

Recent Changes in Health Policy for Low-Income People in New Jersey

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Overview

In recent years, New Jersey has substantially expanded its role in health financing. Public coverage has increased, especially for low- and moderate-income children, and so has public oversight of private coverage. This is a marked shift from the prior era of active public retrenchment and downsizing. During the early to mid-1990s, the state had been implementing hospital deregulation, major reductions in support for hospital uncompensated care, cuts in hospital and nursing home rates, and mandatory Medicaid managed care for cash-assistance beneficiaries. Such downsizing had been prompted both by economic downturn and a shift in political philosophy as Republicans assumed control of the governorship and both houses of the legislature in the early 1990s.

Politically, the early priorities of new leadership were reducing taxes, controlling public spending, promoting economic development, restructuring public pensions, and reforming welfare. From the mid-1990s, the accelerating economy brought rapid growth in revenues even as tax cutting continued, and budgetary pressures eased. Given new federal support for children's health care coverage and also tobacco settlement funds, in the latter 1990s New Jersey became an enthusiastic promoter of expanded coverage. NJ KidCare came first, for children, then became NJ FamilyCare, which also covered parents and some childless adults. Earlier state-only expansions had either languished with low funding (adults' coverage) or were never enacted (children's coverage).

In the late 1990s, public coverage expanded incrementally to quite generous levels. By early 2001, New Jersey offered coverage to children with family incomes up to 350 percent of the poverty level, parents up to 200 percent, and childless adults up to 100 percent, funded by a mix of funding streams. Some state funding is contributed without any federal match. The state's income eligibility levels are among the highest in the nation. Medicaid, children's, and adult coverages now operate as varying benefit packages within a single program, dubbed NJ FamilyCare. At higher income levels, NJ FamilyCare benefits are scaled back from Medicaid levels to match a benchmark private managed care plan. Another expansion provides premium assistance to help qualified beneficiaries pay for private coverage. For higher income beneficiaries, the program is not an entitlement. Administrators may trim the program as necessary to stay within appropriated funds, which they have done.

Other expansions have also occurred: The hospital charity pool won permanent funding in 1997, then increases in support. Moreover, that support comes from general state sources, not from an off-budget industry assessment as elsewhere. Drug coverage for seniors has just been increased as well, along with support for community-based long-term care services and other initiatives. Tobacco settlement funds have been devoted mainly to health policy concerns, not used for general purposes as is typical in other states, though roughly one-third goes for education.

The state is an eager maximizer of federal support but more cautious with its

Recent New Jersey health policy has combined liberal support for public coverage with conservative enthusiasm for tax cuts and prudent spending controls.

own tax dollars, especially in creating open-ended entitlements. For example, the state limited its support for the most recent expansion to parents and childless adults not eligible for federal matching contributions. When new enrollment reached funded levels much faster than expected, the program cut back on outreach. Faced with revenue shortfalls, the state fiscal year (SFY) 2002 budget added only limited new funds, and non-parent adults' coverage was subsequently scaled far back.

Officials speak warmly of relations with the Health Care Financing Administration (HCFA, since July 2001 known as Centers for Medicare and Medicaid Services or CMS) over program issues, including waiver requests. This congeniality is seen as a change due more to federal than to state developments. Long-term care policy continues to emphasize deinstitutionalization, with more in-community support for disabled persons. The state is seeking cooperative implementation of the Supreme Court's 1999 *Olmstead* ruling on inappropriate institutionalization of disabled Americans. It is recognized that more home- and community-based support is needed, so state policymakers are meeting with various advocacy groups and other constituencies to help set policy and, unlike many other states, New Jersey does not expect litigation.

Control over Medicaid spending has consistently been a key priority and has met with considerable success. Starting from a high spending base, Medicaid grew only 3 percent a year in 1995–2000, compared with 5 percent nationally. Medicaid's share of state general-fund spending accordingly declined from 16 percent to 14 percent. The state has also been able to absorb sizeable declines in federal Medicaid support for hospitals disproportionately serving the needy, with little impact on program operations. New Jersey Medicaid does not seem to crowd out other state priorities, unlike the situation in some other states. Officials give much credit for spending restraint to managed care for the welfare-related population, begun in 1995, but fee-for-service price controls also contributed. Managed care is also praised for making qualitative improvements to care, which is the primary rationale for expanding it to the aged, blind, and disabled. That expansion has just begun, after a long planning process. Major consolidations have occurred among managed care plans, dropping participation from 13 to 5 plans, and officials would like to add another plan. Consolidation has also occurred for Medicare and private markets, however, and does not seem a major public concern as yet.

As of mid-2001, prominent health policy issues include coping with reaching the ceiling on coverage expansions for children and families, implementing Medicaid managed care for the disabled, closing institutions for people with mental illness and people with developmental disabilities, expanding long-term care alternatives, as well as implementing the recently strengthened state financial oversight of health plans and patient protections, including potential for-profit conversion of the state's large Blue Cross plan. Other 1990s initiatives that seem to be stable, and hence less salient, concerns include reorganization of the health department, administration of Medicaid managed care for poverty-related beneficiaries, expansion of state subsidies for prescription drugs for aged and disabled persons, redesign of the state's hospital uncompensated care pool, and most of the quality regulation of HMOs.

Two new developments create considerable uncertainty for continued expansion. The first is a slowdown in revenue growth. The SFY 2002 budget required \$1 billion in adjustments between the governor's proposal of January 2001 and the enacted budget of June. The 2002 adjustments included revenue enhancements in the collection of business taxes, but major political resistance ruled out broad tax increases and recession has since worsened the picture, especially after the terrorist attacks of September 11. The state also incurred unexpected costs from September 11 and its aftermath, and from the anthrax emergency. The November election realigned political power, with Democrats reclaiming the governorship and the assembly and tying in the senate. Governor Jim McGreevey repeatedly attacked the record of the last eight years for overspending and has repeatedly promised not to raise taxes. Given the fiscal outlook, the future challenge may not be to craft further growth in public activities but rather just to maintain past expansions.

The foregoing are the main findings of this case study of recent health care policy affecting low-income people in New Jersey, which builds on a 1997 baseline study.¹ This report and others like it examine representative states' responses to the new opportunities and challenges of the last half decade.² This report is based on personal interviews in mid-March 2001, supplemented by telephone and written responses, as well as documents, newspapers, and Web sites. Interviewees were given the opportunity to comment on a draft. Fiscal developments, major budget changes, and Medicaid shifts were followed through November 2001.³ The following presentation tracks the five key issues studied: First, how have political and fiscal circumstances changed in New Jersey? Second, how has the state changed its public or private health insurance coverage? Third, how have Medicaid managed care and other acute care issues changed? Fourth, how did New Jersey policymakers respond to pressures to expand home- and community-based services for persons with disabilities? Fifth, what other issues were prominent?

Background to Policymaking

Demographics, Insurance Coverage, and Politics

New Jersey is a populous, wealthy, and densely populated state (table 1). The state's ethnic and racial composition is broadly similar to the national average, though immigrant populations are changing the mix. A smaller share of the state's population lives in poverty than in the nation at large, but that share dropped less than elsewhere between 1996 and 1998.

TABLE 1. Selected New Jersey Characteristics

| | New Jersey | United States |
|---|------------|---------------|
| Population Characteristics | | |
| Population (2000) (in thousands) ^a | 8,414 | 281,422 |
| Percent under age 18 (1999) ^a | 24.8% | 25.7% |
| Percent Hispanic (1999) ^b | 14.4% | 12.5% |
| Percent black (1999) ^b | 14.2% | 12.8% |
| Percent Asian (1999) ^b | 5.7% | 4.1% |
| Percent nonmetropolitan (1999) ^b | 0.0% | 20.3% |
| State Economic Characteristics | | |
| Per capita income (2000) ^c | \$36,983 | \$29,676 |
| Percent change per capita income (1995–1999) ^d | 11.1% | 10.8% |
| Unemployment rate (2001) ^e | 4.2% | 4.5% |
| Family Profile | | |
| Percent children in poverty (1998) ^f | 12.8% | 17.5% |
| Percent change children in poverty (1996–1998) ^f | –4.4% | –15.0% |
| Percent adults in poverty (1998) ^f | 7.5% | 11.2% |
| Percent change adults in poverty (1996–1998) ^f | –6.3% | –10.4% |
| Political | | |
| Governor's affiliation (2001) ^g | Republican | N/A |
| Party composition of senate (2001) ^h | 15D-25R | N/A |
| Party composition of house (2001) ^h | 35D-45R | N/A |
| Percent of Poor Children Covered by Welfare | | |
| 1996 (AFDC) ⁱ | 74.5% | 59.3% |
| 1998 (TANF) ⁱ | 57.1% | 49.9% |
| Income Cutoff for Children's Eligibility for Medicaid/State Children's Health Insurance Program (Percent of Federal Poverty Level) | | |
| 1996 ^{j,k} | 98% | 124% |
| 1998 ^{j,l} | 200% | 178% |
| 2000 ^{j,m} | 350% | 205% |

Table 1 notes begin on page 30.

New Jersey residents are more likely than average to have employer-sponsored health insurance coverage (table 2), while Medicaid covers the same share of the remaining uninsured as nationally, resulting in a slightly lower than average share of total population with public coverage. New Jersey's higher rate of employer-sponsored coverage is most pronounced for children. Public coverage also protects a higher percentage of poor children and an average share of poor adults in New Jersey, where the rate of poverty itself is rather low. The bottom line is that the overall rate of uninsurance is below the national average.

Republicans dominated state politics from the time they gained complete control of the legislature in 1992 and the governorship in 1994 until losing power in the November 2001 election. Voters elected Christine Todd Whitman over incumbent Governor Jim Florio, who was discredited after breaking clear campaign promises by pushing through a large tax increase in 1990 to maintain services during the recession. Tax cutting and economic development were Governor Whitman's key priorities. Health care was not a prominent issue, and the key health policy shift of the early 1990s, deregulation of hospital rates, had already begun. Over time, she gave health care higher priority, especially for coverage expansions beyond conventional Medicaid, through NJ KidCare and then NJ FamilyCare. The strength of political support for state health spending and for public involvement in hospital and insurance markets shows in political outcomes and polling data.⁴

Whitman won a second term in 1997, although narrowly, then resigned a year early, leaving in January 2001 to run the federal Environmental Protection Agency in the Bush

TABLE 2. Health Insurance Coverage by Family Income and Type of Insurance, New Jersey and the United States, 1999

| | Children (Ages 0–18) ^a (%) | | Adults (Ages 19–64) ^b (%) | |
|-----------------------|--|---------------|---|---------------|
| | New Jersey | United States | New Jersey | United States |
| Below 200% FPL | | | | |
| Employer-sponsored | 41.7 | 38.7 | 40.1 | 41.7 |
| Medicaid/SCHIP/state | 38.1 | 35.2 | 16.9 | 14.7 |
| Other coverage | 3.9 | 3.8 | 9.0 | 8.8 |
| Uninsured | 16.3 | 22.4 | 34.1 | 34.9 |
| Above 200% FPL | | | | |
| Employer-sponsored | 89.2 | 85.3 | 86.4 | 83.7 |
| Medicaid/SCHIP/state | 3.1 | 3.8 | 0.9 | 1.1 |
| Other coverage | 2.9 | 4.9 | 3.2 | 5.8 |
| Uninsured | 4.8 | 6.0 | 9.5 | 9.4 |
| All Incomes | | | | |
| Employer-sponsored | 75.9 | 66.7 | 78.1 | 72.3 |
| Medicaid/SCHIP/state | 12.9 | 16.4 | 3.8 | 4.8 |
| Other coverage | 3.1 | 4.5 | 4.3 | 6.6 |
| Uninsured | 8.0 | 12.5 | 13.9 | 16.3 |

a. Kenney, Genevieve, Lisa Dubay, and Jennifer Haley. 2000. "Health Insurance, Access, and Health Status of Children." In *Snapshots of America's Families II: A View of the Nation and 13 States from the National Survey of America's Families*. Washington, D.C.: The Urban Institute.

b. Zuckerman, Stephen, Jennifer Haley, and John Holahan. 2000. "Health Insurance, Access, and Health Status of Adults." In *Snapshots of America's Families II: A View of the Nation and 13 States from the National Survey of America's Families*. Washington, D.C.: The Urban Institute.

Notes: Figures in bold represent values that are statistically significantly different from the national average at the 0.10 confidence level or better.
FPL = federal poverty level
SCHIP = State Children's Health Insurance Program

administration. Senate President Donald DiFrancesco then became acting governor as well, pending the election of November 2001. He withdrew from the race after a few months in office, blaming hostile media coverage.⁵

In November's gubernatorial election, Democrat Jim McGreevey defeated Republican Bret Schundler 56–42 percent.⁶ McGreevey campaigned as a fiscal conservative, repeatedly promising not to raise taxes and complaining about the run-up of state debt and local property taxes under the Republican administration. Schundler was perceived as socially too conservative for New Jersey, opposed even by much of the state Republican establishment. Health policy was not a significant issue in the campaign.⁷

Democrats also made large gains in the legislature. When the 210th legislature convened on January 8, 2002, Democrats controlled the assembly 45–35, having gained 10 seats, and will share power in the 20–20 senate after a 5-seat gain.⁸

In the legislative races, many observers think Democrats are likely to score big gains. The state is increasingly Democratic in voter identification; Democrats dominate national elections (President Bush lost by 15 percentage points); and Democrats also appear to benefit from post-census redistricting.

State Fiscal Circumstances

New Jersey's economy performed robustly for a decade after a difficult emergence from the early 1990s recession. The state ranks second among states in per capita income—\$36,983 in 2000, about \$7,000 above the national average (table 1). In recent years, growth in per capita income exceeded national growth rates. Governor Whitman took office in 1994 in the aftermath of the recession, when annual expenditures exceeded base revenue by roughly \$1.59 billion.⁹ As she left in January 2001, the state was projecting a \$1 billion surplus in the \$22 billion budget proposed for 2002, of which about two-thirds constitute a formal rainy day fund whose use is restricted. A similar 4 percent surplus had been projected in the budget for 2000, which closed with an even higher level of unspent revenues, according to the state budget office.

Improvement in the operating budget came from strong growth in revenues, controlled growth in spending, and restructuring of public debt. Annual budgetary growth was 5.1 percent from the 1994 through the 2001 budgets, the lowest rate of spending growth of any New Jersey administration since 1954, according to the state budget, though debt simultaneously rose at almost 7 percent a year.¹⁰ Growth in debt is said to have been even larger in prior years, but the state today is recognized as having an unusually high debt load. Despite having to finance this debt, the state continued to run a surplus into 2001, and bond-rating agencies have shown confidence by upgrading the state's debt multiple times since 1994.

Budgetary pressures have built, however. In 2000, state expenditures slightly outgrew projections for the fiscal year, but so did revenues. Supplemental appropriations were needed mid-year, for instance, to deal with damage from Hurricane Floyd. The HMO bailout legislation of 2000 subsequently needed a supplemental appropriation, but Medicaid and other health programs did not. NJ FamilyCare enrollment grew far faster than expectations once fully implemented in early 2001, but higher program spending was accommodated within slack elsewhere in the budget. As the SFY 2001 budget was adopted in June 2001, revenue growth was expected to continue, but at lower rates than previously projected, as New Jersey, in common with the rest of the nation, braced for a possible recession.¹¹ The shortfall relative to earlier plans was met by a combination of modest cuts, revenue increases, and one-time adjustments.

Continuing political pressures for spending control also existed. Along with reducing growth in the public sector, other top state priorities were promoting private economic development and running what Whitman-DiFrancesco administrators saw as a fiscally prudent administration. Not only did bond ratings rise, but one-time budget-balancing solutions have decreased—at least until SFY 2002. The state's 1997 sale of long-term bonds seems to have been well timed: It recapitalized the previously under-funded public pen-

sion system, which then benefited from the stock boom of the latter 1990s, freeing up resources for other priorities.

Both governors and the legislature take pride in cutting taxes about 40 times in eight years. For the poor, the big changes have been sharp rises in income excluded from taxation and the introduction of an earned income tax credit for low-income families with children. The credit is being phased in through 2004, at which time it is slated to constitute 20 percent of the federal credit. Cigarette taxes were raised, partly to fund the state's unusual hospital charity pool. The legislature rejected Governor Whitman's plan to raise the gasoline tax. Despite overall decreases, New Jersey's taxes remain very high per capita relative to other states.

Recession has continued to erode revenue projections since summer, especially in the aftermath of September 11. The DiFrancesco administration has estimated that the revenue shortfall for SFY 2002 "will exceed \$700 million," offset by a 2001 surplus found to be \$220 million larger than budgeted (the total budget is \$23 billion). Spending in 2002 through November is said to be higher than budgeted, but can be accommodated through internal shifts. To maintain balance, the governor has announced mainly one-time cuts and spending freezes of over \$500 million. Looking ahead, the administration has also frozen hiring and asked most agencies to plan 5 percent cuts, with 3 percent to be recurring. Governor McGreevey contends that revenues shortfall and spending overrun are both bigger than acknowledged and has threatened to roll back any spending he deems excessive after taking office.¹²

TABLE 3. New Jersey Spending by Category, 1995 and 2000 (\$ in Millions)

| Program | State General-Fund Expenditures ^a | | | | Total Expenditures ^b | | | |
|-------------------------|--|----------------|---------------|------|---------------------------------|----------------|---------------|------|
| | Actual 1995 | Estimated 2000 | Annual Growth | | Actual 1995 | Estimated 2000 | Annual Growth | |
| | | | NJ | U.S. | | | NJ | U.S. |
| Total | 14,945 | \$19,424 | 5% | 5% | \$22,726 | \$29,367 | 5% | 6% |
| Medicaid ^{c,d} | \$2,332 | \$2,665 | 3% | 5% | \$5,344 | \$6,127 | 3% | 4% |
| % of Total | 16% | 14% | | | 24% | 21% | | |
| K-12 Education | \$4,431 | \$6,156 | 7% | 7% | \$4,929 | \$6,671 | 6% | 7% |
| % of Total | 30% | 32% | | | 22% | 23% | | |
| Higher Education | \$1,085 | \$1,768 | 10% | 5% | \$1,120 | \$2,334 | 16% | 5% |
| % of Total | 7% | 9% | | | 5% | 8% | | |
| Public Assistance | \$470 | \$249 | -12% | -6% | \$783 | \$405 | -12% | -5% |
| % of Total | 3% | 1% | | | 3% | 1% | | |
| AFDC/TANF | \$235 | \$64 | -23% | -9% | \$500 | \$180 | -18% | -7% |
| % of Total | 2% | 0% | | | 2% | 1% | | |
| Corrections | \$692 | \$1,039 | 8% | 6% | \$731 | \$1,078 | 8% | 6% |
| % of Total | 5% | 5% | | | 3% | 4% | | |
| Transportation | \$681 | \$865 | 5% | 5% | \$1,625 | \$2,173 | 6% | 6% |
| % of Total | 5% | 4% | | | 7% | 7% | | |
| All Other ^e | \$5,254 | \$6,682 | 5% | 5% | \$8,194 | \$10,581 | 5% | 8% |
| % of Total | 35% | 34% | | | 36% | 36% | | |

Source: National Association of State Budget Officers, 1996 *State Expenditure Report* (April 1997) and 1999 *State Expenditure Report* (June 2000)

a. State general-fund expenditures exclude other state funds and bond expenditures.

b. Total spending for each category includes the general fund, other state funds, bonds, and federal aid.

c. States are requested by the National Association of State Budget Officers (NASBO) to exclude provider taxes, donations, fees, and assessments from state spending. NASBO asks states to report these separately as "other state funds." In some cases, however, a portion of these taxes, fees, etc., do get included in state spending because states cannot separate them.

d. Total Medicaid spending will differ from data reported on the HCFA 64 for three reasons: first, NASBO reports on the state fiscal year and the HCFA 64 on the federal fiscal year; second, states often report some expenditures (e.g., mental health and/or mental retardation) as other health rather than Medicaid; third, local contributions to Medicaid are not included but would be part of Medicaid spending on the HCFA 64.

e. This category could include spending for the State Children's Health Insurance Program, institutional and community care for mentally ill and developmentally disabled persons, public health programs, employer contributions to pensions and health benefits, economic development, environmental projects, state police, parks and recreation, housing, and general aid to local government.

The budget provides one look at recent state priorities. Public safety has been a key goal. Expenditures on corrections have grown faster than the national average, 8 versus 6 percent (table 3), mainly for new prison space. Education is another important priority, in part driven by a Supreme Court order to help poor communities so as to reduce inequality across localities—the latest in decades of such rulings. Funding for primary and secondary education (K–12) increased by 6 percent, near the national average of 7 percent. Higher education spending grew three times as fast as the national average, 16.5 versus 5 percent, and a 1994 law restructured the governance of higher education.

Work First New Jersey reformed welfare in 1997, and the number of recipients has declined by 55 percent since. Total cash assistance (AFDC/TANF) decreased faster than the national average, 18 percent per year versus 7 percent per year under Aid to Families with Dependent Children (AFDC) and Temporary Assistance for Needy Families (TANF). Control over Medicaid spending has consistently been a key priority and has met with considerable success. Starting from a high base of spending, Medicaid growth was lower than nationally (3 percent per year versus 5 percent in 1995–2000); the program's share of state general-fund spending has dropped from 16 percent to 14 percent.¹³

State finances also benefit from the November 1998 tobacco settlement.¹⁴ New Jersey received \$137.8 million through December 2000, and the state expects to receive between \$247.9 million and \$324.5 million per year through 2025. After a dispute over creating a dedicated health care trust fund, settlement proceeds were put into the state's annual budget process. Still, unlike most states,¹⁵ New Jersey has put about two-thirds of these funds into health-related programs—slightly more than one-third for NJ FamilyCare, slightly less than one-third split between prescription drugs for the elderly and tobacco control. Slightly more than one-third goes to school rebuilding.

Medicaid Trends

Medicaid's huge budget dominates health policy, and its growth affects all of state policy-making. The program passed \$6 billion in total spending for SFY 2000, more than one budget dollar in five, a somewhat higher share than in the average state (table 3).¹⁶ Unlike other states, however, New Jersey's Medicaid growth has not pressured other state priorities, including other health care spending. Indeed, Medicaid's share of the state budget declined from 24 percent to 21 percent during 1995–2000 because the state held down Medicaid spending growth relative to other areas and to the national norm. Another indicator of budgetary success is that New Jersey's actual Medicaid spending stayed under planned amounts during this period, so that no supplemental appropriations were needed.

Challenges to efficient program management have changed over time, as different cost drivers have emerged. The composition of Medicaid spending by category and relative to national averages provides a more complete picture through 1998, the most recent year with complete national data (table 4).¹⁷ Enrollment is not responsible for higher costs, as the state's average monthly enrollment dropped just over 1 percent per year during 1995–1998, slightly faster than the national decline.¹⁸ Enrollment declined most after welfare reform in 1997 but edged back up with implementation of NJ KidCare in 1998, whose "aggressive outreach efforts" also find Medicaid eligibles.¹⁹ Traditional Medicaid enrollment in New Jersey continued to decline slowly after 1998.²⁰ Some new efforts have spurred enrollment, including the mailing of over 52,000 letters to former welfare mothers who may still be eligible for coverage. (The next section of this paper describes the NJ KidCare and NJ FamilyCare expansions, which differ from traditional Medicaid, although the expansions are increasingly administered and presented to beneficiaries as a single, integrated program.)

New Jersey's spending on medical services per enrollee remains high, almost \$6,500 in 1998 (table 4), compared with the national average of under \$4,900 (similar compilation by the Urban Institute, not presented). The state ranked seventh highest in the nation overall for 1998 and was high across most beneficiary categories: per child (29th highest), per adult (16th), per disabled enrollee (11th), and per elderly enrollee (18th).²¹ Per enrollee

TABLE 4. Medicaid Enrollment and Expenditures in New Jersey, 1998

| | New Jersey, 1998 | | | Average Annual Growth (%), 1995–1998 | | | | | |
|---------------------------|--|---|--|--------------------------------------|---------------|-------------------------|---------------|---------------------------|---------------|
| | Total Annual Expenditures (in millions) | Avg. Monthly Enrollment (in thousands) | Avg. Annual Expenditures per Enrollee | Total Annual Expenditures | | Avg. Monthly Enrollment | | Expenditures per Enrollee | |
| | | | | New Jersey | United States | New Jersey | United States | New Jersey | United States |
| Total Expenditures | \$5,572 | – | – | 0.7 | 3.9 | – | – | – | – |
| Medical Services | | | | | | | | | |
| By Eligible Group | \$4,431 | 684 | \$6,479 | 2.6 | 5.1 | –1.2 | –1.0 | 3.8 | 6.1 |
| Elderly | \$1,413 | 94 | \$15,056 | 3.0 | 4.3 | 6.0 | 0.1 | –2.9 | 4.2 |
| Blind and disabled | \$2,083 | 152 | \$13,685 | 4.7 | 8.5 | 3.1 | 3.6 | 1.6 | 4.7 |
| Adults | \$388 | 112 | \$3,453 | –10.1 | –1.4 | –7.7 | –4.4 | –2.7 | 3.1 |
| Cash assistance | \$212 | 66 | \$3,201 | –13.3 | –10.4 | –14.0 | –14.9 | 0.7 | 5.3 |
| Other enrollees | \$176 | 46 | \$3,816 | 5.5 | 7.8 | 6.1 | 9.3 | –10.9 | –1.4 |
| Children | \$546 | 325 | \$1,678 | 5.8 | 2.7 | –2.3 | –1.5 | 8.3 | 4.3 |
| Cash assistance | \$199 | 136 | \$1,468 | –12.6 | –8.8 | –14.7 | –12.2 | 2.5 | 3.9 |
| Other enrollees | \$347 | 190 | \$1,829 | 28.9 | 12.4 | 13.6 | 9.8 | 13.5 | 2.4 |
| By Type of Service | \$4,431 | – | – | 2.6 | 5.1 | – | – | – | – |
| Acute care | \$2,286 | – | – | 2.0 | 4.0 | – | – | – | – |
| Long-term care | \$2,145 | – | – | 3.2 | 6.5 | – | – | – | – |
| DSH | \$1,020 | – | – | –7.4 | –7.3 | – | – | – | – |
| Administration | \$121 | – | – | 20.5 | 8.5 | – | – | – | – |

Source: Urban Institute estimates based on data from HCFA 2082 and HCFA 64 reports.

Note: Does not include the U.S. Territories. Enrollment data shown are estimates of the average number of people enrolled in Medicaid in any month during the fiscal year. Expenditures per enrollee shown reflect total annual expenditures on medical services for each group, divided by the average monthly enrollment within that group. “Cash assistance” refers to enrollees who receive AFDC/TANF or SSI or who are eligible under Section 1931 provisions. “Other enrollees” include the medically needy, poverty-related expansion groups, and people eligible under Medicaid Section 1115 waivers. “Acute care” services include inpatient, physician, lab, X-ray, outpatient, clinic, prescription drugs, EPSDT, family planning, dental, vision, other practitioners’ care, payments to managed care organizations (MCOs), and payments to Medicare. “Long-term care” services include nursing facilities, intermediate care facilities for the mentally retarded, inpatient mental health services, home health services, and personal care support services. “DSH” stands for disproportionate share hospital payments.

costs are not high compared with neighboring states, however, and New Jersey traditionally has ranked in the middle of states on generosity of eligibility and benefits.²² The state has always kept physician fees low, cut hospital rates after deregulation in 1993, required managed care for almost all cash assistance beneficiaries starting in 1995, and modestly reduced nursing home payment rates in 1995 and 1999. The state has not sought a broad "Section 1115" waiver to expand eligibility broadly, but it has sought waivers for managed care and for State Children's Health Insurance Program (SCHIP) funding of parents.

New Jersey's Medicaid cost containment was successful during 1995 through 1998, as benefits spending per enrollee grew only 2.6 percent a year, half the national rate of 5.1 percent. The state's 1998 spending was thus one-third of a billion dollars below what would have occurred under the national rate of growth. Before 1995, the state grew faster than the national average. State officials credit managed care for much of the improvement starting in 1995. Economies were also achieved in nursing home payments and elsewhere. During 1995–1998, the overall Medicaid budget was also held down by federal cuts in support for disproportionate share hospital (DSH) payments (table 4). State officials argue strongly that access and quality have improved, even as spending has been held down, in large measure from an increase in physician participation under managed care, which raised physician fees. One of outgoing Governor Whitman's last policy proposals was to budget for a physician payment increase beginning January 2002, within both fee-for-service and managed care sectors of Medicaid.

As in other states, long-term care services account for nearly half of state Medicaid spending (table 4). Institutional expenditures continue to dominate long-term care, though they grew more slowly in New Jersey than in the nation at large during 1995–1998. Spending actually fell for intermediate care facilities for the mentally retarded, compared with no change nationally (Urban Institute compilations, not presented). Home care services (including home- and community-based waivers) grew faster, but even so at only half the rate of the entire country. The state has a very large program of DSH payments, \$1 billion in 1998 even after federal reforms cut DSH by over 20 percent from 1995 levels. Officials believe that the state maximizes available federal revenues. Administrative spending rose much faster in New Jersey during 1995–1998 than nationally, evidently to run managed care and plan for program expansions.

Other than managed care, the fastest growing acute care service from 1995 to 1998 was prescription drugs, though New Jersey's annual growth of 7.7 percent was less than the 11.2 percent national rate.²³ Increases have continued to outpace the rest of the program since then, by some 15–18 percent annually. Prices and utilization are both up, and consumption is moving "upscale" to newer and more expensive drugs.²⁴

New Jersey's Medicaid expenditures have continued to grow since 1998, according to budget figures, at an annual growth rate of 3.9 percent, compared with 6.1 percent nationally.²⁵ According to the state budget, prescription drugs and Medicare Part B premiums were the major Medicaid cost drivers in SFY 2000. In SFY 2001, drugs, managed care, hospital outpatient, clinics, personal care, and Medicare Part B premiums were the major drivers.²⁶ Starting in mid SFY 2001, the state is using county-run nursing homes to make an intergovernmental transfer that will draw down an added \$450 million in federal funds, rising to \$485 million in 2002, after which such transfers will no longer be allowable. Although the transfer effectively reduces state obligations, the 2002 proposed budget built in 9 percent growth for Medicaid, above the 6 or 7 percent typical of recent years, which the legislature enacted, despite emerging concerns about revenue shortfalls.

Economizing remains a constant concern. The state is moving to managed care for aged, blind, and disabled beneficiaries (though less for budgetary than for qualitative reasons), and pharmaceuticals are the focus of several economizing initiatives. The state expects to see lower average wholesale prices (AWPs) as a result of federal investigation of the industry's pricing and reporting patterns. Moreover, New Jersey is planning to increase the 10 percent discount below AWP to 15 percent for high-volume drugstores

(mainly the chains). The state is also making generic prescriptions the default, subject to explicit override by a prescribing physician.

Health Insurance Coverage

New Jersey policymakers have long been interested in expanding health insurance coverage. New Jersey's recent expansions for children, parents, childless couples, and single adults are among the most generous in the nation. From a narrow start, expansions have grown into broad-based, multifaceted coverage initiatives. Health Access New Jersey, enacted in 1992, was designed to use state funds to subsidize private coverage for low-income people not eligible for Medicare or Medicaid. The program was not implemented until 1995 and was never funded as envisioned. Governor Whitman halted enrollment in that program and proposed instead a limited children's health expansion, but her proposal to fund this expansion with a tobacco tax increase was rejected. In 1997, the proposal was revamped to take advantage of newly available federal assistance under SCHIP, and NJ KidCare began in 1998.

The state first enacted Medicaid expansions for children in lower-income families, then nonentitlement initiatives to children in families with slightly higher incomes. After the children's expansions, policymakers shifted to adults, creating a narrow Medicaid expansion for low-income parents of children already participating in Medicaid, as well as a non-Medicaid expansion for a wide range of adults, some with incomes up to 200 percent of the federal poverty level (FPL).

The state now operates an integrated public system for families, renamed NJ FamilyCare. A program to subsidize private employer-based coverage for both children and adults with low family incomes began in mid-2001. That premium-supported program had been under development for some time, as policymakers sought to learn from other states' start-up difficulties. Its goal is to encourage private coverage and forestall "crowd out" of private support.

The Children's Expansion (Initially Known as NJ KidCare)

New Jersey's SCHIP expansion for children is the most generous in the nation, whether measured as the highest income eligibility threshold or the largest rise in threshold after SCHIP. Before SCHIP, the legislature had been interested in expanding coverage for children, but was deterred by the expense. Once given access to federal funds, New Jersey responded quickly.

SCHIP expanded in several phases. The first expansion, in February 1998, covered children up to age 19 in families with incomes up to 133 percent of FPL, who were enrolled in Medicaid. This group included older children, ages 6 to 18, who were not already eligible for Medicaid. A month later, New Jersey began offering non-Medicaid coverage to children with family incomes between 133 and 200 percent of FPL. In July 1999, the state expanded non-Medicaid coverage to children in higher income families (200–350 percent of FPL).

Benefits are generous under the non-Medicaid expansion, exceeding the federal minimums for SCHIP, but policymakers sought to reduce possible crowd out by making benefits no more generous than private coverage. For families with income below 200 percent of FPL, benefits are based on the Federal Employee Health Benefits Plan (Blue Cross Blue Shield Standard PPO), plus some additional benefits. For families with income above 200 percent of FPL, the package builds upon the most widely sold commercial HMO package in New Jersey, again making some additions. NJ KidCare benefits include vision and dental and are more generous than those offered in almost any private plan. Modest cost sharing is required of higher income beneficiaries.

Because of its entitlement nature, state officials were not interested in expanding Medicaid. However, they wanted the Medicaid agency to run NJ KidCare because of its success in implementing Medicaid managed care, on which NJ KidCare is based. All NJ KidCare enrollees must enroll in managed care. Although the managed care service deliv-

ery system is the same for both Medicaid and NJ KidCare, New Jersey pays a lower rate to plans for NJ KidCare enrollees in the higher income groups than for Medicaid.

NJ KidCare also sought to equalize eligibility thresholds across age groups (infants excepted). In other words, within a low-income family, all children are eligible for either traditional Medicaid or for subsidized KidCare. Before, eligibility standards for Medicaid varied by age of child. Despite the state's ambitious expansions, enrollment and expenditures for children were initially lower than anticipated, but then grew over time. In December 1998, enrollment was 23,164, but rose to 55,387 six months later and to 68,520 by June 2000.²⁷ Of these enrollees, 30,563 were in the Medicaid SCHIP expansion, and 37,957 in the non-Medicaid component. According to the program Web site, in February 2001, 75,260 children were enrolled.²⁸ The number of children covered is about one-fifth the number covered under Medicaid. Spillover from NJ KidCare to Medicaid added about 22,000 children to the Medicaid rolls by September 1999.²⁹

Expenditures followed enrollment, rising from only about \$5 million to \$120 million during FFYs 1998–2000 (federal and state funds combined). Still, enrollment growth lagged expectations. New Jersey could only spend a third of available federal dollars in this period; the average state spent only a quarter.³⁰

To boost enrollment, the state eased eligibility rules and administration. The Medicaid-style face-to-face interview was dropped in favor of a mail-in application. The state also shortened the required "waiting period" of uninsurance before granting eligibility to poor children (below 200 percent of FPL). The period was cut from 12 to 6 months for children who had had employer-sponsored coverage and was completely eliminated for children who had had individual coverage and those who were involuntarily dis-enrolled by employers. The state also gave certain providers authority to presumptively enroll poor children, pending final state determinations.

New Jersey also reaches out to potentially eligible people through community groups, paying a \$25 fee for each approved application referred from hundreds of community groups, day care centers, local health departments, federally qualified health centers, and schools. The application form for children seeking a subsidized school lunch now also asks if a family wants health coverage. Other state agencies cooperate as well. The Department of Motor Vehicles inserts flyers into all vehicle driver license and registration renewals, and the New Jersey Lottery inserts flyers into its plastic game cardholders. Kmart promotes enrollment in its stores; the tri-state campaign also includes New York and Connecticut. Some 125 McDonald's locations also offer applications.

State officials clearly like to market NJ KidCare, and are happy that NJ KidCare appears to have avoided any welfare stigma. They point with pride to HMO ads that don't even mention state involvement. HMOs are now allowed to advertise in certain ways, as initial restrictions have been eased. Surveys by the NJ KidCare office find that about one-fifth of new enrollees hear about the program through family or friends and another one-fifth hear through schools.

The program requires premium contributions for families with incomes above 150 percent of FPL. The amount rises from \$15 a month at 150 percent (to cover any number of children) to a maximum of \$100 a month for 301–350 percent of FPL. A limited copayment obligation exists, but not for preventive services.

NJ FamilyCare: Adding Adult Coverage

In December 1999, Governor Whitman proposed a new coverage expansion, NJ FamilyCare.³¹ The original plan was to use new tobacco settlement funds to extend the NJ KidCare model to parents and childless adults. Once the legislature enacted NJ FamilyCare in June 2000, NJ FamilyCare subsumed NJ KidCare. NJ FamilyCare also raised income ceilings for pregnant women. The new program now attempts to create a single, seamless system for families, combining different sources of funding for various types of enrollees. NJ FamilyCare uses the same managed care delivery system as before, but no longer uses the NJ KidCare name. New Jersey (along with Rhode Island and Wisconsin)

received the first federal Section 1115 SCHIP waiver for this type of expansion, in January 2001. The state uses SCHIP funds to pay for parents with income up to 200 percent of FPL whose children already qualify for either Medicaid or SCHIP. The state began operations a few months earlier, using state funds in expectation of the waiver. NJ FamilyCare has quickly surpassed enrollment expectations.

NJ FamilyCare eligibility is somewhat complex because of the mix of funding flows, though families see only one application form. Parents are eligible up to 200 percent of FPL if their children are eligible for either Medicaid or non-Medicaid coverage under the old NJ KidCare/Medicaid rules. The entire family's coverage, however, is now called NJ FamilyCare. Pregnant women, formerly covered under Medicaid up to 185 percent of FPL, are now covered under the SCHIP waiver up to 200 percent of FPL.

Eligible parents who enroll in NJ FamilyCare join the same health plan as their children, though their benefits may differ. Below 133 percent of FPL, NJ FamilyCare provides Medicaid benefits (though not the childhood-specific services of the Early and Periodic Screening, Diagnosis, and Testing Program). Above that level, benefits are based on one of the private insurance benchmarks.³² Parents with incomes between 133 and 200 percent of FPL are covered only under SCHIP funding, and receive non-Medicaid benefits.

NJ FamilyCare also covers childless adults, using state dollars without federal matching. Childless adults with income below 50 percent of FPL are eligible for Medicaid-like benefits, and childless adults with income between 50 and 100 percent of FPL are eligible for a managed care package. In the last days of her administration, Governor Whitman proposed additional coverage for childless adults up to 200 percent of FPL, but this was not enacted. NJ FamilyCare also uses state-only funds to cover legal immigrants who arrived in the United States after 1996 and hence by federal law cannot get federally funded benefits for five years, including Medicaid and SCHIP.

Cost-sharing in the NJ FamilyCare program follows the NJ KidCare model: Premium contributions begin at family incomes above 150 percent of FPL, and rise with income.³³

New Jersey has also moved to subsidize employer-based coverage. In 1999, a New Jersey working group envisioned several options for premium subsidy programs, at that time for children enrolled in employer-sponsored plans but now expanded to include adults as well. In mid-2001, New Jersey implemented a premium assistance program for families whose small employer group coverage is more cost-effective than public coverage. Employers must pay at least 50 percent of premium. The state hopes that a 50 percent subsidy will be enough to encourage currently uninsured employment groups to participate. Administrators recognize, however, that experience in other states like Wisconsin and Massachusetts shows that New Jersey will face significant administrative challenges in implementation.

NJ FamilyCare new enrollment greatly exceeded expectations. The state planned for adult enrollment of 125,000 after three years, but reached 75,000 within three months. Officials cite several reasons for this success, noting that they wanted to learn from the slow start of NJ KidCare. First, the state started by automatically transferring in 23,000 beneficiaries from its general assistance-medical program, which had had limited benefits. Second, the state solicited some 66,000 parents of children in NJ KidCare as already identified potential applicants. Third, a multimillion dollar media campaign promoted the program.

The high demand created administrative problems, and by February 2001 a backlog of some 27,000 applications raised concerns about hitting the budgetary cap. To achieve budget compliance, the administration halted the media campaign, and later ended presumptive eligibility for adults.³⁴ In March, budget officials said that NJ FamilyCare's accelerated spending could be financed within reserves left in the Medicaid budget. Policy officials said in March that it was inconceivable that NJ FamilyCare could be cut, especially in an election year. In June, the final SFY 2002 budget added modest new state funding to help the program to cope with its faster than anticipated enrollment and also authorized administrators to take whatever steps were needed to stay within the new budget. In mid-

August, with enrollment nearing 125,000, officials drastically curbed eligibility for new adult applicants and ended fee-for-service benefits previously available before enrollees entered a managed care plan.³⁵ Existing enrollees and applicants already in the queue were not cut. Overall, adult enrollment surpassed 146,000 by the end of November.

Everyone in New Jersey expressed pride that NJ FamilyCare is a truly New Jersey program, not a federal one. Still, the budgetary challenges posed by past expansions appear to rule out full funding for childless adults, at least pending November's state election and further developments in the economy and in federal policy.

Medicaid and NJ FamilyCare in Combined Perspective

With the NJ FamilyCare expansions and parallel revisions to traditional Medicaid operations outside of long-term care services, New Jersey policymakers designed a system to make health insurance coverage available to all uninsured children below 350 percent of FPL, virtually all parents below 200 percent, and childless adults below 100 percent. New Jersey maximizes federal dollars to cover all populations eligible for federal match, and uses state dollars to fill in some gaps.

Virtually all of the state's expenditures on children are matched with federal dollars, except for certain immigrant children for whom the state picks up the tab. Most children's coverage is provided under Medicaid, for which the state match is 50 cents on the dollar; smaller proportions are covered under the federal SCHIP program, for which the state match is only 35 cents. As a result, most dollars targeted to children are federal dollars. Federal generosity toward children made it far easier to provide coverage broadly, to children in families with income up to 350 percent of FPL; before SCHIP there had been little political enthusiasm for gubernatorial expansion plans.

In contrast, there are few opportunities to access federal dollars to provide coverage for adults—a key reason why adult coverage is more limited than children's coverage. State expenditures on parents are matched with either federal Medicaid or federal SCHIP dollars, whereas state expenditures on childless adults are not eligible for federal match. When asked what NJ FamilyCare would do when it reached its maximum enrollment, one high-level state respondent in March 2001 noted that much would depend on whether the federal government provided new assistance. New Jersey had already cut back advertising for NJ FamilyCare, in early 2001. Thereafter, in May, the state ended presumptive eligibility, the making of immediate payments to hospitals for uninsured applicants believed eligible but not yet enrolled.³⁶ In August, the state curtailed enrollment for childless adults.

NJ FamilyCare's costs beyond KidCare were originally projected to reach \$206 million, the initial dollar cap, which translated to an expected 125,000 new adult enrollees. Of this, \$100 million (49 percent) was to come from the state's tobacco settlement and \$29 million (14 percent) from the state's GA program, \$48 million (23 percent) from the federal government, \$24 million (12 percent) from employer-sponsored coverage, and \$5 million (2 percent) from employee contributions. Roughly two-thirds of the NJ FamilyCare population was expected to be parents and one-third childless adults. State-only funds are used to cover otherwise uninsured childless adults and legal immigrants.

Acute Care Issues

Developments under Medicaid Managed Care

New Jersey relies heavily on managed care, which enrolls most Medicaid recipients—and all enrollees under the NJ FamilyCare expansion. Medicaid managed care enrollment declined somewhat in the late 1990s as state welfare and Medicaid rolls declined, but has since rebounded to an all-time high and was expected to grow further as NJ FamilyCare implementation continued. Since 1995, virtually all TANF and TANF-related Medicaid enrollees have been required to enroll in managed care organizations. Other eligibility groups could voluntarily enroll in managed care, but few did. In October 2000, the state began phasing in mandatory enrollment for aged, blind, and disabled recipients. The state sets capitation and other payment rates by actuarial projection, modified by negotiation

with participating plans. To date, no plan has walked out on negotiations. Rates are somewhat risk-adjusted. Maternity care is paid separately through flat payments per pregnancy outcome. Drug prices are set by discounting AWP, which is why the state expects to benefit from federal AWP-enforcement efforts. Compared with many other states, New Jersey seems constrained in its ability to hold down drug prices within Medicaid; the pharmaceutical industry is very important to the state.

Not all services to managed care enrollees are managed. Notable carve-outs for continued fee-for-service payment are personal care services and, for one group, home health. Since March 1998, the state has managed behavioral services with separate utilization review, in order to reduce duplicative or fragmented services to individuals with mental illness or substance abuse problems. Pharmaceuticals are not carved out, but a small number are funded outside the capitation rate. Prescription drugs for AIDS and hemophilia are carved out, and some high-cost psychotropic drugs also receive separate payment.

Market consolidation cut the number of participating HMOs from 13 to 5 by the end of SFY 2001 in June. Some reduction was predicted during our 1997 interviews, as the state had initially contracted with all willing plans, and the general maturation of the New Jersey insurance market was promoting consolidation in the private sector as well. The last Medicaid consolidation occurred right after our interviews in spring 2001, as the largest plan, Aetna, sold out to the third-largest. The remaining plans are split between ones that serve Medicaid/NJ FamilyCare only, and others that are primarily commercial or have a balanced mix of enrollees.

State officials recognize that, in the abstract, having more plans gives enrollees more choice and increases state bargaining leverage vis-à-vis the plans. However, officials show little concern about dealing with fewer plans. Having fewer plans simplifies administration and provides some reassurance that remaining, larger plans can achieve scale economies and financial stability. More troublesome is that most enrollees now belong to one of only two HMOs, and of those top two, one just sold its Medicaid business to the third largest plan, with state approval.³⁷ Interviewees in March said that discussions were then under way with another plan about entering the program, but as of June 2001, the number of participating HMOs was only five.

Plan representatives sometimes complain about payment rates, but low payment was evidently not the reason for any plan departures, and remaining plans are seeking more Medicaid enrollees. Moreover, the state's rates are more than 11 percent above the national norm even after adjusting for higher New Jersey health care costs,³⁸ and are also higher than average relative to Medicare levels.

New Jersey Care 2000+ is the state's new managed care program for aged, blind, and disabled beneficiaries (or ABD, covering the Supplemental Security Income (SSI) population, except that participation is optional for dual Medicaid-Medicare eligibles).³⁹ Implementation in the first three counties began in October 2000 and is being phased in statewide over 15 months through 2001. State officials say the primary goal is to improve quality through case management of a previously fragmented delivery system, that containing costs is only a secondary motive. A leading advocate agrees, at least through the early enrollment process. It is too early to judge actual performance, as the rollout is in its early phases, but planning and design are seen as good, advocates' access to policymakers is very good, and there are reasonable processes for exceptions as well as for complaints and appeals.

The state planned New Jersey Care 2000+ for over three years, meeting separately with both advocates and plan representatives, going through numerous versions, and delaying implementation until health plans had sufficient capacity of providers who deal with special-needs populations. The same HMOs now enrolling the SSI population had also served the TANF and NJ FamilyCare populations. Enrollment occurs through the state's benefits coordinating firm (the same firm used for NJ FamilyCare), not via direct marketing by health plans. Early problems have occurred because of the unforeseen outpouring of interest in NJ FamilyCare. The same 800 number handles both plans, and a

leading advocate for the disabled complained that the line is often busy. The state's relationship with both plans and advocates seems to be good; there are frequent and ongoing high-level meetings, and the planning process seems to be viewed as fair. Some exceptions were made to mandatory enrollment, notably for Medicare dual eligibles. Moreover, beneficiaries with complex medical conditions who have a long-standing relationship with other providers, even out of state, may petition through an exceptions process to stay in fee-for-service Medicaid. Among early applications for exception, about half have been accepted; some of those rejected appear not to have recognized that their providers were already signed up with one of the HMOs. The program has somewhat stronger consumer protections than even the state's generally strong protections for commercial managed care (see below).

Medicaid DSH Program and Hospital Charity

Cuts in federal DSH payments appear to have affected state policy very little. Between 1995 and 1998, DSH declined 7.4 percent per year, almost precisely the national average (table 4). State officials said that the shift was absorbed within the state budget without much difficulty. It is notable, for example, that while the drop in DSH spending helped hold down overall program growth, this did not result in a bulge of state spending elsewhere in the non-DSH Medicaid budget. Moreover, cost growth was notably low per service and per enrollee, as already noted.

Much of DSH spending is in the state's long-standing uncompensated care pool, refocused, after the hospital rate deregulation of 1993, on charitable services only. The pool paid NJ hospitals some \$320 million in 2000, all from state revenues. No funds came from hospital assessments, unlike the former New Jersey practice, which continues in Massachusetts and New York. In the mid- to late 1990s a major state concern was to find a permanent state revenue source to replace the pool's transitional funding (after deregulation) by a surplus in Unemployment Insurance accounts. Funding was shifted to a new tax on tobacco products in early 1997 and was scheduled to be shifted further, to general revenues, by FY 2004. That plan remains on track.

Meanwhile, there have been no cuts in the pool, unlike the early to mid-1990s. Indeed, there has been an increase, as during FY 2001 hospital charity care was increased by \$36.3 million, to a total of \$356.3 million, mainly through a new supplemental program for hospitals providing lesser amounts of charity. The reform created a minimum floor of pool funding for all hospitals. Previously, pool support had been increasingly concentrated on hospitals providing the most charity, and an increasing number of hospitals had received no subsidies at all. An advisory panel recommended guaranteed subsidies for each hospital, and the 2001 increases are intended to give every facility at least 20 cents on the dollar. Further increases in pool support for hospitals seems quite possible, as was proposed by now Governor DiFrancesco in his 24-point plan issued in fall 2000. Once controversial because of insecure funding, the pool now appears built in to policy and budgetary expectations. Budget officials termed it part of mandatory growth, a program to be routinely funded rather than continually debated as it was before.

In 1997, a concern was how to spend charitable hospital dollars more efficiently, and policymakers appeared to have agreed to shift funds away from hospitals and toward earlier intervention, thus constituting a kind of "managed charity care." The legislature and administration together crafted a plan to have hospitals run managed care networks and in 1998 won a federal waiver for continued DSH support. Hospitals, however, objected to the diversion of scarce charity funds⁴⁰ and high start-up costs for networks, so the statewide mandate was dropped in favor of a voluntary demonstration, which evidently could not be implemented. The issue appears to have lost out in favor of increasing support to hospitals.

Physicians also provide charitable services, without access to the hospital charity pool. Some legislators sought to allocate \$10–15 million in tobacco settlement funds to assist doctors providing uncompensated care. Those funds went for other priorities, but the governor's 2002 budget promised even more to physicians in the form of the first increases in

Medicaid fees in many years, beginning in January 2002. These increases are meant to apply both to fee-for-service payments and within managed care.

Pharmaceutical Assistance to the Aged and Disabled (PAAD)

New Jersey has subsidized prescription drugs for low-income elderly and disabled residents since 1975, reaching nearly 200,000 beneficiaries. As of January 1, 2001, annual income limits were \$19,238 for singles and \$23,589 for married couples. Before July 1, 1998, the program had charged individuals \$5 for a 34-day supply of medicine, or 100 doses, whichever was greater. Funding comes primarily from the state's Casino Revenue Fund.

PAAD spending since 1995 has grown at about 9 percent annually, well beyond the 3 percent rises in casino revenues. The most recent state budget projects appropriations of \$360 million in 2002. Rapid growth spawned attempts at control. New limits were set for PAAD benefits in mid-1998, but political resistance was strong, and by November of that year, policymakers had partially restored benefits. New prescriptions were still limited to a 34-day supply, but more generous policies applied for ongoing prescriptions. Then-Senate leader DiFrancesco entered the debate, proposing not cuts but expansions—covering more seniors, to higher income levels, a proposal he called Senior Gold. Then-Governor Whitman's submitted 2002 budget provided \$50 million of tobacco settlement funds for Senior Gold to cover elderly people who earn too much to qualify for basic PAAD. Senior Gold was enacted in May 2001; its income limits are about \$10,000 a year higher than for PAAD but with higher cost sharing (\$15 plus half the remaining cost of each prescription until a beneficiary reaches the annual out-of-pocket ceiling, \$2,000 for a single person).⁴¹

Long-Term Care Issues

Policy on long-term care is dominated by continuing shifts from institutional to community-based care for the elderly, people with mental illness, and people with developmental disabilities, along with implementing consumer-directed personal assistance services for persons with chronic physical disabilities. Nursing home quality and reimbursement rates have also drawn attention. About 300 nursing homes now serve more than 30,000 Medicaid patients, who represent some 70 percent of these homes' patients. Occupancy rates have dropped to a statewide average of about 90 percent, lower for many homes. Most homes are for-profit facilities, but a substantial share is nonprofit or county-owned.

Nursing Homes and Community-Based Care

Three issues dominate policy on long-term care: (1) how to pay nursing homes, and how much; (2) how to expand community care; and (3) quality of care.

Nursing Home Payment. As have other states, New Jersey has given high priority to holding down nursing home payment rates. The state cut rates in 1995, but still ranked high nationally in nursing home payments.⁴² In 1999, the state again modified its payment system, phasing in reforms during the year ending July 2000. The reforms cut allowances for administrative costs and reduced rates for facilities with vacancy rates above 10 percent for two years, among other measures.

New Jersey uses a prospective payment method that adjusts for case mix. Payments are based on facility-specific base-year costs, trended to the rate year and adjusted for seven patient acuity levels. The state re-bases projections every year. Payments are reduced where base-year costs exceed percentile screens within three peer groupings for each of numerous cost centers. The new occupancy standard will lower rates for homes with occupancy below 90 percent for two years running by disallowing the portion of costs attributable to the lower occupancy. A number of homes are expected to lose funds as this standard "bites" in the next year. Observers agree that federal repeal of Boren Amendment requirements was not a factor in state policymaking, as the state had already cut rates under prior law and won Boren litigation.⁴³

Associations for both for-profit and nonprofit homes lobbied against the changes; the former estimated losses to the industry of nearly \$40 million, or more than \$1,000 per patient each year. According to the larger, for-profit association, the state has taken \$160 million from the industry during the last five years. State policymakers report interest in taking case mix adjustment into consideration and building in ties to quality, but have shelved plans for additional adjustments. The association reports that 46 homes are in bankruptcy proceedings, 39 of which belong to a single regional chain.

Community-Based Initiatives. Demand for alternatives to nursing home care is evidenced by the tremendous growth in the number of (private) assisted living facilities in the state, from none in 1995 to more than 70 by 1999. State policy has recently intensified efforts to shift Medicaid long-term care patients and services to settings outside nursing homes. A federal waiver for community-based services was renewed in 1999. State officials say that relations with CMS have been excellent, especially since the *Olmstead* decision increased the importance of community care.⁴⁴ The old resistance to state innovation is gone, and federal overseers have not placed any restrictive conditions on state planning. There is a cap on slots, but it can be changed at state request. The state's commitment to community care also shows in its winning a \$500,000 grant from CMS to help develop community alternatives and hold cooperative meetings with affected interest groups about *Olmstead* implementation. Unlike other states, New Jersey appears not to expect litigation about such implementation.

The initiatives for the elderly are collectively known as Eldercare. The most visible and seemingly the largest is the Community Choice Counseling Program, begun in 1998. Community Choice has helped several thousand nursing home residents return to the community by linking seniors with supports such as a home health aide, meals on wheels, or other medical or social services.⁴⁵ Four types of placement are available: adult foster homes, assisted living residences, comprehensive personal care homes, and assisted living programs without subsidized housing units. In-home services are also available, including some personal care. All beneficiaries must meet nursing home levels of eligibility. The waiver cap allows 1,500 slots; currently about two-thirds of these are in use.

According to the state budget, Eldercare placements totaled 2,400 over a period of 31 months ending in October 2000. Faster expansion has not been possible owing to the need to assure sufficient in-community services, do background checks on personnel, and the like. There have also been difficulties in getting assisted living facilities to participate in Medicaid, because of payment and other regulatory issues. All beneficiaries have case managers, who are county or nonprofit employees. Program officials want to move to more consumer-directed care, and a legislative proposal would expand adult foster homes.

By the end of 2002, New Jersey officials expect to interview 43,000 seniors in hospitals and nursing homes and assist as many as possible to move out.⁴⁶ A Rutgers survey of program participants found that most (68 percent) are living in home-based settings, one-fifth alone; and most former nursing home residents said that their lives had improved and that they were satisfied.⁴⁷

One of the goals of incorporating Senior Services into the Department of Health in the mid-1990s was to help seniors remain self-sufficient by creating a consumer-focused statewide system known as New Jersey Easy Access, Single Entry (NJ EASE). In partnership with county governments and now available in all but one of the state's 21 counties, the NJ EASE program provides seniors with one-stop information about services for financial, medical, and social needs.⁴⁸ The budget reports that some 2,300 clients will receive community-based services through NJ EASE during SFY 2002.

Nursing Home Quality. The quality of nursing home care is a long-standing concern in New Jersey, as in the nation. State officials note that New Jersey has the advantage of being relatively compact, so that it is easy to conduct on-site audits and educational efforts, but these officials see enormous challenges in improving quality. (Assisted living facilities have grown rapidly; they are state licensed, but appear to face less quality oversight than nursing homes.)

The state's traditional approach has been regulatory. It enforces regulatory standards through unannounced on-site surveys, averaging fully four visits a year to each home. It also provides technical assistance and training for meeting the standards. The key recent state initiative is report cards, started in January 1998. Report cards are based on 44 federal standards as scored in the surveys; homes start with the maximum score of 88, and subtractions are made for each deficiency found.⁴⁹ The Web site has received tens of thousands of "hits" from viewers of the report cards, but still fewer than there are Medicaid residents of nursing homes. Officials believe that the main users are families shopping for an initial placement. They have no information on other users, for example, insurance plans that increasingly cover participating long-term care facilities.

A first round of refinements was slated to take effect in April 2001, including, for example, a 100-point scale based on 50 measures and with fractional points lost for deficiencies, weighted for the immediacy of the threat posed to safety. There is desire to incorporate outcomes measures but no agreement on how to do so. The industry complains that although the state's homes do well by national standards, state and federal surveyors in New Jersey keep looking until they find problems. Homes feel constrained by a tight labor market, high staff turnover, and increasing severity of patients' conditions because of earlier discharges from hospitals and the loss of healthier patients to assisted living. A knowledgeable state interviewee agreed that these factors pose substantial challenges to improving quality and also mentioned tightened nursing home reimbursement policy.

A different approach to quality is being tried in 20 homes, with Robert Wood Johnson Foundation grant support. This approach contemplates continuous quality improvement, benchmarking performance against standards of excellence rather than seeking out deficiencies. In March 1999, the state began a new grant program for nursing homes interested in the Eden Alternative™, which emphasizes holistic methods of care, including allowing residents to keep pets.⁵⁰ Finding funds and staff to implement major changes is seen as a hurdle.

People with Mental Illness. Since the 1960s, movement of mental health patients out of institutions has been the most important state mental health policy, as in other parts of the nation. The pace of deinstitutionalization has varied over time. New Jersey has 2,070 patients in state psychiatric facilities in 2001, down from 2,550 in 1994 and 8,000 in 1980.⁵¹ After lengthy planning, the state closed its largest psychiatric hospital, Marlboro Psychiatric, on June 30, 1998, promising to redirect all money saved to other mental health programs. That left six psychiatric hospitals in the state.⁵²

Closures have generated less controversy in New Jersey than in neighboring New York and Pennsylvania. A state retrospective report on deinstitutionalization found that patients had been successfully placed and that all savings were reallocated to community care; an outside evaluation commissioned by the state found that patients received as good or better care.⁵³ Nonetheless, the wisdom of community living has been questioned. Recently, community opposition to group homes has risen, as neighbors expressed concerns that individuals released from mental health facilities might pose risks of violent behavior. The state responded with a temporary moratorium on placing anyone who had ever committed a violent crime to licensed group homes and a new "good neighbors" policy to educate communities about placements, to meet with local leaders, and to share information across providers as they decide where to site nursing homes. Advocacy groups and legal experts argued that this last practice violated state and federal discrimination laws, and the state rescinded the policy. Enough political concern remained that a resolution was introduced in the state assembly for a task force on site selection for residential facilities, although it never passed, and the Human Services Commissioner at the time signaled that there was no rush to close another state institution for persons with mental illness.⁵⁴

However, in April 2000, almost two years after the closure of Marlboro, Governor Whitman ordered the closure or dramatic reconfiguration of Greystone Park Psychiatric Hospital, in response to a report of unsanitary, unsafe, and overcrowded conditions. The

state will eventually replace Greystone with a much smaller, modern hospital, a process expected to take two to three years. The state says it is also adding staff and reducing census by about 80 patients through transfers to other settings. After the report, the Health Care Financing Administration (HCFA) inspected Greystone twice and threatened to cut off Medicaid and Medicare funding if deficiencies were not corrected.⁵⁵ Some observers still question whether the institution will be closed any time soon; evidently, promises of improvement or closure have been made for many years.⁵⁶ Governor DiFrancesco is on record as favoring closure or downsizing.

A different type of initiative focuses on the service delivery system for troubled youths. New Jersey has launched a major program, the Children's System of Care Initiative, to expand community-based, early-intervention services for emotionally or behaviorally disturbed children. A key component is the creation of a statewide systems administrator to register children and track and coordinate their care across all child-serving systems. Under the current system, children receive different assessments or care depending on whether they enter the system through the child welfare, mental health, Medicaid, or the juvenile justice system.⁵⁷ Within Medicaid, children are meant to make less use of expensive institutional placements such as psychiatric hospitals and residential treatment centers and more use of community settings.

People with Developmental Disabilities

Here too, policymakers seek to deinstitutionalize and increase community services. In 1986, the Division of Developmental Disabilities (DDD) served about 5,500 residents in developmental centers, out of a total of just over 13,100 people served. In 2001, about 3,500 residents were in centers, out of a much larger total of about 29,500 served. Residents still account for nearly half of the division's budget, although their share has declined somewhat.⁵⁸

Despite these increases, there is a waiting list for community-based residential services; state planning evidently does not expect to eliminate waiting until 2008.⁵⁹ To increase community-based services, 1997 legislation required that savings from closures of developmental centers be redirected to community care. According to a report commissioned by DDD, New Jersey should spend \$322.8 million to 2008 (in 1998 dollars) for new community residential programs and close three institutions that serve people with developmental disabilities, which would end a growing waiting list of over 6,000 disabled adults who need community housing. (Other waiting lists exist for those seeking day program services.) The report recommended that New Jersey reduce the number of people living in developmental centers by more than half by the end of FY 2008. In addition, the legislature mandated planning to eliminate the waiting list for community residential services from the DDD by year 2008. Since 1996, the state budget has provided a cumulative total of more than \$160 million to help people move from the waiting list into community programs.⁶⁰ An additional \$52 million in community expansions per year was proposed in the 2002 budget. Despite the general push to remove individuals with developmental disabilities from state institutions, the state has experienced some resistance from community residents, though minimal compared with that against group homes for people with mental illness.

Other Health Policy Issues

Insurance Market Developments and State Regulation

Upheavals in the state's insurance markets have prompted renewed attention to state oversight. The key development has been HMO insolvencies; market consolidation and losses among HMOs are other concerns.

In the late 1990s, state regulators had to take over operations of two insolvent HMOs and one other insurer.⁶¹ The state had long had conventional insurance regulatory protections (solvency and reporting requirements) for both HMOs and conventional health insurers. The insolvency, however, pointed up shortcomings in officials' authority over

how HMOs manage or delegate risk bearing and their ability to cope with unmet patient and fiscal needs after a failure. New legislation was needed both to deal with the immediate financial and medical shortfalls left by the two HMO insolvencies and to increase regulatory powers so as to try to avoid similar shortfalls in the future.

Three Insurer Insolvencies. The largest regulatory and fiscal problems were created by the Health Insurance Plan of New Jersey (HIP), the state's oldest and still fourth largest HMO. HIP's market share had declined from 18.1 to 8.3 percent from 1991 to 1997,⁶² when HIP's financial problems became apparent as the plan tried to stem losses by subcontracting claims risk to a medical management company thought better able to manage spending. State regulators were concerned but decided they lacked authority to make HIP establish new reserves against the new risk of subcontractor failure. The subcontractor's failures led HIP to cancel its contract. HIP still became insolvent because it was responsible for meeting unpaid claims from providers while having lost the large share of premium passed through to the management company.

The state had to act.⁶³ It first placed HIP under administrative supervision in 1998 when the plan failed to make timely payments to providers. Regulators initially sought to rehabilitate the HMO, but soon realized that HIP owed providers approximately \$120 million, a sum far beyond its remaining resources. Regulators restructured debts to providers but then decided to liquidate HIP. Most of HIP's 23 health centers closed, but most of its medical professionals found positions with other HMOs. HIP's 21,400-enrollee Medicaid business was purchased by another plan. The insurance commissioner protected HIP members' coverage by ordering all health insurers in the state to open enrollment for HIP's patients for a limited period of time. Some HIP members had to pay more for coverage, as HIP premiums had been the lowest in the individual market and among the lowest in the small group market.

New Jersey regulators took control of another HMO, American Preferred Provider Plan, Inc. (APPP), which served 44,000 Medicaid recipients and roughly 2,000 others.⁶⁴ State officials accused the owner of diverting state Medicaid funds for personal use. The state assumed management of the plan in October 1998. State regulators acted quickly to sell the HMO before its value dropped further. Within six months, APPP, with state approval, was sold for \$4.4 million to Horizon, the parent company of Blue Cross Blue Shield of New Jersey. At the time of the sale, about 23,000 individuals remained with APPP. Medicaid patients in APPP were transferred to Mercy Health Plan, a Medicaid HMO affiliated with BCBS of New Jersey. Proceeds from the sale were used to pay medical providers and other APPP creditors. At the time of the takeover, the Insurance Department estimated that APPP owed doctors and hospitals \$37.4 million. More than a year after the sale, the state sued APPP's founder, its officers, and its HMO affiliates to recoup millions of dollars.

A third insolvency involved Garden State, an even smaller, indemnity-style carrier that had insured about 26 thousand people. The state took over the carrier in August 1999.⁶⁵

State Response. These failures led to two types of state action. The first was a legislative bailout to deal with the immediate problem of unpaid provider bills. The second was new regulatory authority over plans' finances.

New Jersey had had no preexisting system to address the combined \$150 million losses of HIP and APPP, yet faced strong political pressure from providers and patients for a bailout. When a conventional insurer fails, its unpaid claims are normally met by a state guaranty fund. Such funds are bankrolled by assessments on all similar insurers. New Jersey had created a guaranty fund for life and health insurers in 1991, well after most states, but New Jersey HMOs had been exempted because of disputes about funding.

To deal with its two HMO failures, the state passed the Insolvent Health Maintenance Organization Assistance Fund Act of 2000, splitting the burden of unpaid bills into three roughly equal parts to be borne by doctors and hospitals (through discounting the bills), by the state (using tobacco settlement funds), and by assessments on remaining HMOs (through assessments over three years).⁶⁶ HMOs were prohibited from passing along this

assessment through higher premiums, and they sued on several grounds—unconstitutional taking of property without just compensation (the bar on premium rises would have made them draw down their surplus assets), violation of due process (the retroactive nature of the law), and denial of equal protection (treating HMOs differently from other similar entities). The trial judge ordered the HMOs to contribute their fair share, but said that plans may not be precluded from “realizing a fair and reasonable rate of return on their investments” and may be excused from paying the assessment if doing so would put them in an “unsafe and unsound financial condition.” The state made the first payment to providers from its portion of the fund and ordered HMOs to contribute; the industry eventually decided not to appeal.

New state regulation of insurer solvency was the other policy response.⁶⁷ Even though New Jersey had been thought to have among the strongest net worth and deposit requirements for HMOs of any state in the nation, those controls were insufficient to prevent the problems that occurred with both HIP and APPP. The HIP case highlighted the downside risk of an HMO’s sharing risk of loss with medical providers or management companies that agree to accept capitation or some similar arrangement (called “downstream risk”). Initially, the state promulgated regulations that set more stringent financial standards for HMOs, calling for audits of new HMOs, higher liquidity rules, and more frequent financial reports. In addition, each HMO is required to file a plan that ensures continuation of services to members in the event of insolvency. The regulations also increase state oversight of out-of-state subcontractors, which was further enhanced through subsequent legislation.

Patient Protection. New Jersey’s HMO conduct is regulated by the Health Care Quality Act, which also covers preferred provider organizations (PPOs) and point of service (POS) products.⁶⁸ The act took effect in February 1998, codifying some earlier regulations, but other provisions of the act were not implemented until regulations were finalized on May 1, 2000. A Kaiser Family Foundation study noted that inadequate agency staffing was often cited as a major cause of delay in implementing New Jersey’s managed care protections. Four key regulatory issues are appeals processes, prompt payment of providers, insurer liability of medical injury, and HMO quality.

Appeals processes. The Health Care Quality Act provides consumers with a three-step appeals process when they believe HMOs have wrongly denied care. The first two steps are decided internally by the HMO—first by a medical doctor, then by a committee of physicians. The third level involves an outside panel approved by the state Department of Health and Senior Services.⁶⁹

As of mid-2000, 119 complaints had reached the third level of appeals, with somewhat more than half decided for the HMO. Even though the external panels’ recommendations became binding only with January 2001 legislation, HMOs almost always followed them.⁷⁰ HMOs had supported this legislation as an alternative to lawsuits.⁷¹ One leading advocate noted that the state has strong, though not the strongest, complaint and appeals processes.

A new consumer-assistance program was enacted in January 2001, creating ombudsman-like staff outside of state government to educate managed care consumers on their rights under both state and federal law. Two outside consumer groups were given the job during the program’s first year.⁷²

“Prompt pay” requirements. Responding to provider complaints about delays in payment, New Jersey regulators proposed regulations, later codified by statute, to require insurers to pay claims within 30 days if claims were submitted electronically (40 days for paper). Previously, the state requirement had been 60 days.⁷³ The issue achieved prominence in 1999, when two of New Jersey’s largest HMOs were accused of slow payment, often owing to poor performance of a claims-management subcontractor, which can hurt the plan as well as the health provider. In the aftermath of investigations, one subcontractor was dropped. During 2000, state regulators imposed at least three large fines on health plans, primarily for slow payment. The issue continues to generate controversy in the state, most recently because of a medical society finding of continued problems.

Insurer liability for medical injury. After some years of debate, New Jersey passed a right-to-sue law in June 2001. Governor DiFrancesco had introduced such a bill when he was Senate president, and the measure had bipartisan support. Most states have for some years debated the merits of allowing managed care enrollees to sue HMOs for personal injury, but New Jersey is among the fewer than ten to enact legislation. State authority over workplace benefits is limited by the federal Employee Retirement Security Act of 1974 (ERISA) legislation, especially for benefits provided through self-insurance, as for an estimated half of covered residents under the age of 65. To what extent ERISA will limit the state's new law is disputed.⁷⁴

Quality of care. The Department of Health and Senior Services issues annual report cards on HMO performance to inform consumers, motivate HMOs, and maintain public health. In November 1998, the Department of Health and Senior Services ordered all health plans to devise a strategy, by February 1999, to improve performance in seven areas of preventive health found below national averages. The directive was prompted by evidence that New Jersey plans' performance was below the national average in all seven categories. By the end of 1999, plans were required to improve five percentage points above the highest performing local plan in 1997, a goal seen as unrealistic by HMOs.⁷⁵

When the 1999 HMO Report Cards showed less improvement than hoped, state officials said future results would be used to penalize poor performers that insure state workers. In October 2000, the state released the fourth annual HMO Report Card, which rated plans in 20 areas. Three of the health plans with below-average report card scores may have to forfeit a portion of their administrative fees.

Other Insurance Market Developments. The two salient trends are continuing industry consolidation and the evolution of Blue Cross Blue Shield (BCBS). Recent consolidations⁷⁶ include the December 1997 purchase by Horizon BCBS of New Jersey of Physician Healthcare, a much smaller physician-owned plan. Thereafter, in January 1998, Foundation Health Systems completed its takeover of two New Jersey plans, First Option Health Plan and Physician Health Services. Both were provider-run plans in fiscal trouble that needed to sell to remain solvent.

More controversially, Aetna U.S. Healthcare in December 1998 announced its intention to buy PruCare, an HMO owned by New Jersey-based Prudential Insurance Company. Medical groups including the American Medical Association objected on antitrust grounds, fearing that after the \$1 billion merger, Aetna would dictate medical care standards and payment levels. Both the federal Justice Department and numerous state attorneys general eventually approved the merger. New Jersey authorities were the last to act, in August 1999. As a result, Aetna, already New Jersey's largest HMO, now has nearly a million customers, about 40 percent of the state's HMO market. The merged plan is the nation's largest, with 21 million members nationwide. Consolidation also resulted from managed care plans' exit from Medicaid, including Oxford Health Plans, the third largest HMO, and the recent Aetna departure already noted. Medicare HMO participation in New Jersey has been similarly affected by significant departures, often implemented selectively by county.

The other big development is the make-over of New Jersey BCBS. The Physician Healthcare acquisition marked a new tack toward its strategic goal of becoming a regional carrier and raising capital through stock offerings. Legal and regulatory resistance had frustrated earlier plans for acquisition, merger, or conversion to mutual ownership, which would have facilitated subsequent conversion to for-profit status.

The company has nonetheless remade itself. From a medical service corporation operating in a single state it has become a family of enterprises also operating in three neighboring states. It also changed its name to Horizon, creating a new logo and de-emphasizing its original Blues identity. The original plan, now Horizon Blue Cross and Blue Shield, remains a nonprofit and a Blues Association member, but has won statutory authority to invest more than 8 percent of its assets in HMO subsidiaries, and in the 2000 and 2001 legislative sessions the company sought further authority to endow a nonprofit foundation

with its charitable earnings. This would dedicate hundreds of millions of dollars in assets for charity, and would allow the company or its subsidiaries to sell stock to raise more capital.

Consumer groups remain concerned, but the new foundation proposal had met their strongest objection, that charitable assets would be lost in any conversion. The political climate has changed since BCBS was blocked in 1997: Not only had the former attorney general left to become a Supreme Court judge, himself under ethical investigation, but there was also legislative support for tapping foundation monies for the seniors' pharmaceutical expansion, and numerous other Blues plans around the country had also converted, notably including Empire in New York. The New Jersey legislature passed the foundation bill in March 2001. Acting Governor DiFrancesco agreed in principle, but argued for a more publicly accountable transition. In May he conditionally vetoed the bill, demanding that an oversight commission be added, two-thirds of whose members would be appointed by the governor.⁷⁷

Other Insurance Regulatory Issues

Mental Health Parity and Other Mandated Benefits. In mid-1999, the state enacted legislation that requires insurers to provide benefits for the treatment of certain mental illnesses on the same terms and conditions as the benefits they provide for physical ailments. The measure bars individual and group health plans from applying different copayments, deductibles, or benefit limits to mental health benefits than those applied to medical or surgical benefits.⁷⁸ The law does not govern employment-based self-funded plans, which are exempt from state rules under the federal ERISA preemption. In January 2000, a new law brought the public employees' plan under these mental health parity requirements. These New Jersey enactments came well after the 1996 Federal Mental Health Parity Act, which ostensibly bans differential support for mental and general medical care, but which is often argued to lack regulatory enforcement.

Individual Health Coverage Program and Small Employer Health Benefits

Program. New Jersey passed relatively strong insurance market reforms for both individual and small group coverage in the early 1990s. These regulated markets provide coverage to more than 1 million people without state subsidy but under state regulation of benefits, terms, and services. Enrollment in the individual sector peaked at 220,000 at the end of 1995, then fell substantially; as of mid-1999 fewer than 121,000 had coverage. The decline results in part from the state's decision to stop subsidizing its own assistance program for individual low-income adults, Health Access New Jersey, which peaked at just over 20,000, and instead to focus on children and family coverage. Rates in the individual market have increased moderately for managed care, more dramatically for the standard indemnity plan, which offers the same comprehensive benefits but different cost-sharing. Enrollment in the Small Employer Health Benefit Program rose 7 percent in 1999 to 926,000.⁷⁹

Overall, patterns of employment-based insurance coverage in New Jersey resemble those in the nation as a whole. Although premiums are higher in New Jersey, the shares of employers in small and large firms offering coverage do not differ much from national averages. Lately, concerns have been voiced that employment-based coverage is dropping because of rising prices.⁸⁰

Health Care Market Developments and State Response

Hospital Markets and Political Reactions. New Jersey has 92 hospitals, 82 of which provide acute care.⁸¹ About two-thirds belong to health systems, but no major for-profit hospital systems have entered the New Jersey market. Consolidation among nonprofits is common. Between 1997 and 2000 three closures and a number of mergers and affiliations took place. Some mergers did not last, while other anticipated mergers failed to materialize.

The 1993–1994 state deregulation of hospital rates brought a dramatic rise in managed care, and with it a drive to shorten hospital stays and cut prices. Pressures on health care

providers are expected to continue, with the tug of war played out within state administration and in courtrooms as well as in the marketplace.

Hospital Finances.⁸² On January 1, 1993, New Jersey ended its long-standing system of regulated hospital rates. From 1993 to 1996, hospital finances improved. However, in 1996, New Jersey hospitals began to experience financial stress, as rates of uninsurance and managed care penetration grew. Regionally, hospitals in the central and southern part of the state have performed better than the hospitals in the northern part of New Jersey. Challenges for the northern hospitals include more competition and more urban hospitals. Nearly two-thirds of the state's hospitals lost money in 1999, the worst performance in two decades. In 1999, the Advisory Committee on Hospitals was formed to examine the state's hospital industry, assess the overall financial health of facilities, identify warning signs that a hospital might be in jeopardy, and recommend options for hospitals seeking to merge or convert to other uses.

In 1999, the committee reported that the oversupply of hospital beds is a principal cause of many financial problems. In 1998, average occupancy was at 55 percent. Hospital finances improved in 2001 because of the following federal and state actions:

- The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) contained reimbursement provisions estimated to save New Jersey hospitals some \$280 million over the next five years.
- New Jersey hospitals serving disproportionate shares of low-income patients, about 60 hospitals, benefited from a Medicare settlement of some \$240 million to resolve claims that methodology for Medicare DSH payments underestimated hospitals' charity care.
- The state agreed to bail out New Jersey hospitals together with other providers for up to \$100 million of losses incurred as a result of the HMO failures.
- The FY 2001 budget increased funding for the charity care pool and broadens coverage to hospitals previously unsubsidized.
- The FY 2001 budget increased subsidized health insurance (NJ KidCare and NJ FamilyCare).

The FY 2001 budget establishes a program to help hospitals transition their services to nonacute care lines of business. In addition, private reimbursement rates are improving as some hospital providers achieve better rates from insurers.

Conclusion

Recent New Jersey health policy has combined liberal support for public coverage and private regulation with conservative enthusiasm for tax cuts and prudent spending controls. Provided with federal support and the ability to run a nonentitlement program, New Jersey became an early and enthusiastic promoter of expanded coverage for children, even under a conservative governor and a solidly Republican legislature. Expansions were soon proposed for parents as well, once tobacco settlement funds became available in 1999. The state was first in line for a 2001 federal waiver to use SCHIP as a source of more funds to cover children's uninsured parents.

As of mid-2001, New Jersey had built a strong record of expanding health financing. For now, its significant challenges for the future appear to be maintaining past success and following through with initiatives under way. However, further insurance expansions can be expected to pose both fiscal and political challenges. The same is true in long-term care for further deinstitutionalization and *Olmstead* implementation. Some interviewees suggested that further coverage expansions might depend upon additional federal support,

which itself seems problematic in the wake of large federal tax cuts and a slowing economy.

The biggest imponderable is fiscal—the revenue shortfalls from the recession.⁸³ The state might fare better in any impending recession than it did in the early 1990s downturn. It can be argued that New Jersey now has a more balanced economy, less reliant on the vulnerable manufacturing sector than before, but manufacturing remains sizeable, and production began to slide in September 2000. The service-based economy, moreover, has many jobs in the financial sector, which may be especially hard hit by any prolonged financial slump. Through SFY 2000, New Jersey like most other states enjoyed very strong revenues, but collections fell somewhat in SFY 2001, and projections for 2002 showed a bigger change in expectations, forcing some 2001 changes in program operations and a mix of cutbacks and revenue enhancements for 2002. Future adjustments may also prove necessary. Additional problems may arise from higher than anticipated growth in medical spending, from more failures or departures among Medicaid managed care plans, or from deterioration in employer-sponsored coverage that would pressure eligibility for public coverage.

Politically, it is somewhat surprising to see how expansive New Jersey policy became under Republican fiscal conservatives, given that their route to power was public backlash against expansive services and taxes under the previous Democratic governor, Jim Florio. Given new sources of funds, however, the Whitman-DiFrancesco administration pushed hard for controlled expansion. One might expect the Democratic gains in the November 2001 elections to further bolster public coverage. Yet, even as the SFY 2002 budget had to be adjusted, candidate (now Governor) Jim McGreevey showed little political appetite for tax increases.⁸⁴ Everyone in New Jersey remembers how voters punished the authors of the 1990 increase.

Nonetheless, health care in New Jersey seems well situated to continue as a high priority in state policymaking and budgeting. Recently, strong political support has turned proposed health care cuts into increases—in the seniors' pharmacy program and for the hospital charity pool. The program cuts necessitated in the final SFY 2002 budget, moreover, largely spared health care, whose growth continued to outpace that of other state spending. So did later spending freezes and cuts after September 11. The state also continues to allocate most of its tobacco funds to health, unlike most other states. Such support seems likely to endure even in nonexpansionary times.

Endnotes

1. The earlier study's site visit interviews occurred in February 1997, with follow up through the election that fall. It covered somewhat more topics and contained more historical information. See Bovbjerg, Randall R., Alison Evans, John Holahan, Frank Ullman, and Susan Flanagan. 1998. *Health Policy for Low-Income People in New Jersey*. Washington, D.C.: The Urban Institute. *Assessing the New Federalism* State Report.

2. Twelve other states are also covered: Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New York, Texas, Washington, and Wisconsin. The states were selected to present a balanced view of state activity and its impact on low-income families. See Kondratas, Anna, Alan Weil, and Naomi Goldstein. 1998. "Assessing the New Federalism: An Introduction," *Health Affairs* 17(3): 17–24.

3. Important written sources appear in endnotes.

4. As noted below, New Jersey is unusual in spending tobacco funds mainly for health care, for expanding Medicaid-like coverage with state-only funds, including for legal non-citizens, for not merely maintaining but expanding drug coverage for the elderly, and for running a hospital pool for the uninsured. One-sixth of New Jersey residents in a 1999 poll said that access to health care and the ability to pay for it was the most important issue facing the state. New Jersey Department of Health and Senior Services News Release, 7/7/99. In another poll, 43.2 percent of New Jersey respondents said they worried a lot about the prospects of having good quality, affordable health care available to them over the next ten years. Star Ledger Eagleton Millenium Poll, conducted by the Eagleton Institute of Politics at Rutgers the State University of New Jersey. "Predictions for the Future: Results from a New Poll." *CSHP News*, Spring 2000 1(2).

5. Written sources on the political situation include: Hassell, John, "Awash in scrutiny, acting governor says, I've just had it," *Newark Star-Ledger*, 26 April 2001. <http://www.nj.com/news/ledger/index.ssf?/page1/ledger/1310ec3.html>; Halbfinger, David M., "Substitute

- Candidate Stakes Claim in Race for New Jersey Governor," *New York Times*, 27 April 2001. <http://www.nytimes.com/2001/04/27/politics/27JERS.html>; and *New York Times*, "The 2001 Campaign: New Jersey Governor, Summary of Race," 7 May 2001. <http://www.nytimes.com/2001/05/07/nyregion/07WEB-01NJGOV.html>. [all accessed: May 28, 2001.]
6. Jackson, Herb. 2001. "McGreevey Trounces Schundler in GOP Collapse." *Bergen Record* (online). 7 November. <http://www.bergen.com/news/govrace/07200111071.htm>.
7. McGreevey's Web page noted his support for regulating managed care, but almost all proposed patients protections have already been enacted in New Jersey. Schundler's Web page emphasized his support for insurance reform through Medical Savings Accounts for public employees. Neither candidate much referred to health issues; the worsening economy, response to terrorism, and other general themes predominated.
8. Democrat strength had been growing statewide—President Bush lost the state by 15 percentage points—and also benefitted from postcensus redistricting. Hanley, Robert. 2001. "New districts imperil G.O.P. in New Jersey," *New York Times*, 8 May. <http://www.nytimes.com/2001/05/08/nyregion/08DIST.html>.
9. The early budget was balanced, but only by a variety of one-time stopgaps. Fiscal Year 2002 Budget, Christine Todd Whitman Governor. <http://www.state.nj.us/treasury/omb>. [date accessed January 23, 2001.] See New Jersey state report card published in *Governing*, February 2001, 78. <http://www.governing.com/gpp/gp1nj.htm>. Other sources on the state's fiscal condition include: NASBO The Fiscal Survey of States: December 2000; Moore, Stephen, and Stephen Slivinski. 2001. "Fiscal Policy Report Card on America's Governors: 2000." *Policy Analysis* 391, February 12; and "NCSL State Fiscal Outlook for 2001: February Update." <http://www.ncsl.org/programs/fiscal/upsfo2001.htm>. [date accessed: February 28, 2001.]
10. Fiscal Year 2002 Budget of Christine Todd Whitman, Governor of New Jersey. (See note 8.)
11. Office of Legislative Services, New Jersey Legislature. "Analysis of the New Jersey Fiscal Year 2001–2002 Budget: Tax and Revenue Outlook, April 2001." <http://www.njleg.state.nj.us/budget/2002rev.pdf>. [date accessed: May 28, 2001.] (Revenue shortfall of about \$1 billion expected, \$194 million for SFY 2001, \$836 million for 2002.) Herszenhorn, David M. "New Jersey officials uneasy as deficit estimates soar," *New York Times*, 23 May 2001. (Estimate raised from \$1 billion to \$1.6 billion seven weeks earlier.) *The Economist*, "Can the world escape recession?" 22 March 2001.
12. Siegel, Ralph. 2001. "Officially, Next Budget Is in Red, But How Red?" *Bergen Record* (online). 11 December. Johnson, Linda A. 2001. "Sept. 11 'Morphed' Slowdown into Recession." *Bergen Record* (online). 7 December. Office of the Governor, news release. 2001. "DiFrancesco Orders Hiring Freeze, Additional \$32 Million in Reserve and Budget-Reduction Work Session. Wants Legislature, McGreevey Team to Participate." 3 December. http://www.state.nj.us/cgi-bin/governor/njnewsline/view_article.pl?id=543. [date accessed: December 2001.]
13. National Association of State Budget Officers (NASBO). "State Expenditure Reports, 1996–1999." <http://www.nasbo.org>.
14. *Home News Tribune* (online edition), "State to OK \$7.6 billion tobacco deal," 20 November, 1998. National Center for Tobacco-Free Kids. <http://tobaccofreekids.org/reports/settlements/StateSettlement.php3?StateID=NJ>.
15. National Center for Tobacco-Free Kids. 2001. "Show Us the Money: An Update on the States' Allocation of the Tobacco Settlement Dollars." Updated January 11. <http://tobaccofreekids.org/reports/settlements/>. [date accessed: March 2001.]
16. New Jersey Medicaid accounted for 20.9 percent of the state's estimated total spending for SFY 2000 (rounded to 21 in table 3), whereas the national average was 18.9 percent. National Association of State Budget Officers. 2000. *State Expenditure Report 1999* (published in June 2000, estimating SFY 2000 figures). <http://www.nasbo.org/Publications/PDFs/exprpt99.pdf>. [date accessed: 26 September 2001.]
17. Urban Institute compilations of Medicaid "2082" reports, explained in Bruen, Brian, and John Holahan. 2001. "Medicaid Spending Growth Remained Modest in 1998, But Likely Headed Upward." Kaiser Family Foundation. <http://www.kff.org/content/2001/2230/> [date accessed: February 2001.]; National Association of State Budget Officers. 2000. "The Fiscal Survey of the State," <http://www.nasbo.org/Publications.html>. August [date accessed: March 2001.]; and Ellis, Eileen R., Vernon K. Smith, and David M. Rousseau. 2000. "Medicaid Enrollment in 50 States: June 1997 to December 1999," Kaiser Commission on Medicaid and the Uninsured, October. <http://www.kff.org/content/2000/2210/> [date accessed: March 2001.]
18. The national data of table 4 show a 6 percent annual rise of elderly enrollees, which differs from the national pattern of no change, but state interviewees say that elderly enrollment has been steady for years. New Jersey enrollment among the elderly is encouraged because all applicants for the state's popular prescription drug program for the elderly are told about Medicaid. New Jersey is also one of only a dozen states that use an option created by the Omnibus Budget Reconciliation Act of 1986 to offer Medicaid coverage to aged and disabled people with incomes up to 100 percent of the federal poverty level. In general, New Jersey's level of enrollment is not responsible for its high Medicaid spending, as the state has long enrolled a lower than typical share of its non-elderly population, owing to the state's low level of poverty (table 1). Bovbjerg, Randall R., Alison Evans, John Holahan, Frank Ullman, and Susan Flanagan. 1998. *Health Policy for Low-Income People in New Jersey*. Washington, D.C.: The Urban Institute. *Assessing the New Federalism* State Report.

19. Outreach is said to find one child eligible for regular Medicaid for every three eligible for NJ KidCare. NASBO. 2000. "The Fiscal Survey of States." <http://www.nasbo.org/Publications.html>. [date accessed: August 2000.]
20. Data from the Division of Medical Assistance and Health Services show that enrollment in December 1999 was 639,733 exclusive of new SCHIP enrollees, versus 658,666 in December 1997 and 651,409 in December 1998. Ellis, Eileen R., Vernon K. Smith, and David M. Rousseau. 2000. "Medicaid Enrollment in 50 States: June 1997 to December 1999," Kaiser Commission on Medicaid and the Uninsured, October. <http://www.kff.org/content/2000/2210/StatebyState2210.pdf>. [date accessed: October 2000.] Likewise, the National Association of State Budget Officers (NASBO) reports that Medicaid participation in New Jersey fell by 2.7 percent in SFY 1999 and 2.0 percent in SFY 2000. Nationally, enrollment increased by 1.9 percent in 1999 and 3.9 percent in 2000.
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Table 1 Notes

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- l. The figure for 1998 represents the higher of the state threshold for Medicaid eligibility, or the state threshold for Medicaid expansions or stand-alone programs enacted under the SCHIP legislation.
- m. The figure for 2000 represents the higher of Medicaid or SCHIP eligibility. In 2000, all states covered at least some children through SCHIP; certain groups in some states are only eligible through Medicaid.

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