issues, and education (22). In addition, recent polls find broad support across party affiliations for lowering the cost of prescription drugs, government action to reduce health care prices, and ensuring health care coverage for children (13). The public continues to hold mixed opinions on research using embryonic stem cells, although support for expanding such activities has grown in recent years.

Priorities for Legislators and Other Leaders

In 2007, Congress is expected to tackle the issues of Medicare reforms, prescription drug safety, and coverage for the uninsured, as both parties have eyes on what are anticipated to be important concerns for voters in the next election (5). Congressional policy makers also anticipate that prescription drug pricing, stem cell research, and sustainability for SCHIP will be major issues in the legislative year to come (2)(34). In New Jersey, existing health care resources are being closely evaluated, and significant changes may be in store for the organization of the state's system of hospital care. Additionally, plans to make





health insurance a requirement for all state residents are gaining momentum, and New Jersey may make an effort to follow the few states that have led the charge toward universal health care for their people.

The Cost of Health Care Reform: How Affordable?

At the federal level, the U.S. Congress passed just two out of 11 FY 2007 appropriations bills (those for homeland security and defense) before adjourning for the year in December 2006. A joint funding resolution signed into law Feb. 15 will continue to fund most federal agencies through the end of FY 2007 at FY 2006 levels. This means funding this year for most government health programs will be flat-lined, and that thousands of “earmarked” funds stand to be eliminated as well (58).

Nationwide, health care comprises the largest segment of total state spending, at an average of 32% for FY 2006, including 22% for Medicaid (39). Financing health care within the Medicaid program as well as throughout state government continues to present significant challenges for states.

The health care factors anticipated to exert the greatest pressure on state budgets in the years to come include rising health care costs and increased use of services, the increasing cost of state employee health insurance, the demands of an aging population, growing numbers of uninsured, and changes to Medicaid at the federal level. Even considering more modest health care spending growth rates in recent years, health care spending is estimated to increase an average of 8% annually for the next decade (39).

Although a recent study by the Center for Medicare & Medicaid Services (CMS) determined that health spending as a nation increased by only 6.9% in 2005 (the slowest rate of growth since 1999), this rate still is twice that of inflation (10).

States

State budgets are “mostly solid,” and state revenues are holding steady “for the most part,” as of the end of calendar year 2006, the National Conference of State Legislatures (NSCL) reports, although circumstances are not as solid overall as they were a year ago. These healthier conditions allowed states to increase programmatic funding, enact tax cuts, and refresh budget stabilization funds. Revenue collections exceeded estimates in 23 states (compared to 42 states at the end of 2005), while 22 said revenues were right on target, and only three states claimed below-forecast revenues (42). The National Association of State Budget Officers (NASBO) reports that FY 2006 state revenues exceeded overall estimates by 5.9% (39).

Yet NCSL puts budget pressures third on its list of the 10 key issues forecast for state policy makers in 2007. While FY 2006 revenue increases were generally robust, estimates based on FY 2007 enacted budgets foretell somewhat more moderate growth. States across the country, while currently reporting stable revenues, are finding that concerns about sales tax collections, combined with the burden of finding ways to pay for \$75 billion worth of federal program costs shifted to state responsibility (e.g. No Child Left Behind) in the last three years, have placed added stress on their budgets (42).

Health care and Medicaid are ranked as top concerns for half of the states in developing their FY 2008 budgets (42). States will face difficulties in paying for health care within the Medicaid program as well as throughout state government, with state health care spending increases over the next decade averaging 8% annually, according to the Congressional Budget Office (39). The majority of states are gearing up to deal with nagging education funding issues (teacher salaries, aid formulas, etc.) while simultaneously taking on other important questions related to Medicaid, health care costs, pensions, and infrastructure concerns. Meanwhile, tax reform and property tax debates are anticipated in about a third of the states (42).

Officials in 16 states claim an “optimistic” view toward revenues in 2007, while 28 states hold a “stable” outlook and six are “concerned.” This compares to state perspectives at the end of 2005, when 22 states





were optimistic, 26 were stable, one was concerned and one was “pessimistic.” Since 2002 until this year, the “optimistic” line had trended upward and the “concerned” line downward. It is unclear whether this new trend is short-term or portends future revenue problems (42).

THE “STATE” OF NEW JERSEY

While fiscal conditions across the states continued to improve during FY 2006 overall, New Jersey continues to face a number of budgetary challenges. Still feeling the impact of the tax cuts in the 1990s and recent years in which the state supported ongoing costs of new programs through nonpermanent revenue streams, the state enacted a number of now permanent tax changes and increases in FY 2007 in order to generate additional revenue (36). Of the six states that enacted sales tax increases in FY 2007, New Jersey’s was the largest: the sales tax rate was increased from 6 to 7 percent, resulting in a revenue increase of \$1.25 billion, while the base of the sales and use tax was extended, resulting in a \$300.6 million increase (39). Time will tell if the resulting revenue will be enough to offset lingering deficit-inducing problems and balance budgets in the years to come.

In his State of the State address on Jan. 9, Governor Corzine noted that New Jersey has markedly reduced its structural deficit (even though it is the only state in the nation that still has one), and that the state has “made real progress building a budget that matches recurring revenues to expenditures.” He called for continuing work on budget reforms, and urged an effort this year towards “greater transparency, multi-year projections, updated aid formulas, and an end to midnight spending.” (47). The Governor’s proposed \$33.3 billion FY 2008 budget, while supported in part by increased revenues, is expected to leave a \$1.3 billion gap by the end of the fiscal year (50). An additional pressure is finding sufficient funds to finance the more than \$2 billion in property tax relief, a debate that has been front and center for the legislature for some time and shows no signs of losing intensity.

Policy implications

- *Will the shift in Congressional leadership lead to a renewed focus on the problem of the uninsured?*
- *Will any major health-related programs in New Jersey feel the pinch from the elimination of earmarked funds from federal spending bills?*
- *How will property tax reform compete with plans to expand health care coverage in New Jersey?*

HEALTH CARE COVERAGE AND ACCESS

Approximately 46.6 million Americans lack health insurance, a number that has grown steadily in recent years and represents an increase of roughly 15% since the year 2000 (54). Meanwhile, an additional 16 million Americans are under-insured, meaning their coverage does not grant them access to necessary care or catastrophic protection (51). The high cost of health insurance is one of the top reasons people lack coverage; although most uninsured people are part of working families, they tend to have limited incomes and employers that do not offer health benefits (31). The increasing number of uninsured is due in part to scarcer availability of employer-based coverage and the failure of public “safety net” programs, such as Medicaid, to help compensate for this loss in coverage (55).

In recent polls, respondents name the cost of health care and lack of insurance/health care access as the most pressing issues to which the government should devote attention, factors ranked well above other top health care priorities (8)(12)(13)(22). While federal health care spending actually declined during FY 2006, costs to individual consumers remain high:





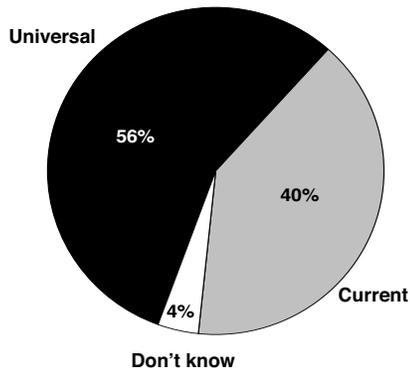
- Eight out of 10 people say they are generally dissatisfied with the total cost of health care, while six out of 10 are very dissatisfied (1).
- Similarly, six out of 10 insured Americans have at least some concern about the affordability of their health insurance over the next few years; that number rises to eight out of 10 among the uninsured (1).
- One quarter of Americans report their family had difficulty paying for care during the last year; meanwhile, 40% of those age 18-29, 42% of those in households earning less than \$35,000 annually, and nearly 60% of the uninsured report the same struggles (1).
- Among those voters who stated health care was an important election issue for them in 2006, 30% were primarily concerned with costs, 21% with expanding coverage and the uninsured, and 21% with Medicare issues, including 14% who mentioned the prescription drug benefit (22).

EXPANDING INSURANCE COVERAGE/UNIVERSAL INSURANCE

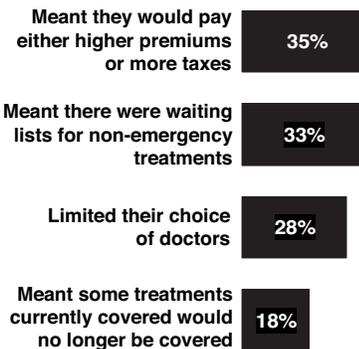
Both health care opinion leaders and the general public see extending health care coverage to the uninsured as one of the top health policy priorities for 2007 (12)(13). Experts have identified a “policy gap” when it comes to health care; that is, the public declares great support for improving the health care system, but not at any cost. Generally, a majority will agree to the need for fundamental changes to the current health system, and that the government should ensure health care coverage for all as well as address problems related to health care costs and the uninsured. However, that same American public will oppose, or greatly withdraw support, for these same ideas if certain tradeoffs are implicated: for example, if reforms would bring about substantially negative changes to their own care or premiums, involve a major tax hike, or damage the economy [See chart] (7).

Opinions About Universal Health Coverage

Which would you prefer: the current health insurance system, in which most people have coverage through private employers, but some people have no insurance, or a universal coverage program, in which everyone is covered by a program like Medicare that is government-run and financed by taxpayers?



Percent who say they would still support a universal health insurance system even if it...



Source: ABC News/Kaiser Family Foundation/USA Today Health Care in America Survey (conducted September 7-12, 2006)





Surveys find widespread concern for the number of uninsured, and broad interest in the theory of various proposals to expand coverage, but this interest wanes when these same people are presented with the potential tradeoffs of such proposals. For example, more than two thirds of Americans believe providing universal coverage is of greater importance than keeping taxes down, and 56% say they would rather have such a system in place over our current system. But after presented with possible disadvantages, such as higher premiums or increased taxes, waiting lists, fewer choices in providers, and more restricted medical treatments coverage, only one third or less of the public still backs the notion. Meanwhile, opinions are split nearly equally on the idea of an actual plan at the state level to increase coverage (52% support, 44% oppose) (1).

What the public think

- For the 2008 presidential election, preferences for health care reform proposals vary widely between voters' party affiliations:
 - Creating a new health plan that would make a concentrated effort to insure everyone without coverage, but would involve a major increase in spending: 37% of Republicans, 73% of Democrats, and 55% of Independents say this would be the top element they would look for in candidates' health platforms.
 - A more limited plan involving smaller spending increases but which would bring a more restricted number of uninsured into coverage is what 32% of Republicans, 18% of Democrats, and 25% of Independents want to see as the top focus for candidates (22).
- Options for increasing coverage strongly favored by a majority of people include:
 - Mandating businesses to offer insurance to full-time employees (the top choice of 35%)
 - Expand existing programs such as Medicaid and Medicare (top choice of 25%)
 - Giving tax breaks to businesses that cover their employees (top choice of 19%)
 - Fourteen percent, meanwhile, say the government should not be doing more to cover more uninsured Americans (22).

What health care leaders think

- NCSL rates expanding health insurance as the fourth biggest issue in its top 10 forecast of urgent topics it expects state health policy makers to be working on this year (41).
- Health care opinion leaders in health care delivery organizations, academic/research institutions, and government/consumer advocacy/labor rated expansion for coverage of the uninsured as the top priority for Congress to address in 2007, while those leaders in the business/insurance/and other health care industries ranked coverage expansion second (after greater use of IT to improve health care quality and safety).
- 83% of all respondents overall (including business sector) chose this as the top priority.
- The best way to achieve the goal of coverage expansion, leaders across all polled sectors agreed, was to permit individuals and small businesses to buy into the Federal Employees Health Benefits Program or another comparable federal group alternative (12).





States

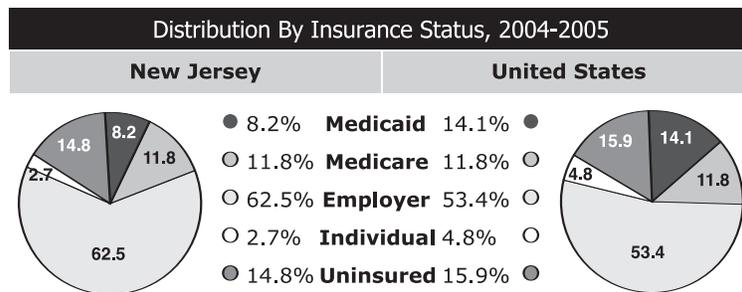
Common themes seem to be emerging among the growing numbers of state-based health care reform initiatives. Many programs focus on cost and quality as well as expanding health coverage. The efforts aim to fill coverage gaps left by the absence of employer-based insurance, and the delivery of care often depends on private insurers. Comprehensive packages expand upon earlier efforts and financing mechanisms and often expect mandatory participation and shared financial responsibility (52).

Universal coverage laws have been passed in a number of states (Maine, Massachusetts, and Vermont) and are being considered in several more, including New Jersey. In Illinois, a state task force approved a plan to require all state residents to obtain insurance; the legislature will consider it this year. California’s proposed plan shares many similarities with the Massachusetts system – it would require all residents to have health insurance, which would remain tied to employment and under the control of private carriers, while the state would offer assistance to those who qualify (53).

In Pennsylvania, Gov. Rendell introduced his “Cover All Pennsylvanians” (CAP) plan to greatly expand health-care coverage for the uninsured while attempting to control health care costs. CAP will be aimed at providing medical coverage to roughly one million uninsured Pennsylvanians and targeting providers with cost-containment measures. Once it receives the necessary federal and legislative approvals, CAP could begin running by Jan. 2008. Pennsylvania would not follow Massachusetts’ universal health-care plan, set to go into effect next spring, which works through government funding and pooled contributions from employers, but would instead follow the model of Rendell’s expansion of the State Children’s Health Insurance Program (SCHIP) last year with pay-ins depending on income level (49).

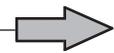
New Jersey implications

Currently, 1.2 million to 1.3 million New Jersey residents are uninsured; nearly double the number of uninsured residents within all the other states that have enacted universal coverage plans combined. Employer-based insurance covers 63% of New Jersey’s population, compared to 53% of the U.S. [See chart] (20). A study group led by state Senate Health Committee Chairman Joseph Vitale (D-Middlesex) and former state deputy health commissioner David Knowlton has been researching the issue since late summer 2006, and lawmakers are preparing a proposal expected to be introduced as legislation in April to require that all New Jersey residents have health insurance.



Source: Kaiser Commission on Medicaid and the Uninsured. “New Jersey & United States: State Medicaid Fact Sheet.” Produced Jan. 19, 2006. Available at: <http://www.kff.org/mfs/medicaid.jsp?r1=NJ&r2=US>

As envisioned, the system would require state residents who currently lack coverage to obtain it; those without coverage who cannot afford private insurance would enroll in a state-subsidized plan. The proposal would also obligate employers who do not currently offer health insurance to establish flexible spending accounts for workers to purchase coverage using pre-tax dollars (56).





The proposal would bring coverage to the approximately 600,000 uninsured middle-income residents whose incomes are too high to qualify for Medicaid and NJ FamilyCare. Those families would pay premiums according to an income-based sliding scale. The plan is also intended to reach the roughly 200,000 additional residents who do qualify for this subsidized coverage but have not yet enrolled.

Specific details still are being worked out, including how to finance the increased coverage (which will not likely happen in the FY 2008 budget), but the intent is for the universal insurance model to supplant the state's current practice of reimbursing hospitals for the treatment of uninsured patients. The plan could cost \$1.7 billion in the first year, an amount expected to be reduced when offset by new enrollees' premiums, and when private insurance premiums are excluded. This does not include the \$232 million it would cost to enroll currently eligible adults and children in Medicaid or NJ FamilyCare. The plan also depends on reopening NJ FamilyCare eligibility to parents up to 200% of the federal poverty level to make the most of federal matching funds. Two to three managed care providers would administer the program. Those behind the effort acknowledge the measure may take years to pass once presented (19)(35)(56).

Governor Corzine made mention of the need to work toward expanding coverage for the state's residents in his State of the State address, but did not commit further than to say that New Jersey "must increase health care access and affordability" for its under- and uninsured (47).

Policy implications

- *How difficult or affordable might it be to pass a universal coverage plan in New Jersey given the intense focus on property tax reform and school aid?*
- *How will New Jersey residents regard universal coverage in their state if it means increased personal costs and potential sacrifices in choice or quality? Will it be difficult for employers to meet the obligations of the plan?*
- *Will voters support candidates who propose major health care reform initiatives that have the tradeoff of large price tags?*

MEDICARE

Prescription Drug Pricing

Part D of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) established an optional prescription drug benefit that became available to Medicare beneficiaries on January 1, 2006. Medicare did not cover outpatient drugs before the act took effect. The drug benefit comprised the most significant expansion of the Medicare program since its creation in 1965. Under Part D, Medicare subsidizes private insurers to provide prescription drug coverage for people 65 and older and disabled or low-income people on Medicaid (11). The current legislation prohibits direct government negotiation with pharmaceutical companies to lower drug prices for beneficiaries.

What health policy makers think

Controlling the rising cost of prescription drugs was ranked as a top priority for Congress to address by only 22% of health care opinion leaders in the Commonwealth Fund's poll (although 44% made Medicare reforms to ensure long-term program solvency one of their top recommendations for action, and 84% of the public said this was "very important"(12)(13)). Congress, however, already has begun the legislative process to compel the federal government to negotiate directly with pharmaceutical companies on the cost of prescription medications under the Medicare Part D benefit, but it is unclear whether such a development would lead to more favorable prices than those obtained by private insurers.





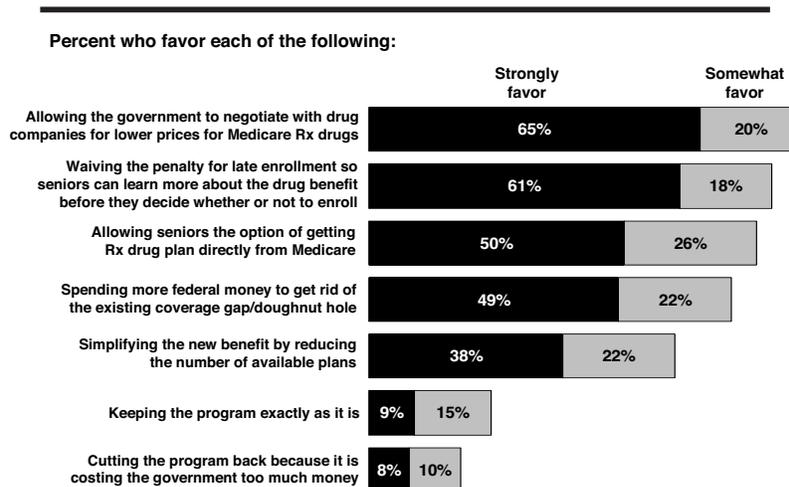
The Medicare Prescription Drug Price Negotiation Act of 2007 (HR 4), passed by the House on January 12, would authorize drug price negotiations under Medicare, requiring the Secretary of Health and Human Services to work toward discounted prices on covered Part D drugs on behalf of Medicare beneficiaries. The legislation, however, plainly forbids the government from creating a formulary – a list of approved drugs that is often a compelling tool when used in pricing negotiations, since the worry of not being included on a formulary is one of the most important motivators for pharmaceutical companies to agree to lower prices (3). As currently enacted, the MMA prohibits the government from interfering in negotiations between manufacturers and insurers, and also stipulates that Medicare cannot establish a list of preferred drugs.

The bill’s opponents maintain that eliminating choice in the types of drugs or how they are obtained are the only ways to garner savings under the program. The White House, citing reports from the Congressional Budget Office (CBO) and the Centers for Medicare & Medicaid Services (CMS) that the bill would not lead to any savings in the Medicare program, promises a veto of the legislation should it pass both houses (18).

What the public think

- Forty-three percent of Americans feel the Medicare Part D drug benefit could be made better with minor changes, while 27% say it is not working well and requires major changes. About the same percentage say it is working well as those who say it is not and should be repealed (22).
- Of proposals to change Medicare Part D, the public “strongly favors” the following [See chart]:
 - Permitting government negotiation with drug companies for reduced prescription prices (65%)
 - Waiving late enrollment penalties to allow seniors more time to learn about the prescription drug benefit (61%)
 - Providing the option to seniors to obtain the drug benefit directly from Medicare (50%)
 - Investing increased federal funds to eliminate the existing “donut hole” gap in coverage (49%)
 - Reducing the number of plans available for simplification (38%) (22)

Proposals to Change Medicare Part D



Source: KFF/HSPH The Public's Health Care Agenda for the New Congress and Presidential Campaign (conducted November 9-19, 2006)





- Of the two-thirds who “strongly favor” permitting the government to negotiate with manufacturers for lower prices on Medicare prescription drugs, the following summarize their beliefs about such a policy:
 - Would result in more affordable drugs (81%)
 - Seems reasonable to pursue because the government does this already for members of the military/veterans (80%)
 - Would result in government price controls for prescription medications (60%)
 - U.S. pharmaceutical companies would not pursue as much research/development (31%) (22)

Despite many early snafus, the program seems to have resolved many of the problems that plagued its implementation. A survey conducted near the close of the 2006 Medicare drug benefit open enrollment period suggests that few seniors intend to switch plans for 2007:

- Only 5% of seniors enrolled in a Medicare drug plan say they expect to switch plans for 2007, while two thirds do not expect to switch and 29% are unsure.
- Three fourths of seniors enrolled in a plan describe their experiences as “positive,” including 46% who say they have been “very positive.”
- Just over half of seniors who have used their new drug plan say that they are paying less for their prescriptions (52%), while 14% say they are paying more.
- One fourth of seniors who have used their plans say that they experienced a problem with their coverage, with 12% overall describing the problem as significant. Almost three fourths of seniors say that the Medicare drug benefit is “too complicated.” (23)

States

Although the drug benefit program under Medicare is now entering its second year, states still play an important role for low-income seniors and disabled individuals in need of medications, particularly those who do not qualify for Medicaid. Many states, in addition to supplementing federal assistance, are adapting their State Pharmaceutical Assistance Programs and making adjustments to Medicaid and other prescription assistance programs. At least 41 states had instituted or authorized programs to offer subsidies for coverage gaps and premiums by late 2006, and while most of those programs use state funds to cover some of the costs, the use of discounts or bulk purchasing methods is becoming more common (43).

New Jersey

The New Jersey Appropriations FY07 budget included updated provisions for "wrap around" supplemental benefits for residents in the PAAD and Senior Gold pharmaceutical subsidy programs. To continue receiving state-paid drug coverage benefits, all Medicare-eligible enrollees must sign up for Part D benefits; residents who decline coverage will be excluded from all PAAD benefits, and PAAD benefits and reimbursement will cover only the beneficiary cost share to in-network pharmacies and deductible and coverage gap expenses.

In addition, the state is developing a "Prescription Drug Retail Price Registry" through the Department of Health and Senior Services (DHSS) to allow consumers to compare retail prices for the 150 most frequently prescribed prescription drugs (43).





Policy implications

- *How might changes to drug pricing regulations at the federal level affect New Jersey's current assistance programs?*
- *How might drug price negotiation efforts potentially affect New Jersey's seniors enrolled in the Medicare drug benefit?*
- *As the drug benefit becomes more established, its success will be gauged through a number of important indicators, including enrollment, benefit design and formulary changes, cost sharing and access, plan stability, and low-income subsidy participation.*

Physician Reimbursement

In late December, President Bush signed into law a tax, trade and health care bill that included provisions to halt a 5.1% reduction in the Medicare physician reimbursement rate scheduled to take effect on Jan. 1, 2007. The law averted the cutback by preserving the 2006 level of Medicare physician reimbursements for 2007, and by giving a 1.5% increase in reimbursements to those physicians who consent to report data on particular quality-of-care measures (21).

While the reimbursement reduction was avoided for this fiscal year, the Congressional Budget Office calculates that, in its final "scoring" of this same law, physician payments under Medicare will be decreased by 10% in 2008 (14). According to the American Medical Association, the rate reduction and other changes in Medicare payment rates planned for 2008 will result in a loss of \$262 million in health care funds that year; and that approximately 91,000 employees, 90,000 TRICARE patients, and more than a million Medicare patients in the state eventually would be affected by the cuts (4).

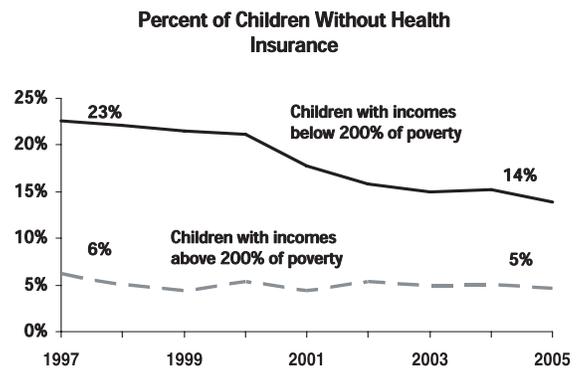
Policy implications

- *To what extent will Medicare physician payment rate reductions expected for future years affect New Jersey's patients and providers?*

MEDICAID

Cost Pressures/Expenditures

A majority of Americans strongly favor the expansion of Medicaid in order to increase the number of people covered (1). FY 2006 marked the first time since the late 1990s that state revenue growth, on the rebound since the severe tumbling between 2001 and 2004, exceeded the growth in Medicaid costs. Now, with states showing improved fiscal standing overall, many are seeking to significantly expand coverage under Medicaid and SCHIP, and a large number have set aside the funding necessary to resume their outreach efforts for their programs. A number of states have reinstated simplified enrollment procedures, and others are initiating major expansions in children's coverage. Increasingly, states are emphasizing targeting enrollment to the large number of children who qualify for, but are not enrolled in these programs. [See chart] For the first time in four years, no state cut income eligibility in Medicaid in the period from July 2005 to July 2006 (28).



Source: National Health Interview Survey data as analyzed by CBPP. See Appendix.





Nevertheless, Medicaid cost pressures still comprise a significant spending challenge for states, at 22% of total estimated FY 2006 state spending. For the majority of states, calculations show state Medicaid funds have increased more than the federal share in FY 2006. A major factor influencing this higher growth rate of state compared to federal funds is due to prescription drug financing for “dual eligibles” (39).

Another issue is the new requirement for people applying for or renewing their Medicaid benefits to show proof of citizenship and identity. States have reported application backlogs and noticeable declines in enrollment since this requirement took effect in July 2006 (28). In addition, Medicaid currently is the largest single provider of funding for long-term care services nationwide, paying for almost half of all long-term care costs. The Bush Administration’s Medicaid Commission expects that the projected expenditures for these services endanger Medicaid’s future sustainability (38).

Cost pressures affecting enrollees resulted from recent years in which Medicaid grew faster than state or federal tax revenues, in the form of increased out-of-pocket burdens more difficult for those with very limited incomes to cover (57). Several approaches to reduce program costs without also shifting the obligation to enrollees have become popular:

- Care management – a focus on a wide variety of activities intended to reduce the need for services by enrollees
- Consumer engagement – policies intended to have enrollees take greater responsibility in paying for and organizing their care.
- Employer engagement policies – combining funds to help cover lower-income working people (57).

Other options, suggested by the Congressional Budget Office, include:

- Reducing the federal contribution
- Restricting coverage or reducing mandatory benefits
- Increasing beneficiaries’ cost sharing
- Promoting increased use of lower-cost services (37)

New Jersey

- The state’s Medicaid program serves more than 900,000 people and costs New Jersey around \$9 billion per year, \$3.2 billion of which is state money (\$3.7 billion in the governor’s FY 2008 spending plan (48)). The program is the second-largest component of total state spending after school assistance (27)(40).
- Total spending for Medicaid in New Jersey as a percentage of total state expenditures for FY 2006 was estimated to be 21.0% (compared to 24.2% for elementary and secondary education for FY 2006), up from 18.2% in FY 2005 (39)(40).
- New Jersey covers about 8% of its population through Medicaid, about half the proportion as the U.S. average across states (14% for 2004-5) (27).
- New Jersey is tied for first (with Maine) for the largest percentage increase in total Medicaid expenditures from FY 2005-6: 18.2%, which includes an 18.4% increase in state expenditures and a 17.9% increase in federal expenditures (40). This 18.2% increase compares to the 5.0% average increase across the U.S.
- A state office of “Medicaid inspector general” will be established under a bill signed into law in March. This post would investigate losses due to Medicaid fraud, estimated at \$900 million per year. Currently, program officials in the state can only project this number from the federal General Accounting Office’s estimate that Medicaid fraud consumes 10% of program expenditures (17).





Policy implications

- *Given the documentation requirements for Medicaid participants, how can states work to ensure simplified enrollment and renewal systems are maintained?*
- *What are the best cost-containment measures to pursue or continue to pursue in New Jersey?*

The “Clawback” Provision and Dual Eligibles

The most significant fiscal impact of the prescription drug benefit program under the MMA of 2003 on overall state budgets concerns the “clawback” contributions, the payments states must make to the federal government for prescription drug coverage under Medicare for dual eligibles, the more than six million low-income seniors and people with disabilities who qualify for both Medicare and Medicaid (40). Dual eligibles used to receive prescription drug benefits through Medicaid, but their drug coverage switched to Medicare Part D plans on January 1, 2006 as the only group required to participate in the otherwise voluntary program (39).

States no longer receive matching federal funds for the provision of Medicare-covered outpatient prescriptions for dual eligibles through Medicaid; instead, each state owes a monthly “clawback” obligation to the federal government representing a percentage of the projected reduction in their Medicaid expenditures. The amount each state pays to the federal government each month is determined by a formula intended to approximate what the state would have paid for dual eligibles’ outpatient prescription drugs through Medicaid; these payments gradually phase down from 90% of estimated FY 2006 state costs (the baseline) to 75% in FY 2015 and beyond (11)(30). For each state, the baseline for the clawback payments was figured using the per beneficiary cost of coverage for Medicare covered prescriptions from 2003, multiplied by the number of dual eligibles in the state to create a baseline adjusted each year by national health inflators for prescription drug costs (39)(32).

The transition to Part D affected dual eligibles more significantly than any other group because they are generally sicker and poorer, meaning they have more extensive and complex health and drug needs, and that their government benefits are far more expensive per capita (39)(25). For average to lower-cost plans, dual eligibles are fully subsidized for the Part D premium, but they may be confronted with new co-payments and more stringent formularies. When the transition to Part D first took effect, states immediately expressed concerns related to the impact on duals, including access to non-formulary drugs and the affect of potential new co-payment requirements (26).

States also raised objection to the clawback, and 15 states stated that their FY 2007 clawback obligation would exceed the amount they would have spent in the absence of Part D (26). In the equation used to assess state clawback payments, the number of full-benefit dual eligibles is the only factor that states can control. This has led to fears that states, as a Medicaid cost-containment measure and an effort to reduce their monthly obligations to the federal government, would act on the incentive to drop optional groups of the most costly duals from their Medicaid rolls (15)(30). A number of states, including Florida, Mississippi, and Missouri, already have taken such steps to reduce or eliminate Medicaid coverage for dual eligibles who then lose an array of services and certain prescriptions not covered by Medicare.

Challenges remain for duals in the complex coordination of care between Medicare and its Part D plans, and Medicaid, which may still provide them with other health care needs. Increasing competition among plans, one of the intents of the new drug benefit, may result in attrition that could threaten dual eligibles’ coverage. As the makeup of the dually eligible population changes over time, assuring their prescription needs are covered will present a similar challenge (25).

The final report from the Bush Administration’s Medicaid Commission recommends presenting states with the option to create Medicaid Advantage plans for dual eligibles to reduce the burden of coordi-





nating the various funding streams that cover benefits for this population. Under such an arrangement, the federal government would assume responsibility for the cost of Medicare services through a capitated, risk-adjusted system, while states and the federal government continue to share costs for Medicaid services (38).

New Jersey

In early 2006, New Jersey joined four other states in filing a lawsuit in the U.S. Supreme Court challenging the provision of the new federal prescription drug benefits plan governing prescription drug coverage for dual eligibles under Medicare, but in June of that year the high court upheld the clawback and declined to hear the case. New Jersey contended the clawback requirement encroaches on state sovereignty. While other states have voiced objection to their financial obligation to Medicare as calculated by the federal government, New Jersey was not, according to the state Attorney General, claiming direct fiscal harm as a result of the Part D transition through the suit (46).

New Jersey's per capita clawback obligation is the highest of any state. This is because it also has the highest monthly per capita drug expenditures (\$144.18) for dual eligibles in the country (32). Dual eligibles represent 17% of New Jersey's Medicaid enrollees, approximately 140,000 individuals, a greater proportion than the 14% of dual eligibles estimated for the entire country. New Jersey provides 42% of total Medicaid spending to dual eligibles, compared to the 40% average across all U.S. states (27).

New Jersey was among the majority of states that reported widespread problems affecting large numbers of dual eligibles in the beginning of the transition period. Duals had trouble obtaining needed medications, and reports of overcharging were prevalent (26). To ensure dual eligibles maintained coverage for needed medications during the transition period, many states implemented temporary assistance programs, including New Jersey. New Jersey plans to wrap around the Part D coverage on a continuing basis.

Policy implications

- *What will be the effect of the "clawback" provision on state finances?*
- *What are projections for Medicaid costs in the coming decade for the state?*
- *Has the incentive to reduce the state's clawback payments resulted in pressures to limit Medicaid enrollment for dual eligibles?*
- *Are early issues from the transition to Part D being resolved for the state's dual eligibles?*
- *What will be the long-term financial impact of the wrap-around coverage provided through the state?*
- *The federally determined clawback formula was intended to calculate payments representative of what states would have paid to fund prescription drugs for its own dual eligibles via Medicaid; does New Jersey consider its obligation to be accurate?*

SCHIP REAUTHORIZATION

The State Children's Health Insurance Program (SCHIP) was authorized and funded for 10 years in 1997 to cover children in families with incomes too high to qualify for Medicaid, but too low to secure private health insurance. The joint state-federal program that now covers more than 4 million children (22 million children are covered through Medicaid) is set to expire in September.

SCHIP reauthorization is one of the top-priority health-related issues the new Congress has taken up in its first few months, in particular the program's aggregate level of funding as well as its distribution among the states. Several bills at the federal level have been introduced with provisions to address shortfalls and guarantee coverage. Efforts to counter funding shortfalls may be hampered, however, by 'pay-





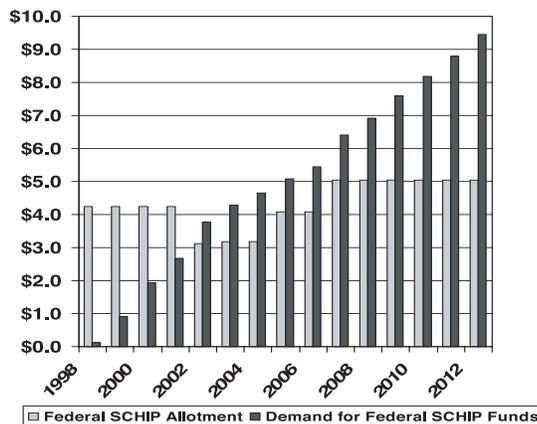
as-you-go' funding rules, which require compensating for increases in spending with additional revenue or budget cuts (33).

SCHIP, unlike Medicaid, is a block grant with an annual funding cap that does not adjust to account for increases in health care costs or greater numbers of eligible children due to normal population growth. Predetermined federal funding for a 10-year period has not been sufficiently flexible to accommodate program needs or demands, so that the gap between funds needed and funds provided grows larger each year (24)(29). If Congress freezes funding for the program at FY 2007 levels throughout the 2008 to 2012 period by holding SCHIP to its budget baseline, states will encounter a combined shortfall projected at \$12.7 billion to \$14.6 billion between FY 2008-2012 (9).

Just before adjourning for 2006, Congress passed a stop-gap measure to prevent currently enrolled children from losing funding through the NIH reauthorization. This provision reallocates \$275 million from states with unspent funds among the 14 states facing shortfalls, but it contains no obligations to reauthorize the program. The measure addresses SCHIP shortfalls only until May 2007 (9).

The SCHIP distribution formula is not based on state funding needs, making it impossible to allocate funds perfectly. The ability for states in need of additional SCHIP funding to draw on unused monies from other states is growing increasingly difficult, as programs have matured and most states fully spend their annual allotments in the three-year period they have to do so. And because since FY 2002 the states have overspent the annual federal grant, leftover funds available for redistribution will not be enough to compensate for shortfalls that frozen annual SCHIP funding in the coming years would produce (9)(24)(29). [See chart].

State Funding Needs Exceed Annual SCHIP Allotments Under the Baseline (in \$ billions)



Source: Center on Budget and Policy Priorities' SCHIP financing model under moderate expenditure growth.

What the public think

- It's no surprise that the American public strongly supports health care coverage for all children and generally stands behind increasing government funding to cover children's health care needs; the detriments of inadequate preventive and emergency care to child development have been well-documented. If Congress is not in a position to guarantee health insurance for everyone, then children should be the group given its first priority for coverage, according to half of the respondents in a recent poll (22).





- In a Nov. 2006 poll conducted for the Georgetown University Center for Children and Families (CCF), 82% of voters said they wanted Congress to add more funding for SCHIP. Two-thirds of those in support of boosted funding supported increasing program funding to be able to cover additional children (56% of the total), while 26% of voters wished funding to remain at a level that would support the current number of enrolled children (16).

What health care leaders think

- Providing federal matching funds for Medicaid/SCHIP coverage for all people below 150 percent of poverty was the fourth-ranked health policy priority overall for health care leaders; academia and government/labor/consumer advocacy sectors ranked this second, while the priority was rated sixth or below by health care delivery and business respondents (12).
- A 2006 CCF report outlines several key issues in reauthorizing SCHIP (16):
 - Providing needed SCHIP funding
 - Protecting and strengthening Medicaid
 - Eliminating enrollment barriers
 - Promoting quality initiatives

State-level implications

- Coverage of low-income children has steadily increased as the SCHIP program intended; the improvement of state economies in 2005 permitted some states to relax previous restrictions that had slowed or decreased growth in SCHIP enrollment, and enrollment grew during 2005 in all but nine states. One third of states expanded access to Medicaid and SCHIP in 2006, and none cut income eligibility for those programs for the first time in four years (28).
- With improved fiscal conditions, a number of states, including Massachusetts, Pennsylvania, and Illinois, have approved significant coverage expansions for children under SCHIP, while several others currently are considering improving access to their SCHIP and Medicaid programs (16)(28).
- To compensate for the projected shortfalls (anticipated in 14 states, despite the last-minute infusion of funds from Congress (29), states will either need to boost their own state funding (likely through tax increases or other program cuts), or else curb their SCHIP programs by restricting eligibility, benefits, provider payments, or enrollment, or by stepping up cost-sharing for enrollees. Improvements to the program's financing structure at the federal level will not sufficiently resolve the problem of funding gaps if Congress flat-funds SCHIP during reauthorization (9).
- Significant numbers of low-income children could lose health coverage in states that scale back their programs; if SCHIP funding is frozen at FY 2007 levels through FY 2012, enrollment is estimated to fall by 1.5 million children. In addition, a few states – New Jersey among them – have extended coverage to certain adult populations, such as the parents of low-income children enrolled in Medicaid and SCHIP. These adults in states facing shortfalls could risk losing coverage, and cutbacks affecting SCHIP coverage of parents would likely lead to restricted or lost coverage for greater numbers of low-income children (9).





New Jersey

- New Jersey experienced a 10% growth in SCHIP enrollment from June 2004-June 2005, one of the largest increases across the states, compared to a 2.2% increase for the entire U.S. over the same period. The state covers children with family incomes of up to 350% of poverty, one of the highest eligibility levels in the country, and also extends coverage to their parents (NJ FamilyCare). Still, 10.9% of New Jersey's children are uninsured (29).
- New Jersey is one of the 14 states that will not have sufficient federal funding under SCHIP in FY 2007 to maintain existing SCHIP programs, with a projected shortfall of \$123 million (reduced from \$179 million after the redistribution of funds last year). These shortfalls have been projected by the Center on Budget and Policy Priorities, CMS, and the Congressional Research Service.
- New Jersey will face a \$214 million shortfall in federal SCHIP funding in FY 2008, and a \$331 million shortfall by FY 2012, assuming moderate expenditure growth and current rules for allocation and redistribution of funds across states (9).

Policy implications

- *What will be the effect on children's coverage in New Jersey if the program continues to be flat funded through FY 2007?*
- *If New Jersey is forced to reduce coverage of parents under SCHIP, what implications would this have for these adults' health care, as well as their children's coverage? What about the assumptions of the proposal for ensuring health insurance for everyone in New Jersey?*

CONCLUDING REMARKS

As is true in any given year, the health policy decisions made at the federal level will significantly influence the progress states can make toward health care system reform and expanded health benefits for their residents. Few challenges national and state lawmakers will likely confront in 2007 appear to be new concerns, and state legislatures in particular, while on average buoyed by rosier fiscal conditions, will face familiar tough decisions about resource allocations among competing priorities. On their own, the states, including New Jersey, are taking bold steps to attempt to improve access, cost-effectiveness, and quality within their health care systems. Maintaining and extending health coverage for children and parents will likely form the core of many health care policy debates in Congress and state capitols in 2007; it is unclear at this point how far these proposals might advance. Events at both levels of government have cleared the way for powerful changes to public health coverage programs this year and in years to come, but momentum at the state level will in many ways depend on sustained federal funding commitments. Meanwhile, the American public, with their eyes toward the next elections, will be closely watching the actions and words of elected officials and hopeful candidates with respect to the health policy topics that matter the most to them.





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