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Coverage Initiatives and Programs for New Jersey's Uninsured: Survival in the Time of Budget Deficits and Cutbacks

Background Information for . . .

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***ISSUE:** How will New Jersey policymakers maintain the integrity of their well-recognized coverage initiatives and health programs for the uninsured as they address the reality of significant budget shortfalls and the reduction or freezing of federal funds?*

Health policy analysts and health services researchers are keenly aware of the complex economic and social factors facing state-level policymakers: increasing numbers of uninsured, an overall economic downturn, escalating health care costs across all sectors and staggering budget shortfalls. We are pleased to include as background information, recent reports from leading health policy research organizations: the Urban Institute; the Center for State Health Policy at Rutgers University; the Commonwealth Fund, and the Kaiser Commission on Medicaid and the Uninsured. The updates were specifically commissioned to analyze the status of public sector programs for the uninsured, as well as other health care initiatives, in New Jersey and other states.[1]

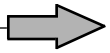
In 1966, American political scientist Morton Grodzins first introduced the metaphor that American federalism is *not* like a layer cake – it is a marble cake, in which policies, programs and authority all "swirl together," constantly mixing different layers of government. James Morone, in his 2001 essay in The New Politics of State Health Policy, points out that this metaphor holds true in any discussion of state health policy in the 21st century (Hackey and Rochefort, 2001), especially in this time of "post-modern" New Federalism and as the ever-more demanding roles of state policymakers as program administrators and designers evolve. During the 1990s, devolution increased states' authority and created a topography of federal, state and local coverage initiatives and programs for the uninsured and underinsured that is quite rugged, varies greatly among states and is not plotted out in a linear fashion.

General Overview – Public Programs for Health Care Access and Coverage

In 2001, findings and recommendations were released by then Governor Christine Whitman's Task Force on Affordability and Accessibility of Health Care in New Jersey. Recommendations from the task force called for strengthening and expanding the state's innovative programs including the Pharmaceutical Assistance to the Aged and Disabled Program (PAAD), NJ FamilyCare and the Federally Qualified Health Centers Expansion Program (FQHCs). The New Jersey's State Children's Health Insurance Program (CHIP) — including the NJ KidCare program (1998) and the NJ FamilyCare Program (2001)[2] — stands out among other such programs in the country as having one of the most generous eligibility criteria (ibid.).[3] An additional recommendation focused on health benefit mandates: the Task Force noted that New Jersey should establish a more systematic process for reviewing proposed and existing health benefit mandates, pointing to review processes in Maryland, Pennsylvania and Virginia as models.

The New Jersey programs highlighted in the Task Force Report are listed in the table in Appendix I, which summarizes current enrollment numbers for:

- Medicaid;
- KidCare and FamilyCare;
- the Small Employer Health Program (SEH);
- the Individual Health Coverage Program (IHC);
- Charity Care (hospital costs);
- Pharmaceutical Assistance to the Aged and Disabled (PAAD);
- Catastrophic Illness in Children Relief Fund; and
- Federally Qualified Health Centers & Community Health Centers (FQHCs and CHCs).



At present, each of these programs is exposed to a specific level of vulnerability. For example, in his update on the status of New Jersey's health programs, Bovbjerg reports that as a result of the state's budget shortfalls, significant health coverage changes were concentrated in NJ FamilyCare, the state's expanded managed care program for more than 219,000 children, parents and uninsured adults, which is funded by Medicaid, SCHIP and state-only monies (2003).[4 5] For FY 2003, the state refocused on its original KidCare goal of covering children, and in May 2002, Human Services Commissioner Gwendolyn L. Harris announced suspension of applications from parents for the FamilyCare program. At the same time, General Assistance medical beneficiaries were removed from the program's comprehensive managed care plans and returned to a fee-for-service program with more limited benefits.

Fox and Cantor (2002) identified key features in New Jersey's strategies to provide coverage and access for its uninsured, which include:

- Individual and small-group market reforms to address issues of health insurance affordability and access in the private sector (1992);
- Private market regulatory reforms to encourage price competition among carriers;
- Expansion of state-subsidized coverage for low-income persons during the latter half of the 1990s;
- Flexibility in the administration and design of public programs to expand eligibility and coverage; and,
- Analysis of the relationship between public programs and private coverage with the goals of "maximizing" private coverage through efforts such as employer buy-in programs and minimizing crowd-out.

New Jersey State Profile and Overview, 1999-2000

New Jersey	
Total Population	8,186,500
Non-elderly Population	7,117,310
Total population under 200% FPL[6]	2,218,490
Insurance Status of Non-Elderly	
Employer	5,295,890
Individual	267,430
Medicaid	562,480
Uninsured	991,520
Insurance Status of Non-Elderly under 200% FPL	
Employer	639,874
Medicaid	106,958
Uninsured	586,190
Percent of Uninsured (under 200% FPL)	59%
Distribution of Total Population by FPL	
Under 100% FPL	996,210
100-199% FPL	1,222,280
200% +	5,968,010
Low-Income (under 200% FPL)	**2,218,490**
Percent of Total Population under 200% FPL	**27%**
Percent of Total Population under 100% FPL	**12%**

Sources: Kaiser Commission on Medicaid and the Uninsured (based on pooled March 2000 and 2001 Current Population Surveys) (www.statehealthfacts.kff.org); "Assessing State Strategies for Health Coverage Expansion: Case Studies of Oregon, Rhode Island, New Jersey and Georgia." Fox and Cantor at 51 (The Commonwealth Fund, 2002).

According to the Employee Benefit Research Institute's (EBRI) data based on the March 2002 Supplement to the Current Population Survey, New Jersey's non-elderly Medicaid beneficiaries stand at over 600,000; January 2002 interviews with New Jersey Medicaid staff indicate current program enrollment stands at 697,768. Regarding current data on the state's non-elderly uninsured, Fronstin reports an increase to 1.1 million, or 15.2 percent of the population. (EBRI, Issue Brief, December 2002).

State Budget Deficits

> "It's pretty hard to be a visionary when you're broke." – Dick Bond, former president of the Kansas Senate

The Center on Budget and Policy Priorities recently reported that states are facing the largest budget deficits in 50 years. Although collectively states across the country have taken action to close $50 billion in budget deficits in state fiscal year 2003, deficits of at least $17.5 billion have reemerged for the current fiscal year as state fiscal crises have deepened, and burgeoning deficits of $60 billion to $85 billion are now projected for fiscal year 2004, which starts July 1 in most states.[7] Because of these large budget shortfalls — which equal 13 percent to 18 percent of state expenditures — a number of states have adopted major reductions in their Medicaid programs or are considering new budget proposals from their governors that include deep Medicaid cuts. On average, Medicaid comprises about 15 percent of state general fund spending, and it is the second largest program in most states' budgets after elementary and secondary education (Kaiser Commission on Medicaid and the Uninsured, Fiscal Year 2003 50-State Update, January 2003). In Fiscal Year 2002, state Medicaid expenditures increased nationally by 13.3 percent.

Donald Boyd, director of fiscal studies at the Nelson A. Rockefeller Institute of Government, summarized that at least 26 states cut spending plans for 2003, especially in higher education, corrections and "even Medicaid" in order to close budget gaps (2003). He observes that: "As the 1990s came to a close, many of the extraordinary factors that caused the fiscal boom ended or began to reverse." Several macro-level factors converged to create the crisis, including dramatic declines in state tax revenues and rapid increases in Medicaid spending, related to the cost of prescription drugs, enrollment increases, increased costs of long-term care and provider payment increases (ibid.). Bovbjerg (2003) points out that the slowing economy had a significant impact on state revenues, especially in states such as New Jersey, California and Colorado, which are heavily dependent on income taxes because of the profound decline in capital gains. In FY 2003, New Jersey was one state that increased taxes on businesses and increased cigarette taxes by 70 cents per pack.

In his essay entitled "The Bursting State Fiscal Bubble and State Medicaid Budgets," Boyd points out that at least 45 states implemented Medicaid cost containment measures in FY 2002; and 41 states planned further cost containment actions for FY 2003 (id). Cost containment plans include reducing and/or freezing provider payment rates; prescription drug price controls; reducing Medicaid benefits; reducing and/or restricting Medicaid eligibility; and increasing beneficiary co-payments.

New Jersey's projected budget deficits for SFY 2002 and 2003 have been among the nation's largest (Bovbjerg, 2002). During the first weeks of 2003, Governor Jim McGreevey, in stating that "the economic situation has simply deteriorated far worse and for far longer than anyone could have anticipated," announced that the state is facing a growing debt of $1.3 billion for the current fiscal year, in addition to an estimated $5 billion shortfall for the state's next fiscal year (Hester and Donohue, 2003). The governor will announce his budget in February 2003, and severe cuts are expected across state government.[8] The Governor also announced that New Jersey has not been approved for close to $350 million in federal Medicaid aid that it was anticipating, nor has it received an expected $149 million in anticipated federal aid for its prescription drug program for the elderly (ibid.). Although New Jersey's Medicaid program has "weathered" severe cutbacks threats in the past year, given the anticipated FY

2004 budget pressures, cutbacks in Medicaid eligibility, benefits and provider rates may be imminent. New Jersey's Division of Medical Assistance and Health Services, which administers the Medicaid program and state and federally-funded health insurance programs for specific groups of low and moderate-income people, reported a FY 2003 operating budget of $4.6 billion (http://www.state.nj.us/humanservices/dmahs).

Consequences of Being Uninsured

There are multi-tiered health, social, mental health and economic consequences to being uninsured and underinsured. In May 2002, the Institute of Medicine (IOM) released *Care Without Coverage: Too Little, Too Late*, a report in which it selected and evaluated the 130 best-designed research studies investigating the health of working-age adults with and without health insurance. The IOM committee consistently found that:

- Lack of health insurance "exacts a serious toll on people's health;"
- Those who do have health insurance tend to have better health and to receive better, more timely care across a range of preventive, chronic, and acute care services than those who do not have health insurance;
- Uninsured adults experience greater declines in health status and die sooner than do those with continuous health care coverage;
- Racial and ethnic minorities and lower-income adults would particularly benefit from increased health insurance coverage because they more often lack stable health insurance coverage and experience disparities in health status.[9]

One major national initiative has brought together a diverse group of national organizations whose goal is to raise awareness of the pervasive and persistent problems related to being uninsured in America. *Covering the Uninsured* is a partnership of 15 major national organizations and two health foundations: The Robert Wood Johnson Foundation and The California Endowment. In 2003, *Covering the Uninsured Week* is set for March 10 to 16 to raise awareness regarding the uninsured on national, state and local levels.[10] [11]

The Kaiser Commission on Medicaid and the Uninsured report – *Sicker and Poorer: The Consequences of Being Uninsured* – concurred with the IOM's research and challenged health services researchers to estimate the size of the economic benefits of continuous health coverage (2002). The report raised overall policy implications affecting individuals as well as the larger systems and communities in which they worked and lived: *"How much could be saved by increasing the efficiency of medical care, so that fewer are delaying care until it becomes more costly to treat? How much would labor force participation increase if coverage were expanded to more Americans? How much would incomes and tax revenues increase? What might be the effects on federal and state disability payments? What are the implications for both Medicare and Medicaid spending of having a healthier population?" (Hadley, 2002)*[12]

Concluding Remarks

Debates about appropriate strategies for coverage and access for the uninsured are long-standing and seemingly intractable, made all the more difficult by the fiscal constraints related to current budget deficits at all levels of government. Health policy analysts stress there is no "silver bullet" or remedy at hand. From the individuals running local non-profit community initiatives focused on providing access to health care, by coordinating donated services, to the halls of Congress where Senator John Breaux (D-La.) states that: "I've come to the conclusion health care is so broken, we need bold ideas about what we should be doing," and Senator Majority Leader Bill Frist (R-Tenn.) underscores, "We need to focus on the uninsured," there is a heightened state of awareness regarding the severity of the issue (Welch, 2003). Efforts to reach consensus and to bridge ideological and partisan differences continue to be a work in progress for all policymakers, in both the public and private sectors.

ENDNOTES

[1] Reference is made to: "Assessing State Strategies for Health Coverage Expansion: Case Studies of Oregon, Rhode Island, New Jersey and Georgia." Prepared by S. Silow-Carroll, E. K. Waldman, J. A. Meyer and C. Williams of the Economic and Social Research Institute and K. Fox and J. C. Cantor of the Center for State Health Policy at Rutgers University for The Commonwealth Fund, November 2002. (www.cmwf.org) and "The State Fiscal Crisis and Medicaid: Will Health Programs be Major Budget Targets?" Prepared by J. Holohan, J. M. Wiener, R. R. Bovbjerg, B. A. Ormand and S. Zuckerman of The Urban Institute for The Kaiser Commission on Medicaid and the Uninsured, January 2003 (www.kff.org).

[2] See the Rutgers Center for State Health Policy October 2002 *Issue Brief* "Health Insurance Coverage in New Jersey: Recent Trends and Policy Challenges," for a "time-line" of major developments in New Jersey's public coverage programs since 1997.

[3] New Jersey was one of the first states to apply for a Section 1115 waiver under CHIP (effective January 18, 2001) in order to initiate its NJ FamilyCare program, financed with a combination of federal funds under Section 1115, tobacco settlement funds and expected employer funds from the premium support program (Fox and Cantor (2002) at 64).

[4] Launched in 1998 as NJ KidCare, the NJ FamilyCare program currently provides health insurance for 219,569 New Jersey residents, including children, parents, childless adults and about 26,000 childless adults who receive Work First NJ/General Assistance (GA). The program began enrolling adults in the fall of 2000.

[5] In 2002, the Federal Poverty Level for a family of four was $18,100.

[6] For a family of four, 200% of FPL is $36,200; for an individual, it is an annual income of $17,720.

[7] Ku, Leighton, M. Nathanson, E. Park, L. Cox and M. Broaddus (2003). "Proposed State Medicaid Costs Would Jeopardize Health Insurance Coverage for 1 Million People." Center on Budget and Policy Priorities. January 6, 2003. http://www.cbpp.org/12-23-02health.html.

[8] See R. Bovbjerg's analysis of New Jersey's budget problems and overall response vis-à-vis health programs in "The State Fiscal Crisis and Medicaid: Will Health Programs be Major Budget Targets?" Prepared by J. Holohan, J. M. Wiener, R. R. Bovbjerg, B. A. Ormand and S. Zuckerman of The Urban Institute for The Kaiser Commission on Medicaid and the Uninsured, January 2003.

[9] Institute of Medicine (2002). Care Without Coverage: Too Little, Too Late; See also, http://coveringtheuninsured.org/factsheets/

[10] The organizations include: the U.S. Chamber of Commerce, AFL-CIO, The Business Roundtable, Service Employees International Union, Healthcare Leadership Council, American Medical Association, American Nurses Association, Health Insurance Association of America, Families USA, Blue Cross and Blue Shield Association, American Hospital Association, Federation of American Hospitals, Catholic Health Association of the United States, AARP and United Way of America.

[11] For background information, reference is made to http://coveringtheuninsured.org/legislation/, where charts may be found which provide side-by-side comparisons of legislation being proposed by members of the United States Congress and the administration of President George W. Bush to extend health care coverage to more Americans. Newly introduced bills include: proposals to expand the availability of health insurance coverage; proposals to increase health insurance coverage though Medicaid, S-CHIP, Medicare and other new public programs; tax credit approaches and tax incentive approaches for employers.

[12] Hadley, Jack. "Sicker and Poorer: The Consequences of Being Uninsured." Prepared for the Kaiser Commission on Medicaid and the Uninsured. May 2002.

REFERENCES

Bovbjerg, R. R. and F. C. Ullman. Recent Changes in Health Policy for Low-Income People in New Jersey. (Urban Institute. Assessing the New Federalism. State Update No. 21. March 2002). http//www.urban.org/UploadedPDF/310445.pdf.

Boyd, Donald J. "The Bursting State Fiscal Bubble and State Medicaid Budgets." *Health Affairs*. January/Februrary 2003.

Fronstin, P. *Sources of Health Insurance and Characteristics of the Uninsured. Analysis of the March 2002 Current Population Survey*. Employee Benefit Research Institute. *Issue Brief Number 252*. December 2002.

Greenblatt, A. "The Gubernatorial Baby Boom." *Governing. The Magazine of States and Localities.* January 2003.

Hackey, Robert B. and D. A. Rochefort. The New Politics of State Health Policy. 2001.

Hester, T. and J. Donohue. "N.J. budget trouble deepens by $1.3 billion." *The Star-Ledger*. January 23, 2003.

Holohan, J., J. M. Wiener, R.R. Bovbjerg, B. A. Ormand and S. Zuckerman. "The State Fiscal Crisis and Medicaid: Will Health Programs be Major Budget Targets?" The Kaiser Commission on Medicaid and the Uninsured. January 2003. (http://www.kff.org/content/2003/20030113/4074.pdf.)

Holohan, J. and M. B. Pohl. *Changes in Insurance Coverage: 1994-2000 and Beyond.*

Kaiser Commission on Medicaid and the Uninsured. August 2002.

Lutzky, A. W., J. Holahan and J. M. Wiener. Health Policy for Low-Income People: Profiles of 13 States. Urban Institute. Assessing the New Federalism. Occasional Paper Number 57. 2002.

Rutgers Center for State Health Policy. "Health Insurance Coverage in New Jersey: Recent Trends and Policy Challenges." *Issue Brief*. October 2002.

Silow-Carroll et al; K. Fox and J. Cantor. "Assessing State Strategies for Health Coverage Expansion: Case Studies of Oregon, Rhode Island, New Jersey and Georgia." The Commonwealth Fund. November 2002.

Smith, V., K. Gifford, R. Ramesh and V. Wachino. "Medicaid Spending Growth: A 50-State Update for Fiscal Year 2003." Kaiser Commission on Medicaid and the Uninsured. *Issue Paper*. January 2003.

State of New Jersey. Department of Health and Senior Services. Report of the Task Force on Affordability and Accessibility of Health Care in New Jersey. January 2001.

Welch, W. M. "Proposal would bring health insurance to all." *USA Today*. January 24, 2003.

APPENDIX I

New Jersey Public Programs for the Uninsured and Underinsured 2001/2002 Enrollment Snapshot

Program	General Eligibility	Numbers Served*	Notes
Medicaid	• All ages • 0-185% FPL	697,768	
FamilyCare/NJKidCare	• Age 0-18 100-350% FPL • Adults 0-200% FPL	219,569	
SEH (Small Employer Health)	• All Ages • All Incomes	875,306	
IHC (Individual Health Coverage)	• All ages • All incomes	83,896	The number served includes all lives under contract i.e., husband, wife, children.
Charity Care	• All ages • 0-300% FPL • Hospital costs only	183,968	
PAAD (Pharmaceutical Assistance to the Aged and Disabled)	• <$20,016 single • <$24,542 married	188,893	2003 enrollment
Catastrophic Illness in Children Relief Fund	• Age 0-18	261	Those served are not uninsured, but underinsured. This program is viewed as a safety net.
FQHCs/CHCs (Federally Qualified Health Centers/ Community Health Centers)	• Lower-income families and individuals	181,000	

Sources: Interviews with New Jersey state agency staff; The Henry J. Kaiser Family Foundation.

* Years reporting vary