REPORT OF THE TASK FORCE ON

AFFORDABILITY AND ACCESSIBILITY

OF HEALTH CARE IN NEW JERSEY

January 2001

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Affordability and Accessibility of Health Care
in New Jersey

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EXECUTIVE SUMMARY

INTRODUCTION

Governor Christine Todd Whitman signed the executive order creating the Task Force on Affordability and Accessibility of Health Care in New Jersey on July 20, 1999. The members of the Task Force were appointed on October 20, and the Task Force held its first meeting on November 29. The Task Force has met each month since then, with the exception of December 1999 and August 2000, and has held four public hearings. This report sets out the Task Force's key findings and recommendations, based on the information reviewed during the past twelve months, the results of the public hearings, and the Task Force's deliberations.

THE TASK FORCE'S CHARGE

The Task Force's charge from Governor Whitman is to:

- Compare the affordability and accessibility of health insurance in New Jersey with the affordability and accessibility of health insurance in other states
- Identify cost and access factors that can be controlled or addressed by State legislation or regulation
- Assess the impact on the quality of health care and the cost of health insurance from mandated health benefits currently required by State law and regulations
- Assess the anticipated health benefits and estimated costs resulting from pending legislative efforts to impose additional mandated benefits
- Take note of the findings and recommendations of the Advisory Commission on Hospitals concerning the stability and efficiency of New Jersey's health care delivery system and its impact on the affordability of health insurance
- Evaluate the amount that employees contribute to the cost of employer-sponsored health coverage through co-payments, contributions toward premiums or other forms of cost sharing
- Consult with the Health Wellness Promotion Advisory Board in the Department of Health and Senior Services, which is charged with reviewing medical testing and services that will encourage health care consumers to engage in healthy lifestyle behaviors
- Provide recommendations concerning steps that need to be taken to ensure that health care is affordable and accessible to the citizens of New Jersey.

The Task Force addressed each of these issues in its meetings and deliberations. This Executive Summary discusses the Task Force's key findings and recommendations. The body of the report provides background information, data, and analysis on the issues that the Task Force considered.

NJ FAMILYCARE AND NJ KIDCARE

On January 21, 2000, Governor Whitman proposed a new program, FamilyCare, to extend health insurance coverage to 125,000 adults with moderate incomes. The FamilyCare program is designed to build on the successful NJ KidCare children's health insurance program by adding coverage for the parents of NJ KidCare and Medicaid children and for other low-income adults with limited access to health insurance coverage, including those in the state General Assistance program.

The Task Force reviewed the Governor's FamilyCare proposal in its February 18 meeting and in several subsequent meetings, comparing it with similar programs in other states and assessing the extent to which it addresses issues that were part of the Task Force's charge from the Governor. The Legislature passed the Governor's proposal, and the Governor signed it into law on July 13, 2000.

NJ FamilyCare will provide health insurance to an estimated 125,000 adults, including:

- 80,000 uninsured parents of children eligible for Medicaid or NJ KidCare, 63,000 in families with incomes below 133 percent of the federal poverty level, and 17,000 in families with incomes between 133 and 200 percent of poverty

- 45,000 uninsured childless adults with incomes up to 100 percent of poverty[1]

Eligible adults who have access to comparable coverage through their employer will be required to purchase that coverage, which will be subsidized by the FamilyCare program. Families with incomes between 150 percent and 200 percent of the poverty level will be required to contribute a monthly premium of $25 for the first adult and $10 for the second. NJ FamilyCare is funded by $100 million a year in tobacco settlement funds and $106 million more from a combination of federal funds, state General Assistance funds, and employer and employee contributions.

The NJ KidCare program has now been combined with NJ FamilyCare. Both are administered as one program under the name of NJ FamilyCare.

KEY FINDINGS

Based on its review of information presented in its monthly meetings, the public hearings, and its own deliberations, the Task Force has made the following key findings:

[1] The federal poverty level is currently $17,050 for a family of four and $8,350 for a single adult.

- The overall percentage of New Jersey's nonelderly population without health insurance dropped to 15.0 percent in 1999, below the national average of 17.4 percent, after being at about the national average for several years.

- New Jersey's employer-based coverage was substantially above the national average in 1999, while the percentage of the state's nonelderly population covered by Medicaid and other state public insurance programs was below the national average.

- New Jersey has taken several important steps to expand health insurance coverage since 1998, including the NJ KidCare program for children, increased outreach in the Medicaid program, and now NJ FamilyCare for adults and children.

- New Jersey has several other programs that put the state in the forefront of states in making health insurance and health care accessible and affordable, including the Small Employer Health Benefits Program, the Individual Health Coverage Program, Charity Care, the Catastrophic Illness in Children Relief Fund, the Pharmaceutical Assistance to the Aged and Disabled Program, and the Federally Qualified Health Centers Expansion Program.

- The remaining gaps in affordability and accessibility of health care are difficult to address through state government programs and regulations:

  - Extending government subsidies to families with incomes substantially in excess of 200 percent of poverty may displace or undermine employer-sponsored insurance.

  - Some individuals and families may choose not to obtain health insurance coverage, even when financial and other barriers are substantially reduced.

  - A significant portion of health care costs may be attributable to individual behavior and choices regarding diet, exercise, smoking, and use of preventive services that state government has a limited ability to influence.

  - Some efforts to address problems of health care affordability and accessibility are more feasible at the federal than at the state level, because the federal government has greater leverage over health care markets and is less susceptible to the pressures of interstate competition for business.

- Statutory and regulatory mandates to include certain benefits in health insurance policies may, in some cases, add unnecessarily to the cost of health insurance by requiring coverage of services and procedures whose costs exceed their benefits, while in other cases mandates have encouraged adoption of coverage that is now widely considered to be beneficial and cost-effective.

- Several states have developed mandate review systems and processes that subject proposed and existing mandates to systematic and objective expert review. Adopting

such a system in New Jersey could make the consideration of new mandates and the review of existing ones more rational and less susceptible to political pressures.

CRITERIA FOR ASSESSING OPTIONS

In reviewing major options and developing its recommendations, the Task Force used a variety of criteria, including:

- ***Effectiveness.*** The likely impact on health insurance coverage and access to and affordability of health care
- ***Equity and distributional effects.*** The impact on people with different incomes, family circumstances, and access to insurance
- ***Impact on quality of health care.*** The impact on providers' ability to provide quality health care
- ***Administrative feasibility for the state.*** The ability of state government to administer the recommendation efficiently and at reasonable cost
- ***Fiscal impact.*** The cost to state government and state taxpayers
- ***Operational feasibility and financial burden for the private sector.*** The ability of the private sector to respond to the recommendation and bear the costs involved
- ***Political acceptability.*** The likely response of the governor, the legislature, and the public

Individual members of the Task Force have likely given different weights to these criteria in their deliberations, and the Task Force as a whole did not seek to explicitly weight the criteria or to apply them systematically to each option and recommendation. The criteria nonetheless provided a general framework for the Task Force's deliberations.

RECOMMENDATIONS

The Task Force has agreed on the following recommendations:

- **New Jersey should adopt as a goal broad access to health insurance coverage for its citizens.** New Jersey has made substantial progress toward that goal with its strong base of employer-sponsored coverage, and innovative programs like the Small Employer Health Benefits Program, the Individual Health Coverage Program, the Pharmaceutical Assistance to the Aged and Disabled Program, NJ FamilyCare, Medicaid, Charity Care, the Catastrophic Illness in Children Relief Fund, and the Federally Qualified Health Centers Expansion Program. Those sources of coverage should be further strengthened and expanded.

- **NJ FamilyCare should be expanded to cover as many working parents and other lower-income adults and children as possible within available fiscal resources, relying as much as possible on employer-sponsored coverage.** New Jersey's FamilyCare program for adults and children is one of the most innovative and comprehensive in the country, and it lays the groundwork for filling many of the remaining gaps in health insurance coverage in the state.

- **New Jersey should establish a more systematic process for reviewing both proposed and existing health benefit mandates.** Existing mandate review processes in New Jersey, Pennsylvania, Maryland, and Virginia provide useful models. Their major features are summarized in a table at the end of this Executive Summary. The Task Force recommends that the new mandate review process have the following characteristics:

  - ***Independence, objectivity, and representativeness.*** An independent commission appointed jointly by the Governor and the Legislature and made up of people with relevant professional expertise and experience and a diversity of concerns and perspectives would meet these standards.

  - ***Manageable size.*** The commission or other entity should be small enough to conduct effective deliberations while still representing an appropriate diversity of interests and areas of expertise; 7 to 13 appointees would be an appropriate size and an odd number of appointees would avoid tie votes.

  - ***Authority and scope of responsibility.*** The entity should provide advice and recommendations to the executive and the legislative branches, but final decision-making authority should remain with elected officials. The new entity should incorporate the responsibilities of the current Health Wellness Promotion Advisory Board.

  - ***Expertise and analytic resources.*** The commission or other entity should have available through its appointed members, staff, and/or outside consultants the financial, clinical, and health and social policy expertise needed to evaluate all aspects of proposed mandates.

  - ***Public visibility.*** The mandate review process should be fully visible to the public. Reports and analyses should be widely accessible, and there should be opportunities for public hearings and consumer input.

  - ***Funding.*** Sufficient funding (about $7,000 to $10,000 per mandate reviewed) should be provided to enable the entity to review thoroughly proposed and existing mandates selected for review by state decision makers.

- **The Task Force has reviewed and supports the findings and recommendations regarding hospital cost control and charity care in the 1999 Final Report of the Advisory Commission on Hospitals.** The Advisory Commission's recommendations

were aimed at reducing excess hospital capacity and lengths of stay and broadening charity care funding. The Commission also recommended establishment of affordable health insurance programs that could reduce the burden of charity care. The Executive Summary from the Commission's final report is reprinted in Appendix A, along with an August 11, 2000 letter from Department of Health & Senior Services Commissioner Christine Grant outlining the steps taken by the Whitman administration to implement the Commission's recommendations.

- **Other approaches to improving affordability and accessibility of health care—including state tax incentives, employer purchasing pools, and bare-bones insurance policies—appear to have relatively limited impact, so the Task Force has made no recommendations in those areas.**

- **The Task Force reviewed selected health care "cost drivers," including prescription drugs, hospital costs, technology, and changing demographics. (The Task Force acknowledges that these are not the only cost drivers in the system, and recommends that others be examined in the future.) Those that were reviewed have complex and interacting effects that both increase and reduce overall health care costs.** State government has only limited ability to influence these effects, and the Task Force was not able to identify new interventions that would have predictably beneficial impacts.

ISSUES FOR THE FUTURE

The Task Force believes that its work over the past year and this report provide a framework for further progress in addressing the issues of affordability and accessibility of health care in New Jersey. There are some issues that the Task Force was not able to address. These "legacy" issues include:

- Additional support for and recognition of the role of community health centers, urban hospitals, and other safety net health care providers

- Transportation to health care services for those unable to afford it

- Health care services for illegal or undocumented immigrants

- Medical errors

- Fraud and abuse

- The implications of telemedicine

- State high-risk pools

- The implications of self-insurance for medium-sized firms

Table 1. State Health Insurance Benefit Mandate Review Processes

	NJ Pension and Health Benefits Review Commission	PA Health Care Cost Containment Council	MD Health Care Commission	VA Advisory Commission on Mandated Benefits
Independent Commission?	Yes	Yes	Yes	Yes
Number and Characteristics of Members	10, selected to represent executive branch and public	21, selected to represent executive branch, business, labor, consumers, insurers, and health care providers	13, selected to represent payers (2), physicians (2), public (2), and others in fields unrelated to health care (7)	16 (10 private citizens appointed by the governor, 4 legislators appointed by the legislature, and commissioners of health and insurance
How Appointed?	By governor and legislature	By governor and legislature (some from limited lists of nominees)	By governor, with advice and consent of state senate	By governor and legislature
Main Responsibilities	Review proposed legislation regarding pensions and health benefits for public employees	(1) Collect and report health care data (2) Study health care access for uninsured (3) Review and make recommendations on proposed or existing health benefit mandates	Collection, analysis, and reporting of health care data; development of quality/performance measures for HMOs and other providers; development of standard health benefit plans; administration of certificate-of-need program; development of reimbursement systems; reviews of proposed and existing benefit mandates	Review proposed mandates, conduct public hearings, and produce reports based on estimated social and financial impacts and medical efficacy of proposed benefit mandates. Proposed mandates are referred to commission before being referred to legislative committees.
To Whom Are Recommendations Made?	Legislature	Governor and legislature	Commission does not make recommendations on benefit mandates	Legislature, at beginning of next legislative session
Are Reports Made Public?	No, but recommendations are	Yes	Yes	Yes
Staff/Contractor Support	Staff administrator and Segal Company (outside actuary)	Council has staff of 50 health care professionals	Commission has staff of 67; mandate reviews are done by Wm. M. Mercer (outside actuary)	Staff from state bureau of insurance
Funding	$7,000 to $9,000 per month to Segal Company	$2.9 million per year state appropriation, plus revenue from sale of data	Commission budget is $8.25 million per year; review of proposed mandates costs $7,000 per mandate; review of existing mandates costs $10,000-12,000 per year	Commission does not have its own budget; no estimates available on cost of reports; commission produces about 6 reports per year

I. INTRODUCTION

Governor Christine Todd Whitman signed the executive order creating the Task Force on Affordability and Accessibility of Health Care in New Jersey on July 20, 1999. The members of the Task Force were appointed on October 20, and the Task Force held its first meeting on November 29. The Task Force has met each month since then, with the exception of December 1999 and August 2000, and has held four public hearings. This report sets out the Task Force's key findings and recommendations, based on the information reviewed during the past 12 months, the results of the public hearings, and the Task Force's deliberations.

The Task Force's charge from Governor Whitman is spelled out in detail in the Executive Summary of this report.

The report has three major sections in addition to the Executive Summary and this Introduction:

- **Section II** includes a summary of current New Jersey programs. It provides background and context for the Task Force's recommendations.

- **Section III** contains a description and analysis of health insurance and health care costs and trends in New Jersey and other states.

- **Section IV** summarizes some of the major issues the Task Force explored, including the relationship between insurance and health care access and utilization, affordability and willingness to pay, and barriers to access for lower-income populations. The section also reviews selected health care cost drivers, including benefit mandates, pharmaceutical costs, hospital costs, technology, and demographics. Finally, it reviews the options for state policy interventions that the Task Force considered but did not recommend, including state tax incentives, employer purchasing pools, and bare-bones insurance policies.

II. CURRENT NEW JERSEY PROGRAMS

New Jersey currently has a wide array of programs aimed at dealing with various aspects of the problems of affordability and accessibility of health care in the state. The Task Force reviewed most of these programs in its January 12, 2000 meeting. This section briefly reviews the major features of each of these programs. Figure II.1 summarizes those features and the numbers served. It also shows the distribution of the nonelderly insured population in 1999 by age, income, and source of insurance coverage.

A. NJ FAMILYCARE/KIDCARE

The Legislature approved the NJ FamilyCare program, and Governor Whitman signed it into law on July 13, 2000. The program provides insurance coverage for working parents of Medicaid and NJ KidCare children in families with incomes up to 200 percent of poverty ($34,100 a year for a family of four), and for individuals and childless couples with incomes up to 100 percent of poverty ($8,350 a year for a single person and $11,250 for a couple), including those eligible for the state General Assistance program.

NJ FamilyCare will cover an estimated 125,000 previously uninsured adults—80,000 parents and 45,000 childless adults—and is funded by a combination of tobacco settlement money, federal and state Medicaid funds, employee and employer contributions, and state General Assistance funds. As of the end of December 2000, nearly 54,000 adults were enrolled in NJ FamilyCare.

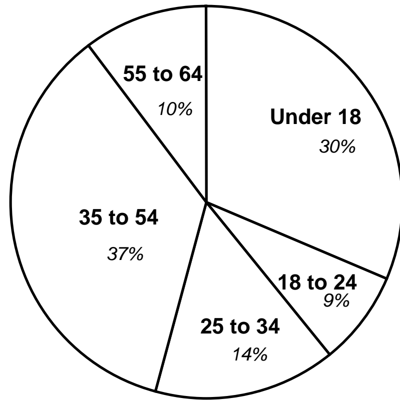
Adults eligible for NJ FamilyCare receive a comprehensive package of health care services through one of the health maintenance organizations (HMOs) available in each county. Families with incomes between 150 and 200 percent of poverty pay a monthly premium of $25 for one parent, $10 for a second parent, and $15 for all children, for a maximum monthly premium of $50.

If the parent's employer offers a comparable benefit package and requires an employee contribution of no more than 50 percent of the cost, the family is required to purchase the employer-sponsored insurance, with a subsidy from the FamilyCare program. This premium support program will start in March 2001.

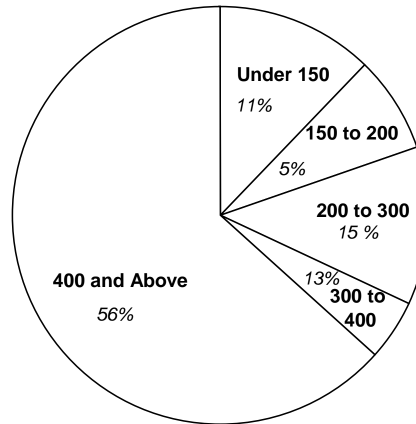
NJ FamilyCare now incorporates the NJ KidCare program, which has been operating since the spring of 1998 and is providing health insurance coverage to nearly 75,000 previously uninsured children. NJ KidCare covers children in families with incomes up to 350 percent of poverty ($59,675 for a family of four), the highest level of any state in the country. (Five states—Connecticut, Missouri, New Hampshire, Rhode Island, and Vermont—cover children in families with incomes up to 300 percent of poverty.) To discourage substitution of NJ KidCare for private insurance, children must in general be uninsured for at least six months to be eligible.

Figure II.1
Nonelderly Insured in New Jersey, 1999
Based on March 2000 CPS
(Total Number Insured = 6.004 Million)

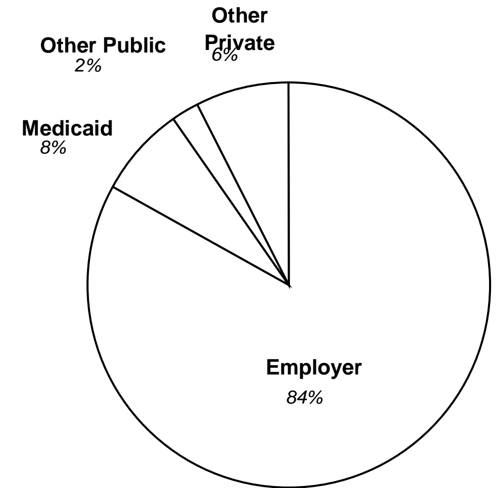
By Age



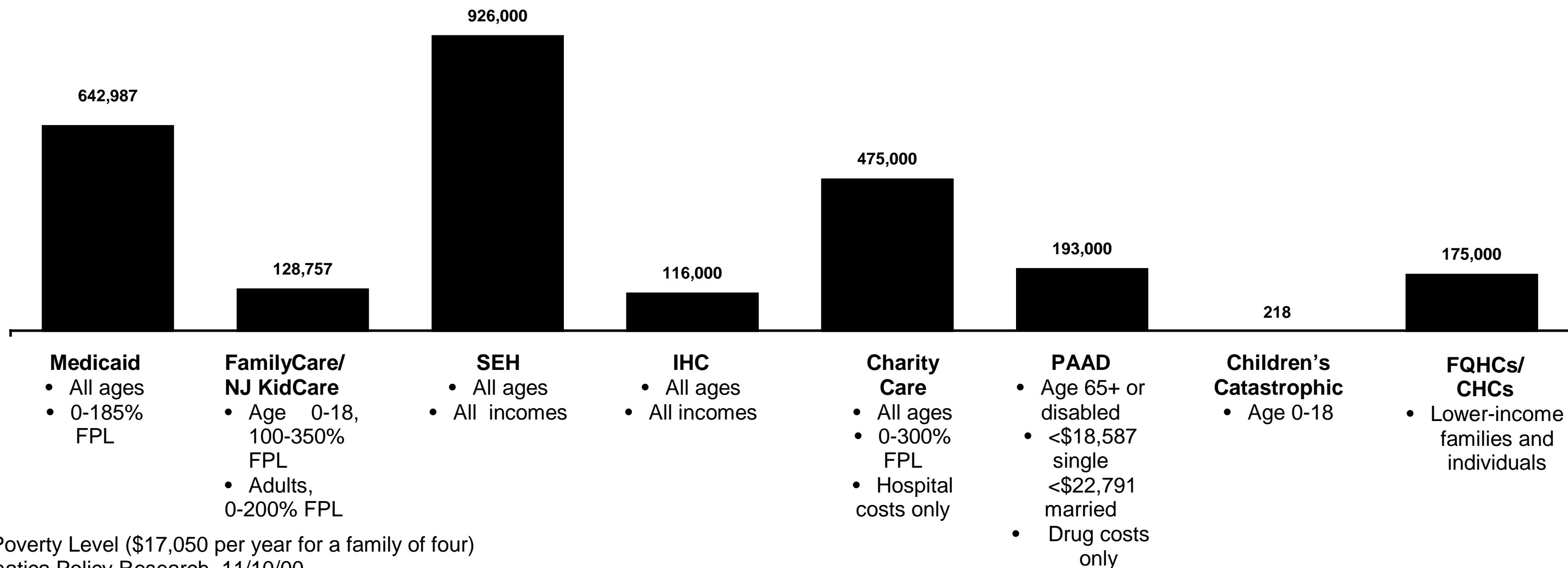
By Income (% FPL)



By Source of Insurance



NJ Programs, by Numbers Served



FPL = Federal Poverty Level ($17,050 per year for a family of four)
Source: Mathematica Policy Research, 11/10/00

The program offers a comprehensive package of health benefits through HMOs. There are premiums of $15 to $100 per month per family, depending on income, and small copayments for some services.

For children not eligible for Medicaid, the federal governments pays 65 percent of the cost of NJ KidCare, and the state pays the rest. (The state share for Medicaid-eligible children is 50 percent.)

B. MEDICAID

The Medicaid program provides health insurance coverage for families with children with incomes up to approximately 36 percent of poverty, pregnant women and young children at higher income levels (up to 100 percent of poverty for children ages 6 through 16, 133 percent of poverty for children between ages 1 and 6, and 185 percent of poverty for pregnant women and children under age 1), and aged, blind, and disabled individuals with incomes up to 100 percent of poverty. (NJ KidCare A, which is a Medicaid expansion, covers children age 6 through 18 up to 133 percent of poverty who were not previously eligible for Medicaid.)

The Medicaid program offers a comprehensive benefit package for those who meet its eligibility requirements. The federal government pays 50 percent of the costs in New Jersey, and the state pays the rest. Currently, more than 640,000 people are enrolled in Medicaid.

1. NJ FamilyCare and Medicaid Outreach and Marketing

New Jersey has developed an extensive outreach and marketing program for NJ KidCare and NJ FamilyCare that has also had an impact on the Medicaid program, because there are substantial overlaps in the target audiences. NJ KidCare began using professional advertising services in August 1998. The state used focus groups and other methods to develop a better understanding of the target audience before launching a multimedia campaign in November 1998.

When NJ KidCare expanded in July 1999 to cover children in families with incomes up to 350 percent of poverty, the state refocused the advertising campaign to emphasize the expansion to higher-income families, and broadened dissemination of newspaper advertising, outdoor media, and broadcasting to reach these additional families.

The NJ FamilyCare legislation the Governor signed in July 2000 brought parents, caretakers, and other adults into the program. The state launched a new media campaign in October 2000, building on the experiences of the NJ KidCare campaign. The new campaign consisted of broadcast (TV, cable, and radio), newspaper, movie, and transit advertisements focusing on the transition from NJ KidCare to NJ FamilyCare. All advertisements are available in Spanish for use in Hispanic media outlets. This statewide multimedia and promotional advertising campaign continued through December 2000.

C. CHARITY CARE/HOSPITAL RELIEF

The New Jersey Hospital Care Payment Assistance Program (Charity Care Assistance) provides free or reduced-charge care to eligible individuals who receive inpatient or outpatient care at acute care hospitals in New Jersey.

To be eligible, individuals must be New Jersey residents who have no health insurance coverage, or coverage that pays only for part of the hospital bill, and must be ineligible for any private or government-sponsored coverage, such as Medicaid. Those with incomes below 200 percent of poverty may have all of their hospital charges covered, while those with incomes between 200 and 300 percent of poverty receive increasingly smaller subsidies. There is no subsidy for those with incomes over 300 percent of poverty. There are also asset limits ($7,500 for an individual and $15,000 for a family), but applicants whose assets exceed those levels may become eligible by "spending down" to those levels by using a portion of their assets to cover the hospital bill and other approved out-of-pocket medical expenses.

In 1999, the most recent year for which data are available, approximately 188,000 individuals received assistance from the Charity Care program for 2.3 million hospital claims. Ninety-four percent of the claims were for individuals with incomes below 200 percent of poverty.

The total Charity Care subsidy payment for state fiscal year 2000 was $320 million. The subsidy is distributed to hospitals based on a formula that takes into account documented charity care, the hospital's profitability, and the portion of its revenue that comes from private payers. The subsidy is paid out of the Health Care Subsidy Fund, which receives payments from the unemployment insurance trust fund, tobacco taxes, and the state general fund. In state fiscal year 2001, a supplemental charity care fund, budgeted at $36 million, was created to ensure that all hospitals that provide charity care receive a subsidy.

D. CATASTROPHIC ILLNESS IN CHILDREN RELIEF FUND

The Catastrophic Illness in Children Relief Fund is funded by a $1 per employee annual surcharge levied on all employers who are subject to the New Jersey unemployment compensation law. The Fund takes in approximately $4.5 million per year. The fund makes payments to families with a child who suffers a catastrophic illness, defined in terms of the economic impact the child's illness has on the family. Families of any income level may quality for assistance, and coverage is not limited to specific diseases or diagnoses.

Fund payments cover medical and related expenses that are not covered by insurance, state or federal programs, or other sources, such as private fundraising. Awards to families have ranged from $476 to $591,423. To be eligible, a child must have been 18 or younger when the medical expenses were incurred, and the family must have lived in New Jersey for three months before applying to the fund. In any prior consecutive 12-month period dating back to 1988, eligible expenses must have exceeded 10 percent of the first $100,000 of annual family income, plus 15 percent of the amount of income over $100,000. In fiscal year 1999, 218 children were covered at a cost of $5 million.

E. FEDERALLY QUALIFIED HEALTH CENTERS/COMMUNITY HEALTH CENTERS

There are 12 community health centers in New Jersey that operate a total of 36 service sites in 11 counties throughout the state. These community health centers served nearly 175,000 people in 1999 and provided nearly 700,000 medical and dental visits. The centers provide comprehensive primary and preventive care services in high-need urban and rural areas. Almost 45 percent of their users are uninsured, and Medicaid covers 42 percent. The centers serve many undocumented aliens who are unable to receive care elsewhere. Physicians, dentists, nurse practitioners, nurses, certified nurse midwives, and clinical social workers staff the centers.

According to the New Jersey Primary Care Association, these centers received $51.5 million in funding in 1999, with the bulk of it coming from Medicaid ($14.1 million), federal grants ($12.9 million), and state uncompensated care funds ($8.8 million).[2] The remainder came primarily from state and local funds, third-party and patient collections, and Medicare.

F. PHARMACEUTICAL ASSISTANCE TO THE AGED AND DISABLED PROGRAM (PAAD)

The PAAD program provides lower-income NJ residents age 65 or older, or who are receiving Social Security disability insurance, with assistance in covering the cost of prescription drugs. The income limits in 2000 are $18,151 for single individuals and $22,256 for married couples. The limits are increased each year by the amount of the Social Security cost-of-living increase. Beneficiaries pay a $5 copayment for each prescription.

The program served 193,000 beneficiaries in 1999 (171,000 aged and 22,000 disabled) at a cost of $249 million. The program is funded by a combination of casino funds ($214 million) and state general funds ($35 million).

The Legislature approved $25 million in tobacco settlement funds for state fiscal year 2001 for a prescription drug program for senior citizens and the disabled who are not eligible for the current PAAD program. A legislative committee in consultation with the state Department of Health and Senior Services will work out details of the new program.

G. INDIVIDUAL HEALTH COVERAGE PROGRAM AND SMALL EMPLOYER HEALTH BENEFITS PROGRAM

The New Jersey Legislature in 1992 created two programs to guarantee access to health coverage for individuals and small employers, regardless of health status, age, claims history, or any other risk factor: the Individual Health Coverage Program (IHC) and the Small Employer Health Benefits Program (SEH).

Under the IHC program, individual coverage is available to anyone who is a resident of New Jersey and does not have access to employer-based group insurance or Medicare. Under the

[2] The New Jersey Department of Human Services (DHS) estimates that total annual Medicaid payments to FQHCs are substantially higher when additional retroactive payments are included. For the 1998 state fiscal year, for example, DHS estimates that total Medicaid payments to FQHCs were $21.7 million.

SEH program, small employers (those with 2 to 50 full-time employees) may purchase standardized health benefit plans, offered by all carriers.

Major features of the two programs include:

- ***Guaranteed access and renewal.*** Eligible individuals or small employers can never be denied coverage except for nonpayment, fraud, or if the carrier withdraws from the entire market.

- ***Standard plans.*** All carriers in the IHC or SEH program must offer five comprehensive standard plans or a standard HMO plan.

- ***Rating restrictions.*** The IHC plans are community-rated, meaning that a carrier must offer a standard plan to everyone at the same rate, regardless of age, gender, profession, health status, or geographic location. The SEH plans are modified community-rated: rates may vary based on age, gender, family status, and geographic location, but not on health status.

- ***Portability and pre-existing conditions.*** Generally, all conditions are covered by a standard plan if an applicant's prior health coverage has not lapsed. In the IHC program, an applicant without prior coverage may have to wait for up to a year for coverage of a pre-existing condition. In the SEH program, a pre-existing condition waiting period of up to six months may be imposed only on groups of two to five that have no prior coverage.

As of January, 2000, there were 30 insurance carriers in the SEH program market, covering 926,000 people, an increase of more than 230,000 since the program began. There were 20 carriers in the IHC program, covering 116,000 people. Enrollment in the IHC program is down from a peak of 186,000 in 1996, due in part to the high and increasing cost of individual coverage and to adverse selection (the individual market tends to attract higher-risk enrollees than the small-group market).

H. NEW JERSEY AIDS DRUG DISTRIBUTION PROGRAM (ADDP)

The New Jersey AIDS Drug Distribution Program (ADDP) provides life-prolonging and life-sustaining medications free to eligible individuals. To be eligible, an individual must be a resident of New Jersey, HIV+, and have an annual income that does not exceed 500 percent of the federal poverty level, which is currently $41,750 for an individual. The ADDP covers 76 medications used to treat HIV disease and the associated opportunistic infections. The ADDP currently has nearly 4,000 enrollees, resulting in annual expenditures of approximately $36 million.

I. SUBSTANCE ABUSE PREVENTION AND TREATMENT

Health & Senior Services Commissioner Christine Grant created by executive order a Substance Abuse Prevention and Treatment Advisory Task Force to examine issues related to the status of substance abuse treatment in New Jersey, and identify capacity and resource gaps in the provision of quality and cost-effective services. The Task Force's initial findings emphasize the

need to address access, adequate managed care coverage based on need, insufficient treatment capacity, and comparisons of rates paid by all public purchasers and—to the extent possible—those paid by private purchasers.

J. HEALTH WELLNESS PROMOTION

Governor Whitman signed the Health Wellness Promotion Act into law in January, 2000 (P.L. 1999, Ch. 339). Following the successful promulgation of regulations, the Health Wellness Promotion Act (HWPA) became effective in November, 2000. Provisions of the law require health insurers (HMOs and indemnity plans) of greater than 50 persons to reimburse any subscriber or other covered person for expenses incurred for annual prevention examinations and other preventive health services in accordance with appropriate age and gender standards. The reimbursement amounts for these services are included in the HWPA and can be adjusted annually by the Commissioner of Banking and Insurance in consultation with the Department of Treasury, based on the consumer price index. Another provision of the HWPA creates an advisory board comprised of three members with backgrounds in epidemiology and preventive health services. The purpose of the Board is to advise the Legislature regarding any recommendations for revisions in preventive health testing and services required by the law.

K. TICKET TO WORK

The federal government has given states the option of expanding Medicaid coverage to allow permanently disabled individuals between the ages of 16 and 64 who are working and whose incomes are below 250 percent of the federal poverty level to purchase Medicaid coverage. Governor Whitman signed legislation in September 2000 allowing New Jersey to choose this option.

This new program will allow disabled individuals to earn up to 250 percent of the federal poverty level, which currently comes to $20,875 a year. However, with earned income disregards allowed under Medicaid rules, a working individual may earn up to $41,000 annually and still qualify. In addition to earned income, an individual is allowed unearned income, such as a pension, in an amount not to exceed 100 percent of the federal poverty level. That monthly income limit is currently $696 for an individual and $938 for a couple. Social Security Disability benefits and Railroad Retirement disability benefits are excluded in determining income eligibility. Also, the asset limit is increased from $4,000 to $20,000 for an individual and from $6,000 to $30,000 for a couple. IRA and 401(k) plans are disregarded when determining resource eligibility. A small premium of $25 per month per adult will be required of all individuals whose net incomes are more than 150 percent of the federal poverty level.

This program also allows for an expansion of personal care assistant services outside of the home to support employment possibilities for these disabled individuals. The DHS Office of Disability Services is the lead agency for this service expansion.

The effective date of the program is February 1, 2001. The State Plan Amendment was submitted to HCFA in December 2000, and regulations were drafted for review by January 10, 2001.

III. HEALTH INSURANCE AND HEALTH CARE COST TRENDS IN NEW JERSEY AND OTHER STATES

Health insurance coverage and health care cost trends in New Jersey are similar to those in the rest of the nation. The broader trends that influence the affordability and accessibility of health care nationally have similar impacts in New Jersey. Specific policy initiatives aimed at increasing affordability and accessibility that have been tried in other states can generally be expected to have similar results in New Jersey. Accordingly, the Task Force has examined both these broader trends and specific policy initiatives from other states to determine which approaches are likely to be most effective in New Jersey.

This section of the report reviews health insurance coverage and health care cost trends, while Section IV covers some of the policy initiatives in other states. This section responds to the Governor's charge that the Task Force compare the affordability and accessibility of health insurance in New Jersey to other states and evaluate the amount that employees contribute to the cost of employer-sponsored health insurance.

A. HEALTH INSURANCE COVERAGE IN NEW JERSEY AND THE UNITED STATES[3]

According to the most recent data from the U.S. Census Bureau's Current Population Survey (CPS), approximately 82.6 percent of nonelderly Americans had some form of health insurance in 1999.[4] As shown in Table III.1, nearly 66 percent had it through an employment-based health plan, 4 percent purchased it on their own, and Medicaid and other state public programs covered just over 10 percent. Approximately 17.4 percent of the nonelderly population was uninsured. New Jersey was generally similar to the rest of the nation in 1999, although the rate of employer-sponsored coverage was higher than the national average, while Medicaid and other state public coverage was lower. New Jersey's overall uninsured rate in 1999 was below the national average for the first time in several years.

Table III. 1
Percentage of Nonelderly Population Insured and Uninsured in the United States and New Jersey, 1999

	Employment-Based	Individually Purchased	Medicaid and Other State Programs	Uninsured
United States	65.7	4.0	10.3	17.4
New Jersey	72.8	3.8	7.3	15.0

[3] The March 2000 CPS data used in this section are based on analyses of Census Bureau data files performed by John Czajka of Mathematica Policy Research, Inc.
[4] Nearly 99 percent of Americans age 65 and over are covered by the federal Medicare program and/or other insurance. The data and the discussion in this section of the report therefore focus on the nonelderly population.

B. CHARACTERISTICS OF THE UNINSURED

As in the rest of the United States, certain portions of the population in New Jersey have disproportionately high uninsured rates, including young adults, poor people, Hispanics, those employed in small businesses, and immigrants.[5] (See Figure III.1.) While the overall 1999 uninsured rate for the nonelderly population in New Jersey was 15.0 percent, 27.2 percent of young adults age 21-24 were uninsured, as were 40.6 percent of people with incomes below the poverty level, 28.9 percent of Hispanics, and 25.1 percent of those employed in very small businesses (fewer than 10 employees).

The rate of uninsurance is especially high for immigrants who are not naturalized United States citizens. According to the March 2000 CPS, 36 percent of noncitizen immigrants under age 65 in New Jersey were uninsured in 1999, nearly two and half times as high as the uninsurance rate for the New Jersey population as a whole. The uninsured rate for naturalized citizens under age 65 in New Jersey was 15.4 percent in 1999, virtually the same as the rate for the rest of the under-65 population. The uninsured rates for immigrants for the United States as a whole were higher: 44 percent of immigrants who are not naturalized were uninsured in 1999, compared with 22 percent of those who are U.S. citizens.

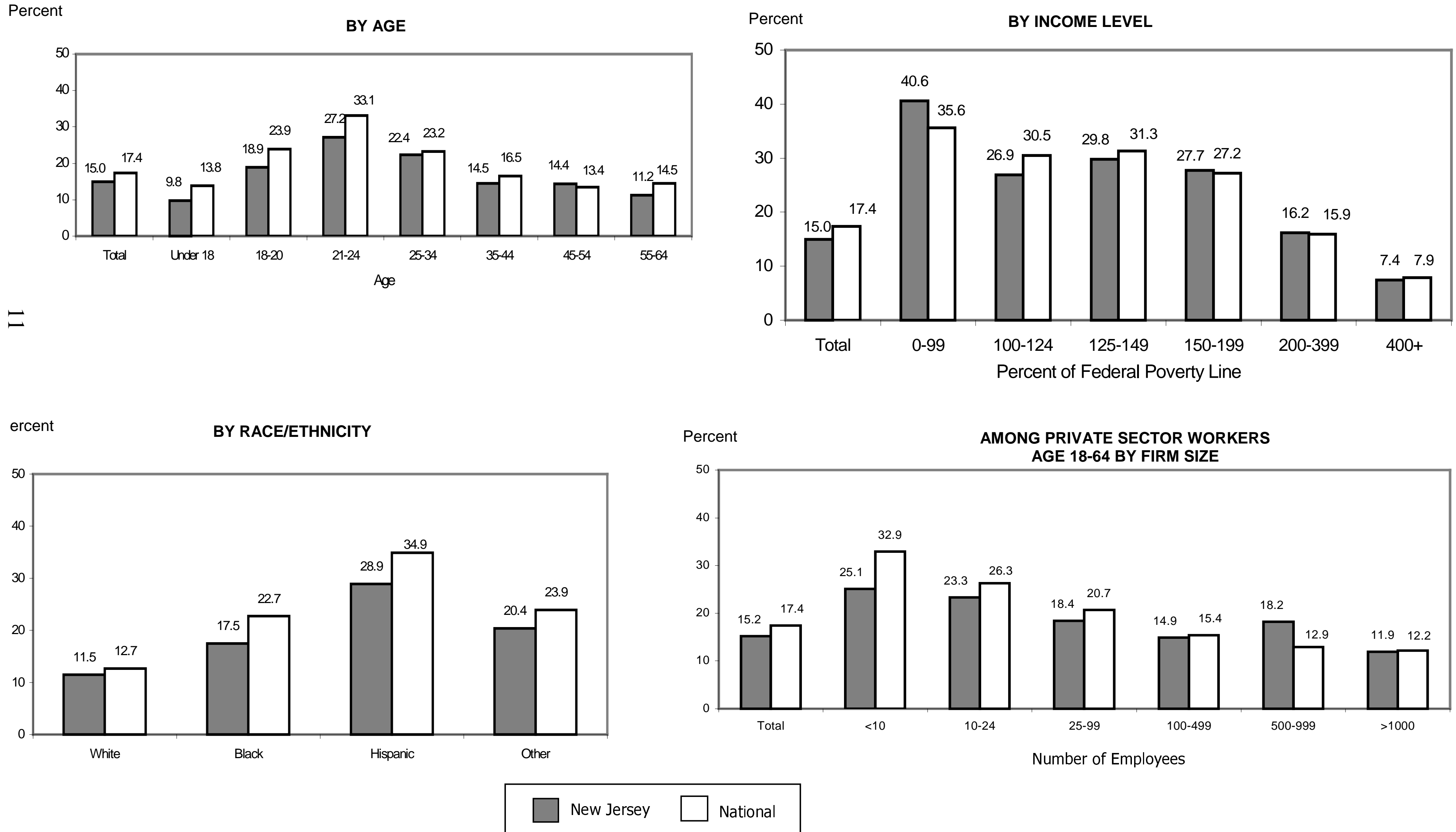
C. COMPARISONS TO SURROUNDING STATES

As shown in Figure III.2, New Jersey's uninsured rate was substantially below the national average from 1987 to 1995, rose to approximately the national average for the next three years, and dropped below the national average again in 1999. The New Jersey uninsured rate has been similar to the rates in New York and Maryland over the past decade, while the uninsured rate in Pennsylvania has been substantially below those in the other three states throughout the decade.

State income levels, employer coverage, demographics, and Medicaid coverage account for most of the state-by-state variation. Figure III.3 shows, for example, that New Jersey's rate of employer-sponsored coverage is comparable to the high rates for this coverage in Pennsylvania and Maryland, but that New Jersey's coverage rate for Medicaid and other state public programs was substantially below the rate in Pennsylvania, perhaps accounting for some of the difference in overall rates of uninsurance between the two states. It is worth noting, however, that the percentage of the population covered by Medicaid and other state public programs in New Jersey, Pennsylvania, New York, Maryland, and the U.S. as a whole corresponds roughly to the percentage of the population with incomes below 100 percent of the federal poverty level. States with fewer low-income residents, like New Jersey, tend to have fewer people who are insured through Medicaid and other state programs than states like Pennsylvania and New York, which have a higher-percentage of low-income residents.

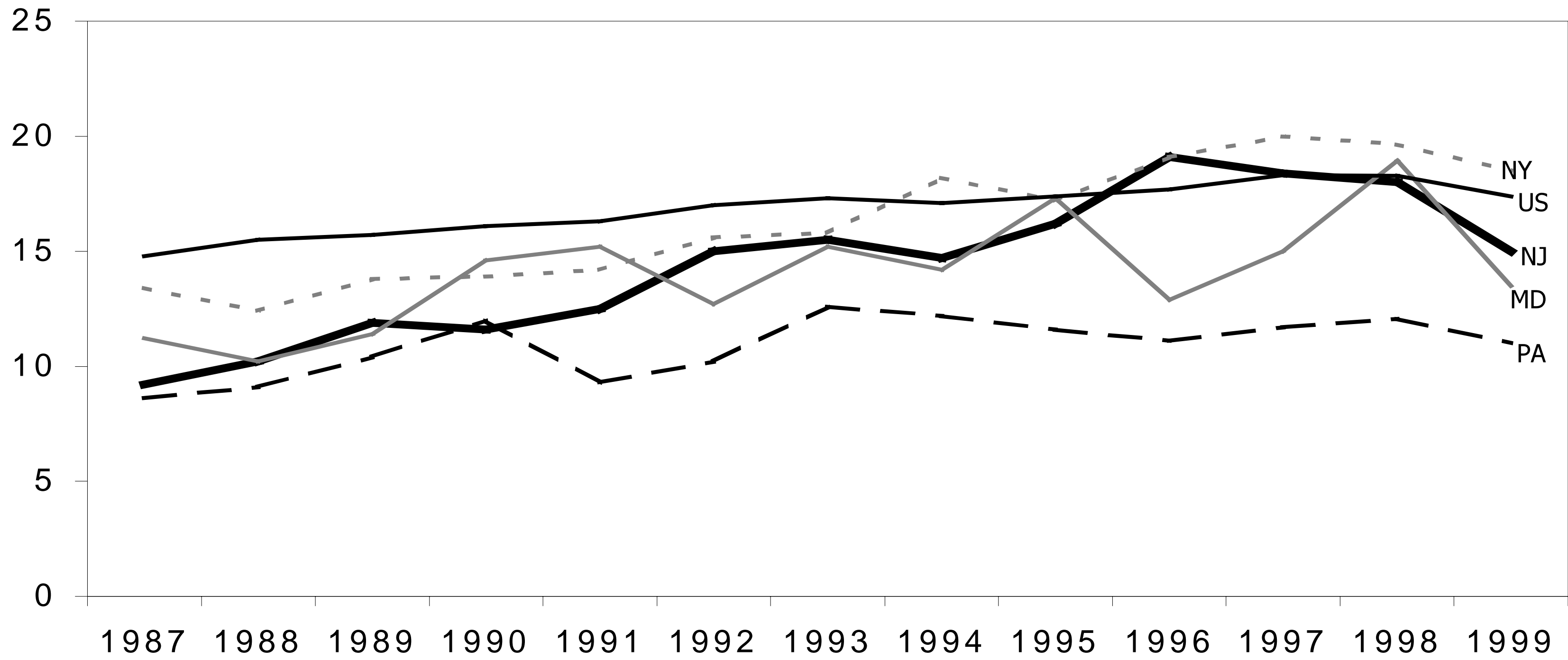
[5] CPS estimates for individual states have significant margins of error, due primarily to relatively small sample sizes. For New Jersey as a whole, for example, the margin of error for the estimated 15.0 percent uninsurance rate for the entire nonelderly population in 1999 is plus or minus 2.6 percentage points, meaning that there is a 95 percent probability that the actual rate is somewhere between 12.4 percent and 17.6 percent. The margin of error in the CPS estimates for smaller subsets of the state population is substantially larger. For example, the estimated 40.6 percent uninsured rate for the 8 percent of the state's nonelderly population that is below 100 percent of poverty has a margin of error of plus or minus 7.2 percentage points.

Figure III.1
Percentage Of Nonelderly Uninsured In 1999
New Jersey Vs. National Average



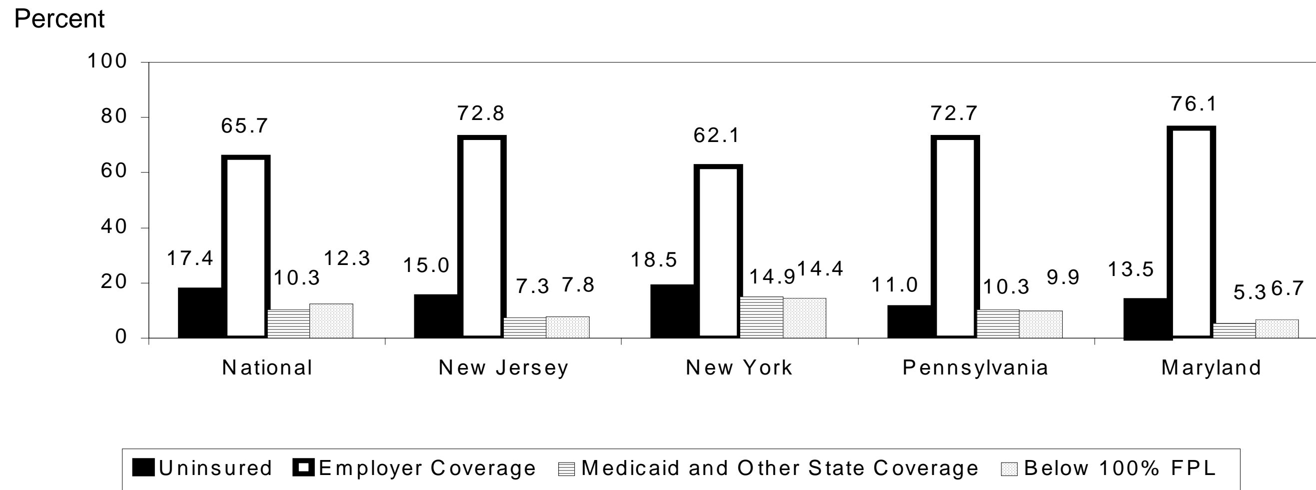
SOURCE: U.S. Census Bureau, March 2000 current population survey.

Figure III.2
Percentage of Nonelderly Uninsured by State, 1987-1999



Source: US Census Bureau, March 2000 Current Population Survey

Figure III.3
Variables that Relate to the 1999 Uninsured Rates



Source: US Census Bureau, March 2000 Current Population Survey

1. New Jersey vs. Pennsylvania

The large and persistent differences between the overall nonelderly uninsured rates in New Jersey and Pennsylvania over most of the last decade, as illustrated in Figure III.2, remain somewhat puzzling. The most noticeable difference between the two states is New Jersey's substantially higher Hispanic population. Approximately 12.6 percent of New Jersey's population was Hispanic in 1999, compared with only 2.7 percent of Pennsylvania's. As indicated in Figure III.1, the rate of uninsurance among Hispanics is approximately double the rate for the population as a whole. New Jersey's population is somewhat younger than that of Pennsylvania, which might lead to lower insurance coverage, but the difference is probably not great enough to account for a significant difference in coverage.[6] Employer-sponsored coverage is more costly in New Jersey for both employers and employees, which might lead to lower coverage in New Jersey, but as shown in Figure III.3, overall rates of employer-sponsored coverage are essentially the same in the two states.[7]

There are other differences between the two states that by themselves might suggest that insurance coverage should be higher in New Jersey than in Pennsylvania. Incomes in New Jersey are significantly higher than those in Pennsylvania, and higher incomes are generally associated with higher rates of insurance coverage.[8] Education levels in New Jersey are also higher than those in Pennsylvania, and higher levels of education are also generally associated with higher levels of insurance.[9] New Jersey is substantially more urban than Pennsylvania; more than 89 percent of New Jersey's population lived in urban areas in 1990, compared with only 69 percent of Pennsylvania's. While the literature on the issue is not fully conclusive, uninsurance rates tend to be higher in rural areas.[10]

Thus, while the factors outlined above might explain some of the differences between the uninsurance rates in New Jersey and Pennsylvania, they point in sometimes opposing and ambiguous directions. Overall rates of uninsurance in specific states are the product of a complex mix of economic, demographic, and cultural factors, not all of which can be isolated and measured.

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[6] The median age of New Jersey's population was 37.0 years in 1999, compared with 37.9 years in Pennsylvania, and 24.6 percent of New Jersey's population was under age 18, compared with 23.8 percent of Pennsylvania's.

[7] The average annual premium for single coverage in 1998 was $2,158 in firms with more than 50 employees in Pennsylvania, for example, compared with $2,441 in New Jersey. Employees paid 13.6 percent of the premium in those larger firms in Pennsylvania, compared to 19.7 percent in New Jersey. Agency for Healthcare Research and Quality, "Medical Expenditure Panel Survey Insurance Component." (Available on the Web at www.meps.ahrq/gov/mepsdata/icindex.htm.)

[8] According to U.S. Census Bureau estimates, median household income in New Jersey was $44,345 in 1995, compared with $34,437 in Pennsylvania, and a smaller percentage of New Jersey's population was below the poverty line.

[9] According to the 1990 U.S. Census, 24.9 percent of the New Jersey population had a college degree, compared with 17.9 percent of the Pennsylvania population. A higher percentage of New Jersey's population also had graduated from high school—76.7 percent vs. 74.7 percent.

[10] Jill A. Marsteller, et al., "Variations in the Uninsured: State and County Level Analysis" (Washington, DC: The Urban Institute, June 1998) p. 7.

D. EMPLOYER-SPONSORED COVERAGE AND COSTS

As noted earlier, about two-thirds of nonelderly Americans receive health insurance coverage through their employer. Employer-sponsored coverage has expanded in the last year or two, responding in part to a strong economy and tight labor markets. The Census Bureau reported in September 2000 the first year-over-year decline in the national uninsurance rate in 12 years in 1999, with an increase in employer-sponsored coverage accounting for most of the decline.[11]

A September 2000 Kaiser Family Foundation report on employer health benefits provides further evidence of the current strength of employer-sponsored coverage. It reports that the percentage of small employers (3 to 199 workers) offering health insurance coverage has increased from 54 percent to 67 percent in the last two years and that employee cost-sharing has actually declined, despite an 8.3 percent increase in monthly premiums for employer-sponsored insurance between 1999 and 2000 (well above the 4.8 percent increase between 1998 and 1999).[12] The report notes that the lack of an increase in employee cost sharing "is likely a reflection of the strong economy and tight labor market."

1. Employer-Sponsored Coverage in New Jersey

As described earlier, New Jersey has a strong system of employer-sponsored coverage. In its November 1999 meeting, the Task Force reviewed a new report by the Rutgers Center for State Health Policy on the characteristics of employer-sponsored health insurance in New Jersey.[13] That report used 1996 New Jersey-specific data from the Medical Expenditure Panel Survey Insurance Component, a national federally sponsored survey with extensive state-by-state detail. Since then, data for 1998 from the same survey have become available.[14] Mathematica Policy Research, Inc., analyzed that new data to provide in Table III.2 updated comparisons between New Jersey and the U.S. average for some key dimensions of employer-sponsored coverage. Similar comparisons using the same survey can be done between New Jersey and surrounding states such as New York, Pennsylvania, and Maryland.

Table III.2 also highlights changes between 1996 and 1998 for New Jersey and the United States as a whole, although only some of those changes are statistically significant, given the sample sizes involved and the resulting margin of error. An asterisk (*) marks changes that are statistically significant.

One significant change between 1996 and 1998 is a substantial increase in participation by eligible employees in New Jersey firms with fewer than 50 employees; employee participation rose from 78.7 percent in 1996 to 85.3 percent in 1998. This increase in participation may be due to smaller employers paying a larger share of the total premium cost for both single and

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[11] U.S. Census Bureau, "Health Insurance Coverage, 1999," (Current Population Reports, P60-211, September 2000).

[12] Kaiser Family Foundation and Health Research and Educational Trust, "Employer Health Benefits: 2000 Annual Survey," (September 2000).

[13] Rutgers Center for State Health Policy, "Employer-Sponsored Health Insurance in New Jersey: Firm Characteristics, Offer Rates, Workforce Enrollment, Premiums, and Employee Contributions," (Issue Brief, October 28, 1999).

[14] Agency for Healthcare Research and Quality, "Medical Expenditure Panel Survey Insurance Component," (available on the web at www.meps.ahrq/gov/mepsdata/icindex.htm).

family coverage in 1998 than they did in 1996. While small employers' total premium cost for both single and family coverage increased between 1996 and 1998, employers appear to have absorbed a substantial share of this premium increase, perhaps reflecting tight labor markets and competition for employees.

Table III. 2
Employer-Sponsored Health Insurance: New Jersey vs. United States, 1996 and 1998

	New Jersey 1996	New Jersey 1998	United States 1996	United States 1998
Distribution of employees by firm size				
Fewer than 50 employees	32.4%	31.6%	29.6%	32.2%*
50 or more employees	67.6%	68.4%	70.4%	67.8%*
Percentage of firms offering health Insurance, by firm size				
Fewer than 50 employees	46.7%	49.3%	42.1%	43.7%
50 or more employees	94.6%	95.9%	93.8%	96.3%*
Percentage of participation by Eligible employees, by firm size				
Fewer than 50 employees	78.7%	85.3%*	81.2%	81.5%
50 or more employees	92.1%	90.0%	86.5%	88.1%*
Average single coverage annual Premium, by firm size				
Fewer than 50 employees	$2,573	$2,802	$2,085	$2,235*
50 or more employees	$2,327	$2,441	$1,974	$2,152*
Percentage employee contribution for single coverage, by firm size				
Fewer than 50 employees	12.7%	11.1%	14.8%	13.8%
50 or more employees	11.2%	19.7%*	17.5%	19.1%*
Average family coverage annual Premium, by firm size				
Fewer than 50 employees	$6,089	$7,129*	$4,890	$5,442*
50 or more employees	$5,814	$6,155	$4,968	$5,622*
Percentage employee contribution for family coverage, by firm size				
Fewer than 50 employees	28.6%	25.0%	32.4%	28.5%*
50 or more employees	24.6%	24.1%	28.3%	24.0%*

* Indicates a statistically significant change from 1996.
SOURCE: Mathematica Policy Research, based on Rutgers Center for State Health Policy, "Employer-Sponsored Health Insurance in New Jersey," October 28, 1999 Issue Brief for 1996 data, and Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey Insurance Component, for 1998 data. Complete data for 1996-1998 are available on the Web at www.meps.ahrq.gov/mepsdata/icindex.htm.

E. INDIVIDUAL HEALTH INSURANCE COVERAGE AND COSTS

Approximately 4.0 percent of the nonelderly population nationally is insured through health insurance policies they purchase directly as individuals, rather than through their employer or through a public program such as Medicaid. In New Jersey, about 3.8 percent of the population has individual coverage.

New Jersey's Individual Health Coverage Program, which was summarized in the preceding section, provides individuals with access to standard plans that are community-rated (insurance carriers must offer these plans to everyone at the same rate, regardless of the applicants' age, gender, profession, health status, or geographic location in the state). Nonetheless, the premiums for individual coverage are substantially higher than those for employer-sponsored coverage, and the individual must pay the entire premium with no contribution from an employer. In the IHC program, for example, the annual premium for a standard $15 copay HMO plan is approximately $4,200 per year, compared with about $2,500 for the same coverage provided through an employer.

There are two main reasons why individual coverage is more expensive. First, marketing, claims processing, and other administrative costs are higher for insurance carriers when they must deal with individuals rather than with one employer on behalf of a large number of employees. Second, insurance carriers are more likely to experience "adverse selection" in the individual market. While individuals buying coverage on their own have a tendency to purchase insurance coverage only when they expect to have substantial health care costs, those who receive coverage through their employer are more likely to be covered whether they expect high health care costs or not, especially when the employer is paying a large share of the insurance premium. Those in the "risk pool" for individual insurance therefore tend to be less healthy and more costly than those in the pool for employer-sponsored insurance, so insurers charge more for the higher risk.

IV. FACTORS AFFECTING AFFORDABILITY AND ACCESSIBILITY OF HEALTH CARE AND OPTIONS FOR STATE ACTION

This section reviews some of the major issues the Task Force explored, including the relationship between insurance and health care access and utilization, the relationship between insurance availability and purchaser willingness to pay, and barriers to access for lower-income populations. The section also reviews selected health care cost drivers, including benefit mandates, pharmaceutical costs, hospital costs, technology, and demographics. It then reviews options for state policy interventions that the Task Force considered but did not recommend, including state tax incentives, employer purchasing pools, and bare-bones insurance policies.

This section responds to the Governor's charge that the Task Force assess the impact on the quality of health care and the cost of health insurance of current and proposed mandated benefits, and identify cost and access factors that can be controlled or addressed by state legislation or regulation.

A. INSURANCE COVERAGE, ACCESS, AND UTILIZATION OF HEALTH CARE SERVICES

There is extensive evidence, based on national surveys, that those who have health insurance have better access to health care than those who are uninsured, make better use of preventive services, and have better health outcomes.[15] The Urban Institute's 1997 "National Survey of America's Families" provides detailed information on the relationship between insurance coverage, access to care, and utilization of health services in New Jersey.[16] For example:

Children

- ***Usual source of care.*** A doctor's office was the usual source of care for 93 percent of privately insured children in 1997, while that was the usual source of care for only 64 percent of uninsured children.[17] Nearly 3 percent of uninsured children used hospital emergency rooms as their usual source of care, compared with only 0.3 percent for privately insured children.

- ***Unmet need.*** Nearly 7 percent of uninsured children had an unmet need for medical or surgical care during the year, compared with fewer than 2 percent for privately insured children.

- ***Dental visit.*** Seventy-four percent of insured children had a dental visit during the year, while only 53 percent of uninsured children had such a visit.

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[15] See, for example, Kaiser Commission on Medicaid and the Uninsured, "Uninsured in America: A Chart Book, Second Edition," (Washington, DC: Kaiser Family Foundation, May 2000) pp. 55-81.

[16] Jennifer M. Haley and Stephen Zuckerman, "Health Insurance, Access, and Use: New Jersey, Tabulations from the 1997 National Survey of America's Families" (Washington, DC: The Urban Institute, July 2000).

[17] Sixteen percent of uninsured children had no usual source of care, and 17 percent had a source other than a doctor's office or an emergency room.

Adults

- ***Usual source of care.*** Eighty percent of privately insured adults said a doctor's office was their usual source of care, compared with only 42 percent for uninsured adults.[18] Nearly 8 percent of uninsured adults said emergency rooms were their usual source, compared with only 1 percent for privately insured adults.

- ***Unmet need.*** Nearly 12 percent of uninsured adults said they had an unmet need for prescription drugs, while fewer than 4 percent of privately insured adults said they had such an unmet need.

- ***Breast exam for women.*** Nearly 63 percent of privately insured women had a breast exam during the year, compared with only 33 percent of uninsured women.

B. AFFORDABILITY AND WILLINGNESS TO PAY

In its deliberations, the Task Force frequently came back to the issues of health care and health insurance affordability. Some aspects of these issues can be measured with reasonable confidence. The price of health care and insurance can be measured relative to people's incomes. How much of income people can "afford" to pay for health care and insurance, however, requires more information about people's values, competing obligations, priorities, and psychology than is usually possible to obtain in a systematic and objective way. How important is health insurance to them, compared with other potential uses of their income? What are their attitudes toward risk?

Assessing the affordability and accessibility of health care therefore requires some exploration of people's willingness to pay, and how that varies for people in different circumstances. It also requires better knowledge of insurance options and prices than is usually available. The Task Force looked closely at that these issues in its February 18, 2000, session, focusing in particular on willingness to pay among those with higher incomes, who presumably have greater ability to pay.

The most common reason people give for not having insurance is that it is "too expensive" or they "can't afford it."[19] For many people with lower incomes, that may be a sufficient explanation. (Financial and other barriers to participation among lower-income populations are discussed further below.) But for those with higher incomes, the issue is more complex. Nearly 90 percent of the nonelderly population in New Jersey with incomes over 200 percent of poverty ($34,100 a year for a family of four) was insured in 1999, according to the CPS. Why did nearly 9 in 10 of those at these moderate and higher income levels have coverage, but not the others?

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[18] Thirty-two percent of uninsured adults had no usual source of care, and 18 percent had a source other than a doctor's office or an emergency room.

[19] In a national survey earlier this year of uninsured adults, 74 percent of respondents said that a "major reason" they did not have insurance was that "it is too expensive," and 47 percent said that was the most important reason. See *The NewsHour with Jim Lehrer/*Kaiser Family Foundation National Survey on the Uninsured 2000, summarized in Kaiser Commission on Medicaid and the Uninsured, "Uninsured in America: A Chart Book" (May 2000) p. 35.

1. California Survey of Higher-Income Uninsured

A 1998 survey of uninsured people in California with incomes above 200 percent of poverty provides some answers.[20] These people gave the following reasons for not buying health insurance:

• I can't afford it	75%
• I'm in good health	48%
• I'm waiting until my employer offers it	37%
• My health care costs less than insurance	33%
• I don't think I need it	25%
• I don't know enough about it	24%

Many of those surveyed perceived health insurance as being more expensive than it actually is. Thirty-four to 68 percent overestimated the costs of typical plans, and 27 to 56 percent said they are "willing to pay" more than the costs of typical plans.

In a further effort to get at the factors that affected the likelihood that these higher-income people would purchase health insurance, the survey study divided respondents into four categories, which the study described as follows:

- ***Prime prospects.*** (26 percent of respondents). They value health insurance, worry about risks, and are less healthy.

- ***Tough sells.*** (26 percent) They don't value insurance, don't worry about risks, are healthy, younger, and 73 percent male.

- ***Cost constrained.*** (16 percent) They value insurance and worry about risks, but have lower incomes.

- ***Unworried well.*** (31 percent) They don't value insurance and don't worry about risks, are very healthy, and 65 percent male.

The researchers who did the California survey concluded that for higher-income people, reducing the costs of insurance and publicizing lower costs and the risks of no insurance can increase coverage, but in the end there are some who just won't buy insurance.[21] Economists have estimated that in the individual insurance market a 10 percent reduction in the cost of insurance would lead 4 percent more people to participate (and vice versa).[22] (People may be

[20] California HealthCare Foundation, "To Buy or Not to Buy: A Profile of California's Non-Poor Uninsured," 1999. (Available on the web at www.chcf.org/uninsured/fieldsurvey.cfm).

[21] In a just-released survey, 30 percent of uninsured respondents said they were not interested in having health insurance. Seven percent of uninsured respondents said they were not willing to pay anything for health insurance, and fewer than one-third said they were willing to pay more than $100 per month. See Employee Benefit Research Institute 2000 Health Confidence Survey, released November 3, 2000. (Available on the Web at www.ebri.org/prrel/pr549.htm).

[22] See, for example, M. Susan Marquis and Stephen H. Long, "Worker demand for health insurance in the non-group market," *Journal of Health Economics* 14 (1995) pp. 47-63.

more responsive to price changes in the employer-sponsored market, however.[23]) There are obviously limits on the extent to which price reductions can be used to encourage coverage. Some studies have indicated that even when the cost of insurance is reduced to zero, significant portions of the population may remain uninsured.[24]

C. BARRIERS TO ACCESS FOR LOWER-INCOME POPULATIONS

For programs such as Medicaid, which provide health insurance at essentially no direct financial cost for eligible low-income families, researchers have identified various non-financial barriers to participation. A 1998-1999 Kaiser Family Foundation survey of low-income parents whose children were eligible for Medicaid but not enrolled uncovered a number of such problems:[25]

- ***Problems with the enrollment process.*** Sixty-seven percent of the parents had tried to enroll their children in Medicaid in the past, nearly half of them successfully.

- ***Lack of knowledge.*** Among the 31 percent who never tried to enroll their children, 58 percent did not think their child would quality, 56 percent did not know where to apply, and 50 percent found the rules and forms too complicated.

- ***Medicaid enrollment "hassle factor."*** The parents said Medicaid enrollment takes too long (52 percent), offices were not open when they could go (44 percent), and offices were too hard to get to (39 percent).

- ***Concerns about quality of care.*** Forty-six percent of the parents cited quality-of-care concerns.

- ***Medicaid "welfare stigma."*** Thirty-eight percent did not want to go to a welfare office to apply, and 37 percent said they did not want their child to be considered a Medicaid "recipient."

Nonetheless, almost all the low-income parents surveyed said having insurance coverage for their children was important, including 97 percent of parents with Medicaid-enrolled children, and 91 percent of parents with eligible but unenrolled children.

1. Impact of Insurance Subsidies on Participation Among Lower-Income Populations

The Task Force reviewed a 1997 Urban Institute study of the effects of premiums on participation in subsidized health insurance programs, based on programs in three states.[26] These

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[23] For details, see Deborah Chollet, "Assessing the Individual Health Insurance Market in the Post-HIPAA Era: A Review of the Literature," Draft prepared for the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, October 24, 2000, p. 12-13.

[24] See, for example, Kenneth E. Thorpe, "Changing the Tax Treatment of Health Insurance: Impacts on the Insured and Uninsured," in Dallas L. Salisbury, ed., *Severing the Link Between Health Insurance and Employment*, Washington, DC: Employee Benefit Research Institute, 1999, pp. 33-34.

[25] Michael Perry, et al., "Medicaid and Children, Overcoming Barriers to Enrollment: Findings from a National Survey," (Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, January 2000).

[26] Leighton Ku and Teresa A. Coughlin, "The Use of Sliding Scale Premiums in Subsidized Insurance Programs" (Washington, DC: The Urban Institute, March 1997).

programs were aimed primarily at populations with lower incomes, but not so low that they were eligible for Medicaid. According to that study:

- If premiums are 1 percent of income, 57 percent of the uninsured would participate.
- If premiums are 3 percent of income, 35 percent would participate.
- If premiums are 5 percent of income, only 18 percent would participate.

Another recent study supports the conclusion that financial subsidies for health insurance must cover a very high percentage of the total cost to induce lower-income people to purchase it.[27] For a single worker at 150 percent of the poverty level ($12,525 annual income in 2000), the study found that only about one-third would participate if half of the cost was subsidized. Nearly 80 percent of the cost would have to be subsidized to get participation rates up to 50 percent. Even if the insurance was free, only about 75 to 80 percent would participate.

D. SELECTED HEALTH CARE COST DRIVERS

The Task Force reviewed a number of factors that may be driving underlying health care service cost trends, and thus affecting affordability and accessibility of health care. The Task Force's review was necessarily selective, given the complexity of the issues and the limited time available. The Task Force also tried to take into account states' limited ability to influence underlying health care cost trends, and thus focused its review on areas where state action might be relevant or feasible. The Task Force reviewed the impact of benefit mandates in its April 25 meeting, pharmaceutical costs in its May 20 meeting, and technology and demographics in its June 9 meeting. Hospital costs were reviewed as part of the Task Force's review of the findings and recommendations of the 1999 Advisory Commission on Hospitals.

1. Benefit Mandates

New Jersey has more benefit mandates than the average state (16 benefit mandates vs. 14 in the average state), and fewer provider mandates (9 provider mandates vs. 14 in the average state).[28] Mandates can increase health insurance costs and reduce affordability and accessibility of health care, but as discussed below, reliable estimates of these impacts are difficult to obtain. It is especially difficult to determine what benefits would have been provided in the absence of a mandate, and thus what incremental costs can properly be attributed to the mandate itself. Many mandates are now a standard part of insurance benefit packages, including mammograms, minimum maternity stays, breast reconstruction, alcoholism and drug treatment, and mental health services. Insurance purchasers also tend to prefer relatively comprehensive coverage. Mandates may have led insurers to broaden coverage in some areas earlier than they otherwise might have, but many of these mandated benefits and services are now widely acknowledged to be beneficial and cost-effective and would likely be continued whether mandated or not.

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[27] Thorpe, "Changing the Tax Treatment of Health Insurance: Impacts on the Insured and Uninsured."

[28] Susan S. Laudicina and Katherine Pardo, "State Legislative Health Care and Insurance Issues: 1999 Survey of Plans," (Washington, DC: BlueCross Blue Shield Association, December 1999). Benefit mandates are requirements that specific benefits be covered in health insurance policies; provider mandates are requirements that the services of specific types of providers be covered.

a. Impact of Self-Insurance

It is important to note that firms that self-insure are not subject to state benefit mandates. On a national basis, 51 percent of employees worked in firms that self-insure in 2000, up from 48 percent in 1999.[29] In New Jersey, a smaller percentage of all firms self-insured in 1998 than in the United States as a whole (24.3 percent vs. 26.9 percent). The rate of self-insurance among smaller firms (fewer than 50 employees) was higher in New Jersey than in the United States (15.6 percent vs. 11.2 percent), but it was lower among larger firms (45.4 percent vs. 52.3 percent).[30]

Firms have many reasons to self-insure beyond a desire to avoid mandates, so it is difficult to make direct connections between employer decisions to self-insure and state mandates. In assessing the impact of mandates, however, it is important to keep in mind that they directly affect only about half of all employees and a quarter of all firms.

b. Estimates of Impact of Mandates on Insurance Prices and Coverage

Published research on the impact of benefit mandates on insurance prices and coverage has been quite limited, and some of it is a decade or more old. In a comprehensive 1999 review article, Jensen and Morrisey were able to find only one study that sought to measure the marginal or incremental cost of state mandates (the actual costs of the mandates minus the costs that would have occurred without them).[31] That study, which relied on 1989 data, estimated that all state-mandated benefits combined raised premium costs by 4 to 13 percent.[32] Jensen and Morrisey also cite a 1990 article of their own that estimated the marginal increase in plan premiums for selected benefits, including chemical dependency treatment (9 percent), psychologists' visits (12 percent), psychiatric hospital stays (13 percent) and routine dental services (15 percent).[33]

Another recent article sought to measure the impact of state mandates on health insurance coverage by trying to determine whether there was a relationship between the number of mandated benefits in a particular state and the rate of uninsurance in that state.[34] The authors did not distinguish among types of mandates; all mandates had the same weight in their analysis, irrespective of their potential individual cost. They estimated that the probability of an adult being insured fell by 0.004 percent for each mandate added, and that removing 11 mandates (the average number in their sample) would increase the proportion of adults covered by insurance by 4 percentage points. Since 18 percent of their sample was uninsured, they estimated that between one-fifth and one-quarter of the uninsured problem could be attributed to mandates.

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[29] Christopher Hogan, Paul B. Ginsburg, and Jon R. Gabel, "Tracking Health Care Costs: Inflation Returns," *Health Affairs,* Vol. 19, No. 6 (November/December 2000) p. 221.

[30] Agency for Healthcare Research and Quality, 1998 Medical Expenditure Panel Survey – Insurance Component, Table II.A.2.a (1998). (Available on the Web at www.meps.ahrq.gov/mepsdata/icindex.htm.)

[31] Gail A. Jensen and Michael A. Morrisey, "Employer-Sponsored Health Insurance and Mandated Benefit Laws," *The Milbank Quarterly*, Vol. 77, No. 4, (1999) pp. 425-459.

[32] Acs, G., C. Winterbottom, and S. Zedlewski. 1992. "Employers Payroll and Insurance Costs: Implications for Play or Pay Employer Mandates," In *Health Benefits and the Workforce*. (Washington, DC: U.S. Department of Labor.) Cited in Jensen and Morrisey, "Employer-Sponsored Health Insurance and Mandated Benefit Laws," 1999.

[33] Gail A. Jensen and Michael A. Morrissey, "Group Health Insurance: A Hedonic Price Approach," *Review of Economics and Statistics*, Vol. 72, No. 1 (1990) pp. 38-44.

[34] Frank A. Sloan and Christopher A. Conover, "Effects of State Reforms on Health Insurance Coverage of Adults," *Inquiry*, Vol. 35, No. 3 (Fall 1998) pp. 280-293.

c. Task Force Review of Proposed Family Building Act

The Task Force's review of the proposed Family Building Act, which would require insurers to cover the diagnosis and treatment of infertility for employers with more than 50 employees, illustrated the complexity, emotion, and uncertainty that can be involved in assessing the benefits and costs of proposed mandates. The Task Force held a full-day hearing on this issue on May 17, 2000 and reviewed extensive written submissions, but concluded that it lacked the expertise and resources needed to make a specific recommendation on this proposed legislation.

This experience with the Family Building Act, and the Task Force's review of experiences with mandate review processes in other states, led the Task Force to conclude that assessing the benefits and costs of existing and proposed benefit mandates in an objective manner requires a combination of professional, financial, clinical, and social expertise, internal staff and outside consultant analytic support, and public input that is beyond the capabilities of a temporary task force.

d. State Mandate Review Processes

The Task Force looked at established mandate review processes in Pennsylvania, Maryland, and Virginia that could serve as potential models for New Jersey. Based on this review, the Task Force concluded that a more systematic and objective way of evaluating the costs and benefits of current and proposed mandates in New Jersey is feasible and should be developed. The Task Force's recommendation for a mandate review process is discussed in more detail in the Executive Summary.

2. Pharmaceutical Costs

Although prescription drug spending is a small portion (9%) of health care spending, it is one of the fastest-growing components, increasing at double-digit rates in recent years. According to a new analysis by the Kaiser Family Foundation, three main factors are driving the increase in prescription drug spending:

- ***Increasing number of prescriptions*** (responsible for 43% of the overall increase in prescription spending from 1993-1998)

- ***Replacement of older less-expensive drugs by newer higher-priced drugs*** (responsible for 39% of the increase)

- ***Manufacturer price increases for existing drugs*** (responsible for 18% of the increase)[35]

This Kaiser analysis is generally consistent with the expert presentations the Task Force heard at its May 20 meeting. While the benefits of increasing use of prescription drugs and newer and more expensive drugs are harder to quantify than the costs, they are clearly substantial, and may lead to cost reductions in other areas, such as use of emergency rooms or inpatient

[35] Kaiser Family Foundation, "Prescription Drug Trends," Fact Sheet #3057 (September 2000, available on the Web at http://www.kff.org.)

hospitalization.[36] The Task Force was unable to identify specific policy interventions at the state level that would effectively constrain prescription drug cost increases, while maintaining the benefits of innovation and expanded use of more effective drugs.

3. Hospital Costs

Per capita expenditures for hospital services in New Jersey grew at a faster annual rate than in the rest of the country from 1990 to 1995: an average increase of 8.4 percent a year in New Jersey compared with 6.7 percent a year for the nation as a whole. That trend reversed in 1995, with per capita hospital expenditures in New Jersey increasing at an average annual rate of just 0.4 a year from 1995 to 1998, compared with a national average annual increase of 2.4 percent.[37]

This decline in expenditures on hospital services in New Jersey led to substantial financial pressures for New Jersey hospitals, many of which had relatively high costs that could not be fully covered by declining revenues in the late 1990s. According to a June 1999 analysis prepared by PricewaterhouseCoopers for the Advisory Commission on Hospitals, hospital costs in New Jersey were higher than national averages for much of the 1990s, due in large measure to high average lengths of stay for the over-65 population, high staffing levels, and excess bed capacity.[38] During the latter part of the 1990s, the delayed effects of the 1993 deregulation of New Jersey hospitals, increases in managed care, and reductions in Medicare reimbursement in the 1997 federal Balanced Budget Act combined to produce lower revenues for New Jersey hospitals that in many cases did not cover their costs.

Hospital care expenditures are expected to increase nationally by approximately 5.7 percent a year from 2000 to 2005, below the 6.6 percent annual increase projected for health care expenditures as a whole, but substantially above the 3.7 percent a year increase in hospital expenditures between 1995 and 2000.[39] If hospital expenditures in New Jersey follow this projected national trend, there will be growing pressure on payers to cover increasing hospital costs, and growing pressure on hospitals to reduce costs.

4. Technology

Technology can both increase and reduce health care costs. Costs increase if technology adds expensive treatment options, increases the intensity or length of treatment per patient, or expands the population that can be treated. Costs decline if technology substitutes less expensive treatments, develops more cost-effective treatments, or increases prevention. The net impact is often not clear. Economists have estimated that technology accounted for approximately 30 percent to 50 percent of health care cost increases in the 1980s and early 1990s.[40] Health care

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[36] For example, Dr. Robert Dubois of Protocare Sciences presented data from his studies at the May 20 Task Force meeting showing per-patient savings for asthma patients of $399 in emergency room and hospital treatment costs for every $224 spent on newer asthma drug therapies.

[37] Health Care Financing Administration, "1990-1998 State Health Care Expenditure Tables." (Available on the Web at www.hcfa.gov/stats/nhe-oact/stateestimates/Tables98/).

[38] The executive summary of the PricewaterhouseCoopers report ("Assessment of the Fiscal Condition of New Jersey's Acute Care Hospitals") is in Appendix C of the 1999 Final Report of the Advisory Commission on Hospitals.

[39] Health Care Financing Administration, "National Health Care Expenditure Projections, 1998-2008," (January 2000. Available on the Web at www.hcfa.gov/stats/NHE-Proj/).

[40] See, for example, J.P. Newhouse, "Medical Care Costs: How Much Welfare Loss?" *Journal of Economic Perspectives,* Vol. 6, No. 3 (1992) pp. 3-21.

technology responds to economic incentives, which in the past have rewarded primarily cost-increasing innovations. The cost containment incentives of managed care may push technology toward cost-lowering innovations in the future, as might increased employee/beneficiary responsibility for health care costs and choices. As in the case of prescription drugs, the Task Force was not able to identify state-level policy interventions in this area that would have predictably beneficial net impacts.

5. Demographics

Growth in the population age 65 and over after the year 2010 is the biggest demographic driver of future health care costs. This is primarily an issue for Medicare and Medicaid, but the population age 50 to 64 also has higher health care costs that can drive private health care expenditures. The population under age 1 also has higher-than-average health care costs, as do women of child-bearing age. The population age 21-24 and Hispanics have rates of uninsurance that are well above average. These groups generally represent about the same proportion of New Jersey's population as they do for the nation as a whole, both currently and in Census Bureau projections through the year 2020. The only exception is Hispanics, who currently account for approximately 12.8 percent of New Jersey's population, compared with a national average of 11.4 percent. By 2020, the Census Bureau projects that Hispanics will account for 18.2 percent of New Jersey's population, compared with a national average of 16.3 percent.[41] The Task Force touched briefly on some aspects of health care for the Hispanic population in New Jersey, such as health care services for illegal or undocumented immigrants, but generally left that as a "legacy" issue for the future.

6. Other Cost Drivers

The Task Force recognizes that there are other potential cost drivers in the health care system that it was not able to examine in detail, including provider over-capacity, inappropriate utilization of post-acute services, inappropriate practice patterns, administrative duplication and inefficiency, medical errors, and litigation. These and other issues could be examined more thoroughly in the future.

E. POTENTIAL STATE POLICY INTERVENTIONS

In response to the Governor's charge to "identify cost and access factors that can be controlled or addressed by State legislation or regulation," the Task Force reviewed in its March 10 and April 25 meetings several policy interventions that other states have tried, including state tax incentives, employer purchasing pools, and bare-bones insurance policies. Based on its review, the Task Force decided not to recommend additional efforts by New Jersey in these areas, since experience in other states and some special features of the New Jersey context make it likely that the impacts on affordability and accessibility of health care would be relatively limited.

1. State Tax Incentives

State tax incentives can be aimed at either individuals or businesses. Different considerations apply to each approach.

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[41] Mathematica Policy Research calculations based on U.S. Census Bureau data, presented to the Task Force in its June 9, 2000 meeting.

a. Individuals

New Jersey currently allows medical expenses that exceed 2 percent of income to be deducted on state income tax returns (compared with the federal requirement that expenses exceed 7.5 percent of income to be deductible on federal returns), and allows contributions to Medical Savings Accounts to be deducted on state income tax returns in the same way they are on federal returns. Because New Jersey income tax rates are relatively low and tax-free thresholds are quite high, it is difficult to use the New Jersey tax system to provide incentives that are large enough to have an impact on taxpayer behavior. Marginal tax rates in New Jersey range from 1.4 percent to 6.37 percent, so a $100 deduction would save taxpayers only $1.40 to $6.37 in taxes. In addition, beginning in 2001, New Jersey taxpayers will pay no taxes on their first $20,000 in income (the threshold is $15,000 in 2000), so taxpayers with low and moderate incomes cannot be reached by tax incentives unless they take the form of "refundable" credits, which are paid to taxpayers whether or not they have a tax liability. Refundable credits can present significant administrative problems, as can any tax incentives that have "strings" that make them available only to taxpayers who behave in specified ways. The Task Force concluded that all of these factors combined limit the utility of tax incentives for individuals in the New Jersey context.

b. Businesses

Tax incentives for business present somewhat different issues. Significant tax incentives for health insurance already exist in the federal income tax system and most state income tax systems, because the amounts employers pay for employee health insurance are deductible as a business expense, and employees may also exclude these amounts from their taxable income. However, a new national survey of small employers indicates that 57 percent of them did not know that they can deduct 100 percent of their health insurance premiums, and 48 percent believed (incorrectly) that employees can deduct 100 percent of their premiums if they purchase insurance on their own rather than through their employer.[42] Small employers in New Jersey may be somewhat more knowledgeable about these issues. If not, the Small Employer Health Benefits Program Board may want to consider an educational effort to make certain that small employers are aware of these existing tax incentives for health insurance.[43]

Massachusetts has a program called the "Insurance Partnership" under which the state makes grants to small businesses (50 or fewer full-time employees) of up to $1,000 per year toward health insurance costs for each qualified (low-income) employee.[44] While these grants are direct payments from the state rather than tax credits, such a program could be run through the state tax system. If a small employer's taxes were not as large as the amount of the tax credit for which the employer was eligible, the tax credit could be made "refundable," that is, payable even if the credit exceeded the amount of the employer's tax liability.

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[42] Paul Fronstin and Ruth Helman, "Small Employers and Health Benefits: Findings from the 2000 Small Employer Health Benefits Survey," (Washington, DC: Employee Benefit Research Institute, October, 2000) EBRI Issue Brief No. 226.

[43] The EBRI survey indicates that small employers nationally have a more accurate understanding of direct health insurance costs than they do of health insurance tax benefits. Nonetheless, approximately a third of small employers not offering insurance over-estimated the cost of employee-only coverage to some extent, and another 29 percent said they didn't know the cost. Fronstin and Helman, p. 16.

[44] For details, see Daniel B. Moskowitz, "Massachusetts Enlists Small Business To Slice Number of Uninsured in State," *Medicine & Health*, (April 12, 1999). Additional information on the Insurance Partnership is available on the Web at www.state.ma.us/dma/businesses/ipIDX.htm.

4. Employer Purchasing Pools

The Task Force reviewed experiences with small employer purchasing pools in Florida, California, Colorado, Texas, North Carolina, and Cleveland, Ohio, as described and analyzed in a new report by the Economic and Social Research Institute (ESRI).[45] The Florida and Texas programs have recently ended, and only one or two of the programs have captured more than 5 percent of the small group market. According to the ESRI report, the programs have had little or no impact on price, markets, or the number of uninsured workers. Their basic problem has been a lack of "critical mass," which is hard to achieve as long as participation is voluntary. The biggest selling point for purchasing pools has been their ability to provide employees of small businesses with a choice of plans. In New Jersey, the Small Employer Health Benefit Program already provides this choice. Small employer purchasing pools have also encountered opposition from insurance agents, who see pools as a threat to their role.

The one successful small employer purchasing cooperative ESRI examined was The Council of Smaller Enterprises (COSE) in Cleveland. It is a private organization that was founded and is operated without any special legislative authorization or public funding. It thus has had greater flexibility than the other small employer purchasing cooperatives ESRI reviewed. COSE is not a self-insured organization like the Health Care Payers Coalition of New Jersey, which the Task Force looked at in its October 20 meeting, so it does not have the degree of freedom from state regulation that self-insurance brings. It deals primarily with a single large insurance company, which may provide some of the same administrative and other efficiencies as a large group plan.

The ESRI study also does not look at employer purchasing groups made up primarily of large employers, such as the Buyers Health Care Action Group in Minneapolis, Minnesota, so its conclusions about the general lack of effectiveness of small-employer purchasing cooperatives cannot be extended to large-employer purchasing groups.[46]

5. Bare-Bones Insurance Policies

Bare-bones insurance policies were permitted in 43 states as of 1995, including New Jersey. Such plans can be used to avoid mandates, and thus potentially can reduce insurance costs. They are generally not popular with employers or employees, however. New Jersey has a bare-bones option (Plan A) in its Small Employer Health Benefit program, but it has never accounted for more than 0.03 percent of SEH employers. There was also a bare-bones Plan A option in the New Jersey Individual Health Coverage Program, but it never accounted for more than 4.2 percent of sales and was ended in 1997.

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[45] Elliot K. Wicks, et al., "Barriers to Small-Group Purchasing Cooperatives" (Washington, DC: Economic and Social Research Institute) March 2000.

[46] For background on the Buyers Health Care Action Group, see Brian O'Reilly, "Taking on the HMOs," *Fortune*, Vol. 137, No. 3, pp. 96 *et seq*. (February 16, 1998).

APPENDIX A

Final Report

of the

Advisory Commission on Hospitals

1999

EXECUTIVE SUMMARY

And

Whitman Administration Steps

to Implement Advisory Commission Recommendations

Letter from

Health & Senior Services Commissioner Christine Grant

August 11, 2000

REPORT OF THE ADVISORY COMMISSION ON HOSPITALS

EXECUTIVE SUMMARY

On any given day, one out of every three staffed acute care hospital beds in New Jersey is empty. The health care system's success in creating alternative preventive and ambulatory care services is a major reason for empty beds. If current trends continue through 2002, that figure could rise to one out of every two beds. The cost of this excess capacity, which could be as much as $1 billion annually, puts New Jersey hospitals at a staggering competitive disadvantage in today's healthcare marketplace. High length of stay and staffing levels, among other factors, have contributed to the inability of New Jersey hospitals to cover costs with available revenues.

In addition to having eliminated the need for many acute care beds as well as changing hospital missions, a number of external factors are also reducing revenues available to New Jersey hospitals for remaining capacity. Reductions in Medicare reimbursement, some already in effect, others yet to be implemented, will reduce annual revenues by an estimated $515 million by 2002 to this $10.5 billion industry. Managed care, which is an increasingly popular insurance option for New Jersey employers, is also exerting downward pressure on revenues by seeking to eliminate unnecessary hospital days and services through utilization review. The insolvencies of two managed care organizations further reduced revenues to hospitals during 1998. The state's Medicaid program has turned to managed care as well, in an attempt to provide quality care at reasonable prices.

Further exacerbating the situation is the increasing number of New Jersey residents without health care insurance. As a result, the amount of charity care provided by New Jersey hospitals and physicians has also increased. Although state subsidies have helped offset these rising costs, the growth of care for the indigent has put more financial pressure on the state's hospitals.

The cumulative effect of these trends is a hospital industry with rapidly deteriorating financial performance. By 1998, the median profit margin in the state fell to .55% and 42 out of 84 hospitals had negative profit margins. Other financial indicators, notably cash reserves, had declined as well.

After studying the issues since April 1999, the Advisory Commission on Hospitals has concluded that significant structural changes to the hospital industry in New Jersey are necessary to put the state's hospitals on a sound financial footing. The recommended changes are organized into three areas:

- assistance to hospitals and communities in the transition of hospitals to more efficient organizations providing services in the appropriate physical setting;
- modifications to the state's financial, regulatory, and leadership responsibilities to ensure access to and the quality of health care services in the state; and

- actions to ensure a climate of fair business practices between payers and hospitals.

Those responsible for implementing these changes will include hospital management, boards of trustee, physicians and other health care professionals, the state, payers, managed care companies and the general public.

Assistance to hospitals and communities to appropriately configure the state's health care system should include:

- creation of a Hospital Asset Transformation Program to assist facilities that that are no longer needed nor financially viable as acute care hospitals in transitioning to other uses that the market can support;
- creation of a Hospital Transition Group within the Department of Health and Senior Services (DHSS) that will coordinate state actions to facilitate hospital changes;
- establishment by the DHSS of a quarterly financial monitoring system to identify fiscal problems before they become unmanageable;
- creation of a Post-acute Care Study Group to assess how availability of services and financial incentives hinder efforts to reduce acute care length of stay; and
- education of boards of trustees, health care professionals, and the public of the changing realities of the health care marketplace.

The state's financial, regulatory, and leadership practices should include:

- establishment of a supplemental charity care fund to ensure that all hospitals receive some funding for charity care services provided in excess of a minimum standard;
- more flexible charity care documentation requirements to ensure that eligible patients are appropriately identified;
- establishment of affordable health insurance programs that will reduce the burden of charity care;
- consideration of changes to Medicaid reimbursement, including rebasing to a more current year, establishing a new peer group to recognize facilities serving a disproportionate share of low-income patients, and implementing a periodic interim payment system for Medicaid managed care plans;
- uniting with industry groups to: advocate for changes to Medicare reimbursement cuts where they are excessive (the Balanced Budget Act); maximize revenues to New Jersey hospitals from the federal government (e.g., disproportionate share payments); and align payment incentives between physicians and hospitals;
- adoption of measures to reduce the likelihood of insolvencies by managed care companies and adoption of a plan to pay hospitals money due to them as a result of insolvencies by managed care organizations in 1998; and

- attaining favorable rulings from the Health Care Financing Administration (the federal agency that administers Medicare) regarding the close to $400 million in disproportionate share payments for which New Jersey hospitals may be eligible.

Actions to ensure a climate of fair business practices between hospitals and payers should include:

- completing a study of claims processing and billing processes to accurately assess where problems exist;
- enforcement of existing prompt payment regulations; and
- strengthening of regulations where needed.

(Sent to the Chief Executive Officer of each acute care hospital in New Jersey.)

August 11, 2000

Dear :

On March 17, 2000, I wrote to you to describe the various elements of Governor Whitman's policy and budget initiatives designed to support New Jersey hospitals. These initiatives closely followed the recommendations of the Hospital Advisory Commission in November 1999. I am pleased to report that with Governor Whitman's support these initiatives are in the process of being implemented.

- The FY 2001 budget has created a supplemental charity care fund that guarantees New Jersey acute care hospitals a minimum subsidy of $.30 for every dollar of charity care provided (calculated at the Medicaid rate). The budget requires that this subsidy be based on CY 1999 charity care claims and CY 1998 hospital revenues. However, recently adopted amendments to charity care rules (see below) extend the period for submission of certain CY 1999 charity care claims.

  To prevent undue delay in delivering supplemental charity care payments to hospitals, I have authorized monthly interim payments, based on CY 1998 charity care claims, beginning in August. Attached please find a statement indicating the annualized amount of both supplemental charity care and regular charity care interim subsidies for your hospital. For FY 2001 supplemental subsidies will total approximately $36 million dollars.

  At such time as all CY 1999 charity care claims are audited and final FY 2001 supplemental charity care subsidies are calculated, payment amounts will be adjusted to account for differences between the interim and final payments.

- On July 13th Governor Whitman signed the FamilyCare bill into law. FamilyCare will not only make comprehensive, affordable health insurance available to low income uninsured adults in New Jersey; it can also reduce the financial burden of charity care on your hospital if you actively work to enroll eligible people.

  A distinctive feature of FamilyCare is presumptive eligibility. During the first two years of the program's start-up, hospitals providing care to eligible adults will receive reimbursement during a one-time presumptive eligibility period for services, at the Medicaid fee-for-service rate, prior to an individual's completed enrollment with a FamilyCare insurer. The Department of Human Services is administering FamilyCare and will advise hospitals shortly of the process for submitting presumptive eligibility claims.

  - Family Care creates not only an opportunity for hospitals to receive additional revenue, but also a corresponding responsibility to aggressively support enrollment of eligible patients in the program to reduce the number of uninsured New Jerseyans. I look to you to ensure that your hospital management and staff rapidly enroll eligible uninsured New Jerseyans into FamilyCare.

- On July 17th the state adopted revised rules on charity care documentation to increase flexibility for patients admitted through emergency departments. To ensure that hospitals can benefit from this enhanced flexibility as soon as possible, the rules also provided a thirty-day period, ending August 16th, during which hospitals may submit newly eligible CY 1999 charity care claims to the Department.

  Details on this rule change were sent to you on July 7th and July 24th. I urge you to take advantage of this opportunity and submit your additional claims by the August deadline.

- The FY 2001 budget set aside $8 million for creation of the Hospital Asset Transformation Program, which will allow the State to offer a possible source of assistance for hospitals that transition from acute care services to other services.

- Last May the Department of Human Services announced a policy for HMOs contracting with Medicaid, NJ KidCare, and now FamilyCare to make periodic interim payments (PIP) to qualifying hospitals. These payments are intended to ease cash flow problems for hospitals with a significant proportion of patients enrolled in these programs.

- Last April Governor Whitman signed into law a bill creating a $100 million fund to help reimburse health care facilities and professionals for claims left unpaid as a result of the insolvencies of two of our State's HMOs, HIP Health Plan of New Jersey and American Preferred Provider Plan. Under this law, the State and remaining HMOs are to share the cost of this fund.

- As a result of cooperative efforts by the Whitman Administration, New Jersey's Congressional delegation, and hospitals, the Health Care Financing Administration agreed to include charity care days, on a retrospective basis, and Medicaid-eligible days both prospectively and retrospectively, when Medicare DSH-eligible days are totaled. The State worked closely with the hospital industry to identify and document eligible DSH days from previous years, and we are pleased that Medicare interim payments covering 85% of anticipated settlements have already been made to hospitals.

Governor Whitman has not only fulfilled her commitment to address the problems and concerns of New Jersey's hospitals, but has also done so in record time. My colleagues and I look forward to continuing to work with you to implement these important measures.

Sincerely,

Christine Grant
Commissioner

c. The Honorable Christine Todd Whitman
Governor

The Honorable Michele Guhl
Commissioner, Human Services