

**Report of the Health Care Task Force
to the
New Jersey Government Efficiency and Reform Commission**

September 5, 2007

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EXECUTIVE SUMMARY

In April 2006 Governor Jon S. Corzine signed an Executive Order creating the Government Efficiency and Reform Commission to advise his Administration "... on governmental restructuring, effectiveness, best practices, efficiencies, cost-saving measures, and how best to achieve economies of scale in the delivery of services and programs, at the lowest possible cost, consistent with mission and quality" (New Jersey Executive Order 9; April 7, 2006). In pursuit of this goal, the Commission convened a Health Care Task Force consisting of senior Administration officials and members of the public (see Appendix I for membership).

From September 2006 to February 2007, the task force undertook a broad review of New Jersey health spending, consulted with experts in state agencies and the private sector, and crafted 20 recommendations for improving the efficiency and cost-effectiveness of major state health programs. The recommendations primarily focus on the structure of health insurance plans and on lowering the cost to the state of prescription drugs and long-term care. This report reflects a robust discussion of policy options among the members of the task force with the recognition that some of the recommendations would require further analysis and refinement prior to implementation. One member did not fully embrace one of the recommendations. There was, however, a consensus among members on the need for the state to examine all of the areas identified.

In keeping with the Governor's charge to the GEAR Commission to seek efficiencies while maintaining the quality of services, the task force sought to achieve savings for the state and for local governments while minimizing negative impact on the availability and provision of health care for government employees and public program beneficiaries. The task force recommendations concentrate on structural changes that can lead to sustained cost containment. While mindful of the need to assure that access to and quality of services are maintained, the task force did not engage in detailed analysis of all of the possible repercussions of each recommendation.

The task force believes that some of the recommendations, such as increasing investment in disease management and health promotion initiatives, have unquestionable potential to improve the health of state program enrollees while reducing costs to the state. Other recommendations, such as improving management data for the Charity Care program, require initial investment of additional resources and are not likely to yield short-term savings, but should lead to improved care for the affected populations and more efficient program operations in the long term.

Formal analysis of probable cost savings from our recommendations was also beyond the scope of the task force's work. However, approximately \$190 million in annual recurring savings from the recommendations were identified by drawing on available analyses. A detailed enumeration of these cost estimates is provided in Appendix II. The task force could not make an estimate of the total potential savings from all recommendations because cost estimates were not available for many of them.

The programs addressed by the task force include the state health benefits system; the New Jersey Medicaid program; hospital charity care; mental health facilities; health provision through the department of corrections; pharmaceutical assistance for seniors and the disabled; and Veterans Affairs nursing homes. Many of the recommendations in this report are similar to those offered by other groups studying health issues in New Jersey, including the Benefits Review Task Force convened by Governor Codey in 2005.

(http://www.nj.gov/benefitsreview/final_report.pdf) as well as recommendations offered by Governor Corzine's Transition Team (http://nj.gov/governor/home/transition_reports.html).

The recommendations in this report focus on several types of spending and state health payment arrangements that could be improved to ensure:

- Appropriate drug prescribing and efficient prescription-drug purchasing
- Cost-effective and community-based provision of long-term care
- Fair and competitive restructuring of health plans for employees and retirees of the state and localities
- Employment of state-of-the-art disease management, high-cost case management, and health promotion to reduce health care costs by preventing illness and by improving the medical management of people with serious chronic illnesses and high-cost care

The task force concentrated on Medicaid and related programs for low-income populations and on the state health benefit plan, as these programs comprise nearly three quarters of New Jersey state spending on health care. The state is expected to spend \$14 billion on health care in fiscal-year 2007, including \$5 billion in federal match money for Medicaid. The remaining \$9 billion represents nearly 30 percent of the state's budget.

Of that \$9 billion, about 51% is spent on Medicaid and Medicaid-associated programs, while 22% covers active and retired public employees; these represent the two largest types of health spending. State health expenditures have risen considerably faster than other components of the state budget. For example, spending for government worker and retiree health benefits have increased 45% over the past four years, and spending for Medicaid and related programs has increased 27% (including both federal and state contributions) over the same period. In both the state health benefit program and Medicaid-related programs, spending on prescription drugs has risen faster than other areas; and within the Medicaid program, nursing home care is a second area of exceptionally rapid spending increase.

In developing recommendations, the task force relied on comparisons with other states, as well as best practices used in state Medicaid programs and public-employee health plans in other states, while recognizing that the conditions in these states vary from those in New Jersey. The task force sought statistics, advice, and direct input from various state agencies most directly involved in the provision and coverage of health care. The group also considered positive programs already being implemented by state agencies and has recommended expansion of these efforts, where appropriate. The recommendations yielded by this process not only reflect the study of other states and the guidance of state agencies within New Jersey, but also the identification of the main cost drivers and the most skewed incentives.

The task force aims for all relevant public officials and beneficiaries in New Jersey to take heed of the recommendations listed below and consider their feasibility, adoption, and the measures needed to implement them:

Medicaid and Related Program Recommendations

1. Maximize opportunities now available to states under the Deficit Reduction Act of 2005.

The federal DRA permits states to create new home and community-based waiver opportunities for long-term care populations and alternative Medicaid benefit packages for Medicaid clients without regard to comparability across covered populations. The state

should consider redesigning benefits in Medicaid and related programs to achieve cost savings without compromising access to or quality of care. Adjustments to benefit packages for higher-income eligible clients (primarily in NJ FamilyCare) should be made to minimize substitution for private coverage.

- 2. Investigate the feasibility of strategies for reducing prescription drug costs in Medicaid and other state programs while maintaining patient access to medically necessary drugs.** A broad range of strategies for controlling prescription drug spending have been adopted by other states and the private sector; New Jersey should investigate and identify those strategies that garner the greatest savings while preserving patient access to necessary prescription drugs. While the implementation of the Medicare Part D prescription drug benefit has reduced the state's liability for prescription payments (this reduction is significantly offset by "claw-back" payments to the federal government), implementation of prescription drug cost control strategies in state programs would result in additional savings. Strategies to reduce prescription drug costs include bulk purchasing, a preferred drug list, an aggregate negotiation program utilizing a Pharmacy Benefit Manager for certain populations, limiting pharmacy dispensing fees to a single fee for each 90-day supply for chronic illness medications, a tiered step-therapy approach for medically appropriate classes of drugs, moving prescription drug coverage that are currently paid on a fee-for-service basis for Medicaid managed care beneficiaries into managed care contracts, and required utilization of over-the-counter and generic drugs before brand names are dispensed when possible medically.
- 3. Expand the use of disease management and high-cost case management programs.** These strategies involve engaging medical care organizations, pharmaceutical companies and disease management vendors to coordinate and manage care for certain high-cost patients and patients with costly chronic conditions. In some instances, disease management vendors offer guarantee savings to the state. Such vendors should be carefully evaluated and engaged where appropriate. A formal partnership with the University of Medicine & Dentistry of New Jersey should be pursued to help lower the expenses of high-cost cases by managing these patients' care, as well as preventing patients from migrating to other states to seek expensive specialized care. Partnerships with the pharmaceutical industry should be sought to help finance independent care management programs.
- 4. Enable better coordination of Medicaid and Medicare benefits by encouraging enrollment of dually eligible clients into Medicare Advantage Programs.** This strategy would provide incentives for managed care plans that cover dual eligible clients to use state Medicaid resources prudently and avoid shifting costs from the federal Medicare program to New Jersey's Medicaid program.
- 5. Expand the Personal Care Assistance Program, which has been instrumental in allowing clients to remain in the community, often at work, and living independently, rather than in long-term care facilities.** Supporting services for persons with disabilities to remain in the community can lead to improved quality of life as well as reduce the cost to the state of institutionalization.
- 6. Accelerate the mandate to rebalance the Medicaid Long-Term Care system by reducing institutional care and increasing more cost-effective Home and Community Based Services.** The state should develop Medicaid program waivers, provide incentives to assisted

living, at-home care, and other resources for seniors and people with disabilities. When well managed, these strategies can reduce expenditures on expensive institutional care.

- 7. Implement a long-term care insurance partnership program.** The Deficit Reduction Act permits states to create insurance partnership programs whereby private long-term care insurance benefits can be used to preserve client assets that would otherwise have to be "spent down" before Medicaid eligibility for long-term care would be available. This strategy has the potential to reduce Medicaid long-term care expenditures over the long term by delaying spend down of family assets.
- 8. Evaluate the utilization of private managed care plans to administer long-term care services.** Other states have employed insurance firms to better control the rise in long-term care costs by monitoring patients in both institutionalized and home settings, managing their care, and making sure health expenses are appropriate; a capitation model could be used.
- 9. Develop support programs for family and neighborhood caregivers.** Even middle class individuals can rapidly spend their assets and become eligible for Medicaid long-term care services. The support of family and friends for persons with LTC needs who require assistance to remain in the community can help delay or prevent the need for costly LTC services.

State Health Benefits Program Recommendations

- 10. Restructure local governmental participation in the SHBP to restore fairness to workers, reduce administrative costs, and promote cost containment.** In fiscal year 2007, the state will spend \$747.5 million to finance health benefits of workers retired from local boards of education and county colleges, a practice that encourages rising health care costs, inefficient use of health care resources, unnecessary expenditure on state program administration, and creates gross inequities between these retirees and retirees from other units of government and the private sector. Strategies under this recommendation involve returning the amount the state currently spends to fund retiree health benefits to boards of education and county colleges along with responsibility for negotiating and managing retiree health benefits, differential premium rating for local government entities, and local-government flexibility to offer SHBP plans and modify premium-sharing.
- 11. Restructure State Health Benefit Program (SHBP) plan offerings to encourage enrollment in lower-cost plans while assuring access to a comprehensive array of plan options and vigorous competition among plans.** The SHBP Traditional plan does not employ standard cost containment strategies and should be replaced with a plan that offers a cost-effective network of providers (i.e., a Preferred Provider Organization) as well as payment for out-of-network services with significant member cost-sharing. Point of Service plan options that offer in-network and out-of-network coverage should be expanded by permitting HMOs within the SHBP to offer such plans. Fee schedules for out-of-network services in SHBP plans are currently reimbursed at rates above those of comparable private market plans and should be reduced.
- 12. Adopt commonly used cost saving measures for the reimbursement of prescription drugs.** These measures include a preferred drug list with a three-tiered co-payment structure, requirement of mail-order delivery for prescriptions for SHBP members (with appropriate

exceptions), mandatory generic substitution for drugs where clinically appropriate, and a thorough review of the drug-purchasing practices of member plans within the SHBP, with an eye toward implementing and rewarding more cost-effective measures. These practices follow those used in many other states.

- 13. Restructure member premiums to encourage enrollment in the most cost-effective plans.** SHBP members should share in the payment of the cost of all plans, with the lowest cost sharing for the least expensive comprehensive plan option; and the state should pay the same amount for all plans. Members who elect to cover family members should contribute some or all of the incremental cost above the single premium premiums.
- 14. Promote the effective medical management of SHBP members, promote utilization of recommended clinical preventive services, and promote member health generally.** Chronic disease management, high-cost case management, and requiring plans to use prescription drug best-practice models to ensure cost-effective prescribing can lead to improved care as well as cost savings. The state should work with New Jersey employers to identify strategies that have successfully reduced cost and improved quality of care through disease management and health promotion.
- 15. Adopt other structural changes in the SHBP to reduce inefficiencies.** End duplicate coverage for families with more than one SHBP-qualifying member; limit the number of HMO plans offered through the SHBP; assure effective competitive bidding of all plan options.
- 16. Require comprehensive fiscal impact analysis of any proposed changes to SHBP eligibility or coverage and periodically (e.g., every 3 years) compare the scope of benefits, premium structure, and other features of the SHBP with public employee health benefits in comparable states and with New Jersey private-sector employee benefit plans.**

Other Recommendations

- 17. Invest in a “Healthy New Jersey Program” addressing such chronic and high-cost problems as obesity, diabetes, high blood pressure, and other conditions that lead to avoidable medical care.**
- 18. The New Jersey Board of Medical Examiners should change requirements for the uniform prescription form to require mandatory generic substitution unless the prescribing provider specifically indicates that the brand alternative is medically necessary.**
- 19. The New Jersey Hospital Care Payment Assistance Program (Charity Care administrative procedures should be upgraded to increase efficiency, determine state-program eligibility for patients otherwise using Charity Care when they visit hospitals and clinics, and implement strategies for managing the care of frequent and high-cost Charity Care users.** The Charity Care program utilization data system should be modified to support analyses of cost, utilization, and care management. System improvements will require new resources in the near term with the expectation that the efficiency and effective of services will be improved over the longer term.

20. Conduct a thorough financial review of New Jersey's Veterans' (VA) Homes to ensure the most cost-effective operation of the facilities.

New Jersey health care programs have been slow to adopt cost-containment practices that are widely employed by the private sector and other states. Thus, significant savings are possible through the redesign of New Jersey's programs. The task force believes that adopting its recommendations would save significant resources for the state and for local governments while preserving the attractiveness of public employment in New Jersey and promoting fairness across groups of public employees and between the public and private sectors. In addition, many of the changes recommended in this report, including disease management and health promotion strategies, would lead to improved care. In a few instances, implementing task force recommendations would require modest up-front investment of new resources, for example to improve data systems and care management strategies, but we believe that these changes are essential for the long-term moderation of cost increases.

INTRODUCTION

In his 2007 Budget Address, Governor Jon S. Corzine announced the creation of a Government Efficiency and Reform Commission (GEAR). The Commission was charged with advising "...the Governor on governmental restructuring, effectiveness, best practices, efficiencies, cost-saving measures, and how best to achieve economies of scale in the delivery of services and programs, at the lowest possible cost, consistent with mission and quality" (New Jersey Executive Order 9; April 7, 2006). In pursuit of this goal, the Commission convened a Health Care Task Force (HCTF) consisting of senior Administration officials and members of the public (See Appendix I of this report for a list of Health Care Task Force members).

From September to December 2006, the HCTF undertook a broad review of New Jersey health spending and crafted specific recommendations for improving the efficiency and cost-effectiveness of major state health programs. In keeping with the Governor's charge to the GEAR Commission, the HCTF sought to achieve savings for the state and for municipalities while minimizing any negative impact on the availability and provision of health care for government employees and public program beneficiaries. The aim of the task force, therefore, was to identify inefficiencies and skewed incentives, and then to develop and recommend strategies to eliminate or curtail them. The task force recommendations concentrate on structural changes that can lead to sustained cost containment. The task force also sought to compare New Jersey health program strategies to those of other states to review whether promising innovations can be implemented here. To achieve its objectives, the HCTF met with staff members from relevant state agencies, reviewed practices in other states, and studied the most current health-policy research.

This report reflects a robust discussion of policy options among the members of the task force with the recognition that some of the recommendations will require further analysis and refinement prior to implementation. One member did not fully embrace one of the recommendations (see Appendix V). There was, however, a consensus among members on the need for the state to examine all of the areas identified.

The programs addressed by the task force include the state employee benefits system; the New Jersey Medicaid program and its charity care to hospitals; mental health facilities; health provision through the department of corrections; pharmaceutical assistance for seniors and the disabled; and three Veterans Affairs nursing homes. Given New Jersey's tight fiscal situation at

present and the need to revisit programs that have not been subject to comprehensive review in years, the task force was charged with seeking comprehensive reforms that would reduce the financial burden on the state while maintaining adequate levels of care for beneficiaries.

Nearly three quarters of state spending on health care in New Jersey is comprised of insurance programs that provide benefits for state and local employees and retirees and for low-income and disabled people through the Medicaid program and charity care. Of the \$9 billion in non-federal money spent by the state in fiscal year 2007, 51% will be spent on Medicaid and Medicaid-associated programs, while 22% will go to cover active and retired public employees; these represent the two largest types of spending. As a result of these large expenses and because certain other spending areas serve populations that are particularly vulnerable – such as the physically and mentally disabled and the impoverished elderly – the task force focused primarily on Medicaid and state benefits plan spending. However, the task force identified several other opportunities pertaining to state health spending and provision of health services that it believed should be addressed; recommendations for those areas are included below.

State Health Costs in New Jersey

New Jersey spending on health programs is substantial. The State of New Jersey is slated to spend about \$14 billion on health related benefits and programs in fiscal year 2007. Moreover, state health expenditures have risen considerably faster than other components of the state budget. For example, spending for government worker and retiree health benefits have increased 45% over the past four years, and Medicaid and related program spending, the state's largest health program for low income individuals and families, has increased 27% (including both federal and state contributions) over the four years from 2003 to 2006.

Of the \$14 billion in planned health for fiscal year 2007, \$5 billion is provided by the federal government, primarily in the form of Medicaid matching dollars. Of the remaining \$9 billion, about 29% came from the state general fund with the balance from special health-related revenue sources (e.g., casino revenue, tobacco taxes and hospital revenue surcharge). While New Jersey's health-related spending is not unusual, New Jersey ranks ninth in state health spending per capita, according to the Kaiser Family Foundation, and the state's health programs put significant and growing demands on taxpayers.

Of the \$9 billion in state spending that is not reimbursed by the federal government, about \$2 billion, or 22%, is spent on health, drug, and dental coverage for current and retired state and local public employees. Local governments spend another \$1.6 billion on health coverage through the State Health Benefits Program (SHBP), making it a \$3.6 billion system. In fiscal year 2007, for the first time in the plan's history, the SHBP will spend more on retirees than on active employees.

Appropriations for the state's share of Medicaid spending, administered by the Departments of Human Services (DHS) and Health and Senior Services (DHSS), are over \$4 billion. There are additional programs within DHS that serve vulnerable populations -- including services for persons with developmental disabilities (\$613 million), mental health and psychiatric facilities and programs (\$644 million), and NJ FamilyCare (\$253 million) -- bringing total health care-related spending within the Department of Human Services to \$3.93 billion, or 44% of state health spending.

The budget for the Department of Health and Senior Services totals \$1.8 billion, or 20% of state health spending. However, if the dedicated funding stream for charity care (\$522 million for fiscal year 2007) is included, the department's budget is actually \$2.3 billion, or 26% of total planned spending for this fiscal year. The Department's largest programs include nursing home payments for low-income seniors (\$720 million), pharmaceutical assistance programs for the aged and disabled (\$410 million; a portion of which is from the Casino Revenue Fund), the health care subsidy fund for additional charity care and hospital subsidies (\$115 million), medical day care (\$91 million), early childhood intervention (\$78 million), and funding for cancer research (\$61 million). Among the other substantial state health spending categories are \$165 million for correctional health services and \$285 million for child behavioral health services.

Overview of the Task Force Report

The following sections provide additional background on New Jersey Medicaid, the State Health Benefit Program and other programs, followed by recommendations for improvements in efficiency and cost savings in each area. The task force did not conduct formal estimates of potential savings from its recommendations, but recent cost estimates were available for many of the recommendations from state agencies and other sources. The task force identified

approximately \$190 million in potential annual savings where estimates were available. Because cost savings estimates were not available for some of the task force recommendations and some of the available estimates reflected conditions in earlier years, this total estimate should be viewed as conservative. About two thirds of the identified potential savings would derive from reforms to the SHBP with the remainder coming from Medicaid and related programs. (See Appendix II for further discussion of cost savings estimates)

While mindful of the need to assure that access to and quality of services are maintained, the task force did not engage in detailed analysis of all of the possible repercussions of each recommendation. Therefore, additional analysis of the potential impact of some of the recommendations on consumers and the state health system should be completed prior to their implementation.

Most of the savings identified by the task force would accrue from adoption of practices commonly used in other states and the private sector to manage prescription drug expenditures (e.g., employing preferred drug lists, requiring mail order, and mandating generic substitution when medically appropriate), with other significant savings coming from updating health plan design, ending dual coverage in the SHBP, and controlling long-term care costs. As medical costs increase by percentages in the double digits annually across the nation, many states have taken action to reduce the costs of prescription drugs, long-term care, and acute care for those with chronic conditions, particularly among Medicaid beneficiaries and public employees, as these programs represent the largest policy levers available to the state. Some states have reduced benefits while others have devised solutions to tie cost-sharing with utilization and to eliminate inefficiencies, and those will be described briefly below.

Some of the recommended strategies contained herein would not generate budgetary savings, at least in the near term, but could lead to improved program effectiveness, efficiency, or quality. In a few areas, the task force recommends that the state make modest new investments of resources in the near term, with the expectation that these outlays would reap cost savings and improvements in program efficiencies and effectiveness in the future. The task force aimed to take a long-term approach, reflecting the belief that improvements in behavior and chronic illness management can reduce health system utilization, and thus costs to the state, down the line, while helping to improve the lives of individuals enrolled in state programs.

The following sections provide additional background on state programs and detailed policy recommendations.

MEDICAID AND ASSOCIATED PROGRAMS

The Medicaid program provides health benefits for low-income families with dependent children, children under the age of 21, individuals 65 and older, and the blind and disabled (including those available for federal supplemental income assistance through SSI or SSDI). State residents in these categories with income at 100 percent of the federal poverty level (FPL) or lower are eligible for the program, which ranks as the 14th most generous parental requirement in the country. However, waivers under New Jersey's State Children's Health Insurance Program (SCHIP), most of which encompassed in NJ FamilyCare, permit some parents with income up to 200 percent of the poverty level to qualify (currently all parents up to 115% of poverty may enroll, a threshold that will increase to 133% in September 2007). Eligibility for children to qualify for NJ FamilyCare coverage through one of a few programs is typically at family income up to 350 percent of the FPL, tied for the most generous SCHIP eligibility level in the country, according to the Kaiser Family Foundation. Eligibility for SSI recipients is at 74 percent of the FPL or lower; eligibility for the permanently disabled who also work is at 250 percent of FPL or lower.

New Jersey Medicaid provides a 'General Assistance' program, or limited health benefits for single individuals whose monthly income does not exceed \$140 (or \$210 for those unable to work) and for couples without children whose monthly income does not exceed \$193 (or \$289 for those unable to work). The Medicaid system also provides various levels of medical coverage for certain lower-income patients, such as breast and cervical cancer patients, acute-care emergency services for non-U.S. citizens, pregnant women, and aged and disabled people who would not otherwise qualify for Medicaid because of excess income or resources.

Benefits for the elderly represent one of the largest services provided by Medicaid; the program reimburses nursing homes for residents whose income and assets do not exceed certain levels. The asset level is subject to resource "spend-down," in which potential beneficiaries can essentially unload assets in anticipation of receiving Medicaid long-term care coverage. There are several types of federal waivers to provide support care for seniors, as well as persons with disabilities, in their homes or in assisted living communities rather than requiring them to enter

nursing homes to receive long-term care benefits. Under federal rules, enrollment under home and community-based long-term care waivers is capped.

Other significant programs that complement Medicaid are Pharmaceutical Assistance to the Aged and Disabled (PAAD), Senior Gold, and charity care. PAAD (\$410 million) provides assistance with the payment of prescriptions for those 65 and older and disabled people with annual incomes under \$20,016 for individuals or \$24,542 for couples. Senior Gold (\$25 million) provides limited assistance for the purchase of prescription drugs by seniors in a higher income bracket than PAAD beneficiaries. Charity care is a combination of funding mechanisms for health care providers with a base level of \$583 million in state funds available to hospitals for uncompensated care and an additional \$203 million in related programs that provide support for hospitals and clinics that serve vulnerable populations, such as psychiatric facilities, HIV/AIDS care, and substance abuse centers.

Cost and Enrollment

The state spent \$8.57 billion on Medicaid and its associated programs in fiscal year 2006; 60 percent is state spending, the rest are federal matching funds. The state's total spending (state and federal contributions combined) on Medicaid and associated programs rose 27 percent from 2002 to 2006, from \$6.72 billion to \$8.57 billion. The growth in the state's share of costs for Medicaid and related programs (such as NJ FamilyCare and pharmacy benefit programs for seniors and persons with disabilities) grew slightly slower than the total spending (24 percent) during this period, from \$3.72 billion to \$4.6 billion.

Medicaid and related programs cover one million beneficiaries, about 70 percent of whom are enrolled in Medicaid managed-care plans. For these plans, the state contracts with HMOs and pays a fixed capitation rate for each beneficiary, who receives a base package of benefits comparable to the commercially available plans these insurers sell. Even for Medicaid managed care beneficiaries, some services, such as mental health care, are paid on a fee-for-service basis by Medicaid.

Though the managed-care option helps limit costs, particularly for prescription drugs and acute care, currently most of the high-cost beneficiaries are outside of the managed-care system, particularly the aged, blind, and disabled populations, whose benefits are the richest in the program. New Jersey has begun enrolling aged, blind and disabled Medicaid clients in managed

care, with the option for clients to opt out to sustain their existing relationships to providers. In addition, Medicaid covers scores of patients who have difficult-to-manage chronic diseases and visit providers on multiple occasions every year; they represent an extraordinarily high portion of the program's overall costs. For the most part, these high-cost beneficiaries have access to services on a fee-for-service basis without any managed care. These patients generate a disproportionate share of Medicaid costs; nationally, the 25 percent of patients represented by the aged, blind, and disabled populations typically account for about 75 percent of Medicaid program costs.

Analyzed by area of spending, prescription drugs and long-term care represent the program's largest costs. Medicaid spending in New Jersey (including federal matching funds) on prescription drugs approached \$2 billion last year, and spending on nursing facilities (exclusive of other long-term care services) was \$1.75 billion. Both types of spending have increased markedly between 2001 and 2005; drug spending increased 17.6 percent per year on average (excluding the share of capitation rates and inpatient hospital costs attributable to prescription drugs but also excluding rebates due from drug makers). The implementation of the Medicare "Part D" prescription drug benefit has reduced the state's liability for prescription costs. Beginning in 2006, clients eligible for both Medicaid and Medicare were enrolled in Part D, reducing the amount that New Jersey pays for prescription drugs for these individuals (the state currently pays for some prescription costs for 'dual eligible' clients that are not covered by Part D). In the current state fiscal year, the state share of the Medicaid program's spending for prescription drugs is projected to decline by \$479 million. However, while the state no longer manages a substantial portion of prescription drug costs for dual enrolled Medicaid-Medicare clients, savings have not accrued to the state. Specifically, New Jersey Medicaid savings from Part D have been offset by the loss of manufacturer rebates and state payments covering client Part D co-payments and drugs excluded from Part D (primarily behavioral health drugs). In addition, in fiscal year 2007, New Jersey is slated to pay \$274 million to the federal government for the so-called "claw back" to help the federal government finance Part D. In fiscal-year 2007, New Jersey is slated to pay \$274 million to the federal government for this purpose. Spending in New Jersey's Pharmaceutical Assistance for the Aged and Disabled (PAAD) program was also reduce with the introduction of Medicare prescription drug coverage, between state fiscal years 2005 and 2006 PAAD spending declined by \$25.8 million from a base of over \$380 million.

Additional savings to the state are expected in future years as the result of implementation of Part D.

Medicaid nursing home spending has also risen substantially recently. On average, nursing home costs between fiscal years 2001 to 2005 rose 4.35 percent per year (net of 2005 provider tax payments). Managed care capitation payments represent the third-largest cost, but those have remained relatively steady since 2002, and enrolling beneficiaries in managed care is believed to save costs overall. Additional data on Medicaid expenditure trends is presented in Appendix III.

Charity care is funded with a combination of state and federal funds through a Medicaid funding mechanism called the disproportionate share program. In New Jersey, disproportionate share payments represent 13.5 percent of total Medicaid spending, among the highest in the nation primarily because of state charity care spending for poor uninsured residents. Despite this significant commitment of public funds, the cost of charity care incurred by hospitals has outpaced state spending for these services. Over time, charity care costs (including the portion incurred by hospitals but not reimbursed by the state) could be reduced with improvements in the management of care for charity care patients and expansions of coverage for very low income residents. The charity care program currently lacks adequate administrative procedures and data systems to support needed care management improvements.

Comparison with Other States

State spending on Medicaid and its associated programs is relatively sizable even though neither enrollment nor spending per enrollee is high. Only 11 percent of New Jersey residents are enrolled in Medicaid, compared with 19 percent nationally. Spending per enrollee ranked 7th in the nation as of 2003, driven by high spending on the elderly and disabled, according to the Kaiser Family Foundation. However, New Jersey is an exception among states, as it does not plan to implement seven of the nine most often-used and substantial Medicaid cost-control mechanisms during fiscal-year 2007, and only employed three in fiscal-year 2006, according to Kaiser. And one of the strategies New Jersey is using in both years -- reducing payments to health care practitioners -- is no longer a viable policy option, as the state's Medicaid reimbursements to providers are already the lowest in the country.

Over the past five years, many states have implemented methods of cost-cutting that limit services for beneficiaries. Those strategies are manifold and affect different populations of Medicaid beneficiaries, but fall into general categories: stricter eligibility requirements, cuts to reimbursements for various providers, hurdles and restrictions in the Medicaid application and renewal processes (particularly relating to asset/income levels and to citizenship status), premium-sharing, initiation of or increases in patient cost sharing, and restrictions to certain types of benefits.

But other areas of cost-containment can have a lower impact on vulnerable patients. New Jersey prescription drug spending represents about 23 percent of Medicaid acute-care costs, far higher than Pennsylvania, New York, Massachusetts, or the U.S. average; but the state has not used a preferred drug list (one of only a dozen states without a PDL as of fiscal-year 2006, according to the Kaiser Foundation), a single-state or multi-state purchasing pool, or other aggressive actions to reduce drug prices paid for non-managed-care Medicaid beneficiaries. Many states have limited dispensing fees to pharmacists as low as the law allows, sought pharmaceutical rebates, or implemented maximum allowable cost programs that limit the prices Medicaid will pay for multi-source drugs.

Some states have pursued creative means of lowering growth rates for long-term care and support services costs. The primary method used is the expansion of home and community-based waivers granted for services to seniors and persons with disabilities, as the expenses for these services (such as assisted living and in-home care) are lower than institutional care (e.g., nursing homes and other facilities). However, increasing the number of community-based placement slots with waivers may simply raise total costs because more clients will seek them than just the population of clients with the greatest support needs, who opt for institution-based care. New Jersey and other states are pursuing strategies to constrain the potential cost-increasing effects of permitting more home and community-based options. Other approaches to cost control include reducing the number of beds in nursing homes or other facilities and freezing or reducing the per-diem reimbursement rates for institutional care. A change in the way long-term care is funded is also being explored by some states, both by providing incentives for the purchase of long-term care insurance and by involving private managed care companies in the care of long-term care populations.

Georgia employed a case-management program for frail elderly people and for persons with disabilities to prevent hospital and nursing-home admissions; the program uses primary medical care and supportive services such as case managers who make house calls and monitor beneficiaries. According to the National Governors Association, average costs for participants in this program were lower than for beneficiaries with home care services not coordinated with primary care (\$15,350 vs. \$19,751) and participants had fewer nursing-home placements and shorter length of hospital stays. New Hampshire created a similar program that provided two meals per day, personal care, housekeeping and laundry service, transportation to medical appointments and emergency response. Because the program targeted many seniors living in public housing for the elderly, the state was able to obtain funding from the U.S. Housing and Urban Development department, as well as money from the United Way and other organizations. The program saved \$8,100 per participant and prevented some nursing-home admissions, according to the University of New Hampshire.

Other states, such as Washington, Colorado, and Minnesota, have used targeted public-health campaigns, disease management, and case management for the chronically ill as part of holistic strategies to reduce long-term state costs. These programs typically target at-risk populations that would overlap with the Medicaid population; some have dedicated revenue streams, such as increased tobacco taxes, or investment from insurance and drug companies.

Medicaid and Related Program Recommendations

1. Maximize opportunities now available to states under the Deficit Reduction Act of 2005 (DRA) to reform and reshape Medicaid. The DRA permits states to create new home and community based waiver opportunities for long-term care populations (discussed further below) as well as to create alternative benefit packages for Medicaid clients, without regard to comparability across covered populations, “statewideness,” freedom of choice, or certain other traditional federal Medicaid restrictions. States may make these changes without waivers, through their Medicaid state plans. The Division of Medical Assistance and Health Services should continue its review of benefits now available to Medicaid and NJ FamilyCare clients to determine whether cost savings may be achieved by redesigning benefits without compromising access to or quality of care. Adjustments to benefit packages for higher-income eligible clients (primarily NJ FamilyCare) should be made to minimize

substitution for private coverage. That is, public program benefit packages should be designed so that they do not exceed plans in the private sector.

- 2. Investigate the feasibility of strategies for reducing prescription drug costs in Medicaid and other state programs while maintaining patient access to medically necessary drugs.** New Jersey should investigate and identify strategies used successfully in other states to reduce drug costs without reducing access to medically necessary prescription drugs for program clients. Such strategies should be examined, individually or in combination, to determine their potential savings.
 - a. **Investigate bulk purchasing of prescription drugs.** New Jersey is one of very few states that does not currently engage in bulk purchasing (alone or jointly with other states) of prescription drugs. Centralizing prescription drug purchasing for the Medicaid, PAAD/Senior Gold, Corrections and State Health Benefits Programs can lead to savings without reducing services to the state's beneficiaries. Furthermore, centralization (e.g., within the state Department of the Treasury) can reduce state administrative expenses. Multi-state purchasing programs for Medicaid and related programs provide an alternative strategy for reducing drug expenditures for those programs. The state should explore the tradeoffs between consolidating prescription drug purchasing among state programs versus joining multi-state purchasing efforts for Medicaid and select the most cost-effective approach.
 - b. **Limit pharmacy dispensing fees to a single fee for each 90-day supply for chronic illness medications.** Currently, pharmacies receive three dispensing fees for each 90-day supply. Medicaid, Senior Gold, PAAD, the Cystic Fibrosis program and the AIDS Drug Distribution Program now limit prescriptions to a maximum 34-day supply. This policy should change for chronic care drugs to permit more efficient (i.e., 90 day) dispensing.
 - c. More than 40 states have adopted or intend to adopt Preferred Drug Lists (PDL's) and negotiated agreements whereby manufacturers pay supplemental rebates to states in return for the state agreeing to cover that manufacturer's drugs under the Medicaid program. The state should investigate the potential savings and implications for patient

access to necessary drugs of a Medicaid preferred drug list, along the lines implemented in other states.

d. **Move coverage for prescription drugs that are currently paid on a fee-for-service basis for Medicaid managed care beneficiaries into the managed care contracts.**

Currently, many clients eligible for Medicaid because they receive federal supplemental security income or are aged, blind, or disabled are enrolled in managed care plans for most services but their prescription coverage is “carved out” and paid on a fee-for-service basis. The separation of drug coverage and managed care benefits does not encourage optimal management of health care resources. Prescription benefits for these populations should be included in the managed care benefit.

3. **Expand the use of assertive disease management and high-cost case management programs.**

a. **Engage disease management vendor(s) to provide statewide care coordination and disease management for high-risk patients with chronic conditions and provide guaranteed savings to the state.**

Nationally, less than 5% of Medicaid beneficiaries account for 50% of total Medicaid expenditures and the top 1% represent 25% of total Medicaid expenditures. Most of high-cost individuals have multiple chronic physical and behavioral health conditions and disabilities. Implementing an innovative chronic disease management program for this small but high-cost group of patients can result in more cost-effective care and improved quality of care. Chronic disease management programs identify high-risk patients with predictive modeling, guarantee a medical “home,” use interdisciplinary care teams, promote self management tools for consumers, and improve outcomes by using evidence-based medicine. The program would create savings equivalent to the costs of the contractor/vendor fees. The vendor would be at risk for guaranteeing medical and pharmacy savings equivalent to the cost of the program. The vendor would also be responsible for ensuring improved health outcomes. Potential pharmaceutical company support for the state cost of the program would offset state spending and produce savings. A comprehensive evaluation of the program would be conducted by an independent non-interested party to assess the program’s effectiveness.

- b. **Create a formal partnership the University of Medicine & Dentistry of New Jersey (UMDNJ) to improve quality and maximize cost-savings through the availability of necessary medical expertise.** Health services provided to Medicaid clients can be improved by partnering with UMDNJ to develop evidence-based guidelines for the care delivery system. The Division of Medical Assistance and Health Services should engage UMDNJ to develop high-cost case management strategies and to assist in reducing out-of-state hospital admissions and procedures, where appropriate. High-cost case management strategies should complement those developed through vendors providing guaranteed savings. They should focus on managing very high-cost cases and developing management tools to monitor clients and prevent acute episodes of a disease. (For example, clients with hemophilia account for a high level of program costs; many incur in excess of \$500,000 annually). UMDNJ should also be engaged to reduce out-of-state hospital admissions and medical procedures to take full advantage of in-state capabilities, where appropriate. Out-of-state care is used by some Medicaid clients with rare or complex illnesses. From October 2005 through September 2006, New Jersey paid \$42 million for out-of-state hospital care for the top three diagnoses (respiratory disorders, neonatal cases, and childhood mental disorders) for which such care was provided. New Jersey pays higher provider reimbursement rates for these cases than they otherwise would if the clients received care at in-state facilities, and the greater distance that clients and their families must travel for out-of-state care can be burdensome. Along with the development of an effective mechanism for managing cases in New Jersey, Medicaid should also consider requiring prior authorization for care provided out of state.
- c. **Encourage the pharmaceutical industry to partner with the state to help finance disease management programs.** Since at least 2003, New Jersey has attempted to garner fiscal and policy support for disease management initiatives from the pharmaceutical industry. Disease management generally enjoys wide support among pharmaceutical industry groups and is relatively inexpensive to implement. To date, New Jersey Medicaid has implemented two very limited disease management programs – both of which are funded by Eli Lilly and Co. The Division of Medical Assistance and Health Services should continue to seek the engagement of pharmaceutical companies to provide financial support for independent disease management vendors. This strategy should

complement those developed through vendors providing guaranteed savings and should be subject to independent, impartial evaluation.

- 4. Enable better coordination of Medicaid and Medicare benefits by encouraging enrollment of dually eligible clients into Medicare Advantage Programs.** This initiative would work in tandem with the recommendation (discussed below) to promote the use of private-care managed care to administer long-term care benefits. Encouraging the enrollment of clients in managed care plans covered by both Medicare and Medicaid who are not already enrolled in managed long-term care plans aligns incentives to use health care resources efficiently through better coordination of Medicare and Medicaid-funded services and will likely reduce Medicaid costs and improve care for the clients. Where feasible, the state should also encourage the development of Special Needs Plans. These plans, authorized under the Deficit Reduction Act, integrate Medicare and Medicaid funding streams for enrolled dually eligible clients, maximizing opportunities to coordinate care and achieve savings.
- 5. Expand the Personal Care Assistance Program.** This program has been instrumental in allowing clients to remain in the community, often at work, and living independently, rather than in long-term care facilities. In the absence of this program, many clients would be forced into a nursing home, thereby requiring more expensive care.
- 6. Accelerate the mandate to rebalance the Medicaid Long-Term Care (LTC) system by reducing institutional care and increasing more cost-effective Home and Community Based Services (HCBS).** Currently, 74% of all New Jersey Medicaid LTC clients receive care in nursing facilities and 26% through HCBS. The Department of Health and Senior Services (DHSS) has set a 50/50 target ratio to be achieved over the next decade. We recommend the following steps be taken to promote more rapid transition to home and community based services:
 - Facilitate timely Medicaid eligibility by expanding the new fast-track eligibility process to all counties. Rapid processing of Medicaid eligibility helps promote more HCBS utilization as HCBS providers are unwilling to assume the risk of providing care without being assured payment by Medicaid. This often results in the placement of the client in a nursing home. A pilot program underway in Warren and Atlantic

counties is being evaluated to determine if proxy measures, such as existing eligibility in other state or federal programs, can be used to accurately and quickly assess the client's financial status so as to enroll them in Medicaid, if eligible.

- Continue to control nursing home placements and expenses by declining requests to build additional beds. Redesign the nursing home reimbursement system to implement mechanisms that reward facilities with high occupancy.
- Redesign reimbursement policies to increase support for HCBS. Current rates for HCBS services have not been adjusted since 1999 and others have never been updated.
- Develop home and community-based options for clients with mental illness. Under the Deficit Reduction Act, states may develop HCBS programs for mentally ill clients. These programs are designed to promote wellness and recovery for this population, and enable additional opportunities for savings by diverting clients from avoidable institutionalization.

7. Implement a long-term care insurance partnership program. The Deficit Reduction Act permits states to create LTC insurance partnership programs whereby private LTC insurance benefits can be used to essentially preserve client assets that would otherwise have to be "spent down" before Medicaid eligibility for long-term care would be available. In addition to preserving the assets of potential LTC clients, this strategy has the potential to reduce Medicaid expenditures over the long term by delaying enrollment in the program. The state should work with the insurance industry to make people aware of the LTC insurance partnership initiative and its potential benefit, as uptake of LTC insurance has been limited.

8. Evaluate the utilization of private managed care plans to administer long-term care services. Other states have used or are planning to use private managed care companies to administer LTC benefits. Case management and oversight are critical to ensuring that costs are controlled and the most appropriate services are utilized. A full-risk capitation model would carry an inherent financial incentive to lower the costs of home and community based LTC services. In addition, as the demand for and use of HCBS grow, additional resources will be required to manage the services. Savings may result from both the administrative

(fewer public employees needed to manage the program) and service components of the program.

- 9. Develop support programs for family and neighborhood caregivers.** Even middle class individuals can rapidly spend their assets and become eligible for Medicaid LTC services. The support of family and friends for persons with long-term care needs who require assistance to remain in the community can help delay or prevent the need for costly LTC services. Without strong support networks, family members are more likely to be admitted to a nursing home and ultimately become eligible for Medicaid. This is particularly true in cases of Alzheimer's disease or dementia where the person's physical condition does not deteriorate at the same pace as their mental faculties and the stay at the nursing home could last for several years. We recommend that the state expand supportive "respite care" services targeted for the families of those with Alzheimer's disease or dementia and other disabling conditions.

STATE HEALTH BENEFIT PROGRAM

The State Health Benefit Program (SHBP) offers health insurance to state employees; to employees of local units of government and boards of education, including uniformed workers; to retired members of each of these groups; and to their dependents. First established in 1961, it is administered by the Division of Pensions and Benefits within the New Jersey Treasury Department. The state is financially responsible for the coverage of its employees and most of its retirees. Local government units and boards of education may opt to participate in the SHBP or may purchase coverage for their employees in the general marketplace. Some also elect to pay for coverage for their retirees; however, the state is required to pay the cost post-retirement medical coverage for most local education retirees and a portion of the cost for certain local police and fire retirees.

The SHBP offers three types of health plans to active employees, retirees, and their dependents: a point-of-service plan (called NJ Plus), a traditional indemnity plan, and health maintenance organization plans. The indemnity plan, which is no longer available to new active state employees but is available all local employees and retirees who participate in the SHBP, allows the choice of any medical provider or facility. Those state employees who remain eligible for the plan, and some state retirees, pay a premium amounting to 25 percent of the total

premium cost for the Traditional plan. HMO plans provide access to closed networks of participating providers managing care for the enrolled members. State employees enrolled in HMOs generally pay a five-percent premium while the state pays the rest. Currently, HMO products are available from Aetna, Cigna, Oxford, AmeriHealth, and HealthNet. The NJ Plus plan, currently administered by Horizon Blue Cross Blue Shield of New Jersey, is a point-of-service plan that uses a ‘gatekeeper’ approach, as out-of-network services are available with coinsurance and often deductibles. More than 65 percent of active state employees opt for the NJ Plus plan, which has no employee premium sharing and nearly free in-network services; the percentage enrolled has been rising steadily. Retirees more frequently opt for the Traditional plan, in part because education retirees do not share in payment of premiums and therefore choose the plan without network restrictions.

The SHBP provides separate plans for both dental care and prescription drugs. The dental plans include choice of an indemnity plan or prepaid HMO-like plans. The prescription drug plan for all state employees is administered by Caremark, a pharmacy benefits manager, through Horizon. Caremark employs the typical cost-control mechanisms of a pharmacy benefit manager, including obtaining rebates from manufacturers. Brand name prescriptions require \$3 and \$10 patient co-payments for a 30-day supply of generic and brand drugs, respectively; 90-day supplies are available through an optional mail order program and carry roughly 50% lower co-payments. Preferred drug lists with tiered co-payments are not used in the state employee prescription drug program, but do apply to all retirees enrolled in the SHBP.

Cost and Enrollment

SHBP costs are projected at \$3.6 billion in 2006, including about \$2 billion from the state and \$1.6 billion from local governments and boards of education. The state share was \$1.1 billion just four years ago. State officials cite the availability and use of more expensive drugs, payment for improvements in technology, the aging population, high health-system utilization, health plan design, and overall medical price inflation among the culprits for higher spending. The program included 804,000 beneficiaries as of June 30, 2006. Of those, about 150,000 are state employees and retirees, about 215,000 are local employees and retirees, and the remainder consists of dependents. The number of primary beneficiaries, or “contracts,” in the program has increased by about 20 percent since 2000; the number of local employees and retirees grew at a

faster pace than the number of state employees and retirees. Detailed enrollment and expenditure trends for the NJ SHBP are provided in Appendix III.

The number of retirees has been rising much more rapidly than the number of active employees. The number of retirees and their dependents for which the state is at least partially financially responsible has increased 11 percent annually since 2002 and totaled 108,310 in 2005, while the number of active workers and their dependents for which the state is at least partly responsible is up two percent annually over the same period and totaled 277,618 in 2005. The growth in retirees is driven primarily by the statutory obligation for board of education retirees who retire with 25 years of service credit or on disability retirement, who are permitted to receive any of the state health plans for free upon retirement even if they were insured by their local school districts outside the SHBP while they were active; 60,300 of the state-paid retiree direct beneficiaries are education retirees.

In general, retirees are costlier per person than active workers because of their age and rising number of both chronic diseases and acute illnesses. Overall, retirees and their dependents are expected to cost the state \$1.1 billion in fiscal year 2007, compared with \$962 million for active workers and their dependents, even though there are far fewer retirees. The per-enrollee cost for retirees and their dependents was \$8,413 in calendar year 2005, and had increased 26 percent annually since 2002, while the per-enrollee cost was \$3,569 for active workers and their dependents, and had risen 11 percent annually between 2002 and 2005, using Treasury Department statistics. New Jersey's state plan cost increases have generally outpaced those in other states. A 2002 study by the Kaiser Family Foundation showed that state health benefit program costs rose by 12.5% in 2002, similar to increases for active employees in New Jersey but much lower than per capita costs for retirees.¹ Moreover, the rate of cost increase for New Jersey presented in the Kaiser Foundation study (17.3%) was considerably higher than other Northeastern states with similar economic and demographic composition (MD 3.9%; MA 11.0%; NY 11.5%; PA 8.3%).

¹ Kaiser Family Foundation and Health Research and Education Trust, 2002 State Employee Health Plans, available at <http://www.kff.org/insurance/upload/Kaiser-HRET-Survey-2002-State-Employee-Health-Plans-Report.pdf>.

Comparison with Other States

The cost structures of the insurance plans offered through the New Jersey program are also more generous than those of nearby states (see Appendix IV for New Jersey benefit comparisons to neighboring states). While the NJ Plus plan carries no employee premium share, New York state employees are not offered any free plans; Pennsylvania did have PPO and HMO plan options that required no premium, but employees hired after 2003 pay one percent of their base pay. Furthermore, New Jersey's retiree plans in general require less cost-sharing than those of nearby states, particularly because of the free benefits offered retiring board of education employees and uniformed workers. While cost sharing in New Jersey plans is similar to other states for physician visits and hospital stays, New Jersey pays a much higher proportion of the total premium compared to other states. On average, state employers across the country paid for 91 percent of the premium cost for single coverage in 2006 and 81 percent of the premium cost for family coverage for actives; New Jersey pays about 97 percent of the premium costs for active workers and their families overall, based on New Jersey Division of Pensions & Benefits statistics on enrollment numbers and plan designs. In general, the more generous health benefit contribution rates in New Jersey are not offset by reductions in other forms of compensation. For example, wages for New Jersey public employees modestly exceeds that of comparable private sector workers according to a recent Rutgers study, and New Jersey public employees are compensated competitively compared with public employees in other states.

Given the rising expense of purchasing health care goods and services and tightening state budgets, several states around the country have attempted to curtail health costs by reducing benefits, increasing cost-sharing, or altering the structure of the health plans they offer. Arkansas, Florida, Kansas, Oklahoma, South Carolina, South Dakota, and Utah have offered health savings accounts to their state employees; these plans typically include high deductibles and use pre-tax dollars to purchase care. Florida and Michigan, among other states, have established preferred provider organizations (PPOs) as the primary and most attractive choice for public employees; these plans impose cost-sharing and ensure that beneficiaries are sensitive to utilization outside the specified networks, but they generally do not require patients to seek approval from a primary care "gatekeeper" for access to specialty care or out-of-network providers.

Minnesota has established a plan that uses different tiers of co-payments and deductibles that differentiate between physician clinics based on the cost and quality of their services; patients who choose doctors in the plans' preferred tiers typically pay lower insurance premiums or co-payments. California, through the CalPERS public-employees system, has made a number of structural changes since 2003, including regional premium pricing for local employees, teachers, and other regional agencies; dropping coverage for 23 hospitals, mostly in the Sacramento area, that were underperforming; and excluding some insurers so that only the most efficient plans were offered to state employees through a competitive bidding process. State legislators in California are mulling cuts to payments to higher-cost doctors in the state PPO and raising emergency room and physician-visit fees. Several states have engaged in pooled-purchasing arrangements for all state health purchasing of drugs and medical devices and have implemented wellness and disease management programs to reduce unnecessary utilization.

State Health Benefit Program Recommendations

10. Restructure local governmental participation in the SHBP to restore fairness to workers, reduce administrative costs, and promote cost containment.

- a. **Return responsibility for structuring and financing retiree health benefits to boards of education and county colleges – currently a state expenditure of \$747.5 million in fiscal year 2007 – and eliminate direct state financing of these benefits.** These funds support coverage for over 60,000 retired board of education and college employees, more than twice the number of workers retired from state service for which the state funds coverage within the SHBP. Currently, the state fully funds health coverage for these retirees, a practice that encourages rising health care costs and inefficient use of health care resources, and creates gross inequities between these retirees and retirees from other units of government and the private sector. Moreover, under the current structure, local boards of education and colleges responsible for negotiating salaries and benefits for employees lack accountability for this expenditure, which is both large in absolute terms and a high proportion of employee compensation. Between 2002 and 2006, state spending per retiree in the SHBP, including retired local education employees, has risen an unsustainable 25% per year. Most retired board of education employees enroll in the Traditional plan, with its high and unmanaged expenses. These employees do not share

in the cost of premiums, as do most other retired workers throughout the economy. The cost of enrollment in the Traditional plan in 2007 for retired education workers (\$15,615 per year) is nearly one third greater than enrollment in an HMO plan (410,748) and 14% greater than enrollment in NJ Plus (\$13,397). (Other retired state workers with 25 or more years of services or who retire on disability are subject to premium-sharing only if they enroll in the Traditional plan). The state should return the value of its current contribution for these retirement health benefits to the local boards of education, and local boards should manage retiree benefits as part of their comprehensive benefit negotiation strategies. The amount that the state returns to the local boards could be indexed to measurements of health-plan cost increases.

- b. **Premiums for local governmental entities opting to enroll their current or retired workers in the SHBP should be established under the same rating practices that these units face in the private market.** Under current practice, local governmental entities with low expected costs (e.g., because they have a comparatively young work force) have an incentive to leave the SHBP to obtain premiums closer to their expected medical costs. Consequently, local entities remaining in the SHBP have experienced rising costs. This dynamic is likely to continue, increasing the health benefit costs of local entities with older and less healthy workforces. Establishing variations in premiums within the SHBP that mirror practices permitted in the private market would eliminate the incentive for local entities to exit the SHBP. Such a strategy would ultimately *reduce* the cost of health benefits for local entities with favorable claims experience, because the SHBP has significantly lower administrative costs than commercial carriers (the cost of private insurance broker commissions, premium taxes, and cost of capital can add approximately 15% to costs compared to the SHBP). In redesigning the way local entities are charged for participation in the state program, the SHBP should take steps to assure that localities with especially high expected costs do not experience excessive premium increases.
- c. **Permit local governments the flexibility to offer selected SHBP plans and to modify employee premium-sharing requirements.** Currently local governments and boards of education are not permitted to establish member premium-sharing requirements or to limit enrollment to a subset of SHBP plan offerings. The SHBP should permit local

entities flexibility to encourage enrollment in low-cost plans and to alter premium-sharing as they see fit.

11. Restructure the SHBP plan offerings to encourage enrollment in lower-cost plans while assuring access to a comprehensive array of plan options and vigorous competition among plans.

- a. **The SHBP Traditional plan should be replaced with a Preferred Provider Organization (PPO) plan for active and retired employees.** The Traditional plan offered through the SHBP is an antiquated form of coverage, and most employers have stopped offering pure indemnity plans of that type. State workers who began their service after July 1, 2003 are no longer eligible to enroll in the Traditional plan, but many current and retired participants remain enrolled in this plan. In keeping with market trends, the PPO should have a significant cost-sharing differential between in- and out-of-network services (e.g., low deductible and 20% member co-payment for in-network services and \$500 deductible and 50% co-payment for out-of-network services) to encourage members to remain in network while maintaining access to out-of-network services. In addition, the PPO should have a national network to assure that retirees in the SHBP who leave the area have access to full in-network services.
- b. **Permit HMOs within the SHBP to offer a Point of Service (POS) option.** Permitting HMOs to compete for enrollment by offering a POS option would create new options for SHBP enrollees. Current SHBP enrollees are limited to the POS network offered by NJ Plus. Moreover, as the only POS plan in the SHBP, NJ Plus is not subject to competition, which can stifle innovation and limit plan choice. HMOs with POS options should be permitted to compete with NJ Plus or, alternatively, NJ Plus could be phased out and replaced with competing POS options. This strategy will assure a broad range of cost-competitive options for SHBP members.
- c. **Out-of-network services covered in any SHBP plan should be reimbursed at rates similar those of private market insurers.** Currently, SHBP services within the Traditional plan and out-of-network services within NJ Plus are reimbursed at 90% of the Prevailing Healthcare Charges System (PHCS), significantly higher than private insurance reimbursement rates. The SHBP should require its plans that cover out-of-

network services to reduce their reimbursement rate to 70% of PHCS, more in line with industry standards. The payment schedules for these plans should be reviewed annually, and further adjustments should be made as needed to assure that they are comparable to conventional private reimbursement payment rates in the future.

12. Adopt commonly used cost saving measures for the reimbursement of prescription drugs.

- a. **Require mandatory generic substitution for prescription drugs where clinically appropriate.**
- b. **Require of mail order delivery for prescription drugs for SHBP members.** An appropriate grace period should be permitted for new prescriptions along with other exemptions to assure that members are able to fill prescriptions locally in a timely way in case of unforeseen events.
- c. **Implement a preferred drug list (PDL) and three-tiered co-payment structure for outpatient prescriptions dispensed under the SHBP.** Following practice around the nation, drugs should be reimbursed on a three-tiered co-payment schedule so that a comprehensive range of drugs would be available to members, but members would pay the least out-of-pocket for generic and preferred brand drugs.

13. Restructure member premiums to encourage enrollment in the most cost-effective plans.

- a. **SHBP members should share in the payment of the cost of all plans, with the lowest cost sharing for the least expensive comprehensive plan option; and the state should pay the same amount for all plans.** This level-contribution strategy will encourage enrollment in the lowest-cost plans while maintaining comprehensive plan options. The state contribution level could be indexed to a percentage (e.g., 90% or 95%) of the fair actuarial value of the lowest-cost plan. This strategy would create at least one low-premium option for all employees and retirees. All plan offerings, including low-premium options, should be required to meet high quality-of-care benchmarks.
- b. **All SHBP members enrolling in family coverage should be required to share plan costs.** Consistent with conventional practices in the private sector and other states, SHBP

members who elect to cover family members should contribute some or all of the incremental cost above the single member premiums. As with single member coverage, a level-contribution strategy should be adopted for family coverage.

14. Promote the effective medical management of SHBP members, promote utilization of recommended clinical preventive services, and promote member health more generally.

- a. **Deploy state-of-the-art chronic disease management and high-cost case management.** Patients with chronic diseases (e.g. asthma, cancer, cardiovascular disease and diabetes) account for most health care spending as well as for most of the increases in spending, yet overall, patients receive only about 50 percent of the clinically recommended care. Disease management and high-cost case management are widely used in the private sector and are offered within many of the SHBP plans. The state should work with New Jersey employers to identify disease management and health promotion strategies that have successfully reduced cost and improved quality of care. While it is not clear how much or how quickly these strategies can reduce costs, it is likely that they would improve care for the affected enrollees. Studies have shown that disease management has the potential to reduce hospitalization, and to exact better health care value and better outcomes. A Kaiser Family Foundation Study found that 65 percent of all covered workers are in a plan with at least one disease management program. All participating SHBP plans, including the Traditional plan if it is retained, should be required to have such programs.
- b. **Require plans in the SHBP to employ prescription drug best-practice models to ensure cost-effective prescribing.** The SHBP should require plans to develop strategies to encourage prescribing of the lowest cost and most effective drugs. Such strategies involve profiling prescribing practices and may include denying network membership to providers with inappropriate prescribing patterns.

15. Adopt other structural changes in the SHBP to encourage efficiency.

- a. **End duplicate coverage for families with more than one SHBP-qualifying member.** Duplicate state coverage for married couples permits families to reduce their cost-sharing and circumvent cost controls.

- b. **Limit the number of HMO plans offered through the SHBP and assure effective competitive bidding for plan participation.** Limiting the number of HMO plans offered through the SHBP would provide incentives for plans to offer their services at the lowest price or risk being excluded from the program. All plans offered through the SHBP should continue to be required to meet high standards of network adequacy and quality of care.

16. Assure ongoing review of the SHBP and encourage future improvements in efficiency and benchmarking to prevailing practices.

- a. **Require comprehensive fiscal impact analysis of any proposed changes to SHBP eligibility or coverage.** This requirement should extend to new legislation as well as regulatory or other proposed changes. Fiscal impact analysis is particularly important as the public-sector compensation in New Jersey now exceeds private-sector compensation in most comparisons.
- b. **Periodically (e.g., every 3 years) compare the scope of benefits, premium structure, and other features of the SHBP with public employee health benefits in comparable states and with New Jersey private sector employee benefit plans.** Additional changes to the SHBP should be made to assure that its design keeps pace with conventional practices in the sectors with which New Jersey competes for workers. This review should take into account the total compensation of workers, including wages, health and other benefits and should be directed at maintaining efficient plan design as well as competitiveness of compensation packages. Comparisons should be published for full transparency.

OTHER STRATEGIES

While Medicaid and the State Health Benefit Program represent the largest sources of state expenditures on health services, the task force recommends policy initiatives addressing health care costs system-wide and in other high-cost program areas. These are described below.

Recommendations

17. Invest in a “Healthy New Jersey Program.” Review existing approaches to addressing obesity, diabetes, high blood pressure and other conditions that lead to avoidable and costly medical care. Determine if they need to be supplemented or restructured to assure they result in lower healthcare costs and improved healthcare services. These efforts should dovetail with proposed disease management programs described above.

18. The New Jersey Board of Medical Examiners should change requirements for the uniform prescription form (i.e., “prescription blank”) to require mandatory generic substitution unless the prescribing provider specifically and explicitly indicates that the brand is medically necessary. New Jersey’s generic dispensing rate is among the lowest in the nation. Most states have provisions requiring medically appropriate generic dispensing, according to the Generic Pharmaceutical Association. This recommendation would reduce cost for consumers, private insurers, and employers, as well as government.

19. The New Jersey Hospital Care Payment Assistance Program (Charity Care) administrative procedures should be upgraded.

- a. **Procedures for determining eligibility for Charity Care should be integrated with eligibility determination for Medicaid and NJ FamilyCare.** It is possible or even likely that some Charity Care users are eligible for but not enrolled in Medicaid or NJ FamilyCare. The Charity Care program is intended to be the payer of last resort, and should not be funding care for those eligible for other programs. Federal matching funds available for Medicaid and NJ FamilyCare beneficiaries provides an important source of revenue in New Jersey for care of low-income populations. Moreover, Charity Care supports only individual episodes of care within hospitals, while enrollment in Medicaid or NJ FamilyCare provides beneficiaries with coverage for a more comprehensive range of services, affording them better access to care.
- b. **The Charity Care program utilization data system should be modified to support analyses of cost, utilization, and care management.** Currently, the Charity Care administrative data system lacks identifiers for individual charity care users. As a consequence, this data set cannot be used to identify frequent charity care users, nor can it be linked to information from other state programs serving this population. Analysis of frequent and high-cost users of care is essential for designing strategies for cost and care

management. In addition, linkage of Charity Care to other state data systems, such as information on persons released from state correctional facilities, can be used to develop effective care coordination strategies and prevent recurrences. System improvements will require new resources in the near term with the expectation that the efficiency and effective of services will be improved over the longer term. Data system modifications should incorporate state-of-the-art patient privacy and data security mechanisms.

- c. **Strategies for managing the care of frequent and high-cost users of Charity Care services should be developed and implemented.** Five percent of *episodes* of Charity Care use account for half of all Charity Care utilization, and it is likely that a small group of frequent Charity Care users accounts for a large proportion of expensive episodes of care. Case management strategies should be developed for identifying and managing these individuals and coordinating their care with other available resources (e.g., substance abuse and mental health treatment programs). Dedicating a portion of the existing State Charity Care funds to high-cost case management would likely achieve a high return on investment, saving the state and hospitals significant revenue.

20. Conduct a thorough review of New Jersey's Veterans' (VA) Homes to ensure the most cost-effective, high-quality operation of the facilities. The three veterans' nursing homes spent \$83 million in 2006, \$51 million of which is state money, for their 900 patients, representing a higher per-resident operating cost than average nursing homes. These homes are not subject to strict financial audits, and a thorough review of their operations is necessary. The higher cost of these homes is due, in part, to the higher daily rates paid by the state than for Medicaid patients. We recommend that, if appropriate after a thorough review, a freeze/reduction should be imposed for the VA per diems so long as quality of care can be maintained at high levels. (Lower spend-down thresholds should be considered for qualification to these homes, as the thresholds are currently higher than the norm.) In addition, veterans should be encouraged to apply for Medicaid, when eligible, to reduce the overall cost to the state, as Medicaid daily rates are lower than VA rates.

APPENDIX I: Health Care Task Force Members

Ms. Holly Bakke
Former Commissioner
Department of Banking and Insurance

Mr. Clarke Bruno
Special Counsel
Office of Governor's Counsel
Office of the Governor

Ms. Kathleen Buto
Vice President for Health Policy &
Government Affairs
Johnson & Johnson

Dr. Joel Cantor (Task Force Chair)
Professor of Public Policy &
Director, Center for State Health Policy
Rutgers University

Ms. Annette Catino
President & CEO
QualCare, Inc.

Ms. Hazel Gluck
Partner
MBI-GluckShaw

Mr. Steve Goldman
Commissioner
New Jersey Department of Banking and
Insurance

Ms. Katherine Grant-Davis
Executive Director
New Jersey Primary Care Association

Ms. Heather Howard
Policy Counsel
Office of The Governor

Dr. Fred Jacobs
Commissioner
Department of Health and Senior Services

Dr. Robert Johnson
Interim Dean, New Jersey Medical School
University of Medicine and Dentistry of New
Jersey

Mr. David Kostinas
Principal
David Kostinas & Associates

Dr. Carol O'Cleireacain
Former Deputy State Treasurer
Department of the Treasury

Dr. Stephen A. Somers
President
Center for Health Care Strategies, Inc.

APPENDIX II: Summary of Cost Saving Estimates

Cost savings estimates were available for some of the recommendations in this report. These estimates come largely from recent work conducted by or for managing state agencies. Below is a summary of those estimates. Care should be taken in applying these estimates to the recommendations of the task force, as some time has passed and costs have continued to escalate. In addition, strategies used in implementation of the recommendations or combinations of recommendations can affect the extent to which cost savings are realized. Moreover, recent policy changes (e.g., implementation of Medicare Part D) will reduce potential savings for some populations.

In general, the identified savings should recur or even increase annually compared to retaining the status quo. In some instances, initial investments of new resources would be required to develop system changes or fund new cost-reducing program strategies, with savings coming in later years. All savings identified below represent savings to the state.

Medicaid and Related Programs

Identified savings (total of approximately \$59 million):

- Preferred drug list in Medicaid and General Assistance - \$30.7 million*
- Preferred drug list in pharmaceutical assistance programs - \$6.2 million*
- Medicaid long-term care reforms (rebalancing away from institutional to home and community based services) -\$20 million
- Reduce Medicaid out-of-state utilization where capacity exists in state - \$2.1 million (5% of the \$42 million that New Jersey spend on out-of-state care)

Areas without previous cost estimates but with likely savings opportunities:

- High-cost cast management
- Expand personal care assistance program
- Managed care for long-term care services
- Enable better coordination care of Medicaid and Medicare dual eligible clients through joint enrollment in Medicare Advantage plans and developing Special Needs Plans

Other areas of improved program efficiency or effectiveness without short-term savings:

- Disease management programs
- Implement benefit changes under the Deficit Reduction Act
- Long-term care insurance partnership program
- Develop caregiver support programs

State Health Benefit Program

Identified savings (total of approximately \$131 million)

- Replace SHBP Traditional and NJ Plus with a Preferred Provider Organization - \$40 million
- Preferred drug list in the SHBP - \$38 million
- Mandatory generic substitution and prescription mail order - \$35 million
- End dual coverage in SHBP - \$18 million

Areas without previous cost estimates but with likely savings opportunities:

- Return responsibility for funding and managing local education and college retiree benefits to local entities (initial savings would depend on the level of transfers from the state to localities, but anticipated increases in enrollment in lower-cost plans and possible employee premium cost sharing could lead to considerable savings)
- Requiring contributions to all plans with level-premium contribution by SHBP
- Requiring members to pay all or most of incremental cost of family coverage
- High-cost cost management

Other areas of improved program efficiency or effectiveness without short-term savings

- Limiting number of HMO plans
- Promoting prescribing best practices
- Disease management
- Health promotion
- Permitting HMOs to offer point of service options
- Regular fiscal review of future SHBP changes and re-benchmarking every three years

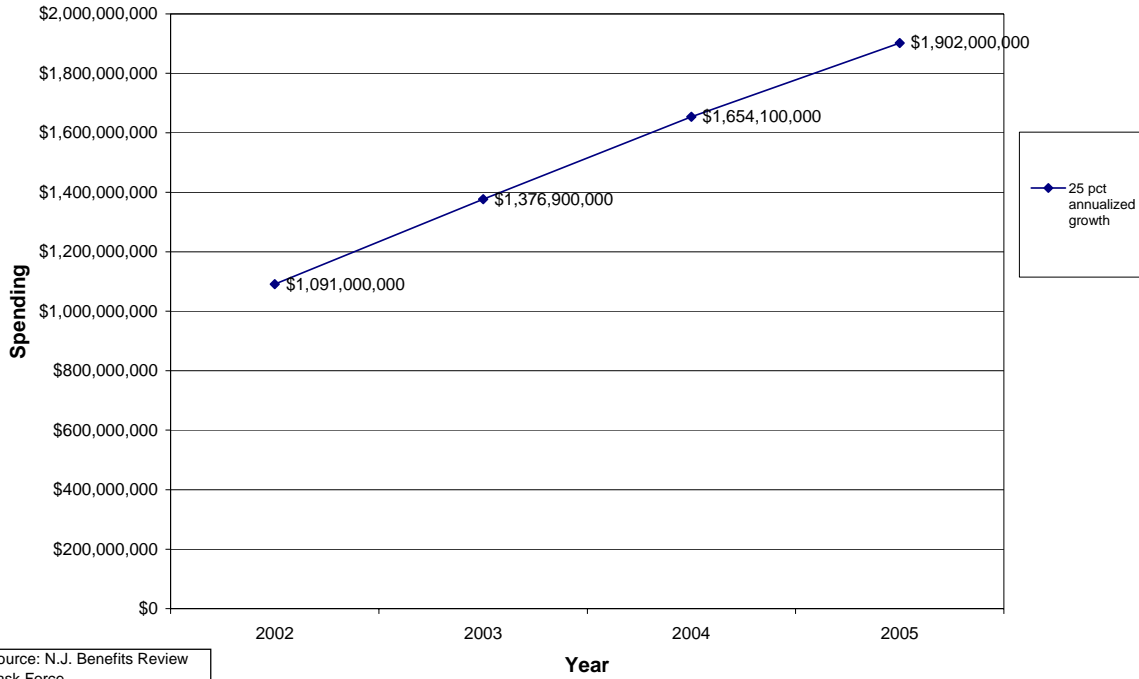
Other Recommendations

- Healthy New Jersey Program – will require initial investment, with potential savings in the long-term
- Require mandatory prescribing of generic drugs unless medically necessary – likely to lead to significant savings in the near term for public and private purchasers of prescription drugs
- Improve data systems and administrative procedures in the Charity Care program – will require in initial investment in system improvement with potential for significantly improved care and better cost management in the future.
- Financial review of New Jersey VA homes – significant potential for recurring state savings

* Savings from implementing cost controls within Medicaid, PAAD and related programs will be less than previous estimates suggest because state liability for these programs was reduced in 2006 as the result of the implementation of the Medicare Part D prescription drug program.

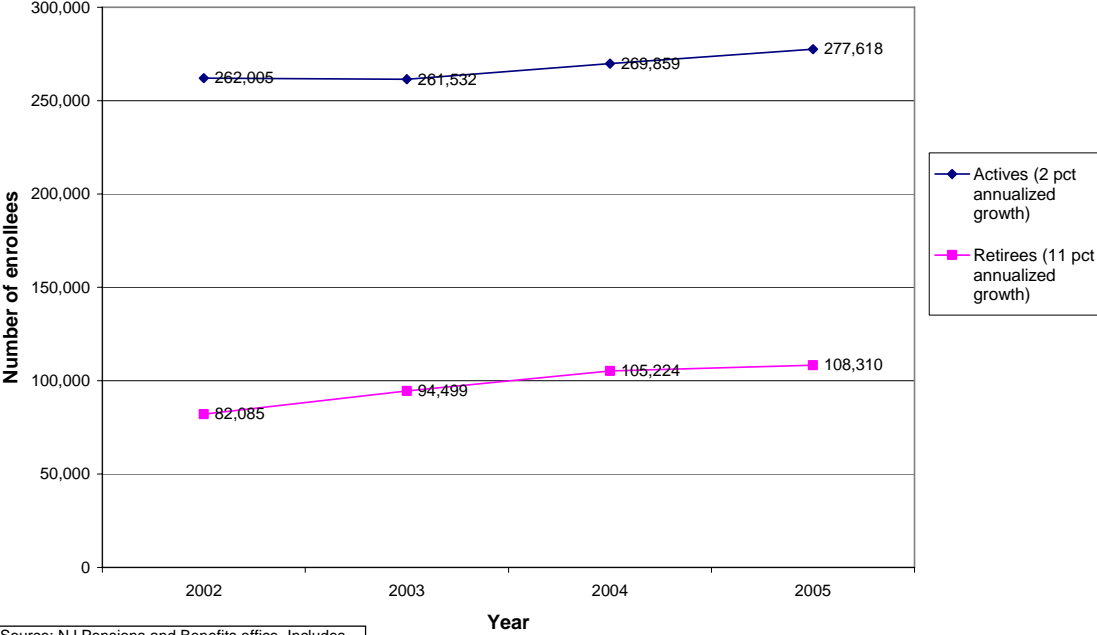
APPENDIX III: State Program Enrollment and Spending Trends

Figure 1: Growth in NJ Total State Health Benefits Plan Expenditures is soaring



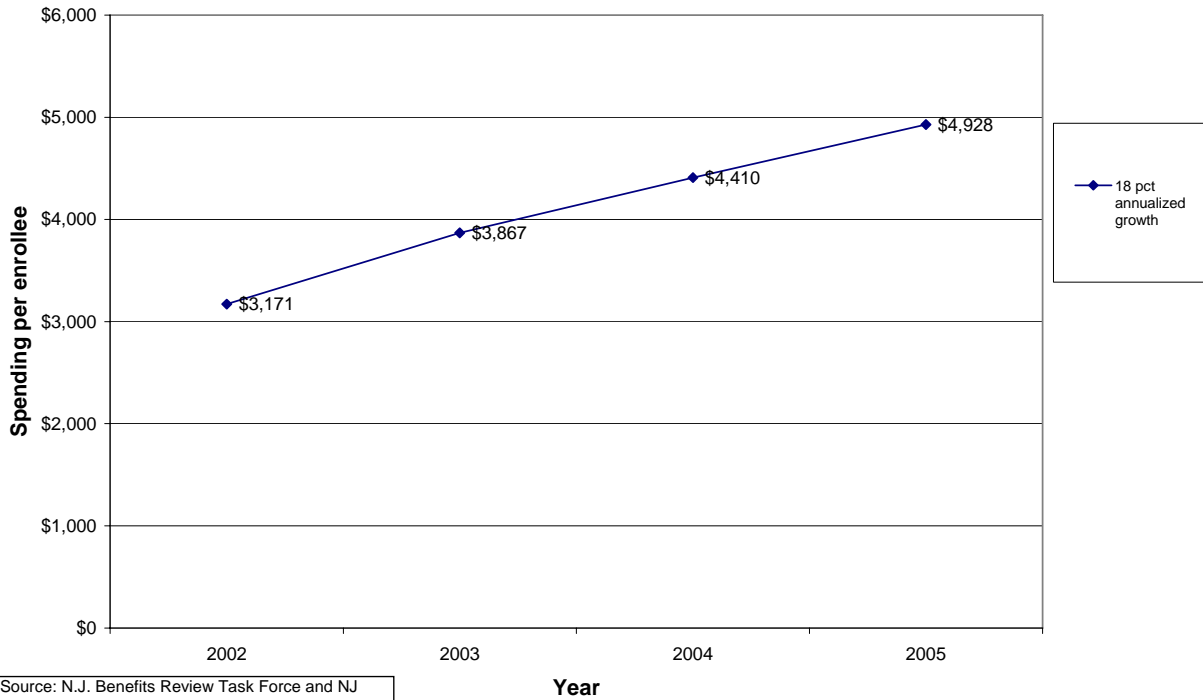
Source: N.J. Benefits Review Task Force.

Figure 2: Active and Retired State Health Benefit Plan Enrollment



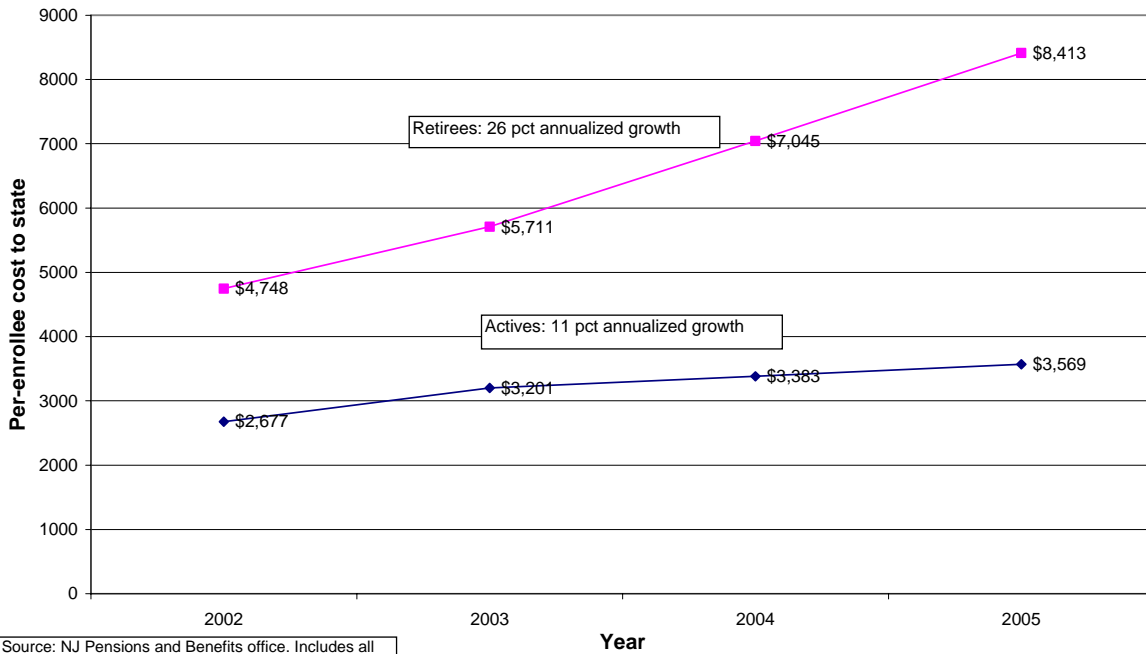
Source: NJ Pensions and Benefits office. Includes all SHBP-covered dependents of actives and retirees. Excludes enrollees who pay for their entire premiums.

Figure 3: Per-enrollee SHBP Spending



Source: N.J. Benefits Review Task Force and NJ Pensions and Benefits Office. Includes SHBP-covered dependents of actives and retirees.

Figure 4: Per-enrollee Cost for Active Employees & Retirees and their Dependents



Source: NJ Pensions and Benefits office. Includes all SHBP-covered dependents of actives and retirees. Excludes enrollees who pay for their entire premiums.

Figure 5: Medicaid Enrollment as a Percentage of Population

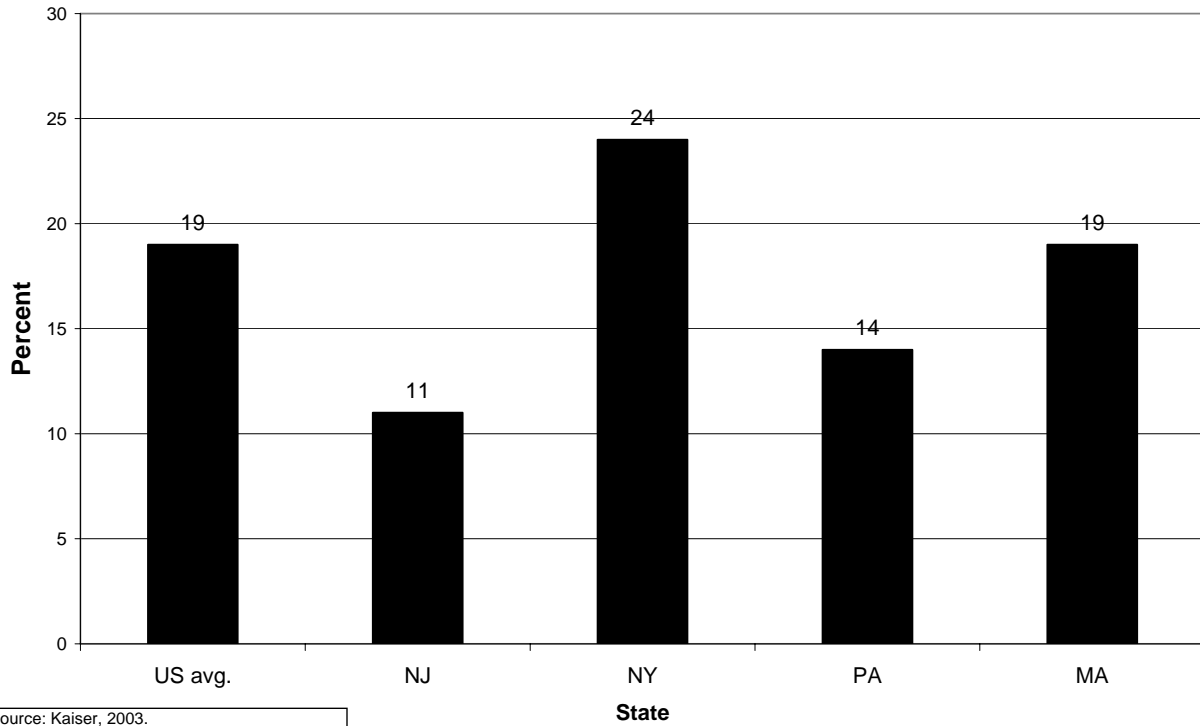


Figure 6: Annual NJ Medicaid Spending per Enrollee

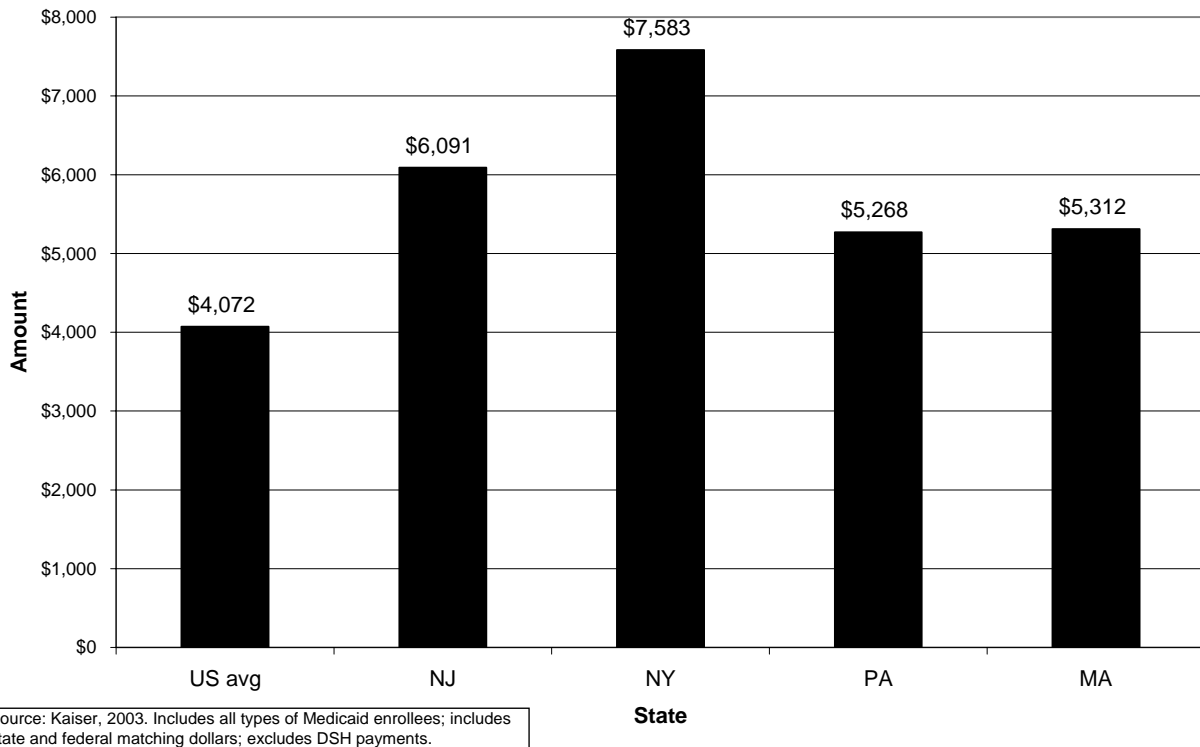


Figure 7: Long-term Care Spending as a Percentage of Medicaid Spending

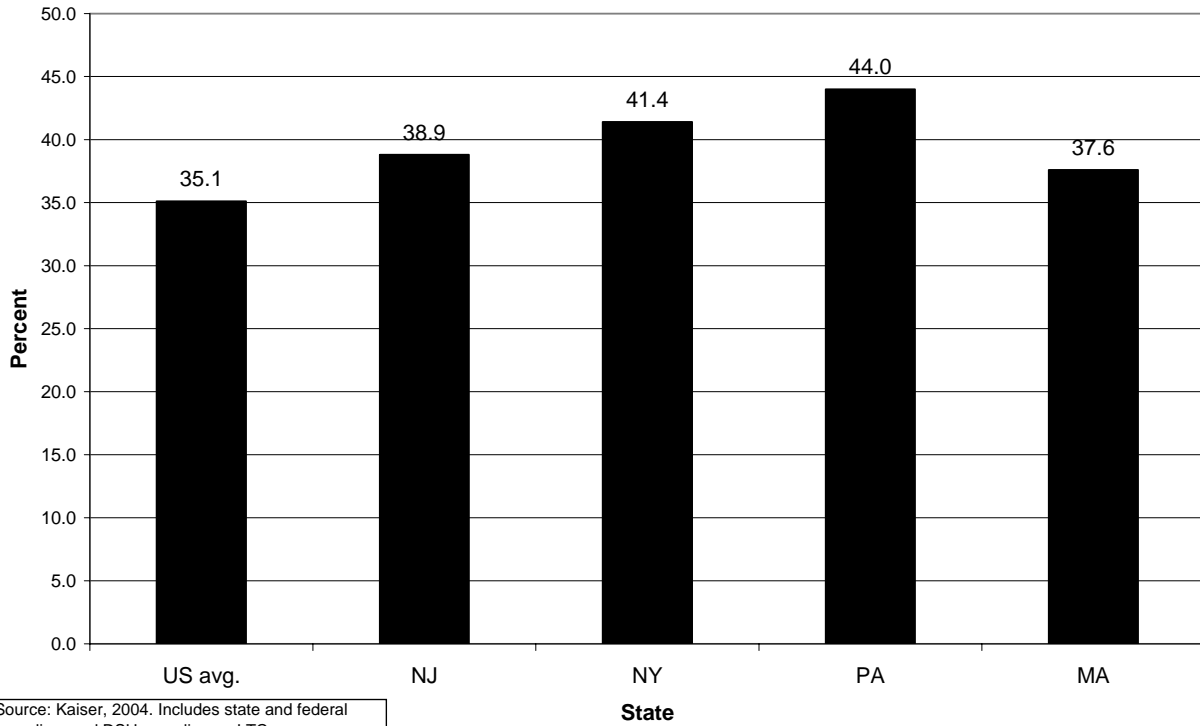


Figure 8: Prescription Drug Spending as a Percentage of Medicaid Acute-Care Spending

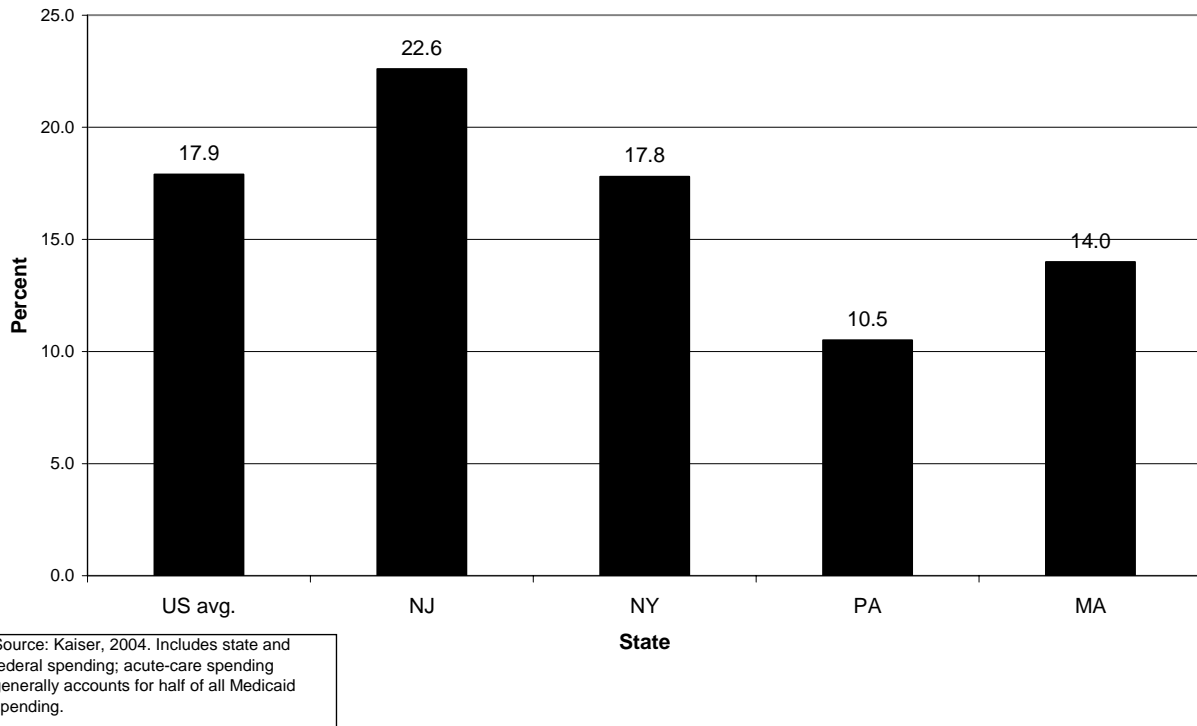
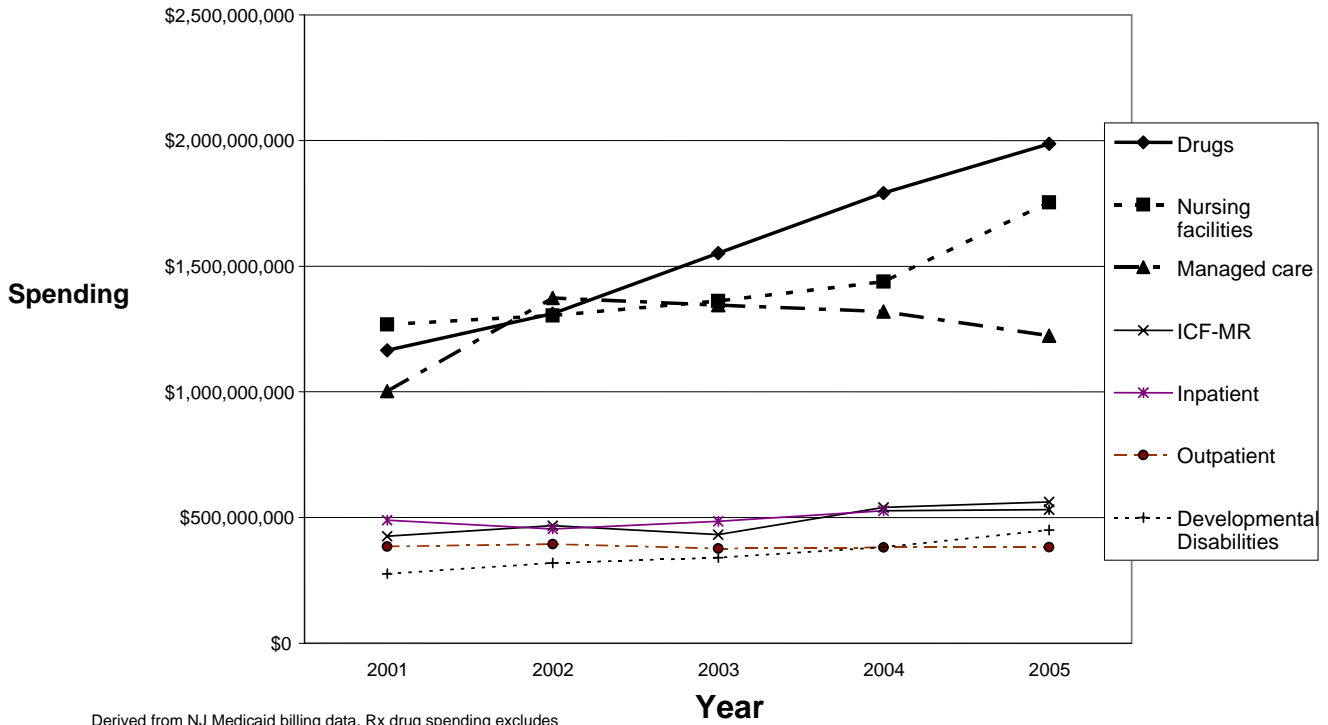


Figure 9: N.J. Medicaid spending by type, 2001-2005



Derived from NJ Medicaid billing data. Rx drug spending excludes drug share of managed care capitation rates and manufacturer rebates. The increase in nursing home costs in 2005 includes the cost of a provider tax. Categories shown represent seven largest spending areas.

Table 1: Medicaid Fee-for-Service Pharmacy Claims Paid and Recipients by Calendar Year & Drug Source Type

**NJ Department of Human Services
Division of Medical Assistance and Health Services**

Year	Drug Source Type	Paid Amount (\$)	# Claims Paid	# Recipients
2004	Generic	178,845,842	6,627,864	321,501
2004	Multi-source brand	48,400,360	1,281,117	183,024
2004	Single-source brand	890,345,896	7,757,424	305,252
2004	Other	23,804,135	63,568	17,590
2004	Total	1,141,396,234	15,729,973	N/A
2005	Generic	228,073,206	7,679,227	338,409
2005	Multi-source brand	56,512,538	1,324,585	197,484
2005	Single-source brand	991,762,905	7,995,170	310,758
2005	Other	24,698,175	47,299	7,288
2005	Total	1,301,046,824	17,046,281	N/A
2006	Generic	135,994,326	5,551,851	330,724
2006	Multi-source brand	37,784,221	918,486	184,867
2006	Single-source brand	543,814,701	5,319,665	296,634
2006	Other	9,806,676	14,434	4,243
2006	Total	727,399,923	11,804,436	N/A
	Grand Total	3,169,842,981	44,580,690	N/A

* Excludes: Payments made to HMOs, long-term care pharmacy capitation payments, and hospital dispensing.

* Includes: fee-for-service use in community/retail, long-term care, and other institutional settings; Medicare Part D and HMO (mental health) wraparound and excluded drugs, and Part D copayment claims (2006 only)

Table 2: Number of Prescriptions by Drug Source Type and Year in the Pharmaceutical Assistance for the Aged and Disabled and Senior Gold Programs

NJ Department of Health and Senior Services

PAAD	Generic	Multi-source	Other	SingleSource
2004	3,212,249 (40.95%)	565,110	31,548	4,035,884
2005	3,220,200 (42.24%)	456,631	10,930	3,936,611
2006	3,347,788 (43.83%)	446,563	9,542	3,834,298
Senior Gold				
2005	395,889 (46.9%)	52,276	599	395,387
2006	418,234 (46.9%)	54,172	568	418,115

**Table 3: Eligibility Costs and Rebates in the Pharmaceutical Assistance for the Aged and Disabled and Senior Gold Programs
NJ Department of Health and Senior Services**

PAAD	FY 2004	FY 2005	FY 2006
# Eligible	192,908	191,577	190,534
Rebates	\$127,920,195	\$143,565,046	\$195,000,000
Gross Costs	\$551,536,638	\$539,833,882	\$558,484,939
Net Costs	\$416,058,812	\$380,191,091	\$354,341,958
Senior Gold			
Eligibles	29,718	30,263	30,589
Rebates	\$4,028,510	\$5,677,173	\$6,000,000
Gross Costs	\$20,693,858	\$23,563,979	\$25,473,246
Net Costs	\$16,665,348	\$17,886,805	\$19,473,246

Note: PAAD-Related Part D Transitional Assistance Grant: \$22 million

**Table 4: Pharmaceutical Manufacturer's Drug Rebates to the NJ Medicaid and General Assistance Programs/Medicare Part D Wraparound
Invoiced & Received from 3Q 2005 through 3Q 2006**

Medicaid			
Calendar Qtr.	Invoiced Amount	Received Amount	Balance Due
3Q 05	\$71,570,969	\$72,745,660	(\$1,174,691)
4Q 05	\$75,096,626	\$72,501,536	\$2,595,090
1Q 06	\$33,444,711	\$31,742,673	\$1,702,038
2Q 06	\$31,235,168	\$33,290,100	(\$2,054,932)
3Q 06	\$32,101,412	\$27,791,122	\$4,310,290
Medicaid Total:	\$243,448,886	\$238,071,090	\$5,377,795
General Assistance and Part D Wraparound			
Calendar Qtr.	Invoiced Amount	Received Amount	Balance Due
3Q 05	\$4,886,964	\$1,861,891	\$3,025,073
4Q 05	\$5,037,538	\$2,007,833	\$3,029,704
1Q 06	\$5,599,377	\$2,958,694	\$2,640,683
2Q 06	\$5,452,941	\$3,104,405	\$2,348,537
3Q 06	\$5,047,598	\$2,065,221	\$2,982,377
GA/Part D Total:	\$26,024,418	\$11,998,045	\$14,026,374

Table 5: NJ AIDS Drug Distribution Program Entollment, Expenditures & Rebates

NJ Department of Health and Senior Services

State Fiscal Year	Enrolled Clients	Gross Expenditures	Pharmaceutical Rebates
2004	7,493	\$64,672,969	\$13,671,661
2005	7,419	\$67,302,276	\$16,072,894
2006	7,153	\$72,122,135	\$18,030,341

APPENDIX IV: Comparison of New Jersey State Health Benefit Plan to Neighboring States

Benefit	New Jersey Plans	New York Plans	Pennsylvania Plans
Premiums Contributions			
State share for active employees	100 pct for NJ Plus; 95 pct for HMO plans	90 pct	100 pct for PPO and HMO plans except new employees
Active employee share	Nothing for NJ Plus; 5 pct for HMO plans	10 pct	Nothing; employees after July 2003 pay 1 pct of base pay
State share for retirees	100 pct for NJ Plus and HMO plans	90 pct	Varies
Retiree share	Nothing for NJ Plus and HMO plans	10 pct	Varies; typically 6.25 pct of base pay
Deductibles	No deductibles for NJ Plus, HMO plans	No deductibles for Empire BCBS and HMO plans	No deductibles for PPO and HMO plans
Benefits			
Physician visits	\$10 copayment per visit in NJ Plus and HMO plans	\$8-\$10 co-payment in Empire;\$5-20 in HMO plans	\$15 copay for PPO and HMO plans
Emergency room	\$25 copay for NJ Plus; \$35 copay for most HMO plans	Empire: no copayment; HMOs: typically \$50 copayment	PPO & HMO: \$50 copay, waived if admitted
Physical therapy/rehab	100% after \$10 copayment/visit in NJ Plus, HMO Plans	Empire Plan: \$8-\$10 co-payment;	PPO & HMO: \$15 copay/visit
Eye care	\$10 copayment for routine visit, only coverage avail.	Not covered in some plans; separate NY vision plan	Separate Vision Plan
Prescription drugs	\$3 copay for generics; \$10 copay for brand-name	Empire: \$5 copay for generics, \$15 for brand-name; \$15 plus difference for brand when generic available; HMOs vary	\$10 copay for generics; \$18 copay for brand-name \$36 non-preferred brand
Mental health-inpatient	NJ Plus: 100 pct covered up to 25 days/yr; 90 pct thereafter up to max \$15,000/yr. HMOs: 100 pct covered up to 35 days/year	No copayments; max. 30 days for HMO plans Empire unlimited days if medically necessary	Separate program; no-copayment if in network
Mental health-outpatient	NJ Plus: 90 pct covered up to \$15,00/yr. HMOs: \$10 copayment per visit; max 30 visits/yr.	Empire: \$15 copay HMO plans vary considerably	Separate program; in-network \$15/visit up to 60 visits
Lab tests	100 pct coverage in both HMO, NJ Plus plans	Empire: \$8-\$10 visit; HMOs: 0 to \$20 copayment	Full coverage in PPO and HMO plans
<p><i>Notes: Traditional indemnity plan not included; NJ Plus benefits & costs are for in-network providers NJ dental plan can be purchased separately Note: Almost all retired NJ uniformed employees and teachers pay no premiums</i></p>			

APPENDIX V: Member Comment



17.

18. KATHLEEN A. BUTO

VICE PRESIDENT
HEALTH POLICY
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February 26, 2007

Dr. Joel Cantor
Professor Public Policy &
Director, Center for State Health Policy
Rutgers University

Dear Joel:

First, I want to thank you for including me as a member on the Health Care Task Force for the GEAR Commission and for doing a good job of keeping our task force on course, over the relatively short period of time we had to address the issue of health care costs and access in state-funded programs. This was a difficult assignment, involving complex issues, and I admire your dedication to doing it in a fair and measured way. I thank you especially for making sure that the task force report accurately reflects the levels of state spending for individual categories of costs and, to the extent we can estimate them, the savings associated with various task force proposals. I think this specificity gives greater context and credibility to the recommendations. I support the vast majority of the report's recommendations.

As you know, one of my major concerns has been that inflated estimates of levels of spending and growth rates for prescription drugs in Medicaid paint a picture of prescription drugs as the major growth driver. The level and growth rate of prescription drug spending are inflated because they do not reflect either the rebates that have been paid to the state or the fact that a large portion of prescription drug costs have now been shifted to the federal Medicare Part D program, for those elderly and disabled Medicaid beneficiaries who are eligible for Medicare as well. The shift to Medicare alone will mean that New Jersey's prescription drug spending will drop \$504.8 million for Medicaid and PAAD in the current fiscal year, or about 25% of all federal and state spending for prescription drugs in NJ Medicaid. Even accounting for "claw back" payments to the Medicare program of \$274 million -- net savings of about \$231 million are about 10% of the state's total Medicaid prescription drug expenditure. In short, spending and growth rates in spending for medicines will be dramatically lower in the future.

Today I received the most recent version of the report, which differs from earlier versions by saying that there are no savings from Part D because of the state's continuing obligation to cover some pharmaceuticals (not covered by Part D) and because it has lost the rebates associated with pharmaceuticals now covered by Part D for the dual eligibles. In previous versions, total expenditures for pharmaceuticals have never been adjusted downward to reflect rebates paid by companies. I strongly urge that the state provide the detailed breakdown of total pharmaceutical spending associated with the dual

eligibles, rebates previously paid, and the costs associated with continuing coverage of some medicines. I assume these will still show net savings. I understand that the state may be counting its continuing “clawback” obligations in total spending, but these are based on a formula and are not subject to any of the price cutting approaches recommended in the report.

In light of what appears to be a significant reduction in spending on medicines, I do not support recommendation 2, which outlines additional strategies for reducing prescription drug costs in Medicaid and other state programs. I appreciate that the recommendation statement says that the intent would be to do so “while maintaining access to medically necessary drugs.” In other states where bulk purchasing and preferred drug lists have been imposed, it has become more difficult for populations suffering from serious mental disease, HIV-AIDS, and other serious illnesses to get their medications. In the appendix, the report acknowledges that savings from these proposals would save \$36.8 million but that these figures are inflated, as they do not reflect savings from Medicare Part D. Again, I think the report would be clearer if a table could show the level of spending, the rebates previously paid, what the net savings of a Part D shift are, and what the incremental savings of additional measure would be.

I am supporting other recommendations aimed at achieving savings in prescription drug spending. As you know, I support the report’s recommendations to reform the State Health Benefits Program, including requirements that plans employ best practice models to ensure cost-effective prescribing, estimated to save \$38 million, and mandatory generic substitution and prescription mail order, estimated to save \$35 million. I would like to recommend that the state work with pharmaceutical manufacturers to implement other cost saving programs that can reduce prescription drug spending without impeding access to medically necessary drugs.

I thank you again for your leadership on this very tough assignment.

Sincerely,

A handwritten signature in black ink that reads "Kathy Buto". The signature is written in a cursive, slightly slanted style.

Kathy Buto
VP Health Policy