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Health Policy for Low-Income People in New Jersey

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New Jersey health policy has generally tried to promote market mechanisms while maintaining the safety net. The state has a large Medicaid program for the relatively small share of New Jersey residents in need. Medicaid is moving rapidly into managed acute care and is promoting community care and deinstitutionalization in long-term care, mental health, and disability programs. New Jersey also has sought to promote private insurance coverage, continued its hospital charity care pool, and maintained its commitment to public health. It has been at the forefront in regulating managed care as well as the individual and small-group health insurance markets.

State Characteristics

New Jersey is a small but populous state. Its nearly 8 million people make it ninth among the states in population, although its

growth rate has long lagged behind that of other states (table 1). New Jersey is the most urbanized and densely populated state, but it has no truly large city. Its municipalities are all small, both in area and in population. Only three municipalities have more than 100,000 residents. The state's population closely reflects the race and age mix of the rest of the country. The state does, however, have a higher proportion of non-citizen immigrants than average—8.8 percent versus 6.4 percent nationwide.*

New Jersey was once dominated by heavy industry (especially steel and petrochemicals), although agriculture was also prominent in the "Garden State." But for decades the state has lost industrial jobs to competitors and farmland to urban development. Over time, the economy has diversified: chemical, pharmaceutical, and electronic manufacturing are important, and growth has been particularly strong in the trade and service industries, such as insurance and financial services. The state remains relatively high in union membership. New Jersey

**New Jersey
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Table 1
State Characteristics

	<u>New Jersey</u>	<u>United States</u>
Sociodemographic		
Population (1994–95) (in thousands)	7,889	260,202
Percent under 18 (1994–95)	25.5%	26.8%
Percent 65+ (1994–95)	12.7%	12.1%
Percent Hispanic (1994–95)	11.1%	10.7%
Percent Non-Hispanic Black (1994–95)	11.9%	12.5%
Percent Non-Hispanic White (1994–95)	72.2%	72.6%
Percent Non-Hispanic Other (1994–95)	4.8%	4.2%
Percent Noncitizen Immigrant (1996)*	8.8%	6.4%
Percent Nonmetropolitan (1994–95)	0.0%	21.8%
Population Growth (1990–95)	2.8%	5.6%
Economic		
Per Capita Income (1995)	\$29,848	\$23,208
Percent Change in Per Capita Personal Income (1990–95)	19.8%	21.2%
Unemployment Rate (1996)	6.2%	5.4%
Percent below Poverty (1994)	9.5%	14.3%
Percent Children below Poverty (1994)	14.1%	21.7%
Health		
Percent Uninsured—Nonelderly (1994–95)	14.6%	15.5%
Percent Medicaid—Nonelderly (1994–95)	8.3%	12.2%
Percent Employer-Sponsored—Nonelderly (1994–95)	71.5%	66.1%
Percent Other Health Insurance—Nonelderly (1994–95)	5.7%	6.2%
Smokers among Adult Population (1993)	18.9%	22.5%
Low Birth-Weight Births (<2,500 g) (1994)	7.6%	7.3%
Infant Mortality Rate (Deaths per 1,000 Live Births) (1995)	7.3	7.6
Premature Death Rate (Years Lost per 1,000) (1993)	53.1	54.4
Violent Crimes per 100,000 (1995)	599.8	684.6
AIDS Cases Reported per 100,000 (1995)	55.5	27.8
<p><i>Source:</i> Complete list of sources is available in <i>Health Policy for Low-Income People in New Jersey</i> (The Urban Institute, 1998).</p> <p>* Three-year average of the Current Population Survey (CPS) (March 1996–March 1998, where 1996 is the center year) edited by the Urban Institute to correct misreporting of citizenship. Please note that these numbers have been corrected since the original printing of this report.</p>		

enjoyed strong economic growth in the 1980s, then suffered heavily in the recession of the early 1990s. Recovery since 1992 has been strong, although growth in per capita income slightly lagged the national average for the period 1990–95 (table 1). Unemployment stood at 4.7 percent in November 1997, close to the national average of 4.3 percent.

New Jersey is a high-income state. Its annual per capita income is nearly \$30,000, a close second to Connecticut among all states, and poverty rates are low (9.5 percent in the state versus 14.3 percent nationally).

A high percentage of New Jersey residents have health coverage, as is

expected for a high-income state, especially a traditional union stronghold. Only 14.6 percent of the non-elderly lacked coverage in 1994–95, which was below the national average (table 1). Medicaid covers fewer people than is typical, but employers cover more. New Jersey's measured health risks and outcomes are similar to those for the United States as a whole, aside from the high number of AIDS cases.

New Jersey has a very strong office of the governor. The governor is the only statewide elected official and wields strong veto powers. Legislators serve part-time, are not highly paid, have small staffs, and usually

have another career. Most observers say that New Jersey has unusually strong traditions of local power.

Once known for urban machine politics, usually dominated by Democrats, New Jersey now has more balanced political affiliations. Party control of the legislature and state house has switched several times in the last generation. The current governor is Christine Todd Whitman, a Republican; Republicans have held 60 percent majorities in both houses of the state legislature since 1992. Yet the state has elected Democrats for national offices in recent years. During the 1970s and 1980s, both parties helped build a high-tax, high-service, interventionist state government. In the 1990s, a tax revolt ushered in the current Republican control of the governor's office and legislature. Since then, New Jersey has been downsizing and deregulating.

Governor Whitman's top priority has been rolling back income taxes. Other priorities have included promoting business through incentives and deregulation, reducing state spending, and enacting welfare reform. Health policy issues have not enjoyed a high profile in New Jersey since an integrated set of reforms passed in 1992. Those laws phased out one of the nation's oldest and most comprehensive systems for hospital rate setting and ended Blue Cross/Blue Shield's long-standing role as insurer of last resort, while moving to more market-oriented strategies.

Medicaid Expenditures and Enrollment

The top health priority in New Jersey is the Medicaid program. As in other states, it claims a large share of the New Jersey budget—fully 24 percent in 1995, including the federal contribution. The state's Medicaid budget was \$5.5 billion in 1995. In the early 1990s growth in Medicaid spending outpaced the national average (32.3 percent versus 27.1 percent per year from 1990 to 1992), but the state trailed the nation during the 1992–95 period (8.7 percent versus 9.9 percent average annual growth) (table 2). Some of the increase in spending in the early 1990s was a

Table 2
Medicaid Expenditures
by Eligibility Group and Type of Service,
New Jersey and United States
 (Expenditures in Millions)

	New Jersey			United States		
	<u>Expenditures</u>	<u>Average Annual Growth</u>		<u>Expenditures</u>	<u>Average Annual Growth</u>	
	1995	1990-92	1992-95	1995	1990-92	1992-95
Total	\$5,460.1	32.3%	8.7%	\$157,872.5	27.1%	9.9%
Benefits						
Benefits by Service						
Acute Care	\$4,104.7	14.8%	10.0%	\$133,434.6	18.8%	11.0%
Long-Term Care	2,154.8	22.4%	8.9%	79,438.5	22.1%	13.0%
Benefits by Group	1,949.9	7.6%	11.3%	53,996.1	14.8%	8.3%
Elderly	\$4,104.7	14.8%	10.0%	\$133,434.6	18.8%	11.0%
Acute Care	\$1,282.7	7.5%	11.4%	\$40,087.4	16.7%	8.1%
Long-Term Care	271.4	3.0%	22.1%	9,673.7	18.5%	11.9%
Blind and Disabled	1,011.3	8.4%	9.1%	30,413.7	16.2%	7.0%
Acute Care	\$1,802.2	12.5%	12.2%	\$51,379.4	17.7%	12.9%
Long-Term Care	924.9	20.0%	11.3%	29,760.7	22.8%	15.2%
Adults	877.3	5.7%	13.1%	21,618.7	12.3%	10.1%
Children	\$518.2	29.4%	1.5%	\$16,556.9	20.4%	9.2%
Disproportionate Share	\$501.5	28.7%	9.2%	\$25,410.9	24.3%	13.3%
Hospital Payments	\$1,286.5	453.6%	5.5%	\$18,988.4	261.5%	2.7%
Administration	\$68.9	16.0%	-2.6%	\$5,449.4	9.8%	12.8%

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.

result of growth in enrollment arising from federally mandated eligibility expansions: In 1995, New Jersey had 37 percent more Medicaid beneficiaries than in 1990. Yet most of the increase was intentional on the part of the state. Spending characterized as Medicaid rose rapidly as the state aggressively pursued disproportionate share hospital (DSH) federal matching funds to cover programs previously funded in other ways. The entire charity care pool, for example, is now funded through DSH—over \$300 million a year (state and federal share). While DSH spending in New Jersey nearly quadrupled from 1990 to 1995 and grew at twice the rate for the nation overall, spending on benefits (acute and long-term care combined) grew more slowly than the national average.

As elsewhere, acute care expenditures in New Jersey's Medicaid program from 1990 to 1992 grew faster than those for long-term care as eligibility expansions boosted coverage of children and pregnant women. During this period, spending on acute care grew by 22.4 percent per year, which was

comparable to the national rate. From 1992 to 1995, the state's annual rate of growth for acute care fell to 8.9 percent and was outpaced by long-term care growth, at 11.3 percent annually.

Overall, New Jersey Medicaid is relatively generous in terms of eligibility rules and spending per enrollee. New Jersey has voluntarily chosen to cover infants in families with income up to 185 percent of the federal poverty level. The state has a broad medically needy program and is one of 13 states to cover the elderly and disabled up to 100 percent of the federal poverty level. Spending per beneficiary is nearly 50 percent above the national average. This level is high, although it is well below the 100 percent differential of nearby New York and Massachusetts. Higher-than-average New Jersey spending mainly benefits the disabled and the elderly. In 1995, for example, the state spent \$13,755 per elderly enrollee, compared with \$9,738 nationally (table 3). Spending per child enrollee in 1995 was about equal to the national average (\$1,156 in New Jersey versus \$1,178 in the United States).

Medicaid Managed Care

Acute care Medicaid cost containment has received the lion's share of policymaking attention. On the fee-for-service side of the program, the state has aggressively used administrative price setting and "prudent purchasing," and has successfully defeated lawsuits alleging underpayment. On the managed care side, the state has mandated enrollment in fully capitated managed care organizations for all welfare- and poverty-related beneficiaries. These changes have occurred through a series of small Section 1915(b) waivers as opposed to a single, large Section 1115 waiver. Officials believe that managed care has achieved some economies even as it has improved services to enrollees—for example, increasing access to physicians by raising historically low physician fees. State officials and advocates agree that the shift to managed care has been administered well, with almost all enrollees actively choosing which plan to join rather than being assigned.

Table 3
Medicaid Enrollment and Expenditures
per Enrollee: Contributions to Total Expenditure Growth

	New Jersey			United States		
	1995	Average Annual Growth		1995	Average Annual Growth	
		1990-92	1992-95		1990-92	1992-95
Elderly						
Total expenditures on benefits (millions)	\$1,282.7	7.5%	11.4%	\$40,087.4	16.7%	8.1%
Enrollment (thousands)	93.3	2.9%	3.4%	4,116.6	5.1%	3.0%
Expenditures per enrollee	\$13,755	4.5%	7.8%	\$9,738	11.0%	5.0%
Blind and Disabled						
Total expenditures on benefits (millions)	\$1,802.2	12.5%	12.2%	\$51,379.4	17.7%	12.9%
Enrollment (thousands)	153.2	10.0%	8.2%	6,405.2	9.8%	9.5%
Expenditures per enrollee	\$11,767	2.3%	3.7%	\$8,022	7.1%	3.1%
Adults						
Total expenditures on benefits (millions)	\$518.2	29.4%	1.5%	\$16,556.9	20.4%	9.2%
Enrollment (thousands)	199	16.9%	0.2%	9,584.2	11.5%	4.6%
Expenditures per enrollee	\$2,604	10.7%	1.3%	\$1,728	8.0%	4.4%
Children						
Total expenditures on benefits (millions)	\$501.5	28.7%	9.2%	\$25,410.9	24.3%	13.3%
Enrollment (thousands)	433.9	10.4%	3.9%	21,566.0	13.1%	4.8%
Expenditures per enrollee	\$1,156	16.6%	5.1%	\$1,178	9.9%	8.2%

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.

Note: Expenditures exclude disproportionate share hospital payments and administrative costs.

Medicaid managed care expenditures have increased rapidly since the implementation of managed care. In state fiscal year 1995, 5 percent of the general medical services budget was appropriated to capitated plans. By contrast, in fiscal year 1998, the state expects to spend 26 percent of the general medical services budget on managed care.

Charity Care and Expanded Insurance Coverage

New Jersey has a historic commitment to supporting health services for uninsured individuals. Like few other states, New Jersey provides funds for hospitals that deliver charity care to the poor. The 1992 state health care reforms, which eliminated the hospital rate-setting system, maintained the charity care hospital pool. Long-term funding of the pool (with heavy reliance on an increased tobacco tax) was agreed to in December 1997.

Current state support is about half of the nearly \$1 billion full reimbursement of charity care plus bad debts that occurred under rate setting. New Jersey also subsidizes safety net hospitals through two smaller but significant state programs. The state recently received federal approval for a limited Section 1115 waiver to implement managed care for its hospital charity care program. (This would require hospitals to arrange for nonhospital care using funds from the charity care pool.) In its 1998 session, the legislature passed a bill to narrow the proposed statewide program to a much smaller pilot program.

The state's 1992 health care reforms created a new subsidy program to help previously uninsured people buy private coverage. The subsidies, which at last count supported coverage for 15,000 persons, have not been funded to originally anticipated levels. Governor Whitman has continued to push for new support, shifting focus in 1996 from the general population to children. The mo-

mentum for children's coverage increased with the enactment of the federal Children's Health Insurance Program (CHIP) in August 1997. (Federal approval came after this report, in April 1998.) Under CHIP, New Jersey is expanding Medicaid coverage to children up to age 19 in families with incomes up to 133 percent of the federal poverty level. In addition, the state will offer non-Medicaid coverage to children with family incomes between 133 percent and 200 percent of the federal poverty level. This new program is entitled NJ KidCare. According to state estimates, New Jersey aims to cover approximately 40 percent of its estimated 248,000 uninsured children through CHIP.

The Health Care Market

Market competition for hospital care has been slow in coming to New Jersey, primarily because until 1993 the state relied on an all-payer rate-setting system. Many forms of managed health care coverage have been

slow in coming as well. The share of population enrolled in health maintenance organizations (HMOs) is about average for the nation. But for New Jersey this HMO penetration rate is very low, given that the state is by far the nation's most urbanized area and has a plentiful, well-distributed supply of physicians and hospitals. Similarly, the enrollment rate for preferred provider organizations (PPOs) is well below national norms because this form of managed care is unable to flourish without the ability to negotiate hospital prices.

After rate setting was ended, hospitals increasingly faced price competition, although most began with a fiscal cushion from extra 1993 receipts. These receipts came from a final reconciliation of rates regulated in prior years. Thus, competition has only begun to "bite." The state bed-to-population ratio is comparable to the national average, the physician-to-population ratio is above average, and lengths of hospital stay are very high. Beds and stays are much lower in advanced managed care markets, so rapid change is expected.

Hospitals are already starting to consolidate somewhat, a process that antitrust enforcers in the attorney general's office are watching but not acting upon, because supply remains plentiful. The state has no for-profit acute care hospitals, although their entry is anticipated. Almost all community hospitals are private nonprofit facilities. There are no public general hospitals run by cities or counties, although one county facility with a long-term care focus has some acute beds and one state medical school hospital is publicly owned. Only three general hospitals have closed in the past decade, most recently a big safety net teaching institution in Newark. State officials did not attempt to keep the hospital open, signaling their seriousness about letting the market work. The state did act to ensure that the departing hospital's "franchise" to run certain specialized children's services was replaced by a certificate-of-need (CON) award to another hospital. New Jersey's CON program offers some hospitals an exclusive right to provide tertiary services. Urban hospitals view the CON as a major competitive protection, and

they fear losing their tertiary "franchise" to suburban hospitals that would not serve the poor. This loss of competitive protection could occur, as there is a strong movement in the state to eliminate CON.

Private Health Insurance Reforms

The 1992 reforms also changed regulations in the private markets for individual and small-group health insurance. All health insurers, no longer just Blue Cross/Blue Shield, were required to offer individual and small-group coverage or pay into a fund to subsidize those insurers that do. Protections against undue losses were created, and rules were standardized. The goals were to ensure that more New Jersey residents had access to coverage and that insurers competed on a level playing field. Officials are pleased with the performance of these regulated markets, although evidence of a positive effect on the uninsurance rate is lacking. The regulated industry continues to support these efforts.

The Whitman administration and state legislature have recently pursued initiatives to respond to public concerns about managed care. New HMO regulations, which took effect in March 1997, emphasize disclosure and consumer protection. Serious work remains for successful implementation of these regulations.

Long-Term Care

In 1996, long-term care and other elderly services were consolidated and moved into the Department of Health, which was renamed the Department of Health and Senior Services (DHSS). The long-term consequences of this shift are not clear, but it seems certain to raise the "clout" of seniors on budgetary and programmatic matters. New Jersey's long-term care system places a heavy reliance on institutional care, but there is widespread interest in expanding home and community-based alternatives. Eighty-five percent of the state's Medicaid long-term care expenditures go to nursing homes. Expansion of home and community-based care depends on reductions of

nursing home spending. Nursing home payment rates are high by national standards and are a specific target for budget cuts.

There is also a strong institutional bias in long-term care services for younger persons with disabilities. Proposals to expand community-based options for this population are popular, but expansions depend on savings from closures of large institutions. These closures face some political opposition from state legislators, communities, and labor unions.

Public Health

As elsewhere, the public health system in New Jersey provides services to the disadvantaged and administers population-oriented programs. The state's public health system currently faces four major challenges. The first is maintaining federal support, on which the Department of Health (now DHSS) depends for two-thirds of its public health revenues. The second is promoting regionalization as a way of improving local public health services and the efficiency of operating units. The third challenge is the impact and opportunities of the general movement to managed care, an issue nationwide. Fourth, unique to New Jersey, is the impact on public health of merging with the larger senior services component within the new DHSS. This enlargement seems certain to raise the department's profile within any administration but not necessarily to increase the attention paid to public health.

Challenges for the Future

Once dominated by declining heavy industry and commuters to nearby New York City and Philadelphia, New Jersey has come of age economically. It has diversified, and the high-tech and service sectors have blossomed. Tax receipts have exceeded expectations, greatly facilitating reductions in tax rates and allowing a balanced budget without cuts in services or programs. Medicaid is by far the biggest health care budget item, and recent policy has sought to

achieve efficiencies without cuts in eligibility or covered services. Prudent purchasing and managed care have helped considerably, as has a decline in welfare-related beneficiaries.

A continuing concern, however, is residents without health care coverage and the burden they place on New Jersey hospitals, which by an unusual state law must serve all comers. Another concern for the future is managed care. In the Medicaid program, the state must build upon its initially successful shift to Medicaid managed care and expand enrollment to include Medicaid populations with more complicated or more chronic health conditions. In addition, the state's challenges in implementing "managed charity care" are expected to be formidable, as there are no models to emulate. The precise impact of Medicaid and other managed care on the role of public health is also not clear. As provision of medical services to the poor increasingly flows through managed care, traditional public health providers may lose out.

New Jersey also faces serious challenges in modernizing its long-term care system. There is considerable interest in expanding home and community-based service options for both the elderly and younger persons with disabilities, funded to date mainly by savings from institutional downsizing. However, obtaining and redirecting savings from nursing homes, state hospitals, and state developmental centers to expand and maintain home and community-based services will likely present some difficulties.

Notes and Sources

This report was issued in May 1998 based on a February 1997 site visit, updated through the end of the year. Sources are given in the report.

* Please note that these numbers have been corrected since the original printing of this report.

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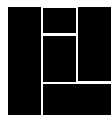
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