STATE OF NEW JERSEY

DEPARTMENT OF INSTITUTIONS AND AGENCIES

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

1970 ANNUAL REPORT

OF THE NEW JERSEY HEALTH SERVICES PROGRAM (MEDICAID)

STATE OF NEW JERSEY
OFFICE OF THE GOVERNOR
TRENTON

WILLIAM T. CAHILL
GOVERNOR

MESSAGE FROM THE GOVERNOR

The adoption of the New Jersey Health Services Program by the Legislature in 1968 signaled the beginning of a new method of delivering health care to the needy citizens of the State of New Jersey. It also signaled the new infusion of federal dollars into the state for the administration of the program.

With the acceptance of federal dollars, the State of New Jersey assumed the obligation of maintaining not only fiscal integrity in the operation of the new program but administrative integrity in the provision of services. In simple terms, this meant that the administration would have to be accountable to the citizens of New Jersey for the ways in which funds were spent and for protecting the Health Services Program from any possible exploitation.

It is evident that these obligations have been fulfilled during the first year of the program's operation. It is also evident that the administration of this program will have considerable impact on the future of health care delivery in this state.

William T. Cahill
GOVERNOR

STATE OF NEW JERSEY
DEPARTMENT INSTITUTIONS AND AGENCIES
TRENTON 08625

MESSAGE FROM THE ACTING COMMISSIONER

This Annual Report of the New Jersey Health Services Program is the first to be submitted to the New Jersey Legislature under the mandate included in the Medical Assistance and Health Services Act.

As a report of a newly formed and administered system of health care services, it reflects the numerous complexities and intricacies of initiating such a program and making it functional. It also reflects in some measure the dedication of the Department of Institutions and Agencies to the success of this program, which represents a milestone in the Department's history.

Now that this program has overcome many of the initial hurdles, we look forward with singular optimism to the kinds of creative innovations which will make New Jersey a leader in the field of health and medical care.

Maurice G. Kott, Ph.D
Acting Commissioner

STATE OF NEW JERSEY

DEPARTMENT OF INSTITUTIONS AND AGENCIES

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

1970

A N N U A L R E P O R T

O F T H E

N E W J E R S E Y H E A L T H S E R V I C E S P R O G R A M

WILLIAM J. JONES
Director

ACKNOWLEDGEMENTS

Appreciation is expressed to the staff of the Bureau of Health Statistics and Economics and to the staff of the Division of Medical Assistance and Health Services for their valuable assistance, suggestions, and cooperation in the daily operation of this program and in the preparation of this report.

A special note of thanks is expressed to the coordinator and major author of this report, Paul L. Grimaldi, Bureau of Health Statistics and Economics, and to Doris White, Division of Medical Assistance and Health Services.

William J. Jones
Director

PART I

INTRODUCTION

In 1965 Congress amended the Social Security Act with the addition of Title XIX, and in so doing paved the way for substantial alterations in the financing of medical care. Title XIX, more popularly known as Medical Assistance or Medicaid, was enacted with the initial purpose of guaranteeing the poor a minimum level of medical care. Its ultimate purpose was to make high quality medical care available to those who could not afford it.

Each state was given until 1970 to establish a Medical Assistance Program. Subject to certain federal guidelines, each state was given wide latitude in deciding the medical benefits to be made available and in defining those eligible to receive such benefits. Upon the establishment of a program, the federal government would finance between 50% and 83% of a state's public medical expenditures. Failure to establish a program, however, would result in the federal government discontinuing to finance any portion of these state expenditures.

SCOPE OF THE REPORT

The annual report which follows is a review of New Jersey's Medical Assistance Program for the first calendar year of its operation. The report is divided into two parts. Part I is a narrative description of the State's program. Part II is a statistical analysis of the program's medical expenditures. It is preceeded by an analysis of the trend of national medical expenditures, this being done in order to understand the background in which the State's program was formulated.

NEW JERSEY'S MEDICAL ASSISTANCE (MEDICAID) PROGRAM

ADMINISTRATION

In New Jersey, Medical Assistance was authorized by the State Legislature through the Medical Assistance and Health Services Act, Chapter 413, New Jersey Laws of 1968. This Act, which went into effect January 1, 1970, designated the Department of Institutions and Agencies to direct the newly created Division of Medical Assistance and Health Services in the latter's administration of the State's program.

The Division was located in Trenton, and twenty-five Local Medical Assistance Units were established throughout the State. While this number was subsequently reduced to eighteen, these units were designed to decentralize many program procedures, and to foster fruitful relations with county welfare boards and medical providers. The central office, however, maintained overall administrative responsibility for the development of the program.

BENEFITS PROVIDED

Any state adopting a Medical Assistance Program had to provide a minimum level of medical care benefits for the poor; namely, in-patient hospital care, outpatient hospital care, other laboratory and x-ray services, skilled nursing home services for individuals

twenty-one or over, and physicians' services. In addition, a state could elect to provide other medical benefits and the federal government would finance approved expenditures on the same percentage basis as it financed the mandated services. The State of New Jersey provided the following additional benefits: prescribed drugs, dental services, optical appliances, home health services, mental and tuberculosis hospital care, medical supplies, optometrists' services, podiatrists' services, prosthetic devices, the services of independent clinics, and medical transportation costs.

ELIGIBILITY CRITERIA

To be eligible for these benefits, a person had to apply to a county welfare board for financial assistance under one of the following federally designated public assistance categories: (1) Old Age Assistance (OAA), (2) Assistance to the Permanently and Totally Disabled (DA), (3) Assistance to the Blind (AB), and (4) Assistance to Families with Dependent Children (ADC). If the person met the income and other eligibility criteria for one of these programs, that person became eligible for public assistance payments and medical assistance benefits. In all cases, the federal government and the State both assumed 50% of the medical costs.

These benefits, as well as their financing, were extended to three other groups. First, children under twenty-one supervised by the Bureau of Children's Services (BCS), who were in foster placement and supported by public funds, were eligible for medical assistance.

Second, the spouse of a recipient of OAA, DA, and AB, who was living with the recipient and whose needs were taken into account in determining the amount of financial assistance for the recipient, was eligible for these benefits. Third, all members of a family receiving ADC, including children 18 to 21, whether in school or not, were eligible for medical assistance.

In addition, but on a different financial basis, the State made these benefits available to the aged and families with dependent children who satisfied all the criteria for categorical assistance, except for the income requirement. In other words, these people had sufficient income to meet personal needs, but not to meet the costs of medical care, especially the costs of hospitalization and nursing home care. For both categories, Medical Assistance for the Aged (MAA) and Assistance to Families with Dependent Children - Insufficient Income (ADC-II), the State assumed 100% of the medical costs.

The Medicaid program, under agreement with the Division of Public Welfare, acts as paying agent for the Cuban Refugee Program. This agreement became effective June 1, 1970. All costs incurred by this program, however, are absorbed by the Federal Government.

ELIGIBILITY DETERMINATION AND REPORTING

Many problems were encountered in the determination and reporting of those eligible to receive medical assistance, most of them

stemming from the fact that twenty-five different agencies were responsible for various aspects of this part of the program. In essence, the twenty-one autonomous County Welfare Boards, two Contractors, the Division of Public Welfare, and the Division of Medical Assistance and Health Services were responsible for separate but mutually interrelated eligibility functions. By the end of the year, these problems were being minimized via special committees serving as liaisons among these agencies.

PROVIDER PARTICIPATION

Prior to the establishment of Medical Assistance, providers of medical goods and services either donated their services or submitted bills on behalf of public assistance clients to county welfare boards. However, not all medical care services were avialable to welfare clients, and there were even variations in allowable services from county to county.

The immediate goal of the new program was to encourage providers to participate actively in making medical goods and services available to all Medicaid patients. To encourage this and to give eligibles the opportunity of selecting providers of their choice, providers were assured by the State that they would be reimbursed according to federally established standards. Overall, the State's policies were quite successful in encouraging providers to participate in the program. A review of the program, conducted by the U.S. Department of Health, Education, and Welfare, indicated that provider participation rates in New Jersey were among the highest in the nation.

PROVIDER FEES

A systematic method of reimbursement was established vis-a-vis the cooperation of the contractors, representatives of the providers, and Technical Advisory Committees (see below). Uniform fee schedules were devised from two sources, namely, experience with the Medicare program, and Statewide medical fees that were usual and customary. However, establishing uniform fees proved to be difficult, especially in the case of physicians' services.

Prior to Medicare and Medicaid, there were no uniform, customary fees for physicians' services. Fees varied between counties and even within the same county. To resolve this problem, the U.S. Department of Health, Education, and Welfare directed that reimbursement be made on the basis of the average charge for a specific service, or up to the seventy-fifth percentile charge, whichever was less.

UTILIZATION CONTROLS

Throughout the year, many utilization-of-services controls were placed on providers in order to insure that they performed only necessary services and that they performed them adequately. Medical Review Teams reviewed decisions pertaining to nursing home care, lengths of stays in hospitals, drugs dispensed, dental services performed, etc. In December, the Bureau of Medical Care

Surveillance was established to expand and implement further utilization controls.

PROVIDER RELATIONS

Since Medicaid was expected to make unprecedented demands on providers, it was essential that each provider group be informed about the policies and guidelines of the new program. The Medicaid administrative staff appointed representatives of each provider group to serve on Technical Advisory Committees. Besides serving as intermediaries between provider groups and the staff, these committees assisted in devising fee schedules, defined and clarified many technicalities inherent in providing specific medical goods and services, and assisted in the preparation and revision of provider manuals.

CONTRACTORS

The State's Medical Assistance and Health Services Act provided that the Commissioner of the Department of Institutions and Agencies contract for processing provider claims for payment and to have the agent so assigned perform any other functions required by the program.

The designated contractors were the Hospital Service Plan of New Jersey or Blue Cross and the Prudential Insurance Company. Providers of hospital services and home health services were to submit claims to the same fiscal intermediary as under Medicare. Blue Cross was

also assigned all claims for pharmaceutical services, the remaining claims, exclusive of those below, being assigned to Prudential.

The Division of Medical Assistance and Health Services, via its Bureau of Claims and Accounts, acted as the fiscal intermediary for the payment of claims made for nursing home care, mental and tuberculosis hospital care, and the costs of Medicare B premiums.

ROLE OF THE CONTRACTORS

In addition to processing claims, the Hospital Service Plan (Blue Cross), maintains the eligibility file for medical assistance. The Prudential advised the Medicaid administration on medical fees. Both contractors assisted in the preparation of policy and procedural manuals, served as intermediaries between provider groups and the administration, and assisted in the preparation of policy and procedural manuals and controls. Their performance enabled us to create a Medicaid program which is acknowledged to be one of the best in the nation.

P A R T II

NATIONAL MEDICAL EXPENDITURES

MEDICAL EXPENDITURES

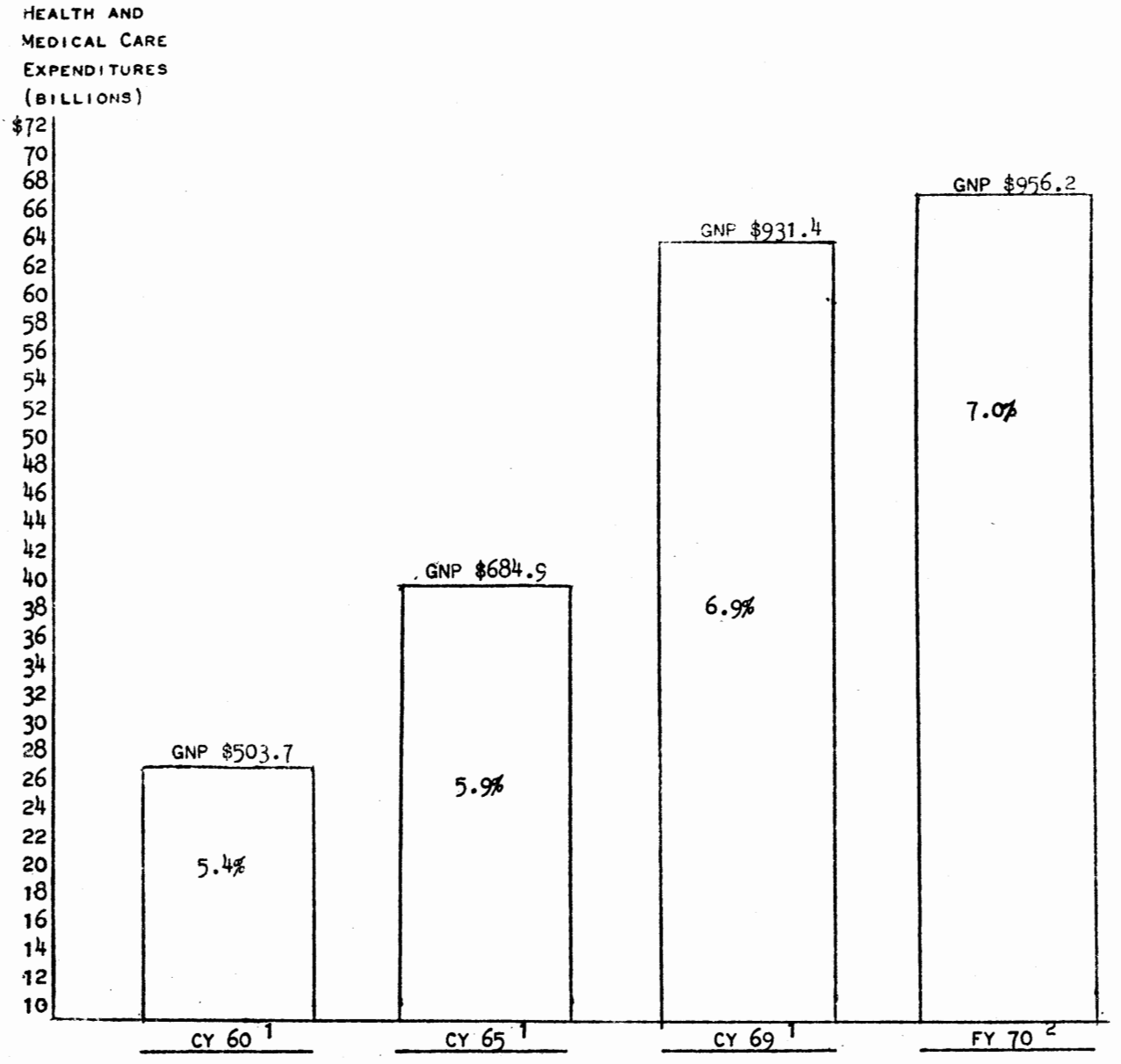
Throughout the sixties medical expenditures, especially after the introduction of Medicare and Medicaid, increased at an accelerating pace. In 1960, $27.0 billion or 5.4% of Gross National Product (GNP) was spent for medical goods and services. Ten years later these expenditures had climbed to $67.2 billion or 7.0% of GNP. On a per capita basis, annual average expenditures increased by $177.12, rising from $147.20 in 1960 to $324.32 in 1970.

MEDICAL PAYMENTS

The financing of these expenditures changed as radically as did the amounts. With the federal government making the receipt of certain medical care a constitutional right, the public sector became accountable for an increasing share of these increasing expenditures. As Table 1 indicates, most of these changes occurred in the second half of the decade. In 1960 the public sector spent $6.6 billion or 24.6% of the total amount spent for medical care. In 1965 these figures were only $3.5 billion and .2% higher. In 1970, however, total public medical expenditures were $14.9 billion higher than they were in 1965, the total of $25 billion representing 37.2% of the total medical outlay.

FIGURE 1

GROSS NATIONAL PRODUCT AND HEALTH AND MEDICAL CARE EXPENDITURES, IN TOTAL AND AS A PERCENTAGE OF GNP, FOR SELECTED PERIODS



SOURCE: SOCIAL SECURITY BULLETIN, JANUARY, 1971.

1. CALENDAR YEAR.
2. FISCAL YEAR ENDED JUNE 30, 1970.

TABLE 1

HEALTH AND MEDICAL CARE EXPENDITURES:
TOTAL, PRIVATE AND PUBLIC AMOUNTS, AND THEIR PERCENTAGES

Calendar Year	Health and Medical Care Expenditures (Billions)	Expenditures (Billions)			
		Private		Public	
		Amount	Percentage	Amount	Percentage
1960	$27.0	$20.3	75.4	$ 6.6	24.6
1965	40.6	30.5	75.2	10.1	24.8
1969	63.8	40.0	62.7	23.8	37.3
1970[1]	67.2	42.3	62.8	25.0	37.2

Source: Social Security Bulletin, January, 1971.

Totals may not add due to rounding.
1. For fiscal year ended June 30, 1970.

This intersectoral shift from the private sector to the public sector was attributable to the expanding role of the federal government in providing medical care for the public. That is, state and local governments, while spending larger amounts annually for medical care, continued to absorb 12% to 13% of total medical expenditures. On the other hand, the federal government's share fluctuated between 11% and 25% for the decade. Thus, the role of state and local governments in the financing of total medical expenditures remained constant, whereas the federal government's more than doubled as it absorbed the shift from the private sector.

TABLE 2

HEALTH AND MEDICAL CARE EXPENDITURES:
TOTAL, PER CAPITA TOTAL,
PER CAPITA PRIVATE, AND PER CAPITA PUBLIC

Calendar Year	Health and Medical Care Expenditures (Billions)	Per Capita Expenditures		
		Total	Private	Public
1960	$27.0	$147.20	$110.00	$36.22
1965	40.6	205.55	154.54	51.02
1969	63.8	309.43	194.11	115.33
1970[1]	67.2	324.32	203.82	120.50

Source: Social Security Bulletin, January, 1971.

Totals may not add due to rounding.
1. For fiscal year ended June 30, 1970.

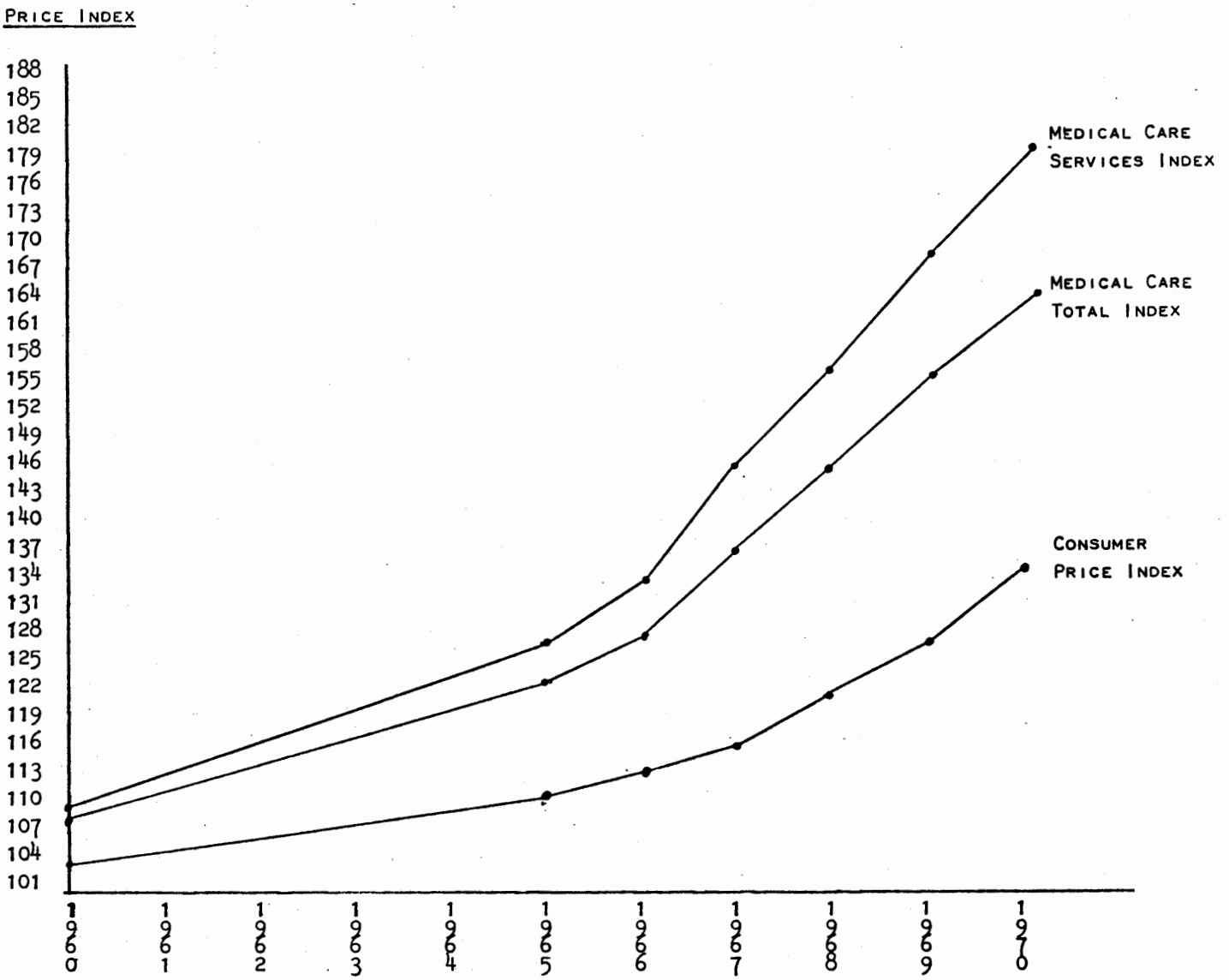
MEDICAL PRICES

While national medical expenditures increased significantly over the decade, they were not matched by a similar increase in the quantity and quality of medical care purchased. Instead a considerable amount of the increase was the result of inflationary pressures within the medical profession. These pressures, which existed prior to Medicare and Medicaid, were aggravated further by the increased level of demand stemming from medical legislation. This rising level of demand, plus a relatively constant supply of medical care, led to catapulting medical prices.

From 1960 to 1965 the medical care price index rose by 14.2%, or an average of 2.8% per year. After the passage of medical legislation, medical prices tripled, increasing by 42.6% or 8.5% per year for the next five years. Overall, for the decade, the total medical care price component of the Consumer Price Index (CPI)

GRAPH I

CONSUMER PRICE INDEX AND MEDICAL INDICES
(1960-1970)



SOURCE: APPENDIX, TABLE A.

increased at nearly twice the rate of the entire CPI. Graph 1 demonstrates this. In 1970 the CPI was 35.3% higher than its base, but the medical care index was 64.9% higher.

This inflationary bias in the medical profession was even more pronounced in the medical care services component of the medical care index, especially physicians' fees and daily hospital service charges after 1965. From 1965 to 1970 the former rose by 45.5% of the base period, the latter, by 134.6%. For 1970 alone, physicians' fees rose by 11.6% and hospital service charges leaped by 31.9%.

MONEY AND REAL EXPENDITURES

The effect of rising prices on money and real medical expenditures is demonstrated in Table 3. Between 1965 and 1969 per capita money expenditures increased by $103.88. But of this dollar increase, 69.6% or $72.32 was the result of rising medical prices, and not from the receipt of more or better medical care. Only 30.4%, or $31.56 of the total dollar increase, was a real increase, that is, an increase in the quantity and quality of medical goods and services purchased.

TABLE 3

PER CAPITA MONEY AND REAL MEDICAL EXPENDITURES, AND PER CAPITA MONEY AND REAL INCREASES AND THEIR PERCENTAGES

Calendar Year	Per Capita Money Expenditures	Per Capita Real Expenditures	Total Per Capita Money Increase	Per Capita Real Increase		Per Capita Money Increase Less Per Capita Real Increase	
				Amount	Percentage	Amount	Percentage
1960	$147.20	$136.17	-	-	-	-	-
1965	205.55	168.08	$ 58.35	$31.91	54.7	$26.44	45.3
1969	309.43	199.64	103.88	31.56	30.4	72.32	69.6
1970[1]	324.32	202.70[2]	14.89	3.06	20.6	11.83	79.4

Sources: Graph 1 and Table 2.

1. For fiscal year ended June 30, 1970.
2. Price index used was the average of 1969 and 1970.

MEDICAL ASSISTANCE (MEDICAID) COSTS

Since its inception in 1966 Medical Assistance or Medicaid costs have continuously outpaced expenditure estimates and the actual expenditures have grown at an alarming rate. Medical Assistance payments have leapfrogged as more states joined the program, as more states liberalized their eligibility requirements, and as medical prices soared. Table 4 illustrates these increases. Over the five calendar years of the program's existence, these expenditures have risen by 361.1%. For 1970 the increase was $1.1 billion, or 26.2% above the expenditures of 1969.

TABLE 4

MEDICAL ASSISTANCE EXPENDITURES:
TOTAL, ANNUAL INCREASE IN AMOUNT AND IN PERCENTAGE

Calendar Year	Medical Assistance Expenditures[1] (Millions)	Annual Increase Amount (Millions)	Annual Increase Percentage
1965	-	-	-
1966	$1,193.8	$1,193.8	-
1967	2,510.5	1,316.7	110.3
1968	3,783.1	1,272.6	50.7
1969	4,360.4	577.3	15.3
1970	5,504.5	1,144.1	26.2

Source: Social Security Bulletin, September, 1971.

1. Includes only those medical vendor payments for which federal participation is available.

States have met these rising costs by increasing taxes, by restructuring their public spending priorities and, especially, from the federal government participating in financing 50% to 83%

of a state's outlay for medical goods and services. However, the unanticipated expensiveness of the program has resulted in a cutback in federal participation, a reduction in the benefits available, and a reduction in the numbers eligible for benefits.

NEW JERSEY'S MEDICAL ASSISTANCE (MEDICAID) PROGRAM

EXPENDITURES BY BENEFIT

For calendar year 1970, the first year of the State's Medical Assistance Program, total public medical assistance expenditures were $130.9 million. Of this amount $124.2 million was spent for benefits received under the new program. The difference of $6.7 million was paid in 1970 for goods received and services rendered prior to the first of the year.

TABLE 5

MEDICAL ASSISTANCE EXPENDITURES: BY BENEFIT, AMOUNT, AND PERCENTAGE

Benefit	Amount	Percentage of Total
General Hospital - Inpatient	$22,859,400	18.4
General Hospital - Outpatient	6,287,900	5.1
Mental and T.B. Hosp.	19,021,100	15.3
Nursing Home	43,493,600	35.0
Home Health	220,400	.2
Independent Clinic	169,300	.1
Physician	13,443,100	10.8
Dentist	6,014,000	4.8
Podiatrist	94,900	.1
Optometrist	765,400	.6
Prescribed Drugs	8,542,200	6.9
Laboratory and X-Rays	200,300	.2
Optical Appliances	1,301,400	1.0
Prosthetics	186,500	.2
Medical Supplies	153,500	.1
Transportation	35,100	.0
Medicare B Premium	1,437,700	1.2
Total	$124,225,700[1]	100.0

Source: Appendix, Table C.

Totals may not add due to rounding.

1. An additional $6,653,400 was spent for goods received and services rendered prior to January 1, 1970, for a total expenditure of $130,879,100. The total shown is the expense directly attributable to Medical Assistance.

Table 5 lists the benefits available to those eligible for medical assistance and the absolute and relative distribution of the expenditures incurred under the new program. Similar information, inclusive of the $6.7 million differential, can be found in Table B of the Appendix. Referring to Table 5, by far the three most expensive benefits provided by the State were nursing home care ($43.5 million), inpatient hospital care ($22.9 million), and mental and tuberculosis hospital care ($19.0 million). Together these three totaled $85.4 million and were accountable for 68.7% of the total public outlay.

EXPENDITURES BY CATEGORY OF ELIGIBILITY

Table 6 yields an absolute and relative breakdown of medical assistance costs by categories of eligibility, that is, the bases upon which medical assistance was provided. Of the seven categories, two, Old Age Assistance (OAA) and Assistance for Dependent Children (ADC) were responsible for 84.3% of the total amount expended. Total OAA costs were $59.0 million and ADC costs totaled $45.8 million.

TABLE 6

MEDICAL ASSISTANCE EXPENDITURES:
BY CATEGORY, AMOUNT, AND PERCENTAGE

Category	Amount	Percentage of Total
Old Age Assistance	$58,962,000	47.5
Disability Assistance	12,379,000	10.0
Assistance for Dependent Children		
1. Regular	38,082,500	30.5
2. Unemployed Father	3,063,200	2.5
3. Insufficient Income[1]	4,683,100	3.8
	45,828,800	36.8
Assistance for the Blind	537,700	.4
Bureau of Children's Services	1,318,600	1.1
Medical Assistance for the Aged[1]	4,189,400	3.4
Cuban Refugees[2]	1,010,500	.8
Totals	$124,225,700	100.0

Source: Appendix, Table C.

Totals may not add due to rounding.
1. Not federally matchable.
2. Totally federally matchable.

As for the financing of these expenditures, with the exception of two categories and a part of a third category, the federal government and the State both assumed 50% of the costs. Amounts spent for Medical Assistance for the Aged and Assistance for Dependent Children - Insufficient Income were not eligible for federal monies. Instead these costs were entirely borne by the State. The costs of Cuban Refugees, however, were fully absorbed by the federal government. Overall, the federal government paid $58.2 million and the State, $66.0 million.

EXPENDITURES BY BENEFIT AND BY CATEGORY

Table C of the Appendix simultaneously classifies medical expenditures by benefit per category and by category per benefit. Except for OAA and MAA, inpatient hospital costs, physicians' fees, and the costs of prescribed drugs accounted for the majority of categorical costs. For the aged, however, these costs were negligible in comparison with those met for nursing home care and for mental and tuberculosis hospital care. In the case of OAA, these costs were $53.7 million, or 91.0% of their total categorical outlay, whereas in the case of MAA these figures were $4.0 million and 95.1%, respectively.

ELIGIBLES

During 1970 the number of those eligible to receive medical assistance rose by 44.5%, increasing from 346,758 in February to 496,788 in December. The monthly average number of eligibles was 429,905, and as Table 7 indicates, 85.1% or 365,736 were ADC cases. On a monthly basis, as Graph 2B shows, except for June, when Cuban Refugees became eligible for medical assistance, ADC was accountable for 86% to 92% of the monthly increases in the eligibility rolls.

TABLE 7

ELIGIBLES AND RECIPIENTS:
BY MONTHLY AVERAGES AND PERCENTAGES

	Monthly[1] Average Number of Elig.	Monthly[1] Average Percent of Elig.	Monthly[1] Average Number of Rec.	Monthly[1] Average Percent of Rec.	Monthly[3] Average Utilization Ratio
Old Age Assistance	26,432	6.2	13,710	10.1	51.9
Disability Assistance	14,626	3.4	8,450	6.3	57.8
Assistance for Dependent Children	365,736	85.1	103,608	76.6	28.3
1. Regular	292,559	68.1	85,217	63.0	29.1
2. Unemployed Father	25,379	5.9	6,518	4.8	25.7
3. Insufficient Income	47,798	11.1	11,872	8.8	24.8
Assistance for the Blind	1,039	.2	470	.4	45.2
Bureau of Children's Services	12,407	2.9	3,097	2.3	25.0
Medical Assistance for the Aged	960	.2	526	.4	54.8
Bureau of Institutional Services	3,384	.8	3,384	2.5	100.0
Cuban Refugees[2]	8,361	1.2	3,189	1.5	38.1
Totals	429,905	100.0	135,293	100.0	31.5

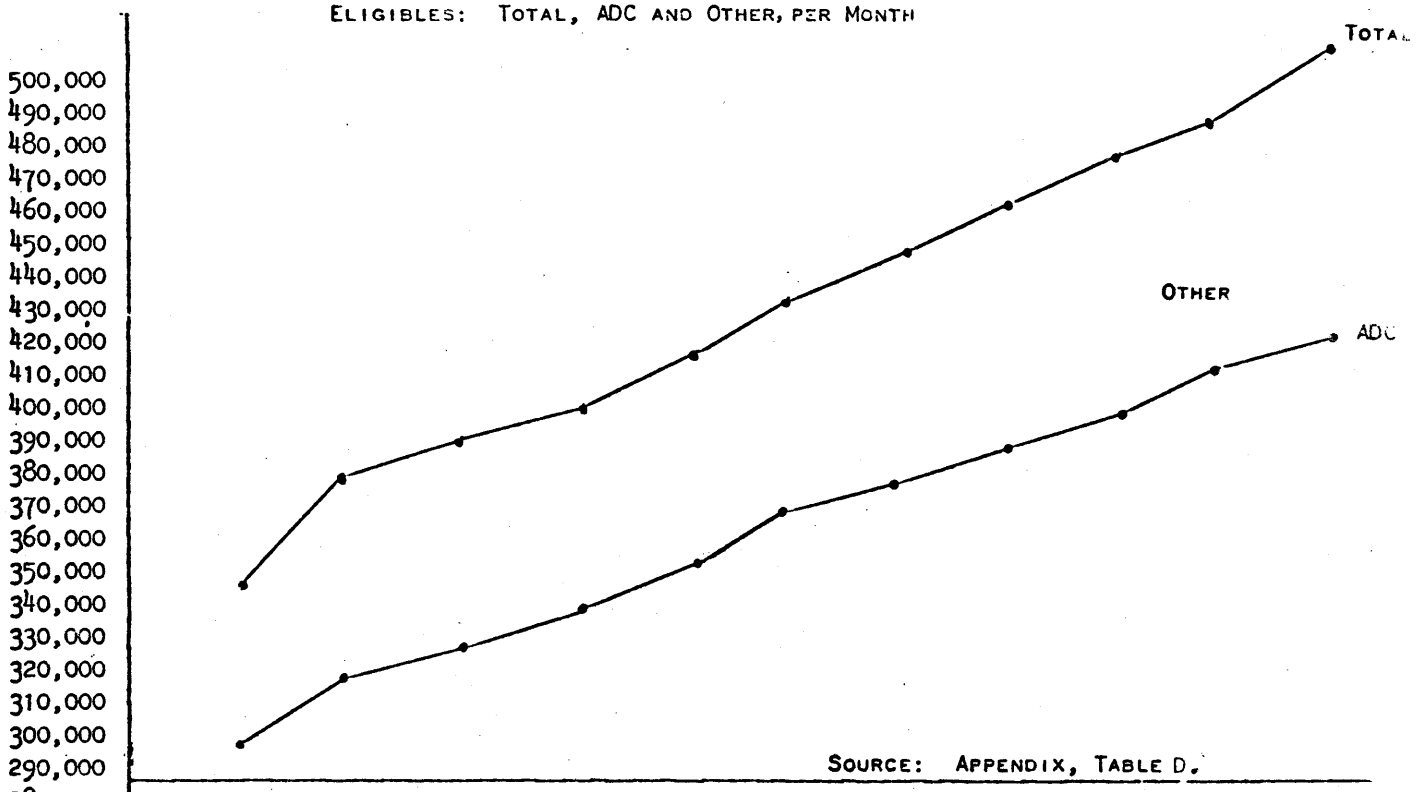
Source: Appendix, Table D, and Table E.

Totals may not add due to rounding.

1. Based on 11 monthly figures.
2. Based on 7 monthly figures.
3. The monthly average number of recipients divided by the monthly average number of eligibles.

GRAPH 2A

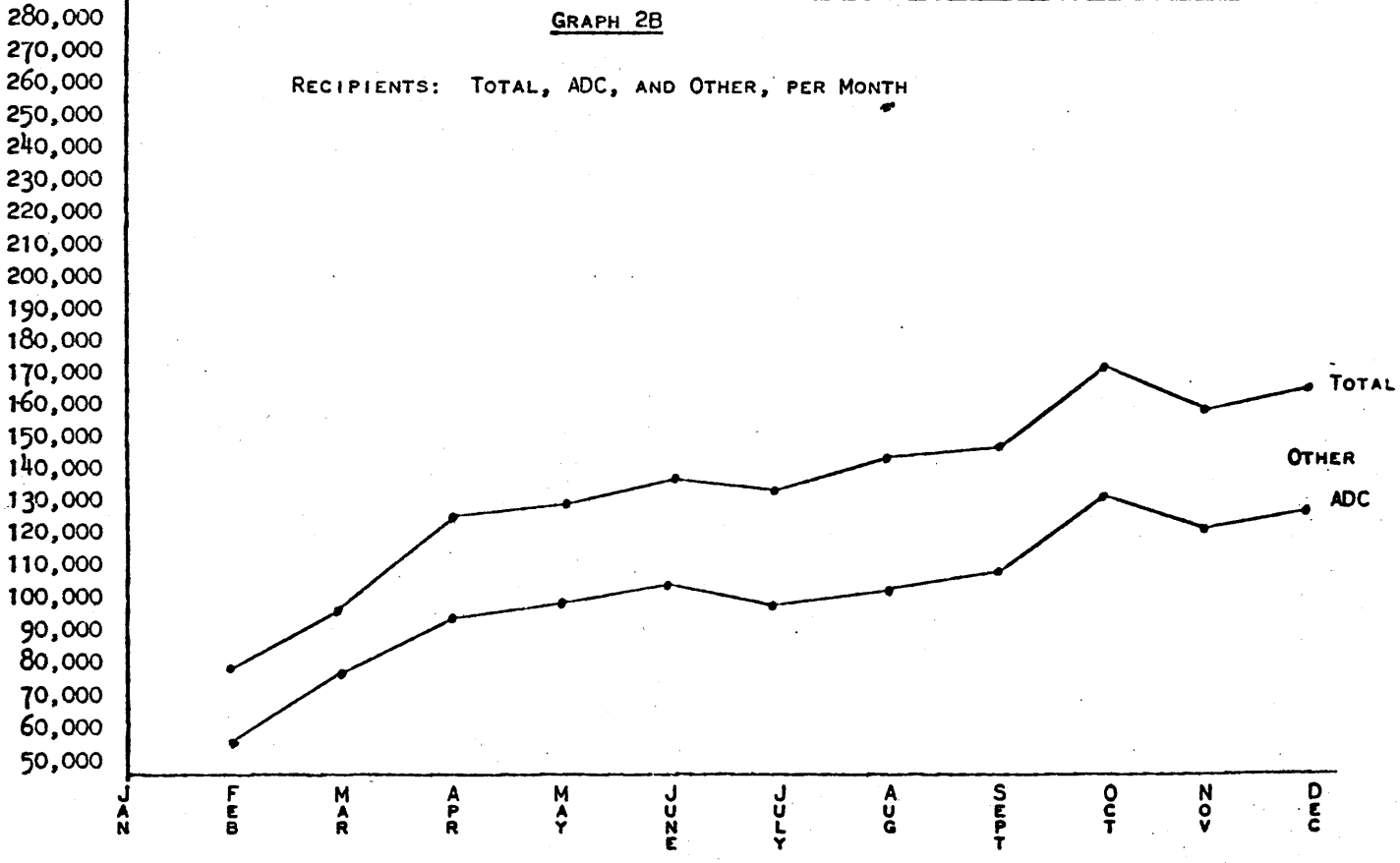
ELIGIBLES: TOTAL, ADC AND OTHER, PER MONTH



SOURCE: APPENDIX, TABLE D.

GRAPH 2B

RECIPIENTS: TOTAL, ADC, AND OTHER, PER MONTH



SOURCE: APPENDIX, TABLE E.

RECIPIENTS

The sharp rate of increase in the eligibility rolls was matched by a sharper rate of increase in the number of recipients. This is explained basically by two considerations. First, the newness of the program raised many difficulties in the determination of eligibility. As these difficulties were settled and as eligibility rolls expanded, the number of recipients also expanded. Second, as larger numbers of those eligible for benefits realized their eligibility, they made increasing utilization of the benefits available.

For the year the number of recipients increased by 114.4%, rising from 77,424 in February to 165,982 in December. The monthly average number of recipients was 135,293. Similar to the increase in the eligibility rolls, ADC was responsible for the vast majority of the monthly growth in the number of recipients. Table 7 demonstrates that of the monthly average of 135,293, 76.6% or 103,608 were from the ADC category. But a caveat is in order in attempting to interpret any monthly recipient figures.

An individual is classified as a recipient at the time that payment is made for goods received and services rendered, not at the time of the receipt of the goods or services. Thus, if a medical provider delays in submitting claims or if there is a delay in the processing of the claims, there will be an extreme variation in the monthly number of recipients. These variations are reinforced by the fact that the incidence of illness also varies. In short, an extreme variation in the number of recipients is something to be expected.

Table 8 illustrates the variation in the number of recipients. For July and November, there was a decrease in the number of recipients, but in the following months, August and December, there was a substantial increase in the number of recipients. In the second quarter of the year, the changes, while always being positive, were just as significant. In May, the number of recipients rose by 5,148, 78.8% less than April's increase. However, June's increase was 118.4% greater than May's.

TABLE 8

RECIPIENTS: TOTAL AND ADC MONTHLY INCREASE, AND ADC INCREASE AS A PERCENTAGE OF TOTAL INCREASE

	Total Monthly Increase	Total ADC Monthly Increase	ADC Increase As A Percentage Total Increase
January	-	-	-
February	-	-	-
March	21,871	18,842	86.2
April	24,229	19,671	81.2
May	5,148	3,524	68.5
June	11,243	8,081	71.9
July	-6,409	-7,901	123.3[1]
August	11,033	7,626	69.1
September	2,413	2,617	108.5[2]
October	26,397	23,493	89.0
November	-18,284	-14,925	81.6
December	10,917	8,549	78.3

Source: Appendix, Table E.

1. ADC decreases were partially offset by other categorical increases.
2. ADC increases were partially offset by other categorical decreases.

UTILIZATION RATIO

Dividing the average number of recipients by the average number of eligibles yields a utilization ratio. This figure is indicative of the extent to which those who are eligible for medical benefits actually demand and receive them. The higher the ratio, the greater is the extent to which an eligible utilizes the program. Assuming that medical costs per eligible, per category are equal, and that the numbers of eligibles per category are equal, the higher the ratio, the higher the medical outlays for that category. If medical costs per eligible, per category are not the same, a lower utilization ratio can still lead to higher medical expenditures per category providing that the number of recipients and/or the medical costs per eligible are offsettingly higher.

Except for the Bureau of Institutional Services, where eligibles and recipients are synonymous, the highest utilization ratios were for the aged and the disabled, the lowest for children. As Table 7 shows, the latter's 28.3% was lower than the State's average of 31.5% and less than one-half of the ratios for the aged and the disabled.

Table F of the Appendix illustrates how these ratios fluctuated within a narrow band for the year, that is, if the April to December readings are considered. These readings are a better indication of the true ratios since the earlier ones reflect the difficulties of operating the program in the first two months. Except for the aged, most ratios fluctuated well within a range of 10%.

COSTS, ELIGIBLES AND RECIPIENTS

Figure 2 is a comparison, by category, of the percentage of medical assistance costs with the percentage of eligibles and recipients. As Table 6 demonstrates, old age costs (OAA and MAA) comprised 50.9% of the total spent by the State. However, in terms of eligibles and recipients, these costs were disproportionately large, that is, 50.9% of the costs covered only 6.5% of the eligibles and 12.8% of the recipients.

TABLE 9

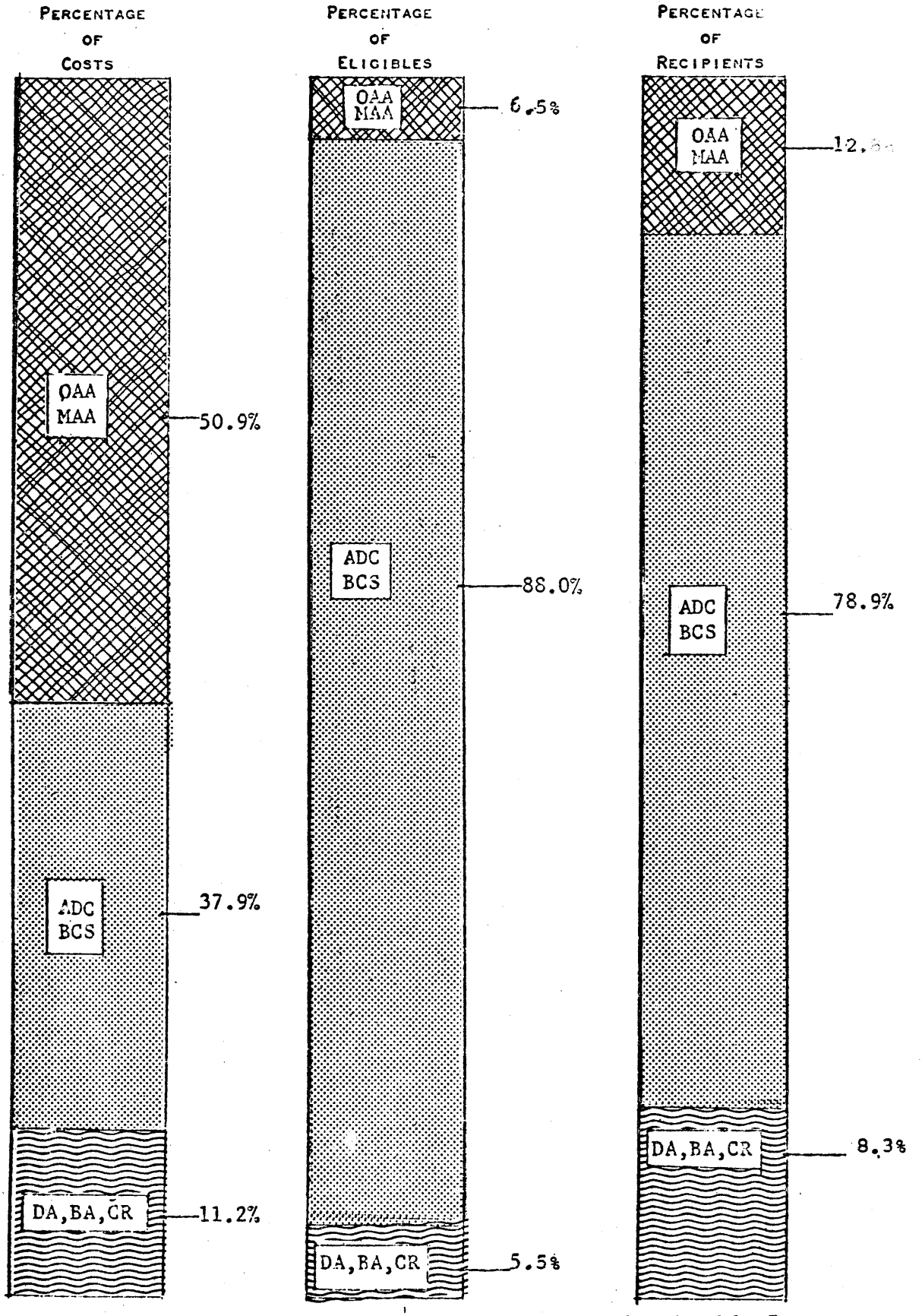
Category	Per[1] Monthly Eligible Expenditures	Per[1] Monthly Recipient Expenditures	Monthly[2] Average Utilization Ratio
Old Age Assistance	$182.69	$322.52	51.9
Disability Assistance	75.68	129.44	57.8
Assistance for Dependent Children	11.39	40.21	28.3
1. Regular	11.83	40.63	29.1
2. Unemployed Father	10.97	42.72	25.7
3. Insufficient Income	8.91	35.86	24.8
Assistance for the Blind	46.30	100.50	45.2
Bureau of Children's Services	9.66	38.71	25.0
Medical Assistance for the Aged	324.58	515.42	54.8
Cuban Refugees	17.26	45.27	38.1
State Averages	$ 26.27	$ 83.47	35.1

Sources: Table 6 and Appendix, Table D and Table E.

1. The Bureau of Institutional Services' eligibles and recipients were allocated on the basis of the payments made for mental and tuberculosis hospitals, nursing homes, and Medicare B premiums. Of the 37,222 eligibles and recipients, 86% were allocated to OAA; 7.2% to DA; 6.3% to MAA; .5% to BA.
2. The monthly average number of recipients divided by the monthly average number of eligibles.

Figure 2

Costs, Eligibles, and Recipients by Percentage of Total



 Sources: Table 6 and Table 7.

This disproportionality results from the expensiveness of old age medical costs and from the high utilization ratio associated with OAA and MAA. (The ratios are a manifestation of the high morbidity rates and long durations of illness encountered by the aged.) Thus, even though the percentage of eligibles and of recipients was low, each was offset by a high utilization ratio (51.9 for OAA and 54.8 for MAA) plus the costs of treatment, the net result being the highest per monthly eligible, per monthly recipient, and total categorical costs.[1] As Table 9 shows, on a per recipient basis, OAA costs were $322.52 and MAA costs were $515.42.

MAA per recipient costs reflect an additional factor which explains why the per recipient costs of this aged group were higher than the per recipient costs of the other aged group (OAA). Referring to Table C of the Appendix, it becomes clear that nursing home costs, and mental and tuberculosis hospital costs accounted for 95.1% of total MAA costs, but 91.0% of total OAA costs. When divided by total eligibles or total recipients, MAA per eligible or per recipient costs were higher because of its smaller base. That is, the per eligible or per recipient MAA costs were higher because a smaller number of people were receiving only very expensive services. In the case of OAA this was not true. Since many more were receiving less expensive goods and services, the per eligible and per recipient costs were correspondingly lower.

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1. In the remainder of this section the word monthly has been omitted when per eligible and per recipient costs are mentioned.

Similar to old age costs, the percentage of ADC costs was disproportionally related to the percentage of ADC eligibles and recipients. However, in this instance, the disproportionality was in the opposite direction, that is, 36.8% of the costs were spread over 85.1% of the eligibles and 76.6% of the recipients. Disproportionality here originated from medical considerations exactly the opposite of those faced by the aged. The utilization ratio was 28.3%, or less than one-half of the ratios for the aged, and medical costs for children were relatively inexpensive. Consequently, the per eligible and per recipient costs were not high. Table 10 illustrates this. Total costs, however, were high since these low per eligible and per recipient costs were incurred for a large number of people.

As for the other categories, there was a much closer relationship among the percentages of costs, the percentages of eligibles and the percentages of recipients. Similar to MAA, per eligible and per recipient costs for the blind and the disabled were high because treatments were expensive and there were high utilization ratios for a small number of people.

EXPENDITURES BY COUNTY

TOTAL COUNTY EXPENDITURES

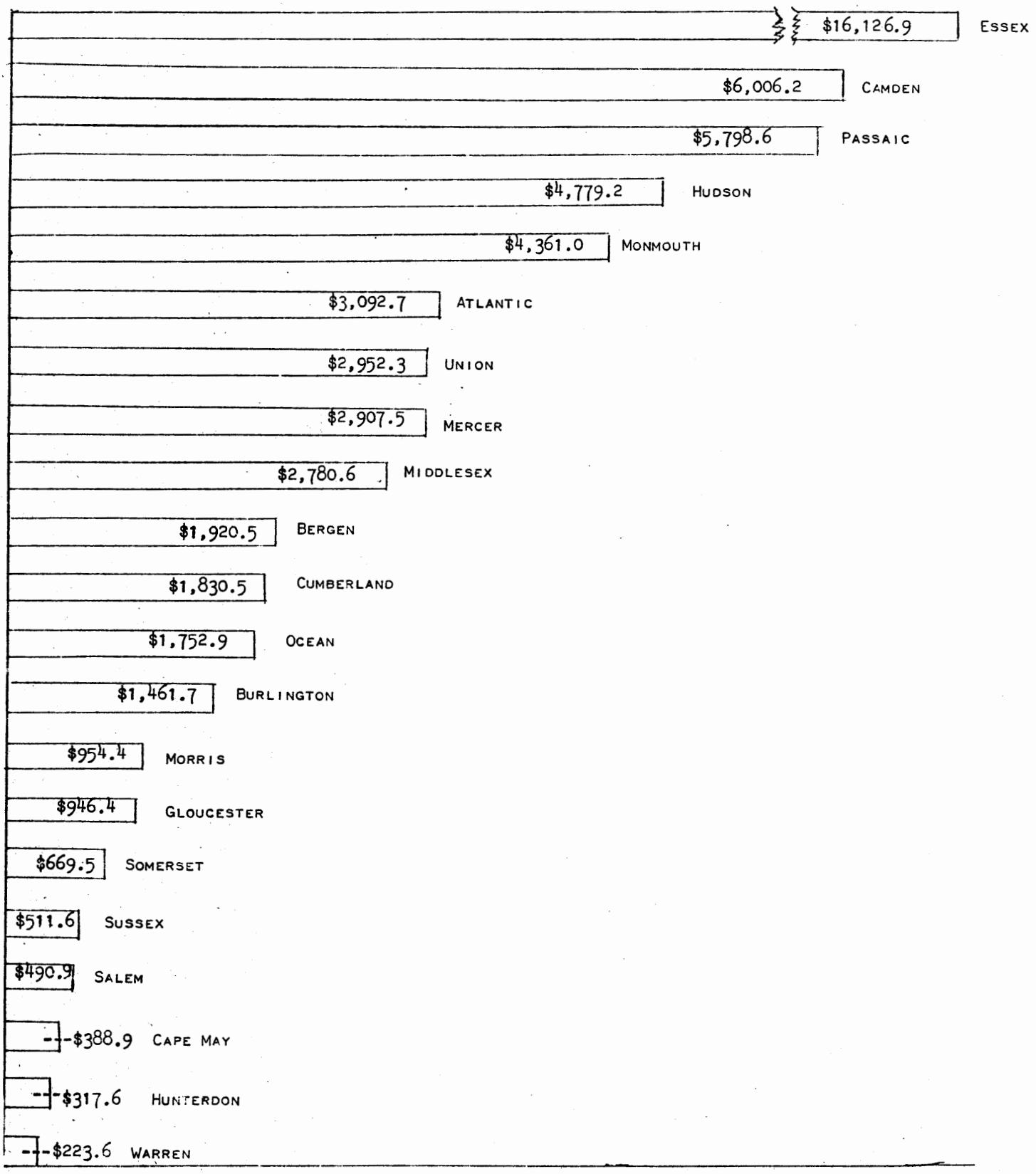
Table G of the Appendix is a distribution of certain Medicaid expenditures by benefit on a county-by-county basis. Nursing home costs, mental and tuberculosis hospital costs, and Medicare B premium costs, or 51.5% of the State outlay, cannot be allocated on this basis for 1970. Given these exclusions, the most important expenditures were inpatient hospital care and physicians' services.

The expenditures, based upon the residence of the recipient, varied from a low of $223,597 in Warren County to a high of $16,126,876 in Essex County. Figure 3 lists the counties in terms of the total amount spent. The first, or lowest twelve, accounted for $11.5 million or 19.1% of the medical payments, whereas the highest three accounted for $27.9 million, or 46.4% of the total. Essex County alone accounted for $16.1 million, or more than the combined outlays of the lowest thirteen counties in the State.

County expenditures varied for many reasons. First, prices for certain medical procedures varied by the county in which the service was rendered. Second, the distribution of eligibles and recipients varied by category and by amount in each county. Third, utilization ratios varied by county. All in all, a county with a large number of recipients and a high utilization ratio had high medical expenditures.

FIGURE 3

SELECTED MEDICAID EXPENDITURES, BY COUNTY [1]
(THOUSANDS)



SOURCE: APPENDIX, TABLE G.

1. EXCLUDES THE COSTS OF NURSING HOME CARE, MENTAL AND TUBERCULOSIS HOSPITAL CARE, AND MEDICARE B PREMIUMS. THESE COSTS WERE 51.5% OF THE TOTAL STATE OUTLAY OF $124,225,700.

Table 10 is a frequency distribution of the expenditures per group of counties and it compares the percentage of total costs per group with the percentage of eligibles and recipients per group. Table 10 illustrates that, for the most part, there was a direct relationship among these variables, that is, the percentages moved in the same direction. For example, Camden and Passaic Counties had 19.6% of the costs, 17.1% of the eligibles and 20.3% of the recipients. Essex County, which had a greater percentage of the costs (26.8%), also had a greater percentage of eligibles (26.7%) and recipients (24.5%).

TABLE 10

FREQUENCY DISTRIBUTION OF CERTAIN MEDICAL ASSISTANCE EXPENDITURES: TOTAL, PERCENTAGE OF TOTAL, PERCENTAGE OF ELIGIBLES, AND PERCENTAGE OF RECIPIENTS, BY GROUPS OF COUNTIES

Medical Assistance Expenditures	Number of Counties	Expenditures for Counties (Thousands)	Percentage of Expenditures	Percentage of Eligibles	Percentage of Recipients
Under $1 million	8	$4,502.9	7.5	7.6	8.2
1 - under 2 million	4	6,965.6	11.6	11.9	12.2
2 - under 3.1 million	4	11,733.0	19.5	19.4	17.9
4 - under 5 million	2	9,140.3	15.2	16.5	14.4
5 - under 6 million	2	11,804.8	19.6	17.1	20.3
over 6 million	1	16,126.9	26.8	26.7	24.5
Totals	21	$60,273.4[1]	100.0	92.2[2]	97.5[2]

Sources: Appendix, Table H, Table I, and Table J.

Totals may not add due to rounding.

1. Excludes the costs of nursing home care, mental and tuberculosis hospital care, and Medicare B premiums. These costs were 51.5% of the total State outlay of $124,225,750.
2. Exclusive of Bureau of Institutional Services' eligibles (.8%) and recipients (2.5%).

MONTHLY AVERAGE EXPENDITURE PER ELIGIBLE[1,2]

Monthly average expenditure per eligible for the State was $12.85, varying from a low of $9.21 in Warren County to a high of $14.98 in Passaic County. Average expenditure per eligible per county differed in ranking from total expenditure per county due to the number of eligibles in relation to the total expenditure. Total county expenditures varied for reasons explained above. When the total was divided by small eligibility rolls the average expenditure increased. In the case of Essex County and Passaic County, the larger expenditure by Essex was offset by its higher eligibility rolls, the result being that Passaic's average expenditure per eligible was higher than Essex's.

MONTHLY AVERAGE EXPENDITURE PER RECIPIENT[1,2]

Monthly average expenditure per recipient was $41.54 for the State, ranging from $29.46 in Warren County to $53.32 in Union County. Average expenditure per recipient differed in ranking from average expenditure per eligible because of the utilization ratio per county. In the case of Bergen and Burlington Counties, Bergen had a per eligible expenditure of $11.30 and Burlington, $11.62; but Burlington had a per recipient expenditure of $35.87, and Bergen, $37.64. Burlington had the lower per recipient expenditure due to its larger utilization ratio. In other words, Burlington spread its medical costs over a greater number of recipients.

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1. All statements are subject to the exclusions mentioned above and are based upon the Appendix, Table J.
2. All averages are on a monthly basis.

ANNUAL EXPENDITURE PER INHABITANT[1]

Annual expenditure per inhabitant was $8.41 for the State, varying from $2.14 for Bergen County to $17.67 for Atlantic County. Annual expenditure per inhabitant differed in ranking from monthly average expenditure per recipient because of the percentage of the population not receiving medical assistance. If a large part of the population does not receive any assistance, any costs spread over the entire population must necessarily result in a low average. Take the case of Essex and Bergen Counties. Both have nearly the same population. However, while 33,094 of Essex's population received medical assistance each month, only 4,638 of Bergen's population received such monthly assistance. Thus, when total county medical expenditures were divided by population per county, Bergen's expenditure per inhabitant fell to $2.14, the lowest of the twenty-one counties.

ADDITIONAL COMMENT

The above statements are not to be interpreted as the only reasons why county rankings change when different averages are considered. Many variables are responsible for these changes. Research is currently underway to ascertain the complicated interrelationships involved in these changes and the results will be forthcoming soon.

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1. All statements are subject to the exclusions mentioned above and are based upon the Appendix, Table J.

DEMOGRAPHIC FACTORS

AGE, ETHNICITY AND ELIGIBILITY

Table 11A stratifies the data by the age and the ethnicity of those eligible for medical assistance at the end of December. At that time, 196,527 or 39% of those eligible were white, and 306,988 or 61% were non-white. For both groups (Table 11B), the majority of those eligible were under the age of twenty-one, the whites having 61.8% of their eligibility rolls under this age, the non-whites having 69.2%. Within each age group (Table 11C), except for those aged sixty-five or over, approximately 61% to 64% were non-white, the remainder white. For the aged the situation was reversed; 67.8% of those eligible were white, 32.2%, non-white.

TABLE 11A

ELIGIBLES: TOTAL, BY AGE AND ETHNICITY

Age of Eligibles	Total	White	Other[1]
0 - 20	334,096	121,399	212,697
21 - 64	136,352	52,725	83,627
65 and over	33,067	22,403	10,664
Total	503,515[2]	196,527	306,988

Source: Bureau of Health Statistics and Economics.

Preliminary results.

1. Other includes: Negro, 232,791; Latin, 67,332; Indian, 426; Oriental, 400; Other, 6,039.

2. Figures for eligibles are based on data for the first week of January, 1971.

TABLE 11B

ELIGIBLES: PERCENTAGE OF ETHNICITY, BY AGE

Age of Eligibles	ELIGIBLES White 100%	ELIGIBLES Other 100%
0 - 20	61.8	69.2
21 - 64	26.8	27.2
65 and over	11.4	3.5
Total	39.0	61.0

Source: Table 11A.

TABLE 11C

ELIGIBLES: PERCENTAGE OF AGE, BY ETHNICITY

Age of Eligibles	ELIGIBLES Total	White	Other
0 - 20	100.0	36.3	63.7
21 - 64	100.0	38.7	61.3
65 and over	100.0	67.8	32.2
Total	100.0	39.0	61.0

Source: Table 11A.

STATE POPULATION, AGE AND ELIGIBILITY

While 66.4% of those eligible for medical assistance were under the age of twenty-one, this age group comprised just 37.8% of the State's population. On the other hand, those over

twenty-one were 33.6% of the eligibles and 62.2% of the population. Clearly, the youth of the population were the majority of those eligible for medical assistance. As Table 12 illustrates, while 7.0% of the population were eligible for medical assistance, 12.3% of the youth were eligible for such assistance.

As for the other two age groups, their eligibles as a percentage of the State population was lower than the percentage of the State population eligible for medical assistance. In the case of the 21-64 group, this difference was the largest. Whereas 7% of the State's population was eligible for assistance, only 3.6% of the eligible percentage of the State's population were from this group.

TABLE 12

STATE POPULATION AND ELIGIBLES: AS A PERCENTAGE AND AS A PERCENTAGE OF STATE POPULATION, BY AGE

Age of Eligibles	STATE POPULATION Number	STATE POPULATION Percentage	Percentage of Eligibles	Eligible[1] Percentage of State Population
0 - 20	2,707,477	37.8	66.4	12.3
21 - 64	3,763,698	52.5	27.0	3.6
65 and over	616,989	9.7	6.6	4.7
State	7,168,164	100.0	100.0	7.0

Sources: Bureau of Census and Table 11A.

1. The result of dividing the number of eligibles per age group by the population per age group.

STATE POPULATION, ETHNICITY AND ELIGIBILITY

Table 13 is a comparison of the State's population by ethnicity with those classified as eligibility by ethnicity. Whites comprised 39% of those eligible, but were 88.6% of the population, while the non-whites were 61% of those eligible and 11.4% of the population. In terms of the population, 3.1% of the whites and 37.5% of the non-whites were eligible for medical assistance.

TABLE 13

ELIGIBLES, STATE POPULATION, AND ELIGIBLES AS A PERCENTAGE OF STATE POPULATION, BY ETHNICITY

	ELIGIBLES		STATE POPULATION		Eligible[1] Percentage of
Ethnicity	Number	Percentage	Number	Percentage	State Pop.
White	196,527	39.0	6,349,908	88.6	3.1
Non-White	306,988	61.0	818,256	11.4	37.5
State	503,515	100.0	7,168,164	100.0	7.0

Sources: Bureau of Census and Table 11A.

1. The result of dividing the number of eligibles per age group by the population per age group.

STATE POPULATION, SEX AND ELIGIBILITY

Table 14 compares the State's population by sex with those classified as eligible by sex. While the general population was approximately 50% male and 50% female, those eligible for assistance were 59.1% female and 40.9% male.

TABLE 14

ELIGIBLES, STATE POPULATION, AND ELIGIBLES AS A PERCENTAGE OF STATE POPULATION, BY SEX

Sex	ELIGIBLES Number	ELIGIBLES Percentage	STATE POPULATION Number	STATE POPULATION Percentage	Eligible[1] Percentage of State Pop.
Male	205,778	40.9	3,467,373	48.4	5.9
Female	297,737	59.1	3,700,791	51.6	8.0
State	503,515	100.0	7,168,164	100.0	7.0

Sources: Bureau of Census and Bureau of Health Statistics and Economics.

1. The result of dividing the number of eligibles per age group by the population per age group.

This difference can be explained by two considerations. First, the majority of ADC households depended upon the female for its source of income. Since these women were either unemployed or were employed at low wages, they were eligible to receive medical assistance. Second, as medical studies have revealed, and is indicated by Bureau data, women tend to outlive men. Consequently, a disproportionally large number of OAA and MAA recipients were female. Overall, the female had a greater probability of receiving assistance than did the male.

A P P E N D I X

TABLE A

CONSUMER PRICE INDEX AND SELECTED MEDICAL INDICES

(1957-59 Base Year)

	1960	1965	1966	1967	1968	1969	1970[2]
Consumer Price Index	103.1	109.9	113.1	116.3	121.2	127.7	135.3
Medical Care, Total	108.1	122.3	127.7	136.7	145.0	155.0	164.9
Medical Care Services[1]	109.1	127.1	133.9	145.6	156.3	168.9	180.8
Physicians' Fees	106.0	121.5	128.5	137.6	145.3	155.4	167.0
Daily Hospital Service Charges	112.7	153.3	168.0	200.1	226.6	256.0	287.9

Source: Social Security Bulletin, Various Issues.

1. Includes daily hospital service charges; operating room charges; x-ray, diagnostic series, upper GI; physicians' fees; dentists' fee; examination, prescription and dispensing of eye glasses; routine laboratory tests.
2. Figures based on a conversion from 1967 base to 1957-9 base.

TABLE B

MEDICAL ASSISTANCE EXPENDITURES:
BENEFIT, AMOUNT, AND PERCENTAGE

Benefit	Amount[1]	Percentage of Total
General Hospital - Inpatient	24,452,400	18.7
General Hospital - Outpatient	6,666,100	5.1
Mental and TB Hospital	19,021,100	14.5
Nursing Homes	43,517,500	33.3
Home Health	234,300	0.2
Independent Clinic	173,200	0.1
Physician	14,865,300	11.4
Dentist	7,089,700	5.4
Podiatrist	94,900	0.1
Optometrist	765,400	0.6
Prescribed Drugs	10,647,800	8.1
Laboratory and X-rays	231,700	0.2
Optical Appliances	1,301,400	1.0
Prosthetics	186,500	0.1
Medical Supplies	156,500	0.1
Transportation	36,900	0.0
Medicare B Premium	1,438,100	1.2
TOTAL	$130,879,100	100.0

Source: Bureau of Health Statistics and Economics.

Totals may not add due to rounding.

1. An amount of $1,064 798 was unallocable. Since it was not spent for nursing homes, mental and tuberculosis hospitals, and Medicare B premiums, it was allocated to inpatient hospital costs, physician fees, dentists' fees, and prescribed drugs on the basis of their percentage of the total outlay for these four benefits.

TABLE C

MEDICAL ASSISTANCE EXPENDITURES: BY BENEFIT AND BY CATEGORY, CALENDAR YEAR 1970
(THOUSANDS)

	Inpatient Hospital	Outpatient Hospital	Home Health	Independent Clinic	Physicians	Dentists	Podiatrists	Optometrists	Prescribed Drugs	Lab and X-ray	Optical Appliances	Prosthetics	Medical Supplies	Transportation	Mental and Tuberculosis Hospitals[1]	Nursing Home[2]	Medicare "B" Premium[3]	Totals
Old Age Assistance	542	126	45	0	640	298	33	44	1,956	31	98	38	31	11	18,508	35,164	1,397	58,962
Disability Assistance	4,053	559	107	4	1,288	308	24	35	1,183	26	79	44	56	14		4,599		12,379
Assistance For Dependent Children	17,239	5,344	53	150	10,873	5,142	33	658	4,998	120	1,060	88	61	9				45,829
Regular	14,597	4,431	50	131	9,019	3,988	28	531	4,218	101	858	72	49	8				38,083
Unemployed Father	1,163	374	1	5	706	363	2	39	328	7	64	5	5	1				3,063
Insufficient Income	1,479	539	2	14	1,147	790	3	88	452	12	138	12	7	0				4,683
Assistance for the Blind	109	17	9	-	50	19	1	1	64	1	4	1	1	0		261		538
Bureau of Children's Services	533	135	1	13	334	155	1	15	88	2	30	9	3	1				1,319
Medical Assistance to the Aged	27	4	5	-	33	6	2	1	84	2	1	1	0	1	514	3,469	41	4,189
Cuban Refugees	356	104	1	1	226	87	1	11	169	18	30	5	1	-				1,011
TOTALS	22,859	6,288	220	169	13,443	6,014	95	765	8,542	200	1,301	187	154	35	19,021	43,493	1,438	124,226[4,5]

TOTALS MAY NOT ADD DUE TO ROUNDING.

SOURCE: BUREAU OF HEALTH STATISTICS AND ECONOMICS

1) TOTAL EXPENDITURE OF $19,021,148 WAS ALLOCATED TO OAA AND MAA ON THE BASIS OF THE ALLOCATION FOR JANUARY-APRIL 1971. THE AVERAGE OF THAT BASIS WAS 97.3% FOR OAA AND 2.7% FOR MAA.

2) TOTAL EXPENDITURE OF $43,493,355 WAS ALLOCATED SIMILAR TO MENTAL AND TUBERCULOSIS HOSPITALS. THE ALLOCATIVE BASES WERE: OAA, 80.850%; DA, 10.575%; AB, .6%; MAA, 7.975%.

3) TOTAL EXPENDITURE OF $1,437,723 WAS ALLOCATED SIMILAR TO ABOVE EXCEPT THE PERIOD USED WAS FEBRUARY-APRIL 1971. THE ALLOCATIVE BASES WERE: 97.137% FOR OAA AND 2.863% FOR MAA.

4) TOTAL EXPENDITURE OF $1,392,500 WAS INCURRED FOR TWO CATEGORIES BUT THEY WEREN'T DISTRIBUTED BY BENEFIT AND BY CATEGORY. BENEFIT DISTRIBUTION BASED ON TABLE 5, EXCLUSIVE OF THE MEDICAL EXPENDITURES OF THE BUREAU OF INSTITUTIONAL SERVICES (BIS). CATEGORY ALLOCATION BASED ON A COMPARISON OF THE TWO SIX MONTH TOTAL EXPENDITURES FOR ADC - INSUFFICIENT INCOME, (ADC-II), AND OLD AGE ASSISTANCE. THE LATTER WAS USED AS A PROXY FOR MEDICAL ASSISTANCE FOR THE AGED AND WAS EXCLUSIVE OF BIS MEDICAL EXPENDITURES. ALLOCATIVE BASES WERE: ADC-II, 96.7%; MAA, 3.3%.

5) TOTAL EXPENDITURES OF $119,800 WERE NOT ALLOCATED BY BENEFIT AND BY CATEGORY. THEY WERE NOT BIS EXPENDITURES. THEY WERE ALLOCATED BY BENEFIT AS IN THE APPENDIX, TABLE G, FOOTNOTE 1. CATEGORY ALLOCATION WAS BASED ON TABLE 6, EXCLUSIVE OF BIS EXPENDITURES.

TABLE D (Continued)

ELIGIBLES: BY CATEGORY, PER MONTH

(February - December 1970)

1970	Total	OAA[1]	DA[2]	ADC[3]	AB[4]	BCS[5]	MAA[6]	BIS[7]	CR[8]
January	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	-
February	346,758	23,003	12,629	294,903	961	11,057	744	3,461	-
March	375,249	24,307	13,250	320,936	989	11,506	800	3,461	-
April	386,005	24,817	13,573	330,791	1,011	11,592	775	3,446	-
May	397,729	25,341	13,959	341,367	1,023	11,765	838	3,436	-
June	420,446	26,227	14,440	355,010	1,041	12,070	915	3,401	7,342
July	434,003	26,741	14,734	367,314	1,042	12,233	968	3,376	7,595
August	447,286	27,214	14,974	379,236	1,046	12,452	994	3,374	7,996
September	461,762	27,737	15,363	391,961	1,057	12,904	1,042	3,362	8,336
October	474,450	27,937	15,680	403,191	1,069	13,359	1,095	3,336	8,783
November	488,476	28,510	16,020	415,629	1,090	13,636	1,181	3,305	9,105
December	496,788	28,919	16,262	422,762	1,100	13,899	1,210	3,264	9,372
Totals	4,728,952	290,753	160,884	4,023,100	11,429	136,473	10,562	37,222	58,529
Averages	429,905	26,432	14,626	365,736	1,039	12,407	960	3,384	8,361

Source: Bureau of Health Statistics and Economics.

1. OAA - Old Age Assistance
2. DA - Disability Assistance
3. ADC - Assistance for Dependent Children
4. AB - Assistance for the Blind
5. BCS - Bureau of Children's Services
6. MAA- Medical Assistance for the Aged
7. BIS - Bureau of Institutional Services
8. CR - Cuban Refugees

TABLE D (Continued)

ADC ELIGIBLES: BY CATEGORY, PER MONTH

(February - December 1970)

1970	Total	Regular	Unemployed Father	Insufficient Income
January	N.A..	N.A.	N.A.	N.A.
February	294,903	242,691	19,361	32,851
March	320,936	260,898	21,967	38,071
April	330,791	267,281	22,616	40,894
May	341,367	275,215	23,012	43,140
June	355,010	285,079	23,955	45,976
July	367,314	292,624	25,205	49,485
August	379,236	301,576	26,449	51,211
September	391,961	310,539	27,563	53,859
October	403,919	319,189	28,634	55,368
November	415,629	328,979	29,730	56,920
December	422,767	334,085	30,676	58,001
Totals	4,023,100	3,218,156	279,168	525,776
Averages	365,736	292,559	25,379	47,798

Source: Bureau of Health Statistics and Economics.

TABLE E (CONTINUED)

RECIPIENTS: BY CATEGORY, PER MONTH
(FEBRUARY - DECEMBER 1970)

1970	TOTAL	OAA	DA	ADC	AB	BCS	MAA	BIS	CR
JANUARY	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	-
FEBRUARY [1]	77,424	7,924	5,772	58,100	323	1,452	176	3,461	-
MARCH	99,295	9,251	6,818	76,942	395	2,165	263	3,461	-
APRIL	123,524	11,627	7,994	96,613	446	3,009	389	3,446	-
MAY	128,672	12,907	8,212	100,137	470	3,060	450	3,436	-
JUNE	139,915	14,294	8,731	108,218	494	3,307	518	3,401	952
JULY	133,506	14,373	8,564	100,317	474	3,290	555	3,376	2,557
AUGUST	144,539	16,215	9,068	107,943	510	3,419	658	3,374	3,352
SEPTEMBER	146,952	16,072	9,046	110,560	494	3,435	652	3,362	3,331
OCTOBER	173,349	16,817	9,814	134,053	551	3,951	731	3,336	4,096
NOVEMBER	155,065	15,014	9,195	119,128	485	3,401	656	3,305	3,881
DECEMBER	165,982	16,316	9,737	127,677	523	3,575	735	3,264	4,155
TOTALS	1,488,223	150,810	92,951	1,139,688	5,165	34,064	5,783	37,222	22,324
AVERAGES	135,293	13,710	8,450	103,608	470	3,097	526	3,384	3,189

SOURCE: BUREAU OF HEALTH STATISTICS AND ECONOMICS.

1. A TOTAL OF 216 RECIPIENTS COULD NOT BE ALLOCATED.

OAA - OLD AGE ASSISTANCE
DA - DISABILITY ASSISTANCE
ADC - ASSISTANCE FOR DEPENDENT CHILDREN
AB - ASSISTANCE FOR THE BLIND
BCS - BUREAU OF CHILDREN'S SERVICES
MAA - MEDICAL ASSISTANCE FOR THE AGED
BIS - BUREAU OF INSTITUTIONAL SERVICES
CR - CUBAN REFUGEES

TABLE E (Continued)

ADC RECIPIENTS: BY CATEGORY, PER MONTH

(February - December 1970)

1970	Total	Regular	Unemployed Father	Insufficient Income
January	N.A.	N.A.	N.A.	N.A.
February	58,100	49,264	3,408	5,428
March	76,942	64,525	4,784	7,633
April	96,613	80,533	5,961	10,119
May	100,137	82,980	6,166	10,991
June	108,218	89,414	6,709	12,095
July	100,317	82,668	6,124	11,525
August	107,943	88,343	6,854	12,746
September	110,560	90,039	7,035	13,486
October	134,053	108,881	8,634	16,538
November	119,128	96,798	7,763	14,567
December	127,677	103,943	8,265	15,469
Totals	1,139,688	937,388	71,703	130,597
Averages	103,608	85,217	6,518	11,872

Source: Bureau of Health Statistics and Economics.

Totals may not add due to rounding.

TABLE F

RANGES OF UTILIZATION RATIOS, BY CATEGORY, CALENDAR YEAR 1970

Category	Ranges of Utilization Ratios[1]	
	February-December	April-December
Old Age Assistance	35.2-60.2	49.9-60.2
Disability Assistance	45.7-62.6	58.9-62.6
Assistance for Dependent Children	19.7-33.4	27.3-33.4
Regular	20.3-34.1	30.1-34.1
Unemployed Father	17.6-30.2	26.4-30.2
Insufficient Income	16.5-29.9	24.7-29.9
Assistance for the Blind	33.6-51.5	44.1-51.5
Bureau of Children's Services	13.1-29.6	26.0-29.6
Bureau of Institutional Services	100.0	100.0
Medical Assistance for the Aged	23.7-66.8	50.2-66.8
Cuban Refugees	33.7-46.6[2]	41.9-46.6[3]

Source: Bureau of Health Statistics and Economics.

1) Monthly number of recipients divided by monthly number of eligibles.

2) June-December.

3) August-December.

TABLE G

CERTAIN MEDICAL ASSISTANCE EXPENDITURES: BY BENEFIT AND BY COUNTY, CALENDAR YEAR 1970

COUNTY	INPATIENT HOSPITAL	OUTPATIENT HOSPITAL	PHYSICIAN	DENTAL	PODIATRY	OPTOMETRIC EXAMS	OPTICAL APPLIANCES	INDEPENDENT CLINICS	LAB & X-RAY	HOME HEALTH	DRUGS	PROSTHETICS	MEDICAL SUPPLIES	TRANSPORTATION	TOTAL
ATLANTIC	$ 837,998	$ 254,117	$ 842,172	$ 392,738	$ 9,027	$ 60,643	$ 97,554	$ 3,645	$ 8,209	$10,648	$ 545,631	$ 9,450	$ 11,913	$ 8,915	$ 3,092,660
BERGEN	562,743	218,857	458,868	235,585	4,852	16,011	30,428	8,288	4,461	18,825	345,225	5,558	9,927	883	1,920,511
BURLINGTON	451,789	149,406	367,081	152,324	3,646	23,859	34,224	3,992	3,545	4,133	258,148	4,162	5,181	197	1,461,687
CAMDEN	1,614,090	437,228	1,647,311	715,265	14,074	114,880	163,014	19,635	15,791	11,166	1,232,510	9,764	10,599	901	6,006,228
CAPE MAY	127,691	17,991	104,352	33,121	1,482	6,210	10,743	1,885	928	6,427	75,284	950	1,449	389	388,902
CUMBERLAND	621,946	120,841	464,762	267,610	2,597	30,832	42,706	5,315	5,292	7,041	251,229	5,921	4,385	58	1,830,535
ESSEX	7,271,933	1,911,752	3,461,832	908,743	21,964	139,088	287,650	32,062	34,861	34,615	1,910,866	62,541	37,756	11,213	16,126,876
GLOUCESTER	245,868	55,134	254,087	161,794	1,764	15,922	23,528	1,512	5,454	2,280	174,654	2,887	1,409	96	946,383
HUDSON	2,135,770	495,714	865,500	441,999	5,120	60,344	114,040	14,568	24,228	12,447	578,824	18,658	11,529	462	4,779,203
HUNTERDON	107,768	25,948	78,872	39,505	304	2,476	5,671	450	301	1,197	53,796	204	1,079	-	317,571
MERCER	1,181,279	366,936	566,651	315,727	2,012	39,912	78,071	18,561	4,929	14,964	303,610	6,937	7,372	524	2,907,485
MIDDLESEX	1,054,488	351,247	498,133	381,685	3,184	34,627	57,174	8,575	20,858	15,744	344,104	4,775	5,437	597	2,780,628
MONMOUTH	1,631,189	539,990	904,148	377,566	5,918	61,647	88,077	10,470	20,754	23,965	662,962	16,380	13,954	4,025	4,361,045
MORRIS	367,629	84,986	202,762	102,404	1,050	9,033	15,029	2,001	3,787	7,241	151,749	3,229	3,376	130	954,406
OCEAN	489,980	125,797	423,348	386,386	1,465	20,175	33,401	2,166	4,573	5,857	244,378	5,840	5,818	3,730	1,752,914
PASSAIC	2,094,426	575,509	1,412,569	643,892	6,269	72,396	124,444	17,523	27,416	21,280	782,182	11,634	7,432	1,593	5,798,565
SALEM	175,182	35,571	121,738	47,932	3,389	9,520	13,091	2,805	850	1,439	78,298	613	439	25	490,892
SOMERSET	228,093	66,503	143,713	92,358	932	11,806	19,166	1,338	3,639	7,953	88,096	2,225	3,532	130	669,484
SUSSEX	196,122	27,733	126,260	46,080	1,159	5,636	10,541	2,606	538	2,717	87,492	2,736	1,941	-	511,561
UNION	1,387,368	410,970	450,494	251,735	4,144	27,559	48,519	11,214	8,955	9,140	322,201	10,895	7,860	1,242	2,952,296
WARREN	76,089	15,640	48,465	19,480	591	2,854	4,315	703	970	1,358	50,960	1,104	1,068	-	223,597
TOTAL	$22,859,441	$6,287,870	$13,443,112	$6,013,929	$94,943	$765,430	$1,301,386	$169,314	$200,339	$220,437	$8,542,199	$186,463	$153,456	$35,110	$60,273,429 [2]

SOURCE: BUREAU OF HEALTH STATISTICS AND ECONOMICS

1. A TOTAL OF $119,864 SPENT FOR THESE BENEFITS COULD NOT BE ALLOCATED. HOWEVER, IT WAS DETERMINED THAT $2,706 WAS SPENT FOR INPATIENT HOSPITAL CARE; $285 FOR OUTPATIENT HOSPITAL CARE; $299 FOR PHYSICIANS' SERVICES; $136 FOR OPTICAL EXAMINATIONS ; $116 FOR INDEPENDENT CLINICS; AND $116,322 FOR DRUGS. EXCEPT FOR THE FIRST AND LAST, ALL WERE ALLOCATED TO ESSEX COUNTY. THE FIRST WAS ALLOCATED TO CAMDEN, ESSEX, HUDSON, AND PASSAIC ON THE BASIS OF THEIR RELATIVE SHARE OF THE TOTAL EXPENDITURES FOR THESE FOUR COUNTIES. THE LAST, DRUGS, WAS ALLOCATED TO THESE FOUR AND ATLANTIC AND MONMOUTH COUNTIES IN A SIMILAR FASHION.
2. EXCLUDES THE COSTS OF NURSING HOME CARE, MENTAL AND TUBERCULOSIS HOSPITAL CARE, AND MEDICARE B PREMIUMS. THESE COSTS ARE 51.5% OF THE TOTAL STATE OUTLAY OF $124,225,700.

TABLE H

ELIGIBLES: TOTALS PER MONTH, PER COUNTY AND AVERAGES PER MONTH, PER COUNTY

(FEBRUARY - DECEMBER 1970)

	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	ANNUAL TOTAL	MONTHLY AVERAGE
ATL.	15,697	17,136	17,934	19,019	19,843	20,533	21,509	22,061	22,809	23,938	24,363	224,842	20,440
BER.	12,298	12,900	13,433	14,145	15,035	15,580	16,259	16,853	17,414	17,828	18,158	169,903	15,446
BUR.	8,794	9,771	10,131	10,447	10,902	11,382	11,843	12,540	12,935	13,362	13,731	125,838	11,440
CAM.	26,110	30,294	33,029	34,846	37,580	40,686	40,774	42,674	43,045	44,837	45,298	419,173	38,107
C.P.	2,625	2,840	2,932	2,985	3,037	2,934	2,957	3,094	3,052	3,294	3,459	33,209	3,019
CUM.	8,920	11,313	11,221	11,525	11,735	11,961	12,500	12,910	13,450	13,627	13,651	132,813	12,074
ESSEX	98,052	103,652	105,266	108,277	112,822	115,679	119,144	122,261	124,708	126,510	128,515	1,264,886	114,990
GLOU.	6,033	6,423	6,287	6,346	6,468	6,827	7,022	7,260	7,515	7,755	8,102	76,038	6,912
HUD.	35,242	36,749	36,757	37,100	41,666	42,671	44,545	46,170	48,083	49,485	51,038	469,506	42,682
HUNT.	1,668	1,836	1,918	1,928	1,988	2,085	2,125	2,198	2,273	2,354	2,452	22,825	2,075
MER.	18,249	18,986	19,046	19,276	19,952	20,602	21,349	21,847	22,281	22,804	23,154	227,546	20,686
MID.	16,795	19,383	20,312	20,886	22,239	23,114	24,161	25,512	25,988	27,108	28,002	253,500	23,045
MON.	23,410	24,610	26,288	27,091	28,428	29,526	29,324	29,139	30,906	32,718	33,074	314,514	28,592
MOR.	3,817	4,544	4,997	5,391	6,085	6,393	6,207	6,546	6,640	6,946	6,879	64,445	5,859
OCEAN	9,581	10,576	10,713	11,015	11,332	11,578	12,265	12,604	13,360	13,474	14,022	130,520	11,865
PAS.	29,757	31,831	32,158	32,909	34,633	34,907	36,272	37,542	38,364	39,453	39,290	387,121	35,193
SALEM	3,072	3,593	3,764	3,887	3,968	4,116	4,168	4,196	4,211	4,451	4,425	43,851	3,986
SOM.	3,686	4,196	4,472	4,653	4,922	4,970	5,269	5,723	6,181	6,571	6,730	57,373	5,216
SUS.	2,897	3,135	3,167	3,254	3,333	3,417	3,532	3,659	3,754	3,812	3,858	37,818	3,438
UNION	14,780	16,035	16,678	17,298	18,990	19,552	20,409	21,221	21,725	22,286	22,772	211,746	19,250
WAR.[1]	1,814	1,985	2,056	2,015	2,082	2,114	2,278	2,390	2,420	2,558	2,551	24,263	2,206
BIS	3,461	3,461	3,446	3,436	3,401	3,376	3,374	3,362	3,336	3,305	3,264	37,222	3,384
TOTAL	346,758	375,249	386,005	397,729	420,446	434,003	447,286	461,762	474,450	488,476	496,788	4,728,952	429,905

SOURCE: BUREAU OF HEALTH STATISTICS AND ECONOMICS.

1. BUREAU OF INSTITUTIONAL SERVICES.

TABLE 1

RECIPIENTS: TOTALS PER MONTH, PER COUNTY AND AVERAGES PER MONTH, PER COUNTY
(FEBRUARY-DECEMBER, 1970)

	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	ANNUAL TOTAL	MONTHLY AVERAGE
ATL.	4,611	6,090	7,226	6,879	7,414	7,418	7,443	8,195	9,230	8,276	8,608	81,390	7,399
BER.	2,290	3,187	4,070	4,318	4,759	4,762	4,827	5,098	6,217	5,434	6,055	51,017	4,638
BUR.	2,199	2,908	3,315	3,502	3,830	3,628	3,884	4,037	4,756	4,389	4,305	40,753	3,705
CAM	8,359	10,928	12,916	13,861	15,072	14,729	15,645	16,606	20,056	18,109	19,283	165,564	15,051
C.M.	728	926	1,195	1,106	1,222	1,126	1,060	1,072	1,306	1,133	1,271	12,145	1,104
CUM.	2,332	3,249	4,080	4,101	4,636	4,200	4,550	4,509	5,417	4,779	5,023	46,876	4,262
ESSEX	18,039	23,848	30,331	32,690	35,318	33,194	36,226	34,828	43,173	36,390	40,002	364,039	33,094
GLOU.	1,592	2,069	2,255	2,306	2,479	2,273	2,410	2,520	2,957	2,972	3,062	26,895	2,445
HUD.	5,514	6,286	8,310	8,471	10,579	9,569	10,894	10,505	13,353	12,116	13,502	109,099	9,918
HUN.	387	495	699	820	844	780	868	777	920	831	953	8,374	761
MER.	3,645	4,515	5,257	5,589	6,110	5,602	5,792	5,924	7,444	6,854	6,945	63,677	5,789
MID.	2,509	3,677	4,986	5,306	5,870	5,881	6,803	7,230	8,123	7,452	7,412	65,249	5,932
MON.	5,307	7,056	9,087	8,992	9,925	9,589	10,765	10,941	11,887	10,508	11,481	105,538	9,594
MOR.	875	1,322	1,765	1,908	2,259	2,093	2,282	2,382	2,579	2,507	2,537	22,509	2,046
OCEAN	2,237	2,961	3,694	3,762	4,123	3,726	4,315	4,418	4,611	4,365	4,795	43,007	3,910
PAS.	8,057	9,555	12,047	12,626	12,587	11,741	12,611	13,087	15,692	14,068	15,078	137,149	12,468
SALEM	820	1,001	1,301	1,224	1,248	1,278	1,294	1,372	1,528	1,460	1,581	14,107	1,282
SOM.	716	1,014	1,319	1,388	1,518	1,434	1,664	1,834	1,931	1,813	2,009	16,640	1,513
SUS.	871	1,000	1,206	1,227	1,210	1,273	1,360	1,444	1,477	1,490	1,451	14,009	1,274
UNION	2,442	3,257	4,396	4,521	4,799	5,113	5,730	6,020	6,439	6,121	6,535	55,373	5,034
WAR.[1]	433	490	623	639	712	721	742	791	917	693	830	7,591	690
BIS	3,461	3,461	3,446	3,436	3,401	3,376	3,374	3,362	3,336	3,305	3,264	37,222	3,384
TOTAL	77,424	99,295	123,524	128,672	139,915	133,506	144,539	146,952	173,349	155,065	165,982	1,488,223	135,293

SOURCE: BUREAU OF HEALTH STATISTICS AND ECONOMICS.

1. BUREAU OF INSTITUTIONAL SERVICES.

TABLE J

AVERAGE ELIGIBLES AND AVERAGE RECIPIENTS, PER MONTH, TOTAL POPULATION AND TOTAL EXPENDITURE, BY COUNTY, CALENDAR YEAR 1970

County	Monthly Average Eligibles	Monthly Average Recipients	Total Population	Total Expenditure[1]
Atlantic	20,440	7,399	175,043	$3,092,660
Bergen	15,446	4,638	898,012	1,920,511
Burlington	11,440	3,705	323,132	1,461,687
Camden	38,107	15,051	456,291	6,006,228
Cape May	3,019	1,104	59,554	388,902
Cumberland	12,074	4,262	121,374	1,830,535
Essex	114,990	33,094	929,986	16,126,876
Gloucester	6,912	2,445	172,681	946,383
Hudson	42,682	9,918	609,266	4,779,203
Hunterdon	2,075	761	69,718	317,571
Mercer	20,686	5,789	303,968	2,907,485
Middlesex	23,045	5,932	583,813	2,780,628
Monmouth	28,592	9,594	459,379	4,361,045
Morris	5,859	2,046	383,454	954,406
Ocean	11,865	3,910	208,470	1,752,914
Passaic	35,193	12,468	460,782	5,798,565
Salem	3,986	1,282	60,346	490,892
Somerset	5,216	1,513	198,372	669,484
Sussex	3,438	1,274	77,528	511,561
Union	19,250	5,034	543,116	2,952,296
Warren	2,206	690	73,879	223,597
BIS[2]	3,384	3,384	-	-
State	429,905	135,293	7,168,164	$60,273,429

Sources: Bureau of Census, Table G, Table H and Table I.

1. Excludes the costs of nursing home care, mental and tuberculosis hospital care, and Medicare B premiums. These costs were 51.5% of the total State outlay of $124,225,700.
2. Bureau of Institutional Services.

TABLE K

Monthly Average Expenditures: Per Eligible, and Per Recipient; Annual Expenditures Per Population; Monthly Average Percentage of Eligibles and Recipients; Annual Percentage of Population; Monthly Average Utilization Ratios, by County, Calendar Year 1970

County	Monthly[1] Average Expenditures Per Elig.	Monthly[1] Average Expenditures Per Rec.	Annual[1] Expenditures Per Popul.	Monthly Average % Elig.	Monthly Average % Rec.	Annual % Popul.	Monthly[2] Average Utilization Ratio
Atlantic	$13.75	$38.00	$17.67	4.8	5.5	2.4	36.2
Bergen	11.30	37.64	2.14	3.6	3.4	12.5	30.0
Burlington	11.62	35.87	4.52	2.7	2.7	4.5	32.4
Camden	14.33	36.28	13.16	8.9	11.1	6.4	39.5
Cape May	11.71	32.02	6.53	0.7	0.8	0.8	36.6
Cumberland	13.78	39.05	15.08	2.8	3.2	1.7	35.3
Essex	12.75	44.30	17.34	26.7	24.5	13.0	28.8
Gloucester	12.45	35.19	5.48	1.6	1.8	2.4	35.4
Hudson	10.18	43.81	7.84	9.9	7.3	8.5	23.2
Hunterdon	13.91	37.94	4.56	0.5	0.6	1.0	36.7
Mercer	12.78	45.66	9.57	4.8	4.3	4.2	28.0
Middlesex	10.97	42.61	4.76	5.4	4.4	8.2	25.7
Monmouth	13.87	41.32	9.49	6.6	7.1	6.4	33.6
Morris	14.81	42.41	2.49	1.4	1.5	5.4	34.9
Ocean	13.43	40.76	8.41	2.8	2.9	2.9	33.0
Passaic	14.98	42.28	12.58	8.2	9.2	6.4	35.4
Salem	11.20	34.81	8.13	0.9	1.0	0.8	32.1
Somerset	11.67	40.23	3.37	1.2	1.1	2.8	29.0
Sussex	13.53	36.50	6.60	0.8	0.9	1.1	37.1
Union	13.94	53.32	5.44	4.4	3.7	7.6	26.2
Warren	9.21	29.46	3.03	0.5	0.5	1.0	31.3
BIS[3]	-	-	-	0.8	2.5	-	100.0
State	$12.85	$41.54	$ 8.41	100.0	100.0	100.0	31.5

Sources: Bureau of Census, Table G and Table J.

1. Excludes the costs of nursing home care, mental and tuberculosis hospital care, and Medicare B premiums. These costs were 51.5% of the total State outlay of $124,225,700.
2. The monthly average number of recipients divided by the monthly average number of eligibles.
3. Bureau of Institutional Services.