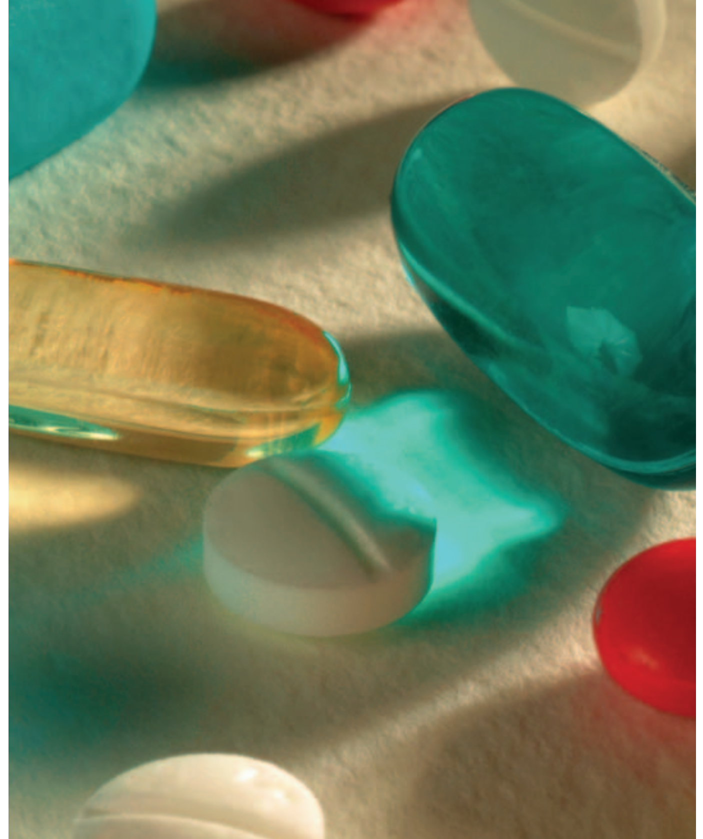

State leaders from around the country will gather in St. Paul, Minnesota April 15-18 for an in-depth look at key trends and policy issues during CSG's 2004 Spring Committee and Task Force Meetings.

CSG offers state policy-makers a diverse and detailed look at the issues facing states today – from school nutrition and childhood obesity to what the new Medicare drug bill means for states; from lake restoration and preservation to dealing with drug abuse and methamphetamine in rural areas. Join state policy-makers and national experts from around the country in these discussions as we look at current implications and potential solutions to these and other public policy areas.

Key

Childhood Obesity

States and their local school districts are experiencing a phenomenal growth in the number of obese children and adolescents. As national coverage of the trend has grown in the past year, finger-pointing has also increased, with health advocates blaming a lack of state regulations or legislation that could improve school nutrition education and physical activity for students. Predictions of the long-term cost of physical inactivity and poor nutrition policy for today's youth make this one of the sleeping giants facing state health, education and fiscal policy-makers.

RTI International and The Centers for Disease Control and Prevention released a study in January estimating that U.S. medical expenditures attributable to obesity reached $75 billion in 2003 and that taxpayers financed about half of these costs through Medicare and Medicaid. The American Diabetes Association reports that the prevalence of diabetes among people under 20 years of age is increasing, with about 151,000 young people suffering from the disease.

Some state legislators have introduced legislation to improve the health of school age children through nutritional regulations or by requiring physical activity. At the same time, state fiscal constraints and education budget cuts have forced local school districts to rely on money from food and beverage contracts – such as those for fast food and soft drinks – that support school programs and provide nondiscretionary funding.

Policy-makers throughout the country continue to grapple with this problem as they seek to develop and implement policies and programs. At least three states have commissioned task forces to look for solutions and to make recommendations about community health practices, school physical activity and nutrition education. State and local officials find themselves walking a fine line as they balance the desire for local control with state responsibility and concern about future expenses related to physical inactivity and poor nutritional policy. Can the states provide guidance and support for community and school district efforts to help curb a future health crisis and to improve the quality of life for their residents?

One win-win solution being introduced across the country increases demand for local agricultural products as it educates students about the source of their food. Schools nationwide are learning the benefits and challenges of buying food directly from local farmers and integrating these products into healthy school lunch

CSG Task Forces Consider Emerging Trends

Issues

and snack menus. The Farm to Cafeteria or Farm to School programs range from school gardens that supply salad bars to lunch menus that feature local items, but the goals remain the same: students learn about the role of healthy foods in their diet, while local producers gain new markets and communities support local businesses.

CSG's Agriculture and Rural Development Task Force and Education Policy Group will host a panel of national experts on April 15 to discuss trends in childhood and adolescent obesity.

With an eye toward identifying the most promising policies and programs, the forum will showcase perspectives and solutions from state policy-makers, physical education and nutrition advocates, farm-to-school programs, and the federal government. Speakers will discuss the issues surrounding this trend as well as strategies states can use to address the issue.

— Charlotte Postlewaite, chief education policy analyst, cpostlewaite@csg.org; Carolyn Orr, chief agriculture and rural policy analyst, corr@csg.org

Preserving and Restoring Lakes

Lakes are one of our nation's most precious natural resources. They supply a large portion of our drinking water, provide critical habitat support, furnish water for industry and agriculture, and serve important aesthetic and recreational functions.

In their 2000 biennial water quality reports to the U.S. Environmental Protection Agency, states assessed approximately 43 percent of the nation's 40.6 million acres of lakes. They reported that roughly 55 percent of the assessed lake acres have good water quality that fully supports all designated uses such as swimming, fishing or drinking. Of this 55 percent, however, 8 percent was classified as good but threatened for one or more uses. States rated the remaining 45 percent of assessed lake acres as impaired for one or more designated uses.

According to the 2000 National Water Quality Inventory Report, excess nutrients are the leading cause of impairment in assessed lake acres. Metals ranked as the second most common pollutant, primarily due to the detection of mercury in fish tissue samples, and siltation or sedimentation ranked third. As for the leading sources of lake impairment, agriculture was listed foremost, followed by hydrologic modifications (such as dredging, dam construction, and flow regulation and modifications), urban runoff and storm sewers, nonpoint sources, atmospheric deposition, municipal point sources, and land disposal.

With almost half of our nation's assessed lake acres partially or not able to support one or more uses, the topic takes on significance for state environmental policy-makers.

During CSG's 2004 National Committee and Task Force Meetings in St. Paul, Minnesota, the Environmental Task Force Policy Meeting on April 16 will feature presentations by the Kansas Water Office and the Kansas Biological Survey on innovative solutions for lake degradation and the evolving use of public-private partnerships, as well as a presentation by the Minnesota Pollution Control Agency on trends in Minnesota lake conditions and management. On April 17, the Minneapolis Park and Recreation Board, with resource expertise from the Minnesota Pollution Control Agency, will conduct a study tour of the Chain of Lakes surrounding Minneapolis. The tour will focus on case studies of lakes that have experienced degradation from a variety of sources, including urban encroachment and storm water, and will highlight projects that have addressed water quality degradation.

Meeting and field study participants will come away with a better understanding of the problems confronting our nation's lakes, as well as some innovative protection and restoration techniques.

— Barbara Foster, associate director for environmental policy, bfoster@csg.org

The Medicare Modernization Act

On December 8, 2003, President Bush signed into law the most far-reaching expansion of health care coverage since the Medicare and Medicaid programs were created. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, also known as MMA, adds prescription drug coverage for the nation's 40 million seniors and disabled individuals enrolled in Medicare. The law contains a host of provisions that will have an enormous impact on state health care programs as well as state budgets.

The Medicare drug law provides for phasing in two basic benefits.

Overall, the Congressional Budget Office estimated that the new law will result in states spending **$1.2 billion more** in Medicaid between 2004 and 2006.

Interim Drug Card

To give the U.S. Department of Health and Human Services time to set up the new prescription drug benefit, Medicare will first establish a prescription drug discount card that will become available in May 2004. The prescription drug discount card program is aimed at providing interim relief to Medicare beneficiaries by providing them with access to discounted drug prices of up to 15 to 25 percent off regular retail drug prices.

The drug cards will be administered through private contractors approved by HHS. The enrollment fee is set at no more than $30. Low-income beneficiaries will receive additional assistance. Medicare will pay low-income individuals' enrollment fee, and drug cards will have a $600 credit on the card that can be applied to their drug costs.

New Medicare Part D

On January 1, 2006, the new Medicare Part D will go into effect, allowing Medicare beneficiaries access to a new prescription drug benefit. Private health plans will be given an unprecedented new role in providing benefits under Medicare. Thus, Medicare beneficiaries will face three choices regarding Medicare Part D drug coverage:

- enroll in a stand-alone prescription drug plan as a supplement to regular Medicare Parts A and B;
- enroll in a Medicare Advantage health plan that covers all health care services, including prescription drugs;
- forgo Part D prescription drug coverage and access other drug coverage, such as that offered by employers to their retirees, or remain uninsured.

Standard Benefit

The new Medicare Part D benefit will have a $35 annual premium, a $250 deductible, and 75 percent coinsurance for up to $2,250 of drug costs. Above $2,250, beneficiaries will have to pay out-of-pocket for additional drug purchases until they reach $3,600 in spending. Beyond $3,600 in spending, the law provides for catastrophic coverage with nominal co-payments per prescription of $2 for generic and $5 or 5 percent of the cost of brand name drugs, whichever is greater. The gap between $2,250 and $3,600, often referred to as the "doughnut hole," was one of the law's more controversial features, but one that enabled it to stay within the $400 billion price tag set aside to pay for the new benefit.

Low-Income Provisions

The standard benefit applies to individuals with higher incomes. People with incomes below 150 percent of the federal poverty level will receive additional assistance under the law. (The federal poverty level, or FPL, is currently $8,980 for a single person and $12,120 for a couple). There is no "doughnut hole" for Medicare beneficiaries with incomes below 150 percent of the federal poverty level. Medicare will cover the full drug costs for institutionalized enrollees without any cost-sharing requirements. The benefit will be structured as follows for different income levels:

- Individuals below 100 percent FPL will have co-payments of $1 for generics and $3 for brand name drugs with no premiums or deductible.
- Individuals below 135 percent FPL will have $2 co-payments for generics and $5 co-payments for brand name drugs with no premiums or deductible; individuals must have less than $6,000 in assets and couples must have less than $9,000 in assets to be eligible for this benefit.
- Individuals below 150 percent FPL will have a $50 deductible, a sliding scale premium, and 15 percent coinsurance up to the catastrophic limit, with $2 and $5 co-payments thereafter; individuals must have assets of less than $10,000 for singles/$12,000 for couples to qualify for this benefit.

Implications for States

The most important change for states is that the new Medicare Part D will assume responsibility for dual eligibles – the low-income seniors and the disabled enrolled in both Medicare and Medicaid. This will relieve states of some of their rising Medicaid prescription drug costs. State Medicaid programs provided drug coverage to more than 6 million dual eligibles in 2002 at a per capita cost of $918 in state spending, according to a report by Brian Bruen and John Holahan for the Kaiser Commission on Medicaid and the Uninsured.

While the transfer of dual eligibles to Medicare sounds like a fiscal boon to states, a number of the law's provisions mean that states may spend more in the short term. States are required to assist with determining who qualifies for Part D low-income assistance under the new law. States will have to hire or retrain staff, modify computer systems and make other changes to accommodate this requirement.

In addition, the law requires that Medicaid savings on dual eligibles' drug costs be paid to Medicare. Officially termed as a "state contribution" but more generally known as the clawback provision, this portion of the law in essence levies a federal tax on state Medicaid spending. Based on a complex formula of the number of dual eligibles, their drug costs and other factors, states must pay the federal government 90 percent of what they would have contributed to covering this population under Medicaid. This percentage decreases gradually over the next 10 years to 75 percent in 2015, meaning that states may see more savings as time goes on.

States will also have to provide data to HHS monthly regarding their enrollment and per capita spending for dual eligibles. HHS will use the data to calculate state contribution payments and to help with eligibility determinations for the drug discount cards.

Overall, the Congressional Budget Office estimated that the new law will result in states spending $1.2 billion more in Medicaid between 2004 and 2006. However, the office estimates that state Medicaid spending will eventually decrease by $17.2 billion, but nearly 80 percent of these savings will come between 2010 and 2013. However, some state analysts are skeptical of any substantial savings for states. A lot can happen in 10 years with the federal budget.

On April 16, CSG's Health Capacity Task Force will examine the Medicare Modernization Act. Presenters will discuss the law's basic provisions, how it affects states, and how state leaders can help their constituents understand this complex new law and what's in it for them.

— Trudi Matthews, associate director of health policy, tmatthews@csg.org

'Meth' Infection

There is an unprecedented level of methamphetamine production and abuse nationwide, making it one of the leading public safety, justice, health and rural policy issues facing the states. The 2001 National Household Survey on Drug Abuse found that 9.6 million Americans have tried meth at least one time and the National Drug Intelligence Center reports that 58 percent of local law enforcement considers the availability of the drug in their communities to range from medium to high.

The production and use of methamphetamine has a far-reaching impact on communities, and states ultimately pay for the strain placed on local hospitals, law enforcement, prisons, family and social services, schools and courts. A study by the National Center on Addiction and Substance Abuse found that more than 13 percent of state budgets deal with substance abuse, and more than 90 percent of those funds go to dealing with the aftermath, not preventing or treating it.

Rural communities are especially vulnerable to the effects of meth, and they most often lack the resources to address the problem. In fact, drug-related crimes in rural areas increased by 10.5 percent from 1997 to 2002. Rural communities make good locations to produce methamphetamine because anhydrous ammonia, which is used as fertilizer, is readily available, and because the toxic fumes produced during the manufacturing process are less obvious than in more crowded urban areas.

The problem is compounded in rural areas because of the lack of drug treatment options that are available to metropolitan communities, and rural communities have a difficult time attracting and keeping drug counselors.

State officials throughout the country are trying to deal with this problem by developing and implementing policies and programs. For example, many states are limiting access to common ingredients; training law enforcement officers to deal with the toxic chemicals; targeting youth for drug prevention efforts; and strengthening drug courts. But are these initiatives working?

CSG's Public Safety and Justice Task Force and the Agriculture and Rural Policy Task Force will host a panel of national experts on April 16 to discuss the rural drug trend with an eye toward promising policies and programs. This session, titled "The 'Meth' Infection – Charting State Strategies," will showcase perspectives and solutions from state policy-makers, public safety and health and human service officials, law enforcement and the federal government. Speakers will discuss the issues around this emerging problem as well as strategies states can implement to address it.

— Chad Foster, public safety and justice policy analyst, cfoster@csg.org; Carolyn Orr, chief agriculture and rural policy analyst, corr@csg.org