Health Policy for Low-Income People in New Jersey

Randall R. Bovbjerg
Frank Ullman
Alison Evans
John Holahan
The Urban Institute

Susan Flanagan
The MEDSTAT Group

State Reports
This report is part of The Urban Institute's *Assessing the New Federalism* project, a multi-year effort to monitor and assess the devolution of social programs from the federal to the state and local levels. Alan Weil is the project director and Anna Kondratas is deputy director. The project analyzes changes in income support, social services, and health programs. In collaboration with Child Trends, Inc., the project studies child and family well-being.

The project has received funding from the Annie E. Casey Foundation, the Henry J. Kaiser Family Foundation, the W.K. Kellogg Foundation, the John D. and Catherine T. MacArthur Foundation, the Charles Stewart Mott Foundation, the Commonwealth Fund, the Stuart Foundation, the Robert Wood Johnson Foundation, the Weingart Foundation, the McKnight Foundation, and the Fund for New Jersey. Additional funding is provided by the Joyce Foundation and the Lynde and Harry Bradley Foundation through a subcontract with the University of Wisconsin at Madison.

The nonpartisan Urban Institute publishes studies, reports, and books on timely topics worthy of public consideration. The views expressed are those of the authors and should not be attributed to The Urban Institute, its trustees, or its funders.

The authors would like to extend thanks to all of the state officials and other individuals willing to meet with the research team. Their contributions to our understanding are too numerous to list.
About the Series

Assessing the New Federalism is a multi-year Urban Institute project designed to analyze the devolution of responsibility from the federal government to the states for health care, income security, employment and training programs, and social services. Researchers monitor program changes and fiscal developments. In collaboration with Child Trends, Inc., the project studies changes in family well-being. The project aims to provide timely nonpartisan information to inform public debate and to help state and local decisionmakers carry out their new responsibilities more effectively.

Key components of the project include a household survey, studies of policies in 13 states, and a database with information on all states and the District of Columbia, available at the Urban Institute’s Web site. This paper is one in a series of reports on the case studies conducted in the 13 states, home to half of the nation’s population. The 13 states are Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin. Two case studies were conducted in each state, one focusing on income support and social services, including employment and training programs, and the other on health programs. These 26 reports describe the policies and programs in place in the base year of this project, 1996. A second set of case studies to be prepared in 1998 or 1999 will describe how states reshape programs and policies in response to increased freedom to design social welfare and health programs to fit the needs of their low-income populations.

The income support and social services studies look at three broad areas. Basic income support for low-income families, which includes cash and near-cash programs such as Aid to Families with Dependent Children and Food Stamps, is one. The second area includes programs designed to lessen the
dependence of families on government-funded income support, such as education and training programs, child care, and child support enforcement. Finally, the reports describe what might be called the last-resort safety net, which includes child welfare, homeless programs, and other emergency services.

The health reports describe the entire context of health care provision for the low-income population. They cover Medicaid and similar programs, state policies regarding insurance, and the role of public hospitals and public health programs.

In a study of the effects of shifting responsibilities from the federal to state governments, one must start with an understanding of where states stand. States have made highly varied decisions about how to structure their programs. In addition, each state is working within its own context of private-sector choices and political attitudes toward the role of government. Future components of *Assessing the New Federalism* will include studies of the variation in policy choices made by different states.
Contents

Highlights of the Report 1

Overview of New Jersey: Thumbnail Sketch of the State 7
  Sociodemographic Portrait of New Jersey 7
  Economic Status 9
  Political Situation 9
  Roadmap to the Rest of the Report 11

Setting the Policy Context 13
  Overview of State’s Health Agenda 13
  State Health and Health Care Indicators 15

State Health Programs 17
  Medicaid 17
  Department of Health and Senior Services and
    Department of Human Services 21

Assessing the New Federalism: Potential State Responses to Additional
  Flexibility and Reduced Funding 23
  General Philosophy Regarding Public Responsibility for the Poor 23
  Interstate Competition 23
  Medicaid-Specific Issues 24

Providing Third-Party Coverage for the Low-Income Population 27
  Medicaid Eligibility 27
  Other Public Financing Programs 29
  Insurance Reforms 34
Highlights of the Report

New Jersey in the 1990s has been downsizing, deregulating, and refocusing after a generation of steady growth in state government under governors of both parties. State politics today are dominated by a fiscally conservative Republican governor and a heavily Republican state legislature. The new governor's first official act in 1994 was to propose a tax cut. Ever since, she has always started her annual "state of the state" message by listing anti-tax and pro-business accomplishments and goals. State spending growth has clearly abated. Health policy issues as such have not enjoyed a high profile in New Jersey since an integrated set of reforms passed in 1992. Those laws phased out one of the nation's oldest and most comprehensive systems for hospital rate setting and ended Blue Cross/Blue Shield's (BCBS) long-standing role as insurer of last resort, while moving to more market-oriented strategies across the board.

In health care as in other areas, New Jersey has generally taken the mixed approach of promoting cost-containing market mechanisms while also maintaining safety net mechanisms. The state has a large Medicaid program for the small share of New Jersey residents in need. Medicaid is moving rapidly into managed acute care and promoting community care and deinstitutionalization in long-term care, mental health, and disability programs. The state has promoted health plan competition in a number of other ways. New Jersey has also sought to promote private coverage, continued its rate-setting-era hospital free-care pool for the uninsured, and maintained its commitment to public health. It has also been at the forefront in regulating managed care as well as individual and small-group health insurance.

The New Jersey economy boomed in the 1980s but fizzled at decade's end. The newly elected Democratic governor, James J. Florio, responded by boost-
ing taxes, and voters responded with a tax revolt. This revolt was not orchestrated by direct citizen action as in California or Massachusetts a decade before, but rather precipitated by a young Republican politician, Christine Todd Whitman. Whitman almost unseated popular U.S. Senator Bill Bradley (D) in 1990, mainly by attacking his failure to condemn the state tax increases. She lost, but Republicans swept the midterm legislative elections in 1991, gaining a veto-proof majority. Whitman completed the sweep in 1993, taking the governorship with a double first: She is the only woman ever to serve as governor of New Jersey and the only candidate ever to defeat a sitting governor in a general election. She nonetheless faced a surprisingly close re-election in 1997, winning a very narrow victory.

The top health priority in New Jersey is the Medicaid program. As in other states, it claims a large share of the New Jersey budget, fully 24 percent including the federal contribution. In the early 1990s, growth in Medicaid spending outpaced the national average, but it lagged behind the rest of the nation during the 1992–95 period. Much of the early 1990s increase was intentional. Spending characterized as Medicaid rose rapidly because the state aggressively pursued disproportionate share hospital (DSH) federal matching funds to cover existing programs previously funded in other ways. The entire charity care pool, for example, is now funded through DSH, more than $300 million a year (state and federal share). Benefits other than DSH grew more slowly than the national average. As elsewhere, acute care expenditures have grown faster than those for long-term care, as eligibility expansions have boosted coverage of pregnant women and children.

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

Overall, New Jersey Medicaid remains relatively generous. Eligibility rules are at or just above national averages, and spending per beneficiary is nearly 50 percent above the national average. This level is high, though it is well below the 100 percent differential of nearby New York and Massachusetts. Higher-than-average New Jersey spending mainly benefits the disabled and the elderly. Measured as spending per child beneficiary, the program is typical.
With regard to the health care safety net, unlike most states, New Jersey provides funds for hospitals that provide charity care for the poor. However, this support is much smaller than rate setting’s previous full reimbursement of all uncompensated care. The 1992 reforms continued the charity care hospital pool, and long-term funding was agreed to in December 1997. The state also subsidizes safety net hospitals through two smaller but still significant state programs. Moreover, the 1992 reforms created a new subsidy program to help previously uninsured people buy private coverage. The subsidies have never been funded to originally anticipated levels, but Governor Whitman has continued to push for new support, shifting focus in 1996 from the general population to children. This shift occurred after the state legislature rejected the governor’s attempts to move to a larger, publicly subsidized program for the near-poor, generally because it relied on a new tax, namely, an increase in the tobacco levies. The legislature had not enacted the latest proposal before it adjourned in June in the run-up to November 1997 elections, but the momentum for children’s coverage increased with the enactment of the new federal Children’s Health Insurance Program in August 1997. The administration’s most recent plans were to cover all children up to 200 percent (or more) of the federal poverty level, beginning in January 1998. The plan is to create new managed care insurance on top of expanded Medicaid coverage.

Federal welfare reform gives states new authority to determine immigrants’ eligibility for Medicaid. In response, New Jersey has elected to preserve Medicaid for legal immigrants where federal financing is available and has created a state program to encourage naturalization.

Market competition for hospital care has been slow in coming to New Jersey, primarily because of the reliance on a rate-setting system until 1993. Many forms of managed health care coverage have been slow in coming as well. The share of population enrolled in a health maintenance organization (HMO) is about average for the nation. But this average HMO penetration rate is in fact very low given that New Jersey is by far the nation’s most urbanized area and has a plentiful, well-distributed supply of doctors and hospitals. Comprehensive, all-payer rate setting for hospitals was ended by the 1992 reform legislation. Hospitals increasingly faced price competition thereafter, but most began with a fiscal cushion from extra 1993 receipts. These came from final reconciliation of accounts for prior years. Thus, competition has only begun to “bite.” The state bed-per-population ratio is comparable to the national average, the physician ratio is above average, and lengths of hospital stay are very high. Beds and stays are much lower in advanced managed care markets, so rapid change is expected. The enrollment rate for preferred provider organizations (PPOs) is well below national norms because this form of managed care cannot flourish without the ability to negotiate hospital prices.

Hospitals are already starting to consolidate somewhat, a process that antitrust enforcers in the attorney general’s office are watching but not acting upon, because supply remains plentiful. The state has no for-profit acute care hospitals, though their entry is expected. Almost all community hospitals are private nonprofits. There are no public general hospitals run by cities or coun-

HEALTH POLICY FOR LOW-INCOME PEOPLE IN NEW J ERSEY
ties, although one county hospital has some acute beds and one state medical school hospital is publicly owned. There have been only three general hospital closures in the past decade, most recently of a big safety net teaching institution in Newark. State officials did not try to keep the hospital open, signaling seriousness about letting the market work. The state acted to ensure that the departing hospital’s “franchise” to run certain specialized children’s services was replaced by a certificate of need (CON) award to another hospital. (This was the only such award granted in that part of New Jersey.)

The 1992 reforms also changed health care regulations in the private markets for individual and small-group insurance. All insurers, no longer just BCBS, were required to offer coverage or pay into a fund for those who do; provisions were created to protect against losses; and rules were standardized. The goals were to ensure that more New Jersey residents had access to coverage and that insurers competed on a level playing field. For the uninsured, the hospital charity care pool was maintained but at a declining level over time, in expectation that increased insurance coverage would fill the gap. Officials are pleased with the performance of these regulated markets, though evidence of a positive effect on the uninsured rate is lacking; and the regulated industry continues to support these efforts.

In 1996, long-term care and other services for the elderly were moved into the Department of Health, which was renamed the Department of Health and Senior Services (DHSS). The long-term consequences of this shift are not clear, but it seems certain to raise the “clout” of seniors on budgetary and programmatic matters, including long-term care. New Jersey’s long-term care system places a heavy reliance on institutional care, but there is widespread interest in expanding home and community-based alternatives. Eighty-five percent of the state’s long-term care expenditures go to nursing homes. Expansion of home and community-based care depends on reductions in growth in nursing home spending. Nursing home payment rates are high by national standards and are a specific target for budget cuts. There is also a strong institutional bias in long-term care services for younger persons with disabilities. Proposals to expand community-based options for this population are also popular, but expansions depend on savings from closures of large institutions, which face some political opposition from state legislators, communities, and labor unions.

During the rate-setting era, the Department of Health benefited from being a lead agency for that era’s overall regulatory strategy for Medicaid cost containment, always a top state priority. That high health policy profile was lowered by hospital deregulation and the shift to managed care strategies, although the department retains significant data and monitoring activities. With regard to the public health side of DHSS, four policy concerns stand out among many ongoing challenges in providing services to the disadvantaged and running population-oriented programs. One is maintaining federal support, on which the department depends for two-thirds of its public health revenues. The second concern is continuing long-term efforts to promote regionalization as a way
of improving local public health services and the efficiency of operating units. Third is the impact and the opportunities of the general movement to managed care. Fourth, unique to New Jersey, is the impact on public health of being joined by the larger senior services component of DHSS. This enlargement seems sure to raise the department’s profile within any administration, but not necessarily to increase the attention paid to the public health aspects of DHSS’s expanded responsibilities.
Overview of New Jersey: 
Thumbnail Sketch of the State

Sociodemographic Portrait of New Jersey

New Jersey is a small but populous northeastern state. Its nearly 8 million people (table 1) make it ninth in the United States in population, down from eighth, as its growth has long lagged that of other states. The state's population quite closely reflects the race and age mix of the rest of the country. Some New Jersey observers commented with pride that New Jersey is now demographically the “most typical” state. The state does have a high level of noncitizen immigrants, 8.8 percent (the national average is 6.4 percent), who come from all over the world; unlike most high-immigration states, no one nationality dominates in New Jersey.

The state is very small in geographic area (46th) and is the most densely populated state. It is also the most urbanized state, but it has no truly large city. The main “New Jersey” cities have always been New York City and Philadelphia. New Jersey’s own municipalities are all small, both in area and in population. Only three municipalities have more than 100,000 residents, and “large” New Jersey cities constitute a very small share of state population. Increasingly, however, population is shifting away from the old urban areas and the borders with New York and Pennsylvania, so New Jersey has become more than commuter bedroom suburbs and exurbanizing truck farms. Many groupings of municipalities have become prosperous new “edge cities” in their own right, and far more residents work in-state than a generation ago.
### Table 1 State Characteristics

<table>
<thead>
<tr>
<th>New Jersey</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population (1994–95)* (in thousands)</td>
<td>7,889</td>
</tr>
<tr>
<td>Percent under 18 (1994–95)*</td>
<td>25.5%</td>
</tr>
<tr>
<td>Percent 65+ (1994–95)*</td>
<td>12.7%</td>
</tr>
<tr>
<td>Percent Hispanic (1994–95)*</td>
<td>11.1%</td>
</tr>
<tr>
<td>Percent Non-Hispanic Black (1994–95)*</td>
<td>11.9%</td>
</tr>
<tr>
<td>Percent Non-Hispanic White (1994–95)*</td>
<td>72.2%</td>
</tr>
<tr>
<td>Percent Non-Hispanic Other (1994–95)*</td>
<td>4.8%</td>
</tr>
<tr>
<td>Percent Noncitizen Immigrant (1996)*</td>
<td>8.8%</td>
</tr>
<tr>
<td>Percent Nonmetropolitan (1994–95)*</td>
<td>0.0%</td>
</tr>
<tr>
<td>Population Growth (1990–95)b</td>
<td>2.8%</td>
</tr>
<tr>
<td>Per Capita Income (1995)c</td>
<td>$29,848</td>
</tr>
<tr>
<td>Percent Change in Per Capita Personal Income (1990–95)c, d</td>
<td>19.8%</td>
</tr>
<tr>
<td>Employment Rate (1996)f, g</td>
<td>60.3%</td>
</tr>
<tr>
<td>Percent below Poverty (1994)h</td>
<td>14.1%</td>
</tr>
<tr>
<td>Percent Children below Poverty (1994)h</td>
<td>9.5%</td>
</tr>
<tr>
<td>Smoking among Adult Population (1993)j</td>
<td>18.9%</td>
</tr>
<tr>
<td>Low Birth-Weight Births (&lt;2,500 g) (1994)k</td>
<td>7.6%</td>
</tr>
<tr>
<td>Infant Mortality Rate (Deaths per 1,000 Live Births) (1995)l</td>
<td>7.3</td>
</tr>
<tr>
<td>Premature Death Rate (Years Lost per 1,000) (1993)m, n</td>
<td>53.1</td>
</tr>
<tr>
<td>AIDS Cases Reported per 100,000 (1995)k</td>
<td>599.8</td>
</tr>
<tr>
<td>Political</td>
<td></td>
</tr>
<tr>
<td>Governor’s Affiliation (1996)p</td>
<td>R</td>
</tr>
<tr>
<td>Party Control of Senate (Upper) (1996)p</td>
<td>16D-24R</td>
</tr>
<tr>
<td>Party Control of House (Lower) (1996)p</td>
<td>29D-50R</td>
</tr>
</tbody>
</table>

---

e. Personal contributions for social insurance are not included in personal income.
g. Employment rate is calculated using the civilian noninstitutional population 16 years of age and over.
h. CPS three-year average (March 1994–March 1996 where 1994 is the center year), edited using the Urban Institute's TRIM2 microsimulation model.
i. "Other" includes persons covered under CHAMPUS, VA, Medicare, military health programs, and privately purchased coverage.
n. Race-adjusted data, National Center for Health Statistics, 1993 data.
Economic Status

New Jersey was once dominated by heavy industry (steel, petrochemicals); agriculture was also prominent in the “Garden State.” For decades, though, the state has lost industrial jobs to competitors and farmland to urban development. The economy has diversified. Chemical, pharmaceutical, and electronic manufacturing remain particularly important (e.g., Merck, AT&T, and Lucent), but growth has been particularly strong in the trade and service industries (insurance, financial services). The state remains relatively high in union membership and health insurance coverage. New Jersey enjoyed particularly strong economic growth in the 1980s, then suffered heavily in the recession of the early 1990s. Recovery since 1992 has been strong, though growth in income per capita slightly lagged the national average for 1990 through 1995 overall (table 1). Unemployment was very high during the recession, but the rate dropped thereafter, to 6.2 percent in 1996, still almost a point above the national average. New Jersey has improved further since then.¹

New Jersey is a high-income state. Its per capita income is nearly $30,000 (table 1), a close second to Connecticut among all the states; and poverty rates are low, whether measured as total population below the poverty level or as children below the poverty level. In the current economic boom, tax revenues have consistently exceeded expectations despite income tax rate cuts; and budgetary pressures have eased.

Political Situation

Once known for urban machine politics, usually strongly Democratic, New Jersey now has more balanced political affiliations—about 20 percent Republican, 26 percent Democratic, and 55 percent unaffiliated and minor parties.² Party control of the legislature and the state house has switched several times in the last generation, and ticket-splitting voters are common. The governor is Christine Todd Whitman, a Republican; Republicans have had 60 percent majorities in both houses of the state legislature since 1992 (table 1). Whitman won with only 49 percent of the vote four years ago but at the time of the research team's February 1997 site visit was heavily favored for reelection in November 1997. Yet in the 1996 presidential election, Democrat Bill Clinton won by a wide margin, as did new Democratic Senator Robert G. Torricelli; and the 1997 gubernatorial campaign election proved much closer than expected before the primaries, as Whitman again won a narrow victory.

During the 1970s and 1980s, both New Jersey parties helped build a high-tax, high-service, interventionist state government. The state created an income tax only in the mid-1970s, in part to pay for court-ordered aid to local schools. Thereafter, state spending rose rapidly through the 1980s boom, mainly under Republican Governor Thomas Kean. The current Republican ascendance began

THE URBAN INSTITUTE

HEALTH POLICY FOR LOW-INCOME PEOPLE IN NEW JERSEY
as a tax revolt. In June 1990, incoming Democratic Governor James J. Florio sharply raised income and other taxes to cope with severe recession and another court mandate for more redistributive state aid for local schools.

The ensuing voter backlash caused a sea change in New Jersey politics and policy. Relatively unknown Republican challenger Christine Whitman nearly unseated popular Democratic U.S. Senator Bill Bradley in 1990 by attacking his failure to oppose higher state taxes. The next fall, anti-tax Republicans swept the midterm state legislative elections, winning veto-proof majorities in both houses. Two years later, Florio’s 1993 defeat completed New Jersey’s turn away from two decades of expanding state budgets and state regulation. Whitman won as a tax-cutting conservative but social moderate from the patrician wing of the eastern Republican party.

New Jersey has a very strong office of the governor, partly because a new state constitution of 1947 intentionally bolstered this formerly weak position. Today, the governor is the only statewide elected official, has unusually extensive power over appointments, and enjoys unusually strong veto powers; she can rewrite substantive provisions when returning a bill to the legislature, which must vote the revised measure up or down. Even leading legislators come a distant second in political importance. They serve part-time, are not highly paid, have small staffs, and usually have other careers. Conventional wisdom suggests that legislative politics are strongly local; most observers say that New Jersey has unusually strong traditions of local power.

Whitman’s top priority by far was rolling back Florio’s income tax hike. She proposed her first tax cut on her first day in office, and further cuts have been a top item in each year’s budget message. Other priorities have included promoting business through incentives and deregulation, reducing state spending, passing anticrime legislation, raising educational standards, and enacting welfare reform. Health issues, by comparison, generally have never had a high public profile, possibly in part because so many basic issues were resolved by a sweeping set of reforms in 1992. Moreover, New Jersey has not sought a comprehensive Medicaid Section 1115 waiver, which in other states occasioned much fundamental policy discussion. However, the recent federal enactment of the State Children’s Health Insurance Program and New Jersey’s response, the new KidCare initiative, will increase the state’s focus on providing health care coverage to low-income children.

Recent policy has resulted from the normal interplay of executive and legislature, often under short-term pressure to balance the annual budget, which has long required numerous one-time adjustments in New Jersey. Although the legislature is heavily Republican, it has resisted some Whitman initiatives, most recently a very large issuance of pension-obligation bonds, which passed only late in the spring 1997 session. Republicans took control of the legislature two years before Whitman won, and her narrow victory provided no coattails.
Roadmap to the Rest of the Report

The rest of this report presents the findings of the case study of New Jersey as of early 1997, with some post-site-visit references. It describes and discusses the following:

• The basics of the state policy agenda;

• Medicaid and other state health programs;

• How New Jersey may respond to increased administrative freedom and potential funding constraints;

• How Medicaid and other coverage reforms affect the poverty population;

• Health care delivery and finance, market changes, and state policy toward managed care;

• Influences on safety net providers and other deliverers of health care to the poverty population; and

• Long-term care for the elderly and disabled.
Medicaid always demands policymakers’ attention. More general health matters, however, have had a lower profile since 1992. Taxes and budget balance have dominated policy discussions, just as they did during Whitman’s campaigns for the U.S. Senate in 1990 and the governorship in 1993. Nor did politicians much emphasize health issues in the 1997 campaign. By tacit agreement, the thorny issues of finding permanent funding to expand private coverage for children and to refinance the hospital charity pool were largely postponed until after the election.

Much of current health policy was set by the Health Care Reform Act of 1992, developed during the second half of Democratic Governor Florio’s administration and enacted by the newly Republican legislature. This comprehensive reform addressed an interrelated complex of problems that had accrued over time and responded to the immediate crises of recession and a judicial decision invalidating hospital rate setting. It ended New Jersey’s long-standing hospital price regulation. It also ended Blue Cross/Blue Shield’s (BCBS) traditional obligation to serve as insurer of last resort and reduced state regulation of hospital investment and services through certificate of need. It partially reregulated the private insurance market for individual and small-group coverage. The reform also called for new state support to help the near-poor buy private coverage. Finally, it continued direct state assistance to hospitals for charity care (but no longer for bad debt), at declining amounts over three years, as insurance coverage was expected to increase.

In a number of ways, the Whitman administration has stayed the course set by the 1992 act. Many key administrators have remained in influential
positions—in human services, Medicaid, and insurance regulation. The governor has consistently supported the private-insurance market reforms against attacks from individual legislators; one key modification has been to allow small groups to retain preexisting coverage at more favorable rates than the community-rated premiums toward which the original reform required them to move. The administration also supports the free-market approach toward hospitals inaugurated by the 1992 act, applying a “prudent purchaser” approach to administrative pricing under the fee-for-service part of Medicaid. The administration also allowed a major safety net hospital in Newark to close in early 1997, letting the market reduce the number of beds in the area, although it intervened to ensure continuation of certain children’s services.

Whitman has also supported the public spending part of the reform by consistently pushing for renewed funding for the hospital charity pool, even after the legislature rejected her first proposal to use tobacco taxation as a funding source. However, after 1992, hospital pool funding continued to decline even beyond the decline scheduled in the act, until an increase was legislated for 1998. The legislature did not fully fund the originally planned level of private insurance subsidy for the near-poor (New Jersey Access), and new enrollment was closed. The governor proposed instead a similar new initiative targeted to children (called Children First during the 1997 legislative deliberations). No funds for the initiative were appropriated during the regular 1997 session, but the governor thereafter has expanded and refocused her plans. Building upon the new federal block funding for state children’s programs, she proposed the KidCare program, which was enacted on December 17, 1997. Planning for an expansive Section 1115 waiver to increase coverage with federal aid under Medicaid has not gone forward; only a limited Section 1115 waiver has been sought, to implement managed care for hospital charity care.

Many new policy initiatives relate to managed care, which got a late start in the state. Whitman has consistently promoted managed care, implementing it not just for Medicaid (under Section 1915 waivers) but also for state employees in a large change to the state benefits program in 1995. New legislation in 1996 also called for the charity pool to be run more like managed care, including authority to substitute cheaper out-of-hospital service. This was largely a legislative initiative and is expected to be implemented in 1998. Both the administration and the legislature have responded to public concerns about managed care and the possibilities for corner-cutting that hurts consumers. New HMO regulations, which took effect in March 1997, emphasize disclosure and consumer protection, and the legislature subsequently clarified departmental authority to extend similar oversight to other forms of managed care.

Administratively, a major gubernatorial act was to consolidate long-term care and other services for senior citizens within the health department, much enlarged and rechristened the Department of Health and Senior Services. Finally, Governor Whitman has vigorously promoted welfare reform, while lessening several of its undesired side effects. One such initiative was the children’s health insurance program just noted. She has also continued support
for immigrants who lost federal welfare eligibility and has created a new state program to help more immigrants achieve naturalization.³

How to deal with managed care, both under Medicaid and through regulation of the private market, will surely continue to be a top health policy issue. Other large, continuing challenges have been stabilizing the state hospital charity pool and finding state support for the enlarged children’s initiative to supplement the federal block grant. For several years, these issues have been caught up in legislative wrangling over each general budget. To date, the safety net has been maintained, contrary to some observers’ fears that it would disintegrate amid general cuts in support for the poor. The Whitman administration’s commitment has been bolstered by favorable growth in tax revenues under a rapidly improving economy. The next downturn may not be as bad for New Jersey as that of the early 1990s, given diversification and other changes since then, ⁴ but hard times will make maintaining the health care safety net more difficult.

State Health and Health Care Indicators

A high percentage of New Jersey residents have health coverage, as is expected for a high-income state, especially a traditional union stronghold. Only 14.6 percent of the nonelderly lack coverage, slightly below the national average (as noted in table 1 earlier). Medicaid covers fewer people than is typical, but employers cover more. New Jersey’s measured health risks and outcomes are mainly similar to those for the United States as a whole, aside from the high number of AIDS cases. Although low birth-weight and infant mortality rates are average, they are much worse among the black population.
Until recently, New Jersey’s Department of Human Services (DHS) oversaw the Medicaid program in addition to welfare programs. The Department of Health, considerably smaller, oversaw public health, licensing, and regulatory activities. As the result of a reorganization in 1996, all senior services, including Medicaid long-term care, were moved to the new Department of Health and Senior Services (DHSS). Consequently, DHSS administers all public health programs and a range of elderly services moved over from several other departments. DHS continues to have responsibility for welfare, acute care Medicaid, and Medicaid managed care not related to seniors. There are no separate departments for substance abuse, mental health, or mental retardation services as in some states. Instead these activities are divided between DHSS and DHS.

Medicaid

Medicaid is the dominant health program in New Jersey. It accounts for 15.6 percent of the state’s general-fund spending (see table 2), but 23.8 percent of spending when other state and federal funding sources are included. As in many states, Medicaid was the fastest growing budget item from 1990 to 1995. Growth has slowed substantially since.

Growth in Medicaid expenditures outpaced the national average from 1990 to 1992 (32.3 percent compared with 27.1 percent), but lagged behind the national average from 1992 to 1995 (8.7 percent vs. 9.9 percent) (table 3). From 1990 to 1992, more than half of the expenditure growth in New Jersey was due to a large expansion of its disproportionate share hospital (DSH) program. In the
same period, growth in benefits (not including DSH or administration) was lower than the national average. Consequently, despite higher-than-average growth in Medicaid expenditures overall, growth in benefits was lower than the national average for the entire 1990–95 period.

Medicaid acute care expenditures in New Jersey have grown faster than long-term care expenditures, as is true nationally (table 3). This pattern is in part the result of eligibility expansions among populations more likely to use acute care services than long-term care services. Over the 1990–95 period, long-term care’s share of benefits dipped from just over half to just under half, but the long-term care share was still higher than the national average of 40 percent (calculated from table 3).

Table 4 shows that New Jersey spends about one and a half times the national average per Medicaid beneficiary ($4,668 in New Jersey vs. $3,202 nationally). Most of the difference is explained by higher-than-average spending per disabled

Table 2 New Jersey Spending by Category, 1990 and 1995 ($ in Millions)

<table>
<thead>
<tr>
<th>Program</th>
<th>State General-Fund Expendituresa</th>
<th>Total Expendituresb</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>$11,811</td>
<td>$14,955</td>
</tr>
<tr>
<td>Medicaidc, d</td>
<td>1,101</td>
<td>2,332</td>
</tr>
<tr>
<td>% of Total</td>
<td>(9.3)</td>
<td>(15.6)</td>
</tr>
<tr>
<td>Corrections</td>
<td>541</td>
<td>692</td>
</tr>
<tr>
<td>% of Total</td>
<td>(4.6)</td>
<td>(4.6)</td>
</tr>
<tr>
<td>K–12 Education</td>
<td>3,613</td>
<td>4,440</td>
</tr>
<tr>
<td>% of Total</td>
<td>(30.6)</td>
<td>(29.7)</td>
</tr>
<tr>
<td>AFDC</td>
<td>183</td>
<td>235</td>
</tr>
<tr>
<td>% of Total</td>
<td>(1.5)</td>
<td>(1.6)</td>
</tr>
<tr>
<td>Higher Education</td>
<td>995</td>
<td>1,085</td>
</tr>
<tr>
<td>% of Total</td>
<td>(8.4)</td>
<td>(7.3)</td>
</tr>
<tr>
<td>Miscellaneouse</td>
<td>5,378</td>
<td>6,171</td>
</tr>
<tr>
<td>% of Total</td>
<td>(45.5)</td>
<td>(41.3)</td>
</tr>
</tbody>
</table>


a. State spending refers to general-fund expenditures plus other state fund spending for K–12 education.
b. Total spending for each category includes the general fund, other state funds, 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. New Jersey reported other state funds of $367 million in 1990 and $473 million in 1995.
d. Total Medicaid spending will differ from data reported on the HCFA 64 for three reasons: first, NASBO reports on the state fiscal year and the HCFA 64 on the federal fiscal year; second, states often report some expenditures (e.g., mental health and/or mental retardation) as other health rather than Medicaid; third, local contributions to Medicaid are not included but would be part of Medicaid spending on the HCFA 64.
e. This category includes all remaining state expenditures (i.e., environmental projects, transportation, housing, and other cash assistance programs) not captured in the five listed categories.
### Table 3  Medicaid Expenditures by Eligibility Group and Type of Service, New Jersey and United States ($ in Millions)

<table>
<thead>
<tr>
<th></th>
<th>New Jersey</th>
<th></th>
<th></th>
<th>United States</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>$2,429.8</td>
<td>$4,253.4</td>
<td>$5,460.1</td>
<td>32.3%</td>
<td>8.7%</td>
<td>$73,662.2</td>
<td>$118,926.0</td>
</tr>
<tr>
<td><strong>Benefits</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefits by Service</td>
<td>$2,338.7</td>
<td>$3,084.8</td>
<td>$4,104.7</td>
<td>14.8%</td>
<td>10.0%</td>
<td>$69,168.7</td>
<td>$97,602.4</td>
</tr>
<tr>
<td>Acute Care</td>
<td>$1,114.8</td>
<td>$1,669.9</td>
<td>$2,154.8</td>
<td>22.4%</td>
<td>8.9%</td>
<td>$36,904.5</td>
<td>$55,059.9</td>
</tr>
<tr>
<td>Long-Term Care</td>
<td>$1,223.9</td>
<td>$1,415.8</td>
<td>$1,949.9</td>
<td>7.6%</td>
<td>11.3%</td>
<td>$32,264.2</td>
<td>$42,542.5</td>
</tr>
<tr>
<td>Benefits by Group</td>
<td>$2,338.7</td>
<td>$3,084.8</td>
<td>$4,104.7</td>
<td>14.8%</td>
<td>10.0%</td>
<td>$69,168.7</td>
<td>$97,602.4</td>
</tr>
<tr>
<td>Elderly</td>
<td>$802.1</td>
<td>$927.1</td>
<td>$1,282.7</td>
<td>7.5%</td>
<td>11.4%</td>
<td>$23,334.3</td>
<td>$31,757.9</td>
</tr>
<tr>
<td>Acute Care</td>
<td>$140.5</td>
<td>$149.1</td>
<td>$271.4</td>
<td>3.0%</td>
<td>22.1%</td>
<td>4,925.4</td>
<td>6,911.5</td>
</tr>
<tr>
<td>Long-Term Care</td>
<td>$611.6</td>
<td>$778.0</td>
<td>$1,011.3</td>
<td>8.4%</td>
<td>9.1%</td>
<td>$18,408.9</td>
<td>$24,846.4</td>
</tr>
<tr>
<td>Blind and Disabled</td>
<td>$1,008.2</td>
<td>$1,276.8</td>
<td>$1,802.2</td>
<td>12.5%</td>
<td>12.2%</td>
<td>$25,771.6</td>
<td>$35,684.6</td>
</tr>
<tr>
<td>Acute Care</td>
<td>$466.0</td>
<td>$671.0</td>
<td>$924.9</td>
<td>20.0%</td>
<td>11.3%</td>
<td>$12,929.2</td>
<td>$19,483.6</td>
</tr>
<tr>
<td>Long-Term Care</td>
<td>$542.3</td>
<td>$605.8</td>
<td>$877.3</td>
<td>5.7%</td>
<td>13.1%</td>
<td>$12,842.4</td>
<td>$16,201.0</td>
</tr>
<tr>
<td>Adults</td>
<td>$296.2</td>
<td>$496.2</td>
<td>$518.2</td>
<td>29.4%</td>
<td>1.5%</td>
<td>$8,765.0</td>
<td>$12,710.1</td>
</tr>
<tr>
<td>Children</td>
<td>$232.2</td>
<td>$384.7</td>
<td>$501.5</td>
<td>28.7%</td>
<td>9.2%</td>
<td>$11,297.8</td>
<td>$17,449.8</td>
</tr>
<tr>
<td>DSH</td>
<td>$35.7</td>
<td>$1,094.1</td>
<td>$1,286.5</td>
<td>453.6%</td>
<td>5.5%</td>
<td>$1,340.9</td>
<td>$17,525.6</td>
</tr>
<tr>
<td>Administration</td>
<td>$55.3</td>
<td>$74.5</td>
<td>$68.9</td>
<td>16.0%</td>
<td>-2.6%</td>
<td>$3,152.6</td>
<td>$3,797.9</td>
</tr>
</tbody>
</table>

*Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.*
<table>
<thead>
<tr>
<th></th>
<th>New Jersey</th>
<th></th>
<th>United States</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Spending per Enrollee</td>
<td>Average Annual Growth</td>
<td>Spending per Enrollee</td>
<td>Average Annual Growth</td>
</tr>
<tr>
<td>Total</td>
<td>$3,643</td>
<td>$3,905</td>
<td>$4,668</td>
<td>3.5%</td>
</tr>
<tr>
<td>By Group</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elderly</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash</td>
<td>$10,067</td>
<td>$10,990</td>
<td>$13,755</td>
<td>4.5%</td>
</tr>
<tr>
<td>Noncash</td>
<td>4,915</td>
<td>4,264</td>
<td>6,097</td>
<td>6.9%</td>
</tr>
<tr>
<td>Blind and Disabled</td>
<td>$10,086</td>
<td>$10,551</td>
<td>$11,767</td>
<td>2.3%</td>
</tr>
<tr>
<td>Cash</td>
<td>$8,317</td>
<td>$8,749</td>
<td>$9,441</td>
<td>2.6%</td>
</tr>
<tr>
<td>Noncash</td>
<td>18,866</td>
<td>19,552</td>
<td>22,845</td>
<td>1.8%</td>
</tr>
<tr>
<td>Adults</td>
<td>$2,045</td>
<td>$2,507</td>
<td>$2,604</td>
<td>10.7%</td>
</tr>
<tr>
<td>Children</td>
<td>$732</td>
<td>$995</td>
<td>$1,156</td>
<td>16.6%</td>
</tr>
</tbody>
</table>

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.
and per elderly beneficiary. New Jersey spends 44 percent more per elderly and 49 percent more per disabled beneficiary. In contrast, spending per child is close to the national average. Spending per beneficiary grew somewhat more slowly than the national average from 1990 to 1992, but was higher from 1992 to 1995. Over the entire five-year period, per-enrollee spending grew more slowly than the national average.

Just as spending per enrollee grew more slowly than the national average, so did the total number of enrollees. In 1995, New Jersey had 37 percent more Medicaid beneficiaries than in 1990, compared with a 44 percent increase across the United States (calculated from table 5).

Department of Health and Senior Services and Department of Human Services

In New Jersey DHSS is responsible for traditional public health activities, including disease control and monitoring, licensing and inspection of medical facilities; the Supplemental Food Program for Women, Infants, and Children (WIC); and some health care delivery programs, such as immunizations, maternal and child health, and family planning. DHSS also oversees substance abuse services. In 1996 numerous programs for the elderly were combined and placed under the DHSS umbrella in order to create “one-stop shopping” and easier access to services. This was intended to mirror changes at the local level that were part of the new New Jersey Easy Access Single Entry (NJEASE) initiative. DHSS oversees Medicaid long-term care, including institutional and home and community-based care programs as well as programs funded through the Older Americans Act. This new senior activity became one of four DHSS divisions—and the one with the largest budget.

The Department of Human Services continues to oversee general Medicaid eligibility, food stamps, Aid to Families with Dependent Children (AFDC)/Temporary Assistance for Needy Families (TANF), social services, and mental health and mental retardation services.
<table>
<thead>
<tr>
<th>By Group</th>
<th>New Jersey</th>
<th>United States</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Enrollment</td>
<td>Average Annual Growth</td>
<td>Enrollment</td>
<td>Average Annual Growth</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>641.9</td>
<td>790.0</td>
<td>879.3</td>
<td>10.9%</td>
</tr>
<tr>
<td><strong>Elderly</strong></td>
<td>79.7</td>
<td>84.4</td>
<td>93.3</td>
<td>2.9%</td>
</tr>
<tr>
<td><strong>Cash</strong></td>
<td>35.0</td>
<td>36.4</td>
<td>38.3</td>
<td>2.0%</td>
</tr>
<tr>
<td><strong>Noncash</strong></td>
<td>44.7</td>
<td>47.9</td>
<td>54.9</td>
<td>3.6%</td>
</tr>
<tr>
<td><strong>Blind and Disabled</strong></td>
<td>100.0</td>
<td>121.0</td>
<td>153.2</td>
<td>10.0%</td>
</tr>
<tr>
<td><strong>Cash</strong></td>
<td>83.2</td>
<td>100.8</td>
<td>126.6</td>
<td>10.1%</td>
</tr>
<tr>
<td><strong>Noncash</strong></td>
<td>16.8</td>
<td>20.2</td>
<td>26.6</td>
<td>9.8%</td>
</tr>
<tr>
<td><strong>Adults</strong></td>
<td>144.9</td>
<td>197.9</td>
<td>199.0</td>
<td>16.9%</td>
</tr>
<tr>
<td><strong>Cash</strong></td>
<td>118.9</td>
<td>133.4</td>
<td>128.3</td>
<td>5.9%</td>
</tr>
<tr>
<td><strong>Noncash</strong></td>
<td>26.0</td>
<td>64.5</td>
<td>70.7</td>
<td>57.5%</td>
</tr>
<tr>
<td><strong>Children</strong></td>
<td>317.4</td>
<td>386.8</td>
<td>433.9</td>
<td>10.4%</td>
</tr>
<tr>
<td><strong>Cash</strong></td>
<td>263.6</td>
<td>288.2</td>
<td>260.5</td>
<td>4.6%</td>
</tr>
<tr>
<td><strong>Noncash</strong></td>
<td>53.8</td>
<td>98.6</td>
<td>173.4</td>
<td>35.3%</td>
</tr>
</tbody>
</table>

*Source: The Urban Institute, 1997. Based on HCFA 2082 data.*
Assessing the New Federalism: Potential State Responses to Additional Flexibility and Reduced Funding

General Philosophy Regarding Public Responsibility for the Poor

New Jersey has historically had a wide array of public programs designed to assist low-income populations, with support from both Democrats and Republicans. Even in the tax-cutting 1990s, interparty differences over maintenance of safety net public programs have been less pronounced than differences over broader economic and social policies. This approach to the safety net may reflect in part many New Jersey Republicans’ roots in the eastern, Rockefeller wing of the Republican party, which historically exhibited a patrician attitude toward the least advantaged. Welfare reform and mandatory Medicaid managed care, however, have also garnered bipartisan support, both for reasons of improving program performance and ending welfare dependence and for budgetary reasons.

Interstate Competition

Interviewees’ comments during the site visit to New Jersey suggested that state health care policy was only somewhat influenced by actions in other states. Medicaid was less affected than welfare, despite the administrative tie
that has historically linked the two programs, as cash assistance was felt to be more of a motivation in people's relocation decisions than was health care coverage. Neither program was seen as subject to cross-boundary currents as great as those influencing taxation or other industrial policy.

Health-related decisionmaking in both New York and Pennsylvania is still monitored by New Jersey, however, because market developments in New York City and Philadelphia have a major impact on health care developments in northern and southern New Jersey.

Many respondents noted that debates about federal devolution in welfare and Medicaid had raised fears that states would compete to cut benefits. However, few individuals cited any specific example of a policy decision in another state that affected decisions in New Jersey. State policymakers did indicate their general concern not to become a cash benefit “magnet” for in-migration and specifically mentioned tracking benefits offered in New York and Pennsylvania. Moreover, New Jersey was one of nine northeastern states that have met to discuss numerous issues related to welfare reform. There was no similar coordination for health care. Advocates for individuals who have historically received cash assistance through the AFDC program continued to express fear of a welfare “race to the bottom.” They expressed less concern over health care coverage, however, because many categories of individuals who can potentially lose cash benefits are expected to retain Medicaid eligibility.

In contrast, a few policymakers saw New Jersey as engaged in a “race to the top” to provide certain in-kind benefits that achieve social goals. For example, New Jersey is proud of its efforts to increase the levels of child care available to low-income populations in aid of successful welfare-to-work transitions. Similarly, New Jersey, like most states, is seeking to provide health insurance to more uninsured children. As a result, the state policymakers specifically examined the types of programs being operated in other states to boost levels of children’s health care coverage.

Medicaid-Specific Issues

Policy debate nationwide has increasingly focused on relations between the federal government and state governments. In health care policy, particularly Medicaid policy, this debate most often manifests itself in concern about relations between state agencies and the Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services.

In recent years, states' relations with HCFA have often been contentious. Specifically, states have been frustrated by HCFA's delays in approving Section 1115 health care reform demonstration waivers. New Jersey officials indicated that they have a good working relationship with HCFA. Like those in other states, however, New Jersey officials interviewed in early 1997 expressed a
desire for greater flexibility in enrolling different populations into Medicaid managed care and in setting reimbursement rates with providers. Subsequently, the federal Balanced Budget Act of 1997 repealed the Boren amendment governing hospital payment rates and also allowed states to move to managed care without federal approval of a waiver.

During site visits, the research team also questioned people about competition among the elderly, disabled, children, and nondisabled populations. The respondents indicated that there was no direct competition among advocates for various eligibility groups but that certain groups were more influential than others. Provider associations and advocacy groups that serve the elderly were viewed as being more influential than those whose primary focus is low-income families.
Providing Third-Party Coverage for the Low-Income Population

Medicaid Eligibility

Approximately 8.3 percent of New Jersey’s nonelderly population is enrolled in the Medicaid program, in comparison with a national enrollment rate of 12.2 percent (as shown in table 1 earlier). New Jersey’s eligibility and enrollment rates are lower than the national average because New Jersey is a high-income state with a small low-income population. Lower eligibility and enrollment rates are not a result of the state’s specific eligibility criteria, which are often the maximum allowed without federal waiver and are always above the national average. For example, New Jersey has voluntarily chosen to cover infants in families with income of up to 185 percent of the federal poverty level. Similarly, the state has a broad “medically needy” program and is one of 13 states to cover the elderly and disabled up to 100 percent of the federal poverty level.

At the time of the visit, few changes in Medicaid eligibility were being contemplated other than those necessitated by the passage of the welfare reform bill of 1996. The state had been considering some broadening of Medicaid eligibility along with expansion of mandatory HMO enrollment under a Section 1115 waiver. No action was ever taken, so no official information on the proposed change was obtained. The Balanced Budget Act of 1997 now permits states to
mandate Medicaid enrollment into HMOs without any waiver, thus ending a key motivation for seeking a waiver.

New Jersey's Medicaid enrollment trends have mirrored national averages (as indicated in table 5 earlier). Between 1990 and 1992, enrollment increased by more than 10 percent a year, largely because of the federally mandated Medicaid eligibility expansions of the late 1980s and early 1990s. The rate of growth decreased from 1992 to 1995 in New Jersey, as it did elsewhere. Enrollment trends by eligibility group also mirrored national patterns; the one exception is enrollment rates for adults (primarily AFDC mothers).

New Jersey Governor Whitman has been perceived as being prominent in the national debate on reforming welfare. The state has moved quickly to implement the federal welfare reform law, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. This reform replaced AFDC with the TANF block grant program, severing the historical link that made persons who received cash assistance automatically entitled to Medicaid. Federal law protects those who received Medicaid eligibility through the AFDC program from potential eligibility cuts by requiring states to use the old AFDC eligibility criteria (July 1996) in determining Medicaid eligibility.

By contrast, a small number of children who traditionally received Medicaid coverage through the Supplemental Security Income (SSI) program were expected to lose eligibility because welfare reform tightened definitions of "disability." However, almost no children were ever actually disenrolled by the reform because they had other pathways to eligibility and because of recent policy changes designed to provide coverage to uninsured children.

The 1996 welfare reform law restricted immigrants’ eligibility for a wide range of benefits, including Medicaid. Before the reform, legal noncitizens were eligible for Medicaid on the same basis as citizens. The new law bars immigrants arriving after August 22, 1996, when the law was enacted, from receiving Medicaid for their first five years in the country. It also gives states the option of providing Medicaid to immigrants already in the United States and to new immigrants following the federal five-year bar.

At the time of the site visit, New Jersey officials indicated that the state had decided to continue providing Medicaid benefits to legal immigrants in the United States as of the passage of the reform law. State policymakers indicated that despite support for immigrant restrictions at the federal level, there was little support among either state policymakers or the public to limit health care benefits to current legal immigrants. In fact, under Work First New Jersey, the state will make current legal immigrants eligible for both welfare and Medicaid. New Jersey officials also indicated that they plan to provide Medicaid benefits to new immigrants after the five-year bar but that the state will not use its own funds to provide Medicaid for legal immigrants during the bar, as some other states have done.
Other Public Financing Programs

In addition to Medicaid, several smaller state programs also address health financing for low-income or high-cost populations. Through the Health Care Subsidy Fund, the state subsidizes hospitals for charity care and for costs incurred serving high-cost populations. The state has also launched subsidized insurance programs. The first was Health Access New Jersey, now being phased out by attrition. It now plans to increase insurance coverage for children who do not qualify for Medicaid by subsidizing insurance through the KidCare program. In addition, the state's General Assistance program covers limited medical services that include physician services and prescription drugs. This coverage offers substantial assistance, though much less than Medicaid—which, at more than $5 billion (state and federal) in 1995, is by far the largest state health program.

New Jersey has historically had a commitment to serve uninsured individuals. Since the late 1970s, state law has mandated that hospitals not turn away prospective patients for inability to pay. The resulting uncompensated care (charity and bad debt) was initially funded through hospital-specific markups passed on to paying patients under comprehensive state hospital rate-setting regulation. In 1987, the state changed to an uncompensated care pool, which was funded by a uniform statewide surcharge on all payers (until 1989 including even Medicare). Collections were distributed according to amounts of uncompensated care delivered. The pool shifted funds from hospitals with high revenues to those high in uncompensated care. It also undercut hospitals’ incentive to collect on bad debts.

After Medicare (the largest payer) withdrew, the pool surcharge reached as high as 19 percent on remaining payers, totaling more than $900 million in 1991 (table 6). Cross-hospital subsidies of this magnitude became politically controversial, and a commission was set up to consider alternatives. Then in 1992, the state lost a federal district court case in which employers argued that the hospital rate-setting law, which included the hospital surcharge, violated the Employee Retirement Income Security Act of 1974 (ERISA). In response, the legislature passed the Health Care Reform Act of 1992 as part of comprehensive reforms. The act deregulated hospital prices, removed the pool surcharge, replaced the single uncompensated care pool with a charity care pool, and called for new subsidy of insurance that would reduce charity and bad debt.

Controversy did not end there, however, and changes continued to be made right up through December 1997.

Health Care Subsidy Fund

Since the 1992 reforms, state subsidies have been made through a Health Care Subsidy Fund. The fund has three accounts: (1) a charity care account for indigent care, (2) a hospital relief account, and (3) a health access fund that sub-
Table 6  New Jersey Charity Care Subsidies, * 1987–98

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Subsidies</strong></td>
<td>$912 million</td>
<td>$726 million</td>
<td>$442 million</td>
<td>$523 million</td>
</tr>
<tr>
<td><strong>Uncompensated Care Pool:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>all hospitals get full cost of charity and bad debt</td>
<td>$912 million (1991 level), from statewide surcharge on all payers (not Medicare, 1989-92)</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td><strong>Charity Care Pool</strong> (no bad debt): increasingly targeted to safety net hospitals</td>
<td>—</td>
<td>$500 million (1993 level), from unemployment insurance trust fund (declining to $400 M for 1995)</td>
<td>$300 million (1997 level), from UI trust fund</td>
<td>$320 million (1998-2002 level), tobacco taxes and general revenues to displace UI trust fund over time</td>
</tr>
<tr>
<td><strong>Other Uncompensated Care</strong> (a.k.a. “Medicare Shortfall” fund): targeted to top 45% of hospitals in OUC percentage</td>
<td>—</td>
<td>$100 million (1993—to $33 M for 1995), from UI trust fund</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td><strong>Hospital Relief Subsidy Fund (HRSF): Hospitals with high caseloads of specified high-risk diagnoses</strong></td>
<td>—</td>
<td>$110.4 million (added mid-1993), from state appropriations, UI trust fund</td>
<td>$124.5 million</td>
<td>$183 million</td>
</tr>
<tr>
<td><strong>HRSF—Mentally Ill, Developmentally Disabled:</strong> Hospitals with high loads of MI, DD</td>
<td>—</td>
<td>$15.4 million (added mid-1993), from state appropriations, UI trust fund</td>
<td>$17.5 million</td>
<td>$20 million</td>
</tr>
</tbody>
</table>

* Presents hospital subsidies only, not insurance initiatives (Largest = KidCare, New for 1998, budget at $1.36 million, state and federal shares) or grants (e.g., Other Health Initiatives).

sidizes health insurance for uninsured persons. Total payouts to hospitals have dropped because of the end to subsidy for bad debt and because of cuts in funding for specific subsidies (table 6), partly in expectation of increased levels of insurance coverage. Another large reform occurred in mid-December 1997, which is to raise subsidy levels while simultaneously implementing a large increase in coverage for currently uninsured children.

Since 1993, the legislature has financed the Health Care Subsidy Fund through three sources: (1) surplus unemployment insurance (UI) trust funds, (2) general revenues, and (3) federal DSH payments. All hospitals in New Jersey are considered DSH providers, so they are all theoretically eligible for charity care payments. For 1998, tobacco levies have been added to the revenue mix. Each account/subsidy program is described in turn in this section immediately below. DSH funding is described further in the next section.

**Charity care account for indigent care**

This successor to the former uncompensated care pool is the main source of aid. In 1992, the pool was refocused on charity care, to the exclusion of bad debt. The majority of the earlier uncompensated care payments had been thought to be for bad debt, though the two are hard to distinguish without careful investigation of a patient’s finances. To receive pool funds today, hospitals must document patients’ eligibility for charity. The new pool was funded at a fixed amount, unlike the former one, whose surcharge had to be changed periodically to fund the levels of uncompensated care being delivered. Just as the pool’s focus was narrowed to charity alone, its dollar funding was cut. The pool was funded at $500 million for 1993, its first year (table 6). Additional, transitional aid was created—the Other Uncompensated Care (OUC) program—which was funded at $100 million for 1993. Both the pool and the OUC program were set to decline over the three years authorized for each—the pool to $400 million in 1995, OUC to $33 million. One rationale was that the 1992 legislature also took steps to increase access to health insurance, which were expected to curb the amounts of bad debt and charity needed at the hospital level. (The next few pages will feature discussions about Health Access subsidized insurance and reforms of the individual and small group insurance markets.)

The new pool also needed new funding, as surcharges could not readily be passed through to other payers under competitive pricing. As a provisional measure, it was determined to use surplus UI trust funds through calendar 1995, covering the full cost of the pool and most of OUC as well. Additional funds came from state revenues, and all of the subsidies were claimed as DSH expenditures for obtaining federal matching payments. (Under the old pool, only the Medicaid share was considered under DSH.) No more permanent solution was found in 1995, as the governor proposed an increase in tobacco taxation that the anti-tax legislature rejected. Pool funding lapsed, and hospitals went unpaid for several months in early 1996 before a stopgap agreement was reached to continue UI funding through 1997.
After the November elections, on December 19, 1997, charity reform legislation was enacted. The law slightly raises the size of the pool and associated subsidies for 1998, then holds support steady through 2002. Also funded was the large new KidCare insurance program. Funding relies heavily on a doubling of tobacco taxes. Over five years that levy and general funds are to displace reliance on UI funds, and after 2002 the subsidies are to be a regular budget item in competition with all other activities for general funding.

As pool funds declined in the 1990s, the distribution formula was changed to target subsidy to hospitals with the highest levels of charity care and the least ability to shift costs to other payers. Before 1996, charity care dollars were allotted to hospitals based on a formula that measures (1) the amount of documented charity care provided at a Medicaid-priced amount, (2) a hospital profitability factor, and (3) a payer mix factor. For 1997, of the state's 84 hospitals, 75 received charity care dollars, but the top nine got half the total dollars.

**Hospital relief subsidy fund**

Additional hospital subsidy programs were created in 1993 via the Hospital Relief Subsidy Fund (HRSF), which has two components. The larger one, called simply the HRSF, helps hospitals that provide services primarily used by Medicaid and charity patients. The HRSF makes payments to hospitals that have a higher rate of care to patients with five diagnoses—HIV, mental illness, tuberculosis, substance abuse and addiction problems, and neonatal complexity. (Two secondary diagnoses were added for 1997.) In calendar year 1997, 30 hospitals received HRSF payments of $124.5 million (table 6).

A second and smaller program is the HRSF for the Mentally Ill and Developmentally Disabled. In 1997, about 30 hospitals received a similar $17.5 million subsidy for maintaining beds to serve these populations. The HRSF programs are funded by state appropriations, which earn matching federal DSH recoveries.

**Health Access New Jersey**

In the Health Care Reform Act of 1992, the state legislature approved a subsidized insurance program for working families. The subsidy program, titled Health Access New Jersey, was in planning for two years and began in 1995. Health Access was designed to provide health insurance subsidies to a broad population. Individuals eligible for the Health Access program include residents with incomes of up to 250 percent of the federal poverty level who are not eligible for Medicare or Medicaid and have no coverage available at work. Subsidies are offered on a sliding scale based on income and the health plan selected. Insurance companies participating in the program offer special rates and agree to hold their administrative expenses and profit margins to 15 percent of the premium, rather than the 25 percent permitted in the commercial individual market, and to refund any difference in their experience and the 15 percent retention to the state.
In its first year of operation, the state planned to provide $50 million in health insurance subsidies to an estimated 30,000 people. As envisioned, $100 million was to have been provided in the second year and $150 million in the third year. However, the state did not identify stable funding sources and these funds did not materialize. Legislation signed by Governor Whitman in May 1996 specified that the Health Access Subsidy Account would be allocated $50 million in 1995, $10 million in 1996 (instead of $100 million), and $25 million in 1997 (instead of $150 million).

The state originally hoped that the program would cover 100,000 individuals in three years. However, funding constraints limited enrollment in the program. The Health Access program accepted enrollees from April 1 to December 31, 1995, ending with some 22,000 individuals covered. New enrollment has since been closed, and attrition cut the number of enrollees in March 1997 to 15,678.

**Children’s Health Insurance Initiatives**

Governor Whitman has made extending children’s health coverage an administrative priority. She first proposed a subsidized insurance program for children, titled Children First, in December 1995 as part of a larger plan to restructure the state’s system for funding charity care. At the time, the governor’s proposal was rejected because it required new taxation, a 25 cent increase in the state’s cigarette tax.

In the 1998 budget, the governor introduced a new proposal to create a subsidized children’s insurance program. The governor’s plan included $5 million in seed money to establish a subsidized health insurance program for children from low-income working families. As under Health Access, the program would have subsidized premiums to families whose incomes fall below 250 percent of the federal poverty level but who are ineligible for health coverage through an employer or another public program. Benefits under the program would have included hospitalization, doctor visits, preventive care, and prescription drugs. The program would also have been available to families who leave public assistance to work and to grandparents who are raising children.

The 1995 and 1997 initiatives failed to win legislative support. With new federal support, Governor Whitman has committed to extend health care coverage to all uninsured New Jersey children by the year 2001. The State Children’s Health Insurance Program, passed by Congress as part of the Balanced Budget Act of August 1997, made new funds available to states. As a result of that act, Governor Whitman announced a $136 million plan to expand Medicaid and also launch a new private, managed care–based health insurance program for children, titled New Jersey KidCare—far larger than Children First and differently administered. The state is to contribute 35 percent of spending. Beginning in January 1998, the state planned to offer health care coverage to children up through age 18 in families with incomes of up to 200 percent of the federal poverty level. New Jersey’s Medicaid program will be expanded to cover all chil-
children from families with incomes of up to 133 percent of the federal poverty level, while New Jersey KidCare will provide managed care coverage to children in families with incomes between 133 percent and 200 percent of the federal poverty level, essentially working near-poor people. In addition, the state hopes to expand the KidCare program further through private foundation support.\textsuperscript{11}

**General Assistance—Medical**

New Jersey has a small General Assistance program that provides cash assistance to single adults and childless couples who were not eligible for cash assistance through the AFDC program. It is estimated that more than 20,000 people per month are eligible for New Jersey's General Assistance program.\textsuperscript{12} This program is now wholly funded at the state level but still administered by municipal agencies; it has a limited medical component that covers physician services and prescription drugs.\textsuperscript{13} Interviewees indicated that medical benefits covered under the General Assistance program play a relatively small role in state health policy.

**Insurance Reforms**

BCBS was historically the insurer of last resort for New Jersey residents; but its capabilities were eroded during the 1980s, and the state has never had a high-risk pool to spread the cost of the least insurable. The 1992 reform replaced the old BCBS obligation with new rules for all carriers of health coverage to address three problems: the rapid growth in the uninsured population in the state from 1989 to 1992, the problems in obtaining and keeping affordable coverage for individuals and small groups, and the concentration of high risks in one carrier, BCBS. (The 1992 reforms also ended rate setting, and thereby raised hospital costs for BCBS relative to those of its competitors.) State administrators expected to be able to comply with the Kassebaum-Kennedy law's requirements on insurance portability by building on the 1992 reforms.

The unusual “play or pay” reform of insurance for individuals took effect on August 1, 1993.\textsuperscript{14} The goal was to encourage carriers to underwrite individual coverage. All carriers selling group policies in the state, almost always to employment groups, must either sell their “fair share” of coverage to individuals themselves or pay a pro rata assessment to fund the program's administration and the reimbursable losses of carriers that do meet target enrollments. A company selling in the market can elect to have allowable losses covered by the program; then it may not earn profits. Those seeking profits must forgo the state's protection against losses.\textsuperscript{15}

The law also required (1) standardized policies (HMO and fee-for-service) with minimum benefit levels and maximum deductibles, (2) immediate coverage of preexisting conditions for the continuously insured, except a 12-month waiting period for prior uninsureds, (3) open enrollment periods (later set as October each year), (4) guaranteed renewal of policies, (5) full community rat-
ing by mid-1995, and (6) a minimum payout percentage (no more than 25 per-
cent of premiums spent on expenses). Premiums are market-determined, but
rebates must be made if administrative expenses rise too high.

The small-group insurance reform is similar; but it applies to employers
with 2 through 49 full-time employees, has no loss-spreading mechanism,
and offers insurers and insureds more flexibility. Effective January 1, 1994,
this reform also requires guaranteed issue of standardized benefits. Initially,
employers were allowed to buy prereform (nonstandard) plans under certain
conditions, but there was to be a “forced conversion” of all employers to fully
standardized plans in 1995. The state has backed away from this uniformity
with 1994 and 1996 amendments, first postponing and then abandoning the
forced conversion. Those in prereform plans are now permanently “grandfa-
thered.” About three-quarters of the “lives” in this market are now in stan-
dard plans. As a result of an amendment, moreover, carriers may now file and
use “riders” to modify benefits under the standard plans, subject to some
restrictions. Small-group community rating was developed and then modified.
Plans may adjust rates for age, sex, and location, although the ratio between
high and low can be no more than 2:1, as set by 1997 legislation. The grandfa-
thering also allows small businesses to retain prereform policies with premi-
ums more favorable to them.

Both programs are overseen by boards representing the state, consumers,
insurers, and HMOs. The small-group board represents businesses and doctors
as well. The boards have been quite active in solving practical problems and
defending the programs against individual legislators who want less regulation.
The boards share administrative staff.

Both state officials and outside observers report that implementation of the
reforms went smoothly. A key factor cited is that the insurance industry wanted
the reforms to succeed, as a way of showing that the private market can pro-
vide reasonable access to coverage for all residents willing to pay their own
way. (The Health Access program was meant to subsidize those too poor to
pay premiums.) The regulation was seen as the price to pay for continuing
largely unregulated operations in the far larger group market, operations that
were being challenged politically by calls for mandatory universal coverage reg-
ulated by federal or state government.

The reforms are thought successful by observers within and outside of gov-
ernment. “Play or pay” has encouraged participation. As of late 1996, more than
20 carriers, including 10 HMOs, had joined BCBS in the individual market, and
60 offered small-group coverage. Some 213,000 people were insured individu-
ally, and another 775,000 in small groups; in each case, many enrollees had pre-
viously been without coverage. In addition, BCBS is no longer losing money
on individual coverage, and in 1996 opted to seek to earn profits rather than
keep program protection against losses. Median premiums for individual poli-
cies have risen by 0 to 14 percent a year (the lowest rise has been for HMOs
and high-deductible policies), though some insurers imposed much larger
increases. Industrywide assessments for the individual program have totaled about 1 percent of the statewide health care premiums for the assessed carriers, that is, those “paying” in lieu of “playing.”

Not all indicators are positive. Overall 1996 enrollment was not high—about 13 percent of state residents—whereas nearly 15 percent of the state’s population remains uninsured (as shown in table 1 earlier). The number of individual enrollees in the new, standard plans was only 180,000 in mid-1996. This figure is little more than the 165,000 that BCBS still carried in 1992, the last year it was the insurer of last resort, albeit one in fiscal difficulty (almost 30,000 remain in prereform BCBS plans). Finally, program successes have occurred in a rising economy; performance during a downturn remains to be seen.
Financing and Delivery System

Changes in the Health Care Market and Their Impact on Access for Low-Income Populations

For 20 years until the mid-1990s, New Jersey regulated the hospital market as heavily as any state in the nation, using both rate setting and health planning by certificate of need (CON). The state's tradition of generous indemnity-style insurance coverage was even older. Both regulation and generous coverage militated against hospital price competition, and managed care was slow to develop.

HMOs began in the mid-1970s but had to pay state-set hospital rates like other payers, which constrained their ability to hold down spending. Even so, HMOs became significant in the late 1980s. When state Medicaid officials wanted to promote HMO enrollment in the early 1980s, they found it necessary to create a state-owned plan, which was recently sold. By December 1994, HMO penetration had risen to 16.9 percent, below the national average of 19.5 percent and particularly low for such a densely populated urban state. Penetration by preferred provider organizations (PPOs) lags much further behind national norms—only 4 percent in December 1992 versus 19.5 percent nationwide. Inability to negotiate hospital rates during the rate-setting era inhibited PPO growth. Perhaps half of the market is in self-insured (ERISA) health plans, by an informed estimate. Very recently, New Jersey has been seen as a fertile area for managed care expansion; national commentators even refer to it as a competitive “hotbed” among managed care organizations. A number of health plans from Pennsylvania and New York operate in New Jersey, and neighboring hospital systems are increasingly planning to expand there as well.
The state has actively promoted managed care in the 1990s. Many Medicaid beneficiaries are required to enroll, and state employees are encouraged by new limits on the state's contribution toward premiums. The state also actively regulates managed care. Solvency of HMOs and insured PPOs is overseen by the Department of Banking and Insurance. Quality and consumer protection are overseen by DHSS, whose authority was enhanced by recent legislation.20

Real hospital price competition began only in 1994. After deregulation, a transitional rate-setting regime applied throughout 1993. Moreover, many hospitals got substantial back payments from the final auditing and reconciliation of rate-setting accounts, payments that cushioned them against early impacts of competition. The charity care pool and hospital relief fund were continued to help shelter charity care from the competitive squeeze, but funding has been cut over time, and the number of uninsured has not been reduced as was initially expected under the 1992 reforms.

By 1995, hospital consolidation and realignment had begun, as hospitals sought to build networks or otherwise improve their access to managed care enrollees or bargain better with health plans. Many affiliations or alliances have occurred, along with some mergers, which still require state CON approval. Most consolidations are occurring regionally within the state, although the state medical schools have formed statewide networks, and the largest regional system, St. Barnabas (north central), now covers much of the state. Some affiliations have occurred with hospitals or systems in New York and Pennsylvania, many of which are trying to expand into New Jersey. New Jersey remains overbedded relative to states with high managed care penetration, and buyers appear to be driving hard bargains. One safety net source complained that HMOs make zero allowance for graduate medical education or for charity, refusing even to discuss those hospital burdens in negotiations.

State law requiring open admissions remains in effect, and state officials say they vigorously enforce it. Some say that in practice, however, poor patients are sometimes steered away from hospitals. However, safety net hospital interviewees said they take all referrals and that otherwise the poor would not get tertiary care. Indeed, they perceived that their CONs to provide tertiary services are a major competitive protection, a form of exclusive “franchise.” The urban hospitals fear losing their tertiary “franchise” to suburban hospitals that would not serve the poor. There is a strong movement in the state to get rid of CONs. Even with a “franchise,” some old urban hospitals with heavy Medicare and Medicaid reliance are said to be in trouble. The Hospital Alliance of New Jersey asked the state to rebudget long-term Medicaid savings on managed care to provide permanent funding for the charity care pool, but without success. Refinancing for the pool was enacted in December 1997, relying heavily on increased tobacco taxes but also phasing in general revenues to replace reliance on UI funds. Nonetheless, safety net hospitals, like others, are having to formulate strategic plans for a worsening future.
Still, in the past 10 years there have evidently been only three hospital closures. Two have occurred within the last year: One midsize southern hospital converted to an ambulatory/outpatient facility, and a major, acute care teaching facility in Newark, United Hospitals Medical Center, closed altogether. United's impending closure brought demands for state intervention, which state officials wanted to be very limited, believing that the market should be allowed to function. The state acted to help the hospital cope with state law requiring advance notice to job losers and to ensure continued access to certain high-tech children's procedures such as open heart surgery on infants. United was the only hospital in northern New Jersey with a CON to perform such procedures, and the state oversaw the award of a successor CON to another facility. One state official indicated some disappointment that state monitoring could have given policymakers earlier warning. Because there will surely be more downsizing and realignment, the state needs to prepare for politically sensitive closures to come.

For-profit conversions have not occurred in New Jersey. There are as yet no for-profit hospitals, in part because large national investor-owned hospital chains have always refused to invest in rate-setting states. However, as a way station to eventual for-profit status, BCBS did try to convert from its separately regulated nonprofit status as a service plan to a conventional mutual insurance company. The company's plan was to make itself a regional carrier. It first sought to purchase Delaware BCBS and then, in a more controversial move, to merge with for-profit Indianapolis-based Anthem, Inc., itself the result of BCBS mergers in Indiana, Kentucky, and Ohio. The state intervened. Early in 1997 the attorney general ruled BCBS a charity with assets that could not be converted; a court supported that ruling, and by spring the company withdrew first the Delaware merger and then the one with Anthem.

Disproportionate Share Hospital Payments and Adequacy of Hospital and Physician Reimbursement

New Jersey is one of only four states that had an all-payer hospital rate-setting system during the 1980s. New Jersey's rate-setting system was ended by the 1992 reforms, in the wake of an adverse lower court decision in a lawsuit that challenged built-in subsidies for hospital charity care. The political support for rate setting had already eroded, in any case, and the system was reformed before an appellate court upheld the former system.

After the end of rate setting, Medicaid rates included payment adjustments to help ease the transition for hospitals. Medicaid rates are based on diagnosis-related groups (DRGs). In 1995, the state reduced hospital payment rates by eliminating the transition and other payment adjustments. In reaction, the New Jersey Hospital Association sued the state under the Boren amendment. The
courts refused to grant immediate injunctive relief, concluding that the state had shown substantial compliance with the Boren amendment, and the case was dropped. Subsequent reductions in hospital payments had lowered Medicaid rates to approximately 85 to 90 percent of costs by the time of the site visit in early 1997. However, payments from the charity pool and the hospital relief funds add substantial revenue, especially for safety net hospitals.

New Jersey has lower-than-average physician fees compared with other Medicaid programs. New Jersey pays 49 percent of the national average Medicaid fee, based on an index of 28 Medicaid services. The shift to managed care is in part a response to a lawsuit over access to care for children and physician and dental fees.

New Jersey has several components to its disproportionate share hospital program. The largest is the charity care pool. In August 1992, the state began treating the entire pool, no longer just the Medicaid share, as Medicaid DSH payments. Claiming a federal match on all pool expenditures sharply increased the state’s DSH qualifying outlays, even though the pool shrank in 1993 when bad debt was excluded. The increase in DSH funds was not used to increase the pool or other payments to hospitals; the federal match for the pool goes to the state treasury.

From 1993 forward, the charity pool and associated hospital subsidies were largely, though provisionally, funded from surpluses from the unemployment insurance trust fund during 1993 through 1995 and mid-1996 through 1997, over the strong objections of employers and labor unions. After the 1997 elections, more stable funding was finally achieved, using tobacco tax increases and general funds and phasing out reliance on the UI funds.

New Jersey has additional DSH programs to assist specific types of hospitals. The Hospital Relief Subsidy Fund ($125 million in 1997) supports hospitals with high caseloads of substance abuse, mental illness, and high-risk pregnancies with secondary diagnosis of substance abuse and HIV. Another $17.5 million, in the Hospital Relief Subsidy Fund for the Mentally Ill, is used to support hospitals with inpatient psychiatric services. Part of the funding of these two programs comes from general revenue and the UI trust fund. Another DSH program supports state- and county-operated hospitals using intergovernmental transfers. In 1995, the state claimed close to $1.3 billion in Medicaid DSH, or 23 percent of New Jersey’s total Medicaid expenditures (as shown in table 3 earlier).

For some years before the latest changes, hospitals complained that state DSH-supported subsidies were not permanent programs and that they were too small, especially because insurance changes did not much reduce the occurrence of bad debt. Between 1991 and 1995 (the latest year available), hospitals reported that the statewide level of uncompensated care increased from $1.04 billion to $1.32 billion (measured as charges), while the state pool decreased from $912 to $400 million (as shown earlier in table 6). State officials...
respond that the new pool is not meant to cover bad debts, or to pay full hospital charges, and that the other new hospital subsidies must also be counted, which raises the 1995 total. Safety net hospitals typically recover about the full amount of their Medicaid-determined costs, according to state officials, and support is rising for 1998 under the charity reform.  

---

**Medicaid Managed Care**

**Prior Coverage**

New Jersey’s Medicaid program has long been interested in promoting managed care, for reasons of access to organized care of good quality as well as cost containment. The state even created its own HMO, the Garden State Health Plan, in the mid-1980s when the private market was little developed. Medicaid HMO enrollment, however, remained voluntary until the mid-1990s. The managed care initiative of New Jersey’s Division of Medical Assistance and Health Services is called New Jersey Care 2000.

**New Jersey Care 2000**

In the spring of 1995, the state sought permission from the federal government to begin to require AFDC and AFDC-related recipients to enroll in HMOs to receive their care. In June 1995, DHS received a Section 1915(b) Medicaid waiver from HCFA that permitted the state to begin implementing mandatory managed care.

With few exceptions, the waiver makes nearly all Medicaid populations eligible to enroll in managed care. Virtually all TANF and TANF-related (formerly AFDC) enrollees must enroll, whereas the other eligibility groups may enroll voluntarily. Generally, the medically needy, individuals in a home or community-based waiver program, and patients who are institutionalized in a long-term care or residential facility are excluded from enrollment.

Mandatory enrollment was phased in by county and eligibility category. The first phase applied to nearly all individuals who were eligible for Medicaid under the then-AFDC program, to pregnant women, and to children enrolled in the New Jersey Care program.

Camden, Gloucester, and Hudson Counties started enrollment in September 1995 and were joined in January 1996 by Essex County. In the spring of 1996, HCFA approved expansion to nine more counties. In August 1996, HCFA approved expansion to the final eight counties. As of May 1997, 87 percent of the state’s TANF/AFDC population was enrolled in managed care (table 7). The share is expected to rise to approximately 95 percent as the last counties are fully phased in. One hundred percent is unattainable because of special exceptions for particular medical circumstances and turnover in eligibility. Penetration rates are much lower for other groups of eligibles, where enrollment...
remains voluntary. Thus, overall, approximately 57 percent of the state's Medicaid population was enrolled in Medicaid managed care in May 1997 (table 7).

Medicaid managed care expenditures have increased rapidly with the implementation of managed care. In state FY 1995, 5 percent of the general medical services budget was appropriated to capitated plans. By contrast, in fiscal year 1998, the state expects to spend 26 percent of the general medical services budget on managed care.25 The managed care share of spending is less than half of its approximately 60 percent share of total enrollment because nonenrollees are much more costly to serve. For example, nondisabled adults and children, who are among the first to enroll in Medicaid managed care, constituted approximately 23 percent of the state's Medicaid expenditures in 1995.26 As the state begins to enroll more costly populations, the percentage of expenditures devoted to capitation will rise dramatically.

### Contracting

To participate in New Jersey Care 2000, an HMO must be a state-defined or a federally qualified/approved HMO. In addition, the HMO must obtain a certificate of authority from DHSS and the Department of Insurance to operate

---

**Table 7  New Jersey Medicaid Managed Care Enrollment—Month of May 1997**

<table>
<thead>
<tr>
<th></th>
<th>TANFa (Temporary Assistance for Needy Families; formerly AFDC)</th>
<th>ABDb (Aged, Blind, and Disabled; SSI Related)</th>
<th>DYFSd (Division of Youth and Family Services)</th>
<th>Other* (i.e., Institutionalized Individuals)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Medicaid Eligibles</td>
<td>432,951</td>
<td>173,211</td>
<td>14,488</td>
<td>52,827</td>
<td>673,477</td>
</tr>
<tr>
<td>Total Managed Care Enrollment</td>
<td>375,883</td>
<td>7,759</td>
<td>6</td>
<td>0</td>
<td>383,648</td>
</tr>
<tr>
<td>Not Enrolled in Managed Caref</td>
<td>57,068</td>
<td>165,452</td>
<td>14,482</td>
<td>52,827</td>
<td>289,829</td>
</tr>
<tr>
<td>Percent Enrolled in Managed Care</td>
<td>87%</td>
<td>4%</td>
<td>0%</td>
<td>0%</td>
<td>57%</td>
</tr>
</tbody>
</table>

*Source: New Jersey Division of Medical Assistance and Health Services, Office of Statistical Analysis and Managed Care Reimbursement.

a. This table indicates HMO enrollment according to the Medicaid/HMO Enrollment file at Unisys, as of April 30, 1997, for May 1997.
b. Excluded from TANF category of total eligibles are persons in the medically needy and presumptive eligible pregnant women categories.
c. Excluded from ABD category of total eligibles are persons in institutional, Health Care Expansion Program, and medically needy categories.
d. Excluded from DYFS category of total eligibles are persons in institutional and temporary categories.
e. Other includes individuals enrolled in home and community-based waiver programs; residents of nursing facilities and state institutions; and nonqualified aliens. These groups are not permitted to enroll in managed care plans.
f. Not enrolled persons listed in the TANF, ABD, and DYFS categories are persons obligated or permitted to enroll in managed care plans but who, for reasons of any of the following circumstances, are not enrolled: in a voluntary category or have not chosen to enroll; recently became eligible; bad address; exempted from managed care on clinical grounds; persons with provider warning or lock-in. Not enrolled individuals in the Other category include individuals who are categorically ineligible from participation in Medicaid managed care.
within a specific county. All such qualified HMOs willing to accept the state’s rates have been able to participate in the program. As of April 1997, 13 HMOs participated. The three largest HMOs—Medigroup, U.S. HealthCare, and Oxford Health Plan—enrolled approximately 50 percent of all Medicaid managed care enrollees. The number of participating HMOs is expected to decline as the state adjusts capitation rates and possibly introduces competitive bidding. Market changes such as mergers and acquisitions are also expected to decrease the number of participating HMOs. Specifically, some individuals suggested that the HMOs with small numbers of enrollees would not be able to remain financially viable in the long term and would, out of necessity, either merge with other HMOs to increase market share or exit the Medicaid managed care market. Some Medicaid-only HMOs were designed to ensure that certain hospitals did not lose Medicaid market share in the transition to managed care.

**Reimbursement**

Since the inception of New Jersey’s managed care program, capitation rates have been set by the state. Thus any HMO that meets the requirements to participate in the program may enter the market. This system was designed to encourage HMO participation. New Jersey now pays contractors monthly capitation rates dependent on the age, gender, eligibility category, and geographic residence of the recipient. Payments to plans may not exceed the upper payment limit established by state Medicaid programs, which is the cost of providing those services on a fee-for-service basis to an actuarially equivalent population group. As of early 1997, state officials expected HMO rates to decline slightly. In the future, once HMO capacity has developed for the Medicaid program, the state may implement a bidding process, which will set rates competitively.

**Benefits**

Most Medicaid-covered benefits are provided by the participating HMOs. A few Medicaid services such as personal care, medical day care, lower-mode transportation, and organ transplants remain in the fee-for-service program. However, the HMOs are required to case-manage these services. In addition, many health services such as family planning, mental health, and substance abuse remain in the fee-for-service program and are available to HMO enrollees outside the HMO.

**Implementation Issues**

New Jersey attempted to implement managed care in a deliberate manner. Even though eligibles were obligated to enroll in managed care, they were given many opportunities to exercise their right to choose a plan. State assignment into plans was used only as a last resort. As a result, fully 89 percent of mandatory enrollees selected their own plan, one of the best voluntary rates in the nation. The high number of voluntary enrollments is a result, in part, of the presence of health benefits coordinators in each of the start-up mandatory counties. A health benefits coordinator, Foundation Health Federal Services, was
hired by the state in 1995 to help educate Medicaid beneficiaries about managed care and help them enroll in the program. Foundation Health representatives set up a presence in the county welfare agencies to counsel welfare recipients about their managed care options.

Although HMOs in New Jersey are allowed to market to potential recipients, the state does not allow plans to officially sign up recipients. Enrollment is filtered through the health benefits coordinator, which is responsible for explaining the program, answering questions, and assisting eligible individuals in selecting a plan. Enrollees eligible for the mandatory managed care program may choose any HMO licensed to participate in their geographic region. Individuals who fail to choose a specific HMO are then assigned to one.
Public Health

State Department of Health

Public health in New Jersey has long been the responsibility of the Department of Health, which changed its name in 1996. That year, Governor Whitman merged into this department all state services provided to elderly populations to create a single Department of Health and Senior Services (DHSS). The impetus for the restructuring initiative was to improve the delivery of services to the elderly, but the restructuring efforts may affect other areas of public health as well.

DHSS now has four major divisions—Public Health Services, Public Health Protection & Prevention Programs, Health Planning and Regulation, and Senior Services. Public Health Services includes the traditional public health programs and focuses efforts in the areas of AIDS, substance abuse and treatment, and family health services. Public Health Protection & Prevention Programs includes responsibility for environmental and occupational health, laboratory services, communicable diseases, cancer epidemiology, and the local health departments. Health Planning and Regulation seeks to emphasize high-quality health care services through the collection and analysis of health care data and reports, assumes a primary role in the department’s regulatory functions in the development of health care services and institutions as well as managed care consumer protection, and administers programs to fund health care services to
those uninsured who are unable to afford them. Senior Services provides
seniors with centralized access to a variety of social, housing, transportation,
and health programs, including Medicaid-funded nursing home services, and
finances certain services for low-income elderly, including state-funded pro-
grams such as Pharmaceutical Assistance to Aged & Disabled, Respite Care,
Lifeline, and Congregate Housing. Senior Services also develops regulatory pol-
icy for long-term care facilities and monitors their quality of care.

The recent reorganization may ultimately raise or lower the potential profile
of and budget for public health activities. Support for public health activities
may increase as the new agency garners greater visibility than it had in the
recent past, or support may decrease as the agency’s focus shifts to providing
services to senior citizens and smaller areas become marginalized. State offi-
cials had mixed responses regarding the impact of the agency restructuring on
public health activities. Most discerned little effect, while some expressed con-
cerns that the reorganization effort would stymie attempts to focus on redefin-
ing the appropriate roles of state and local public health agencies.

Funding

Historically, the New Jersey Department of Health’s budget has been largely
dependent on federal funding (approximately two-thirds of the budget), which
limits the scope for purely state initiatives. The department has had little control
over local public health departments. The state contributes only 13 percent of
the funds of local health departments. Overall, both state and federal funding for
public health in New Jersey have been increasing, but not in a regular pattern.
From FY 1993 through FY 1997, state public health funding increased at an aver-
age annual rate of 2.8 percent per year, from $82.5 million to $92.0 million (table
8). A large increase from 1993 to 1994 was followed by slight decreases in state
funding. Total federal funds increased by approximately 8.1 percent a year,
from $175.3 million to $239.3 million. Most of these funds are designated for the
WIC nutrition program. From 1993 through 1997, state and federal funds com-
bined increased at an average annual rate of 6.5 percent. Since 1995, however,
public health spending, both state and federal shares, has been decreasing—from
$370.7 million in 1995 to $331.3 million in 1997.

The majority of public health expenditures are targeted to health services.
This budget category includes family health services; epidemiology, environ-
mental, and occupational health services; alcoholism, drug abuse, and addic-
tion services; laboratory services; and AIDS services. In most of these areas, ser-
vices are provided by grantees and contractors rather than by state employees.

Overall expenditures on health services increased from $237.0 million in
1993 to $313.6 million in 1997, an average increase of approximately 7.3 per-
cent per year. In 1996, funding for health services began to decline, falling to
$313.6 million in 1997 from a peak of $351.5 million in 1995. From 1993
through 1997, federal spending represented more than two-thirds of the total
health services budget.
During these years, the state witnessed a dramatic increase in federal funding for family health services, primarily because enrollment increases were allowed in the maternal and child health and family planning programs, two of the largest components. By contrast, state general fund appropriations on family health services decreased.

Funding for other health services activities—epidemiology, environmental, and occupational health services; alcoholism, drug abuse, and addiction services; and laboratory services—has remained relatively constant over the past five years. The one other area of public health that has witnessed a dramatic increase in funding is AIDS services.

### County and City Governments’ Safety Net Role

#### Local Health Departments

For more than 100 years, each municipality in New Jersey has been required by state statute to have a local board of public health. There are 578 local boards of public health in the state, many of which are very small. The local boards commonly delegate operational responsibility to a county,
municipality, city, or regional health department, of which there are 116. Increasing consolidation at the local level is a long-term trend and a current state goal. There were twice as many regional entities a generation ago. State officials and some local observers indicated that the state has too many local health departments and that further consolidation is necessary to meet the challenges the local health departments face.

One reason for the large number of local health departments is the state’s long history of home rule, according to state and local interviewees alike. The state has limited authority over many functions by statute given to local health departments. The state has some influence through its state aid, but only parts of the state’s funds are discretionary, and the total is not large as a share of local resources. About 10 percent of local health expenditures are covered directly by the state, most often in the form of grants (see “State” column, table 9). An additional 3 percent are covered by a state fund dedicated to localities, the Public Health Priority Fund (table 9).

Localities in New Jersey engage in typical public health activities, though there is substantial variation in the level of these services by locality. For example, a few run public clinics, but most do not. Overall, spending is split roughly evenly among the five core activities, defined by state administrative code and listed in table 9—administration, environmental health, communicable disease, maternal and child health, and chronic illness. Administration is the largest category, reflecting the great number of boards, the decentralization of activity, and the small size of programs.

By source of funding, approximately 63 percent of local health expenditures in 1994 were provided by local tax revenues, 15 percent from federal government sources, and 13 percent directly from the state.

Local health expenditure trends over time were not available; the data in table 9 are not tabulated regularly. However, state officials and directors of local health departments provided some information on the changing nature of local health activities. According to the 1994 report of the Commissioner’s Working Group on Local Health, compiled by Ronald Bialek, “there has been a clear erosion of local public health expenditures over the past two decades [as] other governmental and private agencies have assumed responsibilities [that were] once the province of local health departments.” This loss of funding, combined with a local public health system that relies on 566 local boards of public health and 116 local health departments, has resulted in a fragmented system. The Bialek report concludes that “neither the current funding levels provided by the state, nor the structure of health departments at the local level, has enabled development of a system that fully protects and serves the public.”

The primary issue in state-local public health relations is redefining their functions at a time when activities historically provided by local health departments are affected by market, governmental, and demographic trends. In an
### Table 9  Source of Funds for Local Health Expenditures ($ in thousands) by Core Public Health Activity (CY 1994)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Totals</th>
<th>Row %</th>
<th>Local Tax</th>
<th>Row %</th>
<th>State</th>
<th>Row %</th>
<th>Public Health Priority Fund</th>
<th>Row %</th>
<th>Federal</th>
<th>Row %</th>
<th>All Other (Permits, etc)</th>
<th>Row %</th>
<th>Column %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration</td>
<td>$31,658</td>
<td>100%</td>
<td>$29,393</td>
<td>93%</td>
<td>$443</td>
<td>1%</td>
<td>$964</td>
<td>3%</td>
<td>$369</td>
<td>1%</td>
<td>$489</td>
<td>2%</td>
<td>26%</td>
</tr>
<tr>
<td>Environmental Health</td>
<td>$25,697</td>
<td>100%</td>
<td>$22,585</td>
<td>88%</td>
<td>$1,720</td>
<td>7%</td>
<td>$24</td>
<td>0%</td>
<td>$339</td>
<td>1%</td>
<td>$1,029</td>
<td>4%</td>
<td>26%</td>
</tr>
<tr>
<td>Communicable Disease</td>
<td>$19,226</td>
<td>100%</td>
<td>$7,941</td>
<td>41%</td>
<td>$1,716</td>
<td>9%</td>
<td>$705</td>
<td>4%</td>
<td>$8,361</td>
<td>44%</td>
<td>$504</td>
<td>3%</td>
<td>21%</td>
</tr>
<tr>
<td>Maternal and Child Health</td>
<td>$23,474</td>
<td>100%</td>
<td>$10,634</td>
<td>45%</td>
<td>$5,350</td>
<td>23%</td>
<td>$1,314</td>
<td>6%</td>
<td>$4,927</td>
<td>21%</td>
<td>$1,248</td>
<td>5%</td>
<td>18%</td>
</tr>
<tr>
<td>Chronic Illness</td>
<td>$24,240</td>
<td>100%</td>
<td>$7,995</td>
<td>33%</td>
<td>$3,003</td>
<td>12%</td>
<td>$676</td>
<td>3%</td>
<td>$4,178</td>
<td>17%</td>
<td>$8,389</td>
<td>35%</td>
<td>20%</td>
</tr>
<tr>
<td>Total</td>
<td>$124,295</td>
<td>100%</td>
<td>$78,548</td>
<td>63%</td>
<td>$12,231</td>
<td>10%</td>
<td>$3,683</td>
<td>3%</td>
<td>$18,174</td>
<td>15%</td>
<td>$11,659</td>
<td>9%</td>
<td>100%</td>
</tr>
</tbody>
</table>


**Note:** DHSS states that the numbers depicted in table 9 should be used with caution, because methods of reporting are not consistent among local health departments and numbers are not regularly tabulated.
effort to address problems of a fragmented local health delivery system, numerous reform initiatives have been introduced in recent years, with varying levels of success. Some of the proposals were designed to address the size of local public health agencies and the inability to provide a broad array of services.

Despite recent activities, observers expressed frustration regarding the pace of change. Specifically, respondents, including state and local public health officials, agreed that there continued to be too many local public health departments. At the time of the site visit, individuals even complained about what the Bialek report called the “gross decentralization” of public health functions and about the lack of control and coordination across localities, which they believe leads to lower funding. A general view was that support for public health functions has declined, though no such trend is yet apparent in state funding (as indicated in table 8 earlier).

As a way to improve coordination between and among the state and local health departments, the state is developing a new, interactive statewide computer network (LINCS, or Local Information Network and Communication System) to track routine public health functions and assist in emergency response.32

The other major current issue is how public health departments should respond to the shift into managed care that affects local service providers, who have traditionally billed Medicaid fees for services. Specifically, the introduction of Medicaid managed care has had a marked impact on local health departments. Medicaid managed care entities are delivering some personal services, specifically maternal and child health services, that have historically been delivered by local health departments. Local health departments had been able to provide these services, in part, because they could maximize Medicaid dollars. As Medicaid managed care penetration has increased, money that formerly went to local health departments on a fee-for-service basis is being redirected to HMOs through capitated payment.

Respondents had various perspectives regarding this trend. Some individuals believe that the introduction of Medicaid managed care will have a positive impact on local health departments because those departments will, by necessity, be forced to reexamine their roles. One individual thought that local public health departments should decrease their provision of personal health services and instead focus on services where managed care entities have less experience and areas where they are less eager to provide services, such as treating communicable diseases at the community level.

**Public Hospitals**

New Jersey has no tradition of public general hospitals, presumably in large part because most localities are so small. There are some public chronic care and specialty care institutions. Only one facility, Bergen Pines Hospital, has general acute beds, and even it is dominated by its long-term care component.
Impact of Government Policies and Market Changes on Safety Net Providers: Jersey City

Jersey City/Hudson County was chosen as the site for a closer look at provider responses to market changes and government policies. Jersey City’s population of 229,000 makes it the second-largest city in New Jersey. It has relatively high unemployment (10 percent in 1991 compared with 6.6 percent for the state as a whole and 6.7 percent nationally) and low incomes (18.9 percent of the city’s population lives below the federal poverty level). Jersey City is also racially and ethnically mixed, with a high proportion of Hispanics (24 percent), blacks (29.7 percent), and foreign-born residents (24.6 percent). This part of the state, Hudson County together with neighboring Essex County, has the highest rates of hospital charity care and bad debt in the state.

Jersey City has four acute care hospitals. It is considered overbedded compared with the surrounding county, the state, and the United States as a whole (524 hospital beds per 100,000 population compared with 377 for the state and 366 nationally). In contrast, the area has a low physician ratio. Physicians in New Jersey tend not to participate in Medicaid to a great degree, and many may be avoiding this high-Medicaid area. The institutional bias is further reflected in the fact that there are more hospitals than clinics in the county. Three health clinics operate in the area, one of which opened in 1994.

Given the high proportion of low-income residents in the area, it is perhaps not surprising that providers, hospitals, and clinics are highly dependent on Medicaid, charity care funding, and grants. They are very sensitive to changes in these programs, and their market strategies reflect responses to public programs. Providers are currently reacting to financial pressure from Medicaid payment reductions and the movement to managed care, as well as declines in charity care funding. Among hospitals, the primary strategies are mergers, staff reductions, greater competition for Medicaid patients, and development of managed care capacity, in some cases by forming hospital-based HMOs. Clinics are also joining networks, competing for managed care contracts, developing information systems to accommodate managed care demands, and changing their service mix.
Long-Term Care for the Elderly and Persons with Disabilities

Supply, Expenditures, and Utilization

New Jersey spent more than $1.9 billion on long-term care services in 1995, including $1.0 billion expended on the elderly and $877 million on the blind and disabled (table 10). New Jersey ranks 11th in the nation for populations aged 65 and older, but 9th in terms of Medicaid long-term care expenditures. The state spent $1.1 billion on nursing home care and another $380 million on intermediate care facilities for the mentally retarded (ICF/MRs). Home health care is the remaining large expenditure category, accounting for $383 million in 1995.

Long-term care spending grew by 11.3 percent annually between 1992 and 1995, considerably faster than the U.S. average of 8.3 percent (as seen in table 3 earlier). Nursing home spending grew by 8.3 percent (elderly) and 10.6 percent (blind and disabled) per year between 1992 and 1995, somewhat faster than the United States average (table 10). Total expenditures on intermediate care facilities for the mentally retarded grew at a similar rate, but much faster for the blind and disabled than for the aged. Mental health spending growth was relatively slow, increasing about 2 percent per year (combining elderly with blind and disabled). The fastest expenditure growth occurred among home care services (close to 20 percent per year for each group), reflecting the state’s efforts to keep elders and persons with disabilities out of institutions.

Despite the state’s relatively high level of long-term care expenditures (as shown in table 3 earlier), the state ranks low in the number of both home health
### Table 10 Medicaid Long-Term Care Expenditures by Eligibility Group, New Jersey and United States ($ in Millions)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Long-Term Care Expenditures</td>
<td>Average Annual Growth</td>
<td>Long-Term Care Expenditures</td>
<td>Average Annual Growth</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>$1,223.9</td>
<td>$1,415.8</td>
<td>$1,949.9</td>
<td>7.6%</td>
<td>11.3%</td>
<td>$32,264.2</td>
<td>$42,542.5</td>
<td>$53,996.1</td>
</tr>
<tr>
<td>Elderly</td>
<td>$661.6</td>
<td>$778.0</td>
<td>$1,011.3</td>
<td>8.4%</td>
<td>9.1%</td>
<td>$18,408.9</td>
<td>$24,846.4</td>
<td>$30,413.7</td>
</tr>
<tr>
<td>Nursing Home Care</td>
<td>$522.7</td>
<td>$666.1</td>
<td>$846.6</td>
<td>8.8%</td>
<td>8.3%</td>
<td>$15,131.3</td>
<td>$20,542.9</td>
<td>$25,571.5</td>
</tr>
<tr>
<td>ICFs/MR*</td>
<td>31.3</td>
<td>29.3</td>
<td>35.3</td>
<td>-3.2%</td>
<td>6.4%</td>
<td>348.9</td>
<td>452.0</td>
<td>615.8</td>
</tr>
<tr>
<td>Mental Health</td>
<td>20.6</td>
<td>21.9</td>
<td>22.9</td>
<td>3.2%</td>
<td>1.5%</td>
<td>973.0</td>
<td>1,286.0</td>
<td>1,107.3</td>
</tr>
<tr>
<td>Home Care</td>
<td>47.1</td>
<td>60.6</td>
<td>106.5</td>
<td>13.5%</td>
<td>20.7%</td>
<td>1,955.7</td>
<td>2,565.6</td>
<td>3,119.1</td>
</tr>
<tr>
<td>Blind and Disabled</td>
<td>$542.3</td>
<td>$605.8</td>
<td>$877.3</td>
<td>5.7%</td>
<td>13.1%</td>
<td>$12,842.4</td>
<td>$16,201.0</td>
<td>$21,618.7</td>
</tr>
<tr>
<td>Nursing Home Care</td>
<td>157.6</td>
<td>181.4</td>
<td>245.4</td>
<td>7.3%</td>
<td>10.6%</td>
<td>3,161.3</td>
<td>3,968.0</td>
<td>4,813.3</td>
</tr>
<tr>
<td>ICFs/MR*</td>
<td>236.0</td>
<td>247.0</td>
<td>344.8</td>
<td>2.3%</td>
<td>11.8%</td>
<td>7,241.3</td>
<td>8,380.4</td>
<td>9,321.1</td>
</tr>
<tr>
<td>Mental Health</td>
<td>10.7</td>
<td>9.9</td>
<td>10.8</td>
<td>-3.9%</td>
<td>3.0%</td>
<td>457.9</td>
<td>662.1</td>
<td>881.3</td>
</tr>
<tr>
<td>Home Care</td>
<td>138.0</td>
<td>167.5</td>
<td>276.4</td>
<td>10.2%</td>
<td>18.2%</td>
<td>1,982.0</td>
<td>3,170.5</td>
<td>6,603.0</td>
</tr>
<tr>
<td>Adults and Children</td>
<td>$20.0</td>
<td>$32.1</td>
<td>$61.3</td>
<td>26.5%</td>
<td>24.1%</td>
<td>$1,012.9</td>
<td>$1,495.1</td>
<td>$1,963.7</td>
</tr>
</tbody>
</table>

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

* Intermediate care facilities for the mentally retarded.
visits and nursing home beds. The state had 37 home health visits per user compared with the national average of 57.4. It also ranks 33rd in the nation in nursing home beds per capita, with 45.8 beds per 1,000 persons aged 65 and over, compared with the national average of 53.1. It has strong certificate-of-need laws and currently has a 95 percent nursing home occupancy rate.

**Long-Term Care for the Elderly**

Of the $1.0 billion spent on long-term care services for the elderly in 1995, $847 million went for nursing home care. Only $106.5 million, or about 11 percent, was spent on home care services. Despite the prominence of institutional care, the state's policy goals for long-term care for the elderly in the near future include expanding the availability of home and community-based services and maximizing personal care services and other long-term care services through Medicaid home and community-based waivers. These expansions would largely be financed through any savings achieved by managed acute care and by any future reforms in nursing home and home health care payment rates.

Nursing home payment rates in New Jersey are high by national standards. The average rate of payment was $112.77 per day, sixth in the nation; the national average was $87.81 per day. New Jersey pays nursing homes on the basis of prospective, case mix adjusted, and facility-specific rates. Cost screens are established for each of five cost centers. Compared with those of many other states, New Jersey's nursing cost screens are relatively liberal, as is reflected in the high per-diem costs. There have been periodic moratoria on nursing home bed growth since the early 1980s, which have resulted in some control over growth and have limited nursing home outlays. Traditionally high occupancy rates have declined. Representatives of the nursing home industry and the state government reported that access to nursing care was not a major problem. There was some concern that some facilities may be selective regarding the acuity of residents, for example, by avoiding patients with significant behavioral problems or complex medical needs.

New Jersey provides home care services through all three Medicaid options: home health care, personal care assistant (PCA) services, and community-based waivers. In 1996 New Jersey ranked fourth in the United States in home care expenditures. Of the total expenditures for home care for the elderly in New Jersey, personal care services accounted for approximately 27 percent, home health services 24 percent, and home and community-based waiver programs 49 percent.

Home health services are provided by licensed home health agencies (HHAs). HHAs provide skilled nursing intervention, home health aide services, physical therapy, speech therapy, occupational therapy, and medical social
services and can be hospital based or freestanding. About 25 percent of HHA patients are Medicaid beneficiaries, 60 to 70 percent are Medicare beneficiaries, and 5 to 10 percent are self-paying. HHAs are subject to state CON rules, and the number of home health care agencies has been limited because of this process. Medicaid home health rates are based on the lowest of reasonable costs, published cost limits, or covered costs subject to a postpayment reconciliation process.

PCA services provide assistance to individuals with activity of daily living (ADL) and instrumental activity of daily living (IADL) deficits. Personal care is an optional Medicaid benefit, and the state has a relatively large program, with a budget of $111.4 million in 1995. PCA services are limited to a maximum of 25 hours per week, with a provision to allow up to an additional 15 hours upon review and prior authorization of the case. PCA services can be limited when their costs are equal to or in excess of the costs of institutional care over a protracted period.

The state also administers nine Section 1915(c) Medicaid home and community-based services waiver programs. The Community Care Program for the Elderly and Disabled (CCPED), which took effect on October 1, 1983, has some 3,000 slots. The waiver program is available to individuals over the age of 65 who are eligible for Medicaid and need nursing-facility level of care. Individuals must have income above the SSI level but less than the maximum eligibility income allowed for Medicaid institutionalization. Case managers are responsible for the development of service plans with family members and for monitoring the costs of the limited service package. In 1995 there were approximately 2,800 persons in the program. Costs are also limited by the number of slots available and by ceilings on per-person expenditures.

A second important waiver program provides an array of supportive and personal care health services that are available 24 hours a day to residents living in one of three assisted-living settings in the state. This program can serve 1,500 individuals. All enrolled beneficiaries are assigned a case manager to monitor services and to maintain costs within the cap limitations. Program costs are also limited by the number of slots and the rates paid to providers.

State policy on long-term care has historically focused on nursing homes. The state spends more than half of its Medicaid long-term care funds on nursing care (table 10). Recently, the emphasis has shifted to home and community-based care. State legislators are eager to expand home-based services but on a budget-neutral basis. The state generally sees home and community-based services as a substitute for nursing facility care. Potential for a “woodwork” effect of inducing more claimants is controlled by managing the number of waiver slots available for each program as well as the cost of service to each person. Currently, there are waiting lists for the majority of the nine home and community-based waiver programs.
New Jersey has not engaged in many serious efforts to maximize Medicare reimbursement, although the state has mandated that nursing homes apply to HCFA to become dually certified by Medicaid and Medicare. This certification enables nursing homes to bill Medicare as the first payor and bill Medicaid only thereafter. Nor have there been any significant private efforts to expand private long-term care insurance, although a task force on the subject is scheduled to meet in 1998. The state has a managed care program that is voluntary for the elderly and persons with disabilities. The state found that individuals with relatively light care needs enrolled, and it subsequently lowered capitation rates. The state plans to enroll elderly and disabled individuals, beginning with the latter, on a mandatory basis (special rules for Medicare-eligible Medicaid beneficiaries). Long-term care services are carved out and paid for on a fee-for-service basis.

Transfer of assets to obtain Medicaid eligibility is considered a major problem for the state and the Medicaid program. There is some debate about the size of the problem, but it has become a major target for Medicaid officials in the state. However, many elected officials are not particularly supportive of tightening Medicaid transfer-of-asset policies. The state does have a small but effective state recovery program that recovered $2.2 million from the estates of deceased Medicaid recipients in 1994.

Future budget pressures will mean more efforts to reduce payment rates in both nursing homes and home health care and tightening eligibility standards for admission into nursing homes. Any reductions in nursing facility expenditures are expected to be used to increase the availability of community-based services. Finally, there is considerable concern in the state over the lack of sophistication in long-term care policy development. It is hoped that the new Department of Health and Senior Services will enhance long-term care policy development.

**Long-Term Care for the Blind and Disabled**

In 1995 the state spent $877.3 million on long-term care services for the blind and disabled (table 10). Of this, $245.4 million was for nursing home care, and another $344.8 million was for intermediate care facilities for the mentally retarded. In addition, the state spent $276.4 million on home care services for younger persons with disabilities (non-aged adults and children). With these patients, as with the elderly, there is a bias toward institutionalization, but there has been a concerted effort by the state to move toward community-based options. The primary objective of the Department of Human Services’ Division of Developmental Disabilities (DDD) is to consolidate and close large intermediate-care facilities for the mentally retarded where possible and redirect institutional funds toward developing exten-
sive community-based services for persons with mental retardation and developmental disabilities.

In programs under the auspices of the Division of Mental Health Services (DMHS), the focus has been to develop a more effective and cost-efficient mental health program by “redirecting” dollars previously spent for institutional services to expand and support community-based care. This has been accomplished primarily through targeted census reduction projects, the consolidation of institutional resources, and the soon-to-be-completed closure of a state hospital (one of seven). The changes have resulted in a 62 percent increase in community-based service expenditures over the last seven years.

The Developmentally Disabled

DDD provides numerous Medicaid-funded services. These include ICF-MRs, respite care, community living arrangements (e.g., group homes, supportive living arrangements, supervised apartments, family care homes, and private institutional placements), and other home and community-based services (e.g., personal care). DDD also provides state-funded programs including adult day care, respite, and family support. Approximately 24,000 individuals receive at least one kind of service from the developmental disabilities (DD) system, which emphasizes placing or retaining individuals in the community.

New Jersey ranks seventh in the nation for Medicaid ICF-MR expenditures. It operates eight large developmental centers that provide residential and habilitative services to persons with developmental disabilities. DDD has developed a series of long-range planning objectives related to persons with developmental disabilities that focus on including such persons in the community and affording them and their families self-determination and choice. In order to meet these objectives, the state closed one large ICF-MR in 1992. Another, North Princeton, is in the process of being closed. Once North Princeton is closed, the state will have closed more than 1,400 beds out of the 5,178 for residents living in developmental centers in 1989. These closures represented a challenge to DDD, and further closures will face opposition from state labor unions and some members of the legislature.

The state has eight Section 1915(c) home and community-based programs that provide long-term care services to non-aged adults and children with disabilities. The largest waiver program in the state serving persons with developmental disabilities is the Community Care Waiver Program, which provides all Medicaid-opted services, including case management, personal care, rehabilitation, and respite care. In 1996, the waiver program served 5,600 clients with a cap of $31,053 per client. DDD recently developed a consumer-directed service program option that allows clients and families to develop client-centered budgets and manage their services through the use of a support broker and a fiscal intermediary service organization, such as Easter Seals of New Jersey.
The state is currently planning to include persons with disabilities in managed care on a mandatory basis. In the past, persons with disabilities have had difficulty gaining access to primary and acute care services under the fee-for-service system. The state hopes that access will improve under a managed care system. Yet to be answered is whether managed care organizations will be willing to serve this population and whether they have the expertise to do so effectively.

Mental Health Services

New Jersey’s public mental health system includes state- and locally funded and operated programs. The state operates six psychiatric hospitals, and New Jersey counties operate six. By statute, 90 percent of the reasonable costs of the county facilities are funded through state aid. As with the developmentally disabled, a major objective of DDD is to develop a more effective and more cost-efficient mental health system. This goal is being met, in part, through the redirection of savings achieved from the consolidation and closure of state hospitals to expand and maintain community services. At the time of the site visit, New Jersey was in the process of closing the state’s largest psychiatric hospital (Marlboro Psychiatric Hospital).

DDD has also sought for some time to reduce the number of inappropriate hospitalizations. Following an assessment of clients in state hospitals, DDD developed a Community Expansion/Census Reduction Plan in December 1993 to serve 450 patients more appropriately in the community. More recently, the Programs for Assertive Community Treatment (PACT) have been implemented to prevent inappropriate hospitalizations using a case-managed “team” approach. Funds were also made available to develop residential and day placements, so that persons identified as being appropriate for community services could be transferred from the hospital. Case management services have also been expanded statewide. DMHS reports that all patients discharged from state or county hospitals receive a minimum of 18 months of support and treatment. DMHS maintains 221 contracts with private community mental health agencies and two mental health centers associated with the University of Medicine and Dentistry of New Jersey.

Thus, in mental health as for developmental disabilities, the state has made community services a key policy focus. In the short term, increases in community-based services for persons with developmental disabilities and mental illness will be funded primarily through the redirection of funds from institutional consolidation and closure. However, wait lists for community-based DD services exist, and institutional closures represent a challenge for DDD and DMHS. If the state is not successful in further institutional consolidations and closures, additional funding for future expansions of community-based services will have to be identified.

Consumer-Directed Personal Assistance Services

Since 1985, the Department of Human Services has administered the state-funded Personal Assistance Service (PAS) Program, which provides up to
40 hours per week of PAS to self-directing persons ages 18 to 65 with chronic physical disabilities. The program is administered on the local level by county-designated agencies, and consumers maintain a high level of choice and control over their PAS and how it is provided.

In 1996, the Department of Human Services and its counterparts in three other states received one-year, $167,600 planning grants from the Robert Wood Johnson Foundation to participate in a national demonstration program to test the effectiveness of using a cash and counseling approach to delivering PAS. Consumers of all ages who have disabilities will be eligible to participate, and it is expected that the project will be implemented in New Jersey in May 1998.
Challenges for the Future

Once dominated by declining heavy industry and commuters to nearby New York City and Philadelphia, New Jersey has come of age economically. Many of its cities have become new “edge cities” in their own right, attracting jobs from out of state; and high-tech and service sectors have blossomed. In the 1990s, New Jersey’s far more diversified economy has outperformed those of its neighbors, though the state still lags the nation on some indicators, including unemployment. Tax receipts have thus exceeded expectations, greatly facilitating cuts in rates and allowing budget balance without cuts in services or programs. Spending restraint has slowed annual budget growth to a crawl. As of mid-1997, the state had a significant cash surplus, even though that spring the state supreme court unexpectedly required higher spending on redistributive state aid to local schools. Medicaid is by far the biggest health care budget item, and recent policy has sought to achieve efficiencies without cuts in eligibility or covered services. Administrative price setting and managed care have helped considerably, as has a decline in beneficiaries of Aid to Families with Dependent Children and its successor, Temporary Assistance for Needy Families.

It will be important for the state to consolidate these achievements in the future. Future pressures seem likely to arise from long-term trends in medical technology and in demographics, in New Jersey and elsewhere. Moreover, in New Jersey today, as in many prior years, budget balance has been achieved in part by one-time mechanisms. The current administration has reduced, but not eliminated, these mechanisms, as was indicated by last summer’s multibillion-dollar sale of long-term state pension-obligation funds, the proceeds of which were used in part to meet a short-term budget shortfall. Many observers objected to “mortgaging the future” rather than ending the current structural deficit, but the administration defended its decision by analogy to refinancing
a mortgage. The bond market snapped up the issue, showing confidence that the state could meet its restructured obligations in the future.

Another continuing concern will be residents without health care coverage and the burden they place on New Jersey hospitals, who by unusual state law must serve all comers. The state has maintained its free-care hospital pool and has just enacted a cigarette tax increase to fund it for at least five years after several years of temporizing.

Gubernatorial efforts to expand private health coverage—first in general, then for children only—met with legislative resistance, overcome with a boost from the federal Balanced Budget Act of 1997, which ensured federal assistance for a children’s initiative. So encouraged, New Jersey undertook a major expansion in December 1997. One challenge for state implementation is reaching and enrolling all eligible children.

Another concern for the future is managed care. The state’s ambitious plans for consumer protection under managed care have been enacted, but serious work remains for successful implementation. In the Medicaid program, the state needs to consolidate the initially successful shift to Medicaid managed care, then to expand enrollment to include Medicaid populations with more complicated or more chronic health conditions. In addition, the state’s challenges in implementing “managed charity care” (requiring hospitals to arrange for nonhospital care using funds from the hospital pool) are expected to be formidable, as there are no models to emulate. The precise impact of Medicaid and other managed care on the role of public health is also not clear. As provision of medical services to the poor increasingly flows through managed care, traditional public health providers may lose out. Nor is it clear whether the merger with senior services will increase public health’s funding or create new intradepartmental competition.

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

1. As of November 1997, unemployment was 4.7 percent closer to the national average of 4.3 percent; 13 states and the District of Columbia were higher. The neighboring states of New York and Pennsylvania had unemployment rates of 5.9 and 4.6 percent, respectively. U.S. Department of Labor, Bureau of Labor Statistics. *Local Area Unemployment Statistics*. Table 5: Unemployment rates by state and selected metropolitan areas, not seasonally adjusted. http://stats.bls.gov/nes.release/laus.t05.htm. February 3, 1998.


8. Ibid.


15. To create balanced incentives, the actual rules are somewhat more complex than just a simple play-or-pay requirement.


21. A would-be purchaser has sued, claiming that its bid for the hospital’s CON was wrongfully rejected, according to one knowledgeable source.

22. Columbia-HCA was interested in entering the state via a contract to manage Bergen Pines, but withdrew from consideration in mid-1997, faced with mounting legal problems nationally and some local concern about for-profit management. Hugh Morley, “Hospital Chain Won’t Bid to Run Pines,” Bergen Record, August 5, 1997.


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


28. The Public Health Priority Fund was established by the state legislature in 1966 to support priority health services performed by local health departments. Eligibility is generally restricted to local health agencies serving at least 25,000 individuals. Office of Local Health, Public Health Priority Fund citation on the Department of Human Services’ Web page.


30. Ibid.

31. NJ LINCS fact sheet provided by Elin Gursky, Sc.D.


34. Johnson, “Diversity Propels New Jersey.”
## Appendix

### List of People Interviewed

**State Government**

- Governor’s Office, Office of Policy and Planning
  - Brian Baxter, Eileen McGinnis
- New Jersey State Assembly, Health and Senior Services and Aging Committee
  - Barbara Wright
- Department of the Treasury (Office of Administration and Budget)
  - Peter Lawrence, Bob Peden, Elizabeth Pugh

**Department of Human Services**


**Department of Health and Senior Services**

- Scott Allocco, Marilyn Dahl, Elin Gursky, Jim Houston, Jean Marshall, Douglas Morgan, Leon Moskowitz, Terrence O’Connor, Ruth Reader, Susan Reinhard, Anne Weiss, Leah Ziskin

**Attorney General’s Office**

- Michael Goldman, Jaynee Laveccia, Basil Merenda, Laurel Price, Mark Siman, Meredith Van Pelt

**Provider Associations**

- Hospital Alliance of NJ
  - Sister Jane Frances Brady
- Medical Society of NJ
  - Vincent Maressa, Neil Weisfeld
- NJ Association of Health Care Facilities
  - James Cunningham
- NJ Association of Non-Profit Homes for the Aging
  - Jane Duggan
- NJ Hospital Association
  - Gary Carter, Ron Czajkowski, Valerie Sellers
- NJ Home Health Assembly
  - Carol Kientz
- NJ HMO Association
  - Paul Langevin
- NJ Primary Care Association
  - Katherine Grant-Davis
Advocacy Groups
Association for Children of NJ Ciro Scalera
Independent Elder Advocate Elena Marvel
New Jersey Developmental Disabilities Council Ethan Ellis

Hospitals
Jersey City Medical Center/Liberty Healthcare System James Lawler, Jonathan Metsch

Community Health Centers
Horizon Health Center Marilyn Bennett
North Hudson Community Health Center Vincent Urgola

Local Health Departments
NJ Association of County Health Officers Louis Lamanna

Others
The Capitol Forums on Health and Medical Care Joanne Fuccello, Jamie Harrison, Katharine Salter-Pinneo
Fund for New Jersey Mark Murphy
NJ Hospital Education and Research Trust Pauline Seitz
NJ Individual Health Coverage Program and Small Employee Health Benefits Program Kevin O’Leary
Princeton University Uwe Reinhardt, Nathan Scovronick
Seton Hall Law School John Jacobi
Southern NJ Perinatal Cooperative Judy Donlen
Randall R. Bovbjerg is a principal research associate in the Urban Institute’s Health Policy Center. His main research interests are health coverage and financing; regulation, competition, and the appropriate role for government; and the workings of law in action, including the influence of legal culture upon policy. Earlier work on changing state policy led him to co-author one book on Medicaid and another on block grants, both from the Urban Institute Press.

Frank Ullman is a research associate in the Urban Institute’s Health Policy Center, where he currently focuses on issues related to children’s health insurance. For the Assessing the New Federalism project, he has conducted case studies on health care developments in New Jersey and Mississippi. His recent research has examined the impact of managed health care on infant health.

Alison Evans is a former research associate in the Urban Institute’s Health Policy Center. She participated in several case studies within the Assessing the New Federalism project, as well as conducting analyses of all-payer rate-setting systems and Medicare budget issues. She is currently a doctoral student at the University of California at Berkeley.

John Holahan is the director of the Health Policy Center of the Urban Institute. He has authored several publications on the Medicaid program, including analyses of the recent growth in Medicaid expenditures, variations across states, the effects of expanding Medicaid on the number of uninsured, and the cost to the federal and state governments. Other research interests include health system reform, changes in health insurance coverage, physician payment, and hospital cost containment.
Susan Flanagan is a program manager in the Research and Policy Division at the MEDSTAT Group in Cambridge, Massachusetts. She is responsible for conducting research and managing government and private-sector projects related to long-term health care issues. Ms. Flanagan is also an adjunct assistant professor at Boston University Medical School, School of Public Health, where she teaches a course on long-term care finance in the health systems department.
Errata

Several published State Reports and Highlights include an error in Table 1, “State Characteristics.” Incorrect figures were included for noncitizen immigrants as a percentage of the population. Corrections were made on August 13, 1998 to both the HTML and PDF version of these reports on the Assessing New Federalism website.

Correct figures for 1996

<table>
<thead>
<tr>
<th>Noncitizens as a Percent of the Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNITED STATES</td>
</tr>
<tr>
<td>Alabama</td>
</tr>
<tr>
<td>California</td>
</tr>
<tr>
<td>Colorado</td>
</tr>
<tr>
<td>Florida</td>
</tr>
<tr>
<td>Massachusetts</td>
</tr>
<tr>
<td>Michigan</td>
</tr>
<tr>
<td>Minnesota</td>
</tr>
<tr>
<td>Mississippi</td>
</tr>
<tr>
<td>New Jersey</td>
</tr>
<tr>
<td>New York</td>
</tr>
<tr>
<td>Oklahoma</td>
</tr>
<tr>
<td>Texas</td>
</tr>
<tr>
<td>Washington</td>
</tr>
<tr>
<td>Wisconsin</td>
</tr>
</tbody>
</table>


The error appears in the following publications:

State Reports:
Health Policy: Alabama, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington
Income Support and Social Services: Alabama, California, Massachusetts, Michigan, Minnesota, Texas, Washington

Highlights:
Health Policy: Alabama, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Oklahoma, Texas, Washington

Income Support and Social Services: Minnesota, Texas