THE CAPITOL FORUMS
On Health & Medical Care

The Issue Brief Review
1997

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THE ISSUE BRIEF REVIEW

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INTRODUCTION

The 1997 Capitol Forums Issue Brief Review marks the close of the 1995-1997 series of The Capitol Forums on Health and Medical Care and the beginning of the 1997-2000 series of forums. The publication consists of two components. It is designed to provide a general overview of selected health related subject areas addressed in previous years. The Issue Briefs provided as background information for the Capitol Forums Programs from June 1996 through March 1997 are included here in their entirety, as well as updated information on selected topics addressed at Capitol Forum programs held in prior years. This updated information is meant to offer an overview rather than an in-depth analysis of what has transpired since the subject was first examined by the Capitol Forums. It is important to note that no attempt was made to repeat information provided in the initial brief, therefore reference should be made to those original briefs as needed.

Historically The Capitol Forums on Health and Medical Care started at the time of the great upheaval, re-examination and transformation in the delivery of health and medical care. The purpose of The Capitol Forums has been and will continue to be to provide New Jersey decision makers at all levels of government and within the private sector with balanced and nonpartisan information, research and analysis of key health care issues. The program also provides an off-the-record "safe harbor" where dialogue about New Jersey's health and medical care system and issues related to access, quality and cost can take place.

As the Capitol Forums revisits these important issues, there will be new Issue Briefs prepared. There will also be short updates prepared regularly for each subject area. Owing to the "lag" in data analysis once the health data has been collected, we have provided for our updates the most recent data available. In cases where we felt confident about the reliability and validity of data projections, we have included them to be used in five-year planning decisions.

For the past four years The Capitol Forums on Health and Medical Care have been convened by the Education Fund of the League of Women Voters of New Jersey as a public service and an information opportunity to relate to the League's legislator and state executive branch constituency. This successful endeavor has been supported by grants from The Robert Wood Johnson Foundation of Princeton. The League is grateful to the Foundation for its support of The Capitol Forums program.

A NEW JERSEY SNAPSHOT

During the course of our publication of the Capitol Forums on Health and Medical Care Issue Briefs, we have made reference to the dynamic quality of the evolving health care marketplace, both in New Jersey and throughout the country. In the past, we have referred to the challenge of trying to describe a certain aspect or component of the health care system as "taking a snapshot of a moving train." This concept remains true, for every dimension of the health care arena is "in process" and not a static thing which can be pinned down and quantified.

With this caveat in mind, Chart 1 offers a type of "snapshot" of New Jersey with data on population, socio-economic characteristics, personal health care expenditures, health insurance and types of health care and insurance legislation currently in place. It serves as a backdrop against which to compare the other charts, tables and graphs in this Chart Book, updating data provided in earlier Capitol Forums issue briefs on a wide range of health and medical care issues.

Chart 1: A New Jersey Snapshot

PEOPLE: POPULATION AND ECONOMIC DATA

Bureau of the Census

Population (in thousands)	
1990	7,740
1991	7,767
1992	7,813
1993	7,859
1994	7,904
Population Projection: 1995 (% of total)	
Under age 18	24.6
Ages 18-44	40.8
Ages 45-64	20.9
Age 65+	13.8
White	80.8
Black	14.6
Asian/Pacific Islander	4.5
American Indian and other	0.2
Hispanic Origin	11.3
Total Households, 1994 (in thousands)	2,845
Household Heads, % Age 65+, 1994	23.2

National Center for Health Statistics

Births: 1993 (US in thousands)	
All Races	15,436
White Mothers	88,852
Black Mothers	23,128
Birth Rate, 1993 (per 1,000 population)	15.0
Fertility Rate, 1993 (per 1,000 women, 15-44)	65.8

National Center For Health Statistics, cont'd

Births to Unmarried Women: 1993	
Total (US in thousands)	
All Races	31,949
White	15,997
Black	15,489
% of births	
All races	27.1
White	18.0
Black	67.0

Bureau of Labor Statistics

Unemployment Rate, Civilian Labor Force, 1994	6.8

Bureau of Economic Analysis

Personal Income, 1994	
Total Per Capita	27,742
Disposable Per Capita	23,622

Bureau of the Census

Population Below Poverty Level (%), 1993	10.9

Social Security Administration

AFDC Recipients: 1993	
Total (in thousands)	340
As % of total population	43
SSI Recipients: 1995	
Total (in thousands)	142
As % of total population	1.8

TOTAL PERSONAL HEALTH CARE EXPENDITURES

Health Care Financing Administration (HCFA), Office of the Actuary

Resident Population	
Annual % growth, 1982-1992	0.5
% Growth 1992-1993	0.6
Personal Health Care Expenditures	
Total, 1993 (in millions)	25,741
Annual % growth, 1982-92	11.1
% Growth 1992-1993	7.4
Total, 1993, divided by population	3,275
% Of gross state product	10.7

PROVIDERS: HOSPITAL CARE

Hospital Care Expenditures	
Total, 1993 (in millions)	10,312
Annual % growth, 1982-92	9.7
% Growth 1992-93	9.6
Total, 1993, divided by population	1,312

STATE LEGISLATION

As of 8/1/95 (except where noted)

Insurance Reform	
Basic Benefits Package	Yes
Guaranteed Issue	Yes
Guaranteed Renewal	Yes
High Risk Pool	-
Individual	Yes
Portability	Yes
Purchasing Alliance	-
Rating Restrictions	Yes
Coverage for Targeted Populations	
Children's health Insurance	-
Indigent Care Programs	Yes
Other Coverage for Uninsured	Yes
Medicaid	
Research and Demonstration Waivers Section 1115, (Status as of 9/15/95):	
• Under Development	Yes
• Submitted	-
• Approved by Federal Government	-
• Implemented Section 1915 Waivers	Yes
Managed Care	
Any Willing Provider:	
• Allied (e.g. chiropractors)	-
• Pharmacies	Yes
• Broad array of providers	-
• Other (e.g. ancillary services; MDs)	-
Freedom of Choice	Yes
Accountable Health Plans	-
Networks	-
Regulation of UR Companies	-
Selected Clinical Mandates	Yes
Cost Containment	
Uniform Claims Forms	Yes
Regulation of Physician Practice	
Clinical Practice Guidelines	-
Self-Referral Restrictions	Yes
Antitrust	
Antitrust Immunity	-

PAYERS: HEALTH INSURANCE

Interstudy Publications

HMO ENROLLMENT: JAN 1995	
Pure (in thousands)	
Employer groups	739.6
Federal Employee Health Benefits Program	44.0
Direct Pay	8.3
Other	63.0
Total Commercial	854.9
Medicare	17.4
Medicaid	29.1
Total Pure	901.5
Open (POS), Total (in thousands)	61.9
Pure & Open, Total (in thousands)	963.4
Interstudy Population Denominator: 1995 (in thousands)	7,931
HMO MARKET PENETRATION: JAN 1995	
Pure (% of Population)	
Employer groups	9.3
Federal Employee Health Benefits Program	0.6
Direct pay	0.1
Other	0.8
Total Commercial	10.8
Medicare	0.2
Medicaid	0.4
Total	11.4
Open (POS), Total (% of population)	0.8
Pure & Open, Total (% of population)	12.1

THE UNINSURED - AN ONGOING UNRESOLVED PROBLEM
I. Charity Care-Delivery Systems and Funding

Original Issue Brief October 21, 1992 • October 11, 1995 • Update April 1997

New Jersey is continuing its commitment to the provision of health care services for the indigent at the state's acute care hospitals through its efforts at exploring new financing mechanisms for charity care. New Jerseyans are eligible for charity care services if there is no other public or private payer available and if certain income and asset standards are met. Under the funding provisions of New Jersey's Health Care Reform Act of 1992 (which eliminated the state's reimbursement to hospitals for bad debt), a Health Care Subsidy Fund was established to compensate hospitals for charity care. Under the 1992 Act, the terms of financing charity care through the state's surplus unemployment revenues expired on December 31, 1995. Between 1993 and 1995, New Jersey diverted approximately $1.6 billion from its Unemployment Insurance Trust Fund to pay for charity care and its subsidized insurance program, Health Access; $600 million was diverted in 1993, $500 million in 1994 and $500 million in 1995. Table 1 shows individual county and state totals for 1995 and 1996 charity care subsidies.

Under P.L. 1996, c. 28 (signed into law May 16, 1996), the state's charity care system was re-authorized for two years, after a five-month "stalemate" over the mechanisms to be used for hospital charity care funding. (The law made no provision for the continuation of the state's Health Access Program; see Section II on the status of New Jersey's insurance programs.) Also, unlike the state of Massachusetts (which is funding its health insurance expansion through cigarette tax revenues), a proposal for a 25 cents-a-pack increase on the state cigarette tax was not found to be a viable solution as a funding mechanism for charity care in the state of New Jersey.

For the years 1996 and 1997, the law is funding charity care for hospitals by continuing to use funds from the Unemployment Insurance Trust Fund and by beginning to use general revenue funds. The law calls for spending levels of $310 million for hospital charity care in 1996 and $300 million in 1997. The Hospital Relief Fund — which supports 30 urban hospitals — will provide $35 million for the second half of 1996 (to be matched by $35 million in Federal Medicaid monies) and $71 million in 1997. P.L. 1996, c. 28 reduced funding for the Hospital Relief Fund by $90 million in 1996.

In 1995, New Jersey's hospitals received approximately $542 million — representing $400 million for charity care and $142 million for the Hospital Relief Fund (*The Times*, May 17, 1996). The 1996 law sets forth that support for the state's charity care program will come from $660 million diverted from unemployment taxes in 1996 and 1997; and $15 million from the state's general revenue fund in 1996 and $41 million in 1997.

Charity Care Managed Care

P.L. 1996, c. 28 directs the State to develop a new model to provide charity care beginning on January 1, 1998: the state must "implement a health care program to provide low income residents . . .with eligible charity care on a managed care basis" (P.L. 1996, c. 28, sec.8). The program is to provide acute, emergent and chronic health services on a managed care basis to low-income persons. The program is to be administered by one or more program administrators under contract with the Department of Health and Senior Services. Eligibility for the managed care program will remain the same as the eligibility for charity care.

Beginning in July 1996, Commissioner of Health and Senior Services Len Fishman created the Charity Care Managed Care Advisory Committee (CCMCAC) to develop guidelines and principles for the charity care-managed care system. In analyzing demographic and claims data on charity care in New Jersey, the Department identified certain trends that are shaping the development of the new system. Specific findings included that: there is significant use of behavioral health services by charity care patients (approximately 10.5 percent of 1994 inpatient charity care expenditures were provided for alcohol or drug abuse and another 7.0 percent for mental health services); that charity care is generally not provided in the emergency room; and that most charity care patients are seen only once in a given time period (in contrast, managed care is most effective for persons with chronic or recurrent conditions). At present, the specific design of the system is in process. On March 24 1997, the New Jersey Department of Human Services submitted an 1115 Waiver application to the Health Care Financing Administration which seeks approval for the restructuring.

Table 1

1995 and 1996 Charity Care Subsidy and Subsidy Payments for New Jersey Hospitals by County

County Totals	1995 Charity Care Subsidy	1996 Charity Care Subsidy Payment
Atlantic	10,552,004	7,419,206
Bergen	37,088,502	28,441,580
Burlington	13,882,891	12,345,892
Camden	29,000,808	20,575,559
Cape May	2,877,688	1,584,380
Cumberland	2,515,185	2,137,387
Essex	109,778,244	81,909,116
Gloucester	2,854,160	1,344,410
Hudson	40,919,509	42,186,596
Hunterdon	886,425	1,301,639
Mercer	8,691,304	7,555,171
Middlesex	19,969,954	15,513,833
Monmouth	18,028,352	12,860,625
Morris	15,937,395	13,830,173
Ocean	7,612,874	5,569,748
Passaic	36,580,628	29,623,566
Salem	1,446,304	551,753
Somerset	1,021,030	979,125
Sussex	6,097,386	1,694,700
Union	33,540,853	21,820,524
Warren	718,506	755,015
GRAND TOTALS	**400,000,000**	**310,000,000**

Note: 1996 subsidy payments are based on 1995 documented charity care. Please refer to original issue brief for more information on subsidy payment formula which is based on volume, revenue and payer mix.

II. Health Insurance Reform Programs

Original Issue Brief April 5, 1995 • Update April 1997

Private health insurance in the United States, primarily an employer based system, has been steadily deteriorating over the last decade. Both prior to and following the failure of comprehensive reform at the federal level, states have attempted to address the issues.

In 1992, the New Jersey Legislature enacted health insurance reforms laws to increase access to coverage for all individuals and small employers. The New Jersey Individual Health Coverage ("IHC") Program and Small Employer Health Benefits ("SEH") Program have present ed new coverage opportunities for some, yet the cost of coverage may be too high for those who seek it.

Individual Health Coverage Program Monthly Rates -Snapshot Comparison-

	March 1995		April 1997	
	Single	Family	Single	Family
Plan A (Bare Bones)	$113-247	$290-680	$124-420	$319-907
Plan E ($150 deductible)	$372-713	$948-1598	$503-1999	$1458-5379
Plan E ($1,000 deductible)	-	$362-1076	-	$660-2116
•Plan D ($1,000 deductible)	$134-322	$317-939	$194-510	$547-1377

(• most popular plan)

The legislation also created a program, Health Access, which provides subsidies to bring payment of insurance premiums within the reach of more low-income New Jerseyans. This program accepted applications between April 10, 1995 and December 31, 1995 with enrollment reaching 22,000 in 1995. Since the funding for this program has not been renewed, enrollment has gone steadily downward as people became ineligible and no more were added. As of March 28, 1997 enrollment stood at 15,678. Almost all are on HMO plans. Should subsidy dollars become unavailable and enrollees notified that their subsidies will be terminated, they may find premiums for these plans beyond their ability to pay.

In the FY 1997-1998 proposed budget, $5 million is dedicated to the Children First program. It is estimated that 5,000 children will be covered by the program. Regulations published in the New Jersey Register on September 16, 1996 stated that: "According to the most recent population survey, there are approximately 200,000 uninsured children in New Jersey."

The newly enacted federal law, The Health Insurance Portability and Accountability Act of 1996 will be taking effect in the near future. Some of its provisions with regard to the definition of a small group and crediting of pre-existing condition for prior coverage will require statutory changes in New Jersey. Interim federal rules have become available only recently. New Jersey has applied to the Federal government to retain its current individual market program.

Both the IHC and SEH programs already meet or exceed the federal standards with respect to guaranteed issue and guaranteed renewability. Standardized plans as required by law have been developed. The IHC program employs community reading. The SEH program employs modified community rating. The law provides for a transition to pure community rating. Beginning in January 1994 premium rates for the highest rated small group and the lowest rated small group could not exceed a three to one band. This narrowed to a two to one band in 1996, and the market is scheduled to become fully community rated in January 1998. Changes being considered include maintaining the current rate structure and alterations in how the loss ratios are calculated; both would require a change in legislation. Currently, carriers may consider only age, gender, family status, and geographic location of the small employer in determining rates.

The enrollment figures provided by carriers in the small employer market have shown that New Jersey's reforms have been successful in reaching out to new employers. Generally, between 20 and 30 percent of all small groups purchasing coverage were not covered in the prior calender quarter. In addition, the number of covered persons has gradually increased since the inception of reform.

The Department of Insurance and Banking has no enrollment figures for the large group market as there is no reporting to the state for that statistic, but decline in employer based coverage in this market, particularly for family coverage, continues as a national trend.

The IHC and SEH Programs offer the following vital statistics as of year end 1996:

Individual Health Coverage Programs

- There are currently 162,986 persons covered by the standard health benefits plans, a decrease of 9% from the previous quarter.
- Enrollment in pre-form non-standard plans declined from 18,391 to 16,487, a decrease of 10% from the previous quarter.
- There are 27 carriers in the individual market, counting HMO and indemnity affiliates separately.
- As of April 1, 1997, the lowest price for single HMO coverage was $196 per month.
- The IHC Board, through assessments of private carriers, has reimbursed carriers for $215 million in losses on their individual business since 1992.

Small Employer Health Benefits Program

- There are currently 816,716 people (367,798 are employees) covered by 88,217 standard and non-standard small employer health benefits plans, unchanged from the previous quarter.
- 74 % are enrolled in standard plans, 26% in non-standard plans.
- Enrollment of small employers has increased by 5% in the last year.
- There are 62 carriers in the small employer market.
- On average, 30% of the small employers who obtained coverage in 1996 were previously uninsured.

There is general agreement that people without health insurance are more likely to have potentially avoidable hospitalizations, higher than average mortality rates and to be more ill at the time of admission to the hospital.

With federal reform methods proceeding at a modest scale, it is expected that states will need to continue to lead the way in innovative purchasing, legislation, rule making, resource development and direct service provision.

THE MEDICAID PROGRAM - TITLE XIX
III. Program Update

Original Issue Brief March 2, 1994 • April 4, 1994 • Update April 1997

General Overview

Medicaid, Title XIX of the Federal Social Security Act, is the country's major public financing program to provide health care for low-income Americans. Medicaid is a means-tested entitlement program financed by the state and Federal governments and administered by the states. The percentage of Federal funding to the states varies from 50 percent to 80 percent, and it is determined through a formula based on annual per capita income. New Jersey is a state with a 50-50 match with the Federal government; the national average has states paying approximately 43 percent of the overall Medicaid budget.

Table 1 shows federal and state shares of Medicaid expenditures by state for 1994. New Jersey's total Medicaid expenditures for 1994 were $4,793,000, representing approximately 15 percent of Medicaid expenditures for the Middle Atlantic states of New York, Pennsylvania and New Jersey. The states of New York and California represent the largest share of Medicaid expenditures, with $21,223,000 and $14,065,000, respectively — close to 20 percent of total national Medicaid expenditures. Table 2 places Medicaid spending in the context of total state spending and federal grants-in-aid. 1994 Medicaid spending represented 21.8 percent of New Jersey's total state budget; just two percent higher than the national average of 19.6 percent (See Table 2).

The states continue to establish their own financial eligibility criteria and have significant flexibility regarding coverage, reimbursement and eligibility for the Medicaid program. As a result, there continues to be substantial state-to-state variation in Medicaid and literally 51 different Medicaid programs are in operation throughout the country. (Reference is made to the 1996-1997 Capitol Forums Issue Briefs on Safety Net Providers and on Health Care for Children and Adolescents for current information about Medicaid program expansions and programs for the uninsured. The Issue Briefs are included at the end of this publication.)

In its 1996 "Medicaid Fact Sheet," the Kaiser Commission on the Future of Medicaid reports that by 1994, 34.2 million individuals — more than 1 in 10 Americans — were covered by Medicaid at a cost of $137.1 billion, comprised of Federal and state sources. During the period from 1992-1994, the number of Medicaid beneficiaries grew by an average of 7.1 percent nationally (See Table 3, "Medicaid Beneficiaries by State, 1988-1994"). By comparison, New Jersey showed an average annual growth of 5.7 percent during that same period. Across the country, 23 states (including New Jersey) reported an average annual growth under 6 percent for the period from 1992-1994.

Medicaid Beneficiary Groups and Enrollment

The Medicaid population is comprised of:

- 3.8 million elderly persons
- 5.4 million blind and disabled persons
- 7.9 million adults in families
- 17.1 million children

Table 4, "Medicaid Beneficiaries by Group, 1988-1994," shows the numbers of beneficiaries in each group — elderly, blind and disabled, adults and children — and the average annual growth of each of these groups between 1988 and 1994. For a general overview of where New Jersey stands in relation to other states, Table 5 lists the percent distribution, by beneficiary group, of Medicaid beneficiaries by state for 1994. New Jersey's beneficiary group percent distribution of 47.4 percent for children; 23.9 percent for adults; 17.5 percent for blind and disabled beneficiaries and 11.1 percent for the elderly closely parallels the percent distributions reported for the national average.

Overall, children and adults in families with children comprise approximately 75 percent of the Medicaid population, and the elderly and disabled account for the remaining 25 percent (Holahan and Liska, 1997). (See Table 6, listing Medicaid beneficiaries by group, for all states in 1994). The Medicaid beneficiary group of low-income children and adults is generally comprised of adults and children in AFDC (now TANF) families; low-income infants, children and pregnant women; medically needy individuals and those with coverage extended through Section 1115 waivers (*Policy Brief,* The Kaiser Commission on the Future of Medicaid, November 1996).

Medicaid Expenditures

Table 7 offers Medicaid expenditure and beneficiary projections for 1996 to 2002 as calculated by the Urban Institute using figures reported by the Congressional Budget Office in April 1996. The highest average annual growth for the period from 1996 to 2002 is for the blind and disabled (8.9 percent) and the elderly (8.2 percent);

Table 1

Federal and State Shares of Medicaid Expenditures by State, 1994

	Total Expenditures (millions)	FMAP[1] 1994	Federal Share (millions)	State Share (millions)
United States	**$137,112**	**57.2%**	**$78,410**	**$58,702**
New England	**$9,962**	**51.7%**	**$5,145**	**$4,807**
Connecticut	2,424	50.0	1,212	1,212
Maine	932	62.0	577	354
Massachusetts	4,696	50.0	2,348	2,348
New Hampshire	830	50.0	415	415
Rhode Island	787	53.9	424	363
Vermont	284	59.6	169	115
Middle Atlantic	**$32,447**	**50.9%**	**$16,520**	**$15,927**
New Jersey	4,793	50.0	2,396	2,396
New York	21,223	50.0	10,611	10,611
Pennsylvania	6,432	54.6	3,512	2,919
South Atlantic	**$20,139**	**59.3%**	**$11,937**	**$8,202**
Delaware	281	50.0	141	141
District of Columbia	790	50.0	395	395
Florida	5,347	54.8	2,929	2,418
Georgia	3,274	62.5	2,045	1,229
Maryland	2,246	50.0	1,123	1,123
North Carolina	3,175	65.1	2,068	1,107
South Carolina	4,900	71.1	1,351	550
Virginia	1,871	50.0	936	936
West Virginia	1,254	75.7	949	304
East South Central	**$7,669**	**71.0%**	**$5,441**	**$2,218**
Alabama	1,769	71.2	1,260	509
Kentucky	1,867	70.9	1,324	543
Mississippi	1,330	78.9	1,049	281
Tennessee	2,694	67.2	1,809	885
West South Central	**$14,317**	**68.0%**	**$9,742**	**$4,575**
Arkansas	1,074	74.5	800	274
Louisiana	4,065	73.5	2,987	1,078
Oklahoma	1,041	70.4	733	308
Texas	8,137	64.2	5,222	2,915
East North Central	**$20,780**	**57.3%**	**$11,915**	**$8,865**
Illinois	5,286	50.0	2,643	2,643
Indiana	2,811	63.5	1,784	1,026
Michigan	4,930	56.4	2,779	2,151
Ohio	5,499	60.8	3,345	2,154
Wisconsin	2,256	60.5	1,364	892
West North Central	**$8,258**	**59.8%**	**$4,941**	**$3,317**
Iowa	1,089	63.3	690	399
Kansas	981	59.5	584	397
Minnesota	2,470	54.7	1,350	1,120
Missouri	2,533	60.6	1,536	997
Nebraska	615	62.0	381	234
North Dakota	279	71.1	198	81
South Dakota	291	69.5	202	89
Mountain	**$5,101**	**64.7%**	**$3,298**	**$1,803**
Arizona	1,571	65.9	1,035	536
Colorado	1,119	54.3	608	512
Idaho	312	70.9	221	91
Montana	344	71.1	245	100
Nevada	418	50.3	210	208
New Mexico	665	74.2	493	172
Utah	513	74.4	382	132
Wyoming	158	65.6	104	54
Pacific	**$18,458**	**51.3%**	**$9,471**	**$8,988**
Alaska	288	50.0	144	144
California	14,065	50.0	7,032	7,032
Hawaii	458	50.0	229	229
Oregon	1,105	62.1	686	418
Washington	2,543	54.2	1,379	1,164

Source. Urban Institute calculations based on HCFA 64 data. State FMAPs are from The Medicaid Source Book: Background Data and Analysis (a 1993 update), Congressional Research Service, 1993.

Does not include administrative costs, accounting adjustments, or the US Territories; total spending for all categories in 1994 was approximately $143.7 billion. Totals may not add due to rounding.

[1] *Federal Medical Assistance Percentage.*

Table 2

Medicaid Spending as a Percent of Total State Budgets & Federal Grants-in-Aid, 1994

	Total State Medicaid Spending as a % of State Only Revenues	Total Federal Medicaid Spending as a % of Federal Grants-In-Aid	Total Medicaid Spending as a % of Total State Budgets[1]
United States	**11.9%**	**42.1%**	**19.6%**
New England			
Connecticut	12.0	46.4	15.9
Maine	13.8	53.4	23.4
Massachusetts	17.5	43.8	19.7
New Hampshire	26.7	52.9	37.5
Rhode Island	n/a	41.6	23.7
Vermont	13.9	31.9	17.9
Middle Atlantic			
New Jersey	13.5	53.2	21.8
New York	26.8	57.1	29.0
Pennsylvania	14.1	38.7	19.8
South Atlantic			
Delaware	4.5	26.7	8.3
District of Columbia	n/a	n/a	n/a
Florida	8.1	42.4	14.5
Georgia	10.4	42.5	19.1
Maryland	11.3	32.6	14.8
North Carolina	8.3	46.3	16.6
South Carolina	8.4	46.1	20.4
Virginia	7.3	36.4	12.1
West Virginia	8.6	48.2	22.0
East South Central			
Alabama	6.7	41.7	17.1
Kentucky	6.7	48.0	17.1
Mississippi	7.9	45.7	22.8
Tennessee	12.5	52.0	24.8
West South Central			
Arkansas	5.7	45.2	16.6
Louisiana	11.2	64.7	31.4
Oklahoma	5.6	38.3	14.1
Texas	11.5	51.0	22.8
East North Central			
Illinois	14.3	44.7	21.7
Indiana	11.7	51.5	24.4
Michigan	13.4	44.5	20.8
Ohio	8.8	30.3	22.4
Wisconsin	7.7	38.1	14.4
West North Central			
Iowa	6.5	32.0	12.9
Kansas	7.7	25.2	10.3
Minnesota	10.9	47.0	18.4
Missouri	13.0	50.0	21.1
Nebraska	8.1	38.4	15.2
North Dakota	7.3	28.6	13.1
South Dakota	9.1	32.3	18.1
Mountain			
Arizona	8.8	33.2	15.3
Colorado	8.9	35.6	15.5
Idaho	5.5	29.2	13.4
Montana	6.1	35.5	14.2
Nevada	6.8	32.5	10.1
New Mexico	4.3	35.5	12.4
Utah	3.9	36.1	11.5
Wyoming	4.0	26.7	8.6
Pacific			
Alaska	3.6	14.0	5.3
California	13.3	29.1	20.1
Hawaii	4.2	27.8	8.2
Oregon	5.3	36.3	11.2
Washington	9.8	40.4	15.4

Source: HCFA 64 and National Association of State Budget Officers.
Does not include the U.S. Territories. Totals may not add up due to rounding.
[1] *Total Medicaid Spending includes both federal and state expenditures.*

Table 3

Medicaid Beneficiaries by State, 1988-1994
ALL Beneficiaries

	Beneficiaries (thousands)				Average Annual Growth			
	1988	1990	1992	1994	1988-94	1988-90	1990-92	1992-94
United States	**22,014**	**24,066**	**29,811**	**34,183**	**7.6%**	**4.6%**	**11.3%**	**7.1%**
New England	**1,070**	**1,187**	**1,412**	**1,525**	**6.1%**	**5.3%**	**9.1%**	**4.0%**
Connecticut	213	243	305	344	8.3	6.8	12.1	6.2
Maine	119	133	162	176	6.7	5.5	10.5	4.2
Massachusetts	555	591	678	704	4.0	3.2	7.1	1.9
New Hampshire	33	43	70	83	16.5	13.8	27.7	8.8
Rhode Island	99	117	119	126	4.2	8.9	0.8	3.1
Vermont	51	60	78	92	10.2	8.5	13.3	9.0
Middle Atlantic	**3,968**	**4,060**	**4,429**	**4,837**	**3.7%**	**1.1%**	**4.4%**	**5.6%**
New Jersey	533	567	697	779	6.5	3.1	10.9	5.7
New York	2,212	2,326	2,557	2,903	4.6	2.6	4.8	6.6
Pennsylvania	1,223	1,167	1,175	1,255	0.4	-2.3	0.3	3.4
South Atlantic	**2,982**	**3,617**	**4,969**	**5,888**	**12.0%**	**10.1%**	**17.2%**	**8.9%**
Delaware	40	50	61	75	11.0	11.5	10.5	10.8
District of Columbia	97	93	108	127	4.7	-1.8	7.7	8.5
Florida	768	989	1,530	1,727	14.5	13.5	24.4	6.2
Georgia	537	649	863	1,070	12.2	9.9	15.3	11.4
Maryland	320	328	373	415	4.4	1.2	6.6	5.5
North Carolina	411	563	785	983	15.7	17.1	18.1	11.9
South Carolina	263	316	427	483	10.7	9.5	16.3	6.4
Virginia	326	379	515	642	11.9	7.9	16.5	11.6
West Virginia	221	250	308	366	8.8	6.4	10.9	9.0
East South Central	**1,802**	**1,864**	**2,321**	**2,876**	**10.2%**	**7.9%**	**11.6%**	**11.3%**
Alabama	305	352	467	538	9.9	7.4	15.2	7.4
Kentucky	452	468	583	621	5.4	1.7	11.7	3.2
Mississippi	366	433	487	526	6.2	8.8	6.0	3.9
Tennessee[1]	479	612	784	1,191	16.4	13.0	13.2	23.3
West South Central	**1,981**	**2,540**	**3,366**	**3,997**	**12.4%**	**13.2%**	**15.1%**	**9.0%**
Arkansas	227	254	319	337	6.8	5.8	12.1	2.8
Louisiana	433	573	684	757	9.8	15.1	9.3	5.2
Oklahoma	260	271	356	388	6.9	2.3	14.6	4.4
Texas	1,062	1,442	2,007	2,514	15.5	16.5	18.0	11.9
East North Central	**3,905**	**4,020**	**4,805**	**5,195**	**4.9%**	**1.5%**	**9.3%**	**4.0%**
Illinois	1,043	1,067	1,313	1,441	5.5	1.2	10.9	4.8
Indiana	328	345	502	601	10.6	2.6	20.5	9.4
Michigan	1,063	1,039	1,128	1,187	1.9	-1.1	4.2	2.6
Ohio	1,118	1,178	1,424	1,496	5.0	2.6	10.0	2.5
Wisconsin	352	391	438	470	4.9	5.3	5.8	3.7
West North Central	**1,304**	**1,463**	**1,728**	**1,928**	**8.7%**	**5.9%**	**8.7%**	**5.6%**
Iowa	228	240	278	302	4.8	2.6	7.7	4.2
Kansas	170	194	225	252	6.7	6.8	7.6	5.8
Minnesota	336	364	401	413	3.5	4.1	5.0	1.4
Missouri	379	448	554	669	9.9	8.7	11.2	9.8
Nebraska	105	118	148	159	7.1	5.9	12.1	3.6
North Dakota	44	49	57	62	5.9	5.1	7.9	4.6
South Dakota	41	49	64	72	9.5	9.0	14.1	5.5
Mountain	**747**	**896**	**1,276**	**1,560**	**13.1%**	**9.5%**	**19.4%**	**10.6%**
Arizona[1]	213	276	402	509	15.6	14.0	20.6	12.5
Colorado	180	191	259	287	8.1	3.0	16.5	5.3
Idaho	46	55	87	110	15.5	8.5	26.2	12.5
Montana	56	61	60	95	9.1	3.9	-0.8	26.0
Nevada	39	47	78	96	16.3	10.3	28.4	11.0
New Mexico	105	129	212	258	16.2	11.1	27.9	10.3
Utah	86	108	137	157	10.6	12.3	12.6	7.0
Wyoming	23	29	42	50	13.5	11.6	21.0	8.3
Pacific	**4,453**	**4,419**	**5,505**	**6,275**	**5.9%**	**-0.4%**	**11.5%**	**6.8%**
Alaska	33	39	56	69	13.1	9.0	21.4	9.4
California	3,675	3,624	4,486	5,008	5.3	-0.7	11.3	5.7
Hawaii	96	81	98	119	3.7	-8.3	10.3	10.3
Oregon	189	227	295	411	13.6	9.6	14.0	18.0
Washington	461	448	569	668	6.4	-1.4	12.7	8.4

Source: Urban Institute calculations based on HCFA 2082 data.

Does not include the US Territories. Totals may not add due to rounding.

[1] For Arizona and Tennessee, expenditure and beneficiary data are based on figures reported directly by the state; adjustments were made to categorize these numbers in the same manner as other states report to HCFA.

Table 4

Medicaid Beneficiaries by Group, 1988-1994
United States

Beneficiary Group	Beneficiaries (thousands)					Average Annual Growth			
	1988	1990	1992	1993	1994	1988-1994	1988-90	1990-92	1992-94
All Beneficiaries	**22,014**	**24,066**	**29,811**	**32,441**	**34,183**	**7.6%**	**4.6%**	**11.3%**	**7.1%**
Cash Assistance	15,945	16,144	18,460	19,475	19,847	3.7	0.6	6.9	3.7
Other Beneficiaries	6,068	7,922	11,351	12,966	14,336	15.4	14.3	19.7	12.4
Elderly	**3,130**	**3,167**	**3,547**	**3,680**	**3,828**	**3.4%**	**0.6%**	**5.8%**	**3.9%**
Cash Assistance	1,664	1,532	1,573	1,564	1,574	-0.9	-4.1	1.3	0.0
Other Beneficiaries	1,466	1,635	1,974	2,116	2,254	7.4	5.6	9.9	6.8
Blind and Disabled	**3,443**	**3,717**	**4,471**	**4,991**	**5,381**	**7.7%**	**3.9%**	**9.7%**	**9.7%**
Cash Assistance	2,753	2,966	3,517	3,906	4,223	7.4	3.8	8.9	9.6
Other Beneficiaries	690	750	954	1,085	1,159	9.0	4.3	12.8	10.2
Adults	**5,081**	**5,696**	**6,982**	**7,451**	**7,860**	**7.5%**	**5.9%**	**10.7%**	**6.1%**
Cash Assistance	3,867	3,865	4,379	4,568	4,571	2.8	0.0	6.4	2.2
Other Beneficiaries	1,214	1,831	2,603	2,884	3,288	18.1	22.8	19.2	12.4
Children	**10,360**	**11,486**	**14,811**	**16,319**	**17,115**	**8.7%**	**5.3%**	**13.6%**	**7.5%**
Cash Assistance	7,662	7,781	8,992	9,437	9,479	3.6	0.8	7.5	2.7
Other Beneficiaries	2,698	3,706	5,820	6,882	7,635	18.9	17.2	25.3	14.5

Source: Urban Institute calculations based on HCFA 2082 data.
Does not include the US Territories. Totals may not add due to rounding. "Cash" refers to beneficiary groups who receive AFDC or SSI. "Other" groups (non-cash, poverty-related) include the medically needy, poverty-related expansion groups, and 1115 waiver eligibles (where identifiable). Beneficiaries are defined as individuals enrolled in the Medicaid program who actually receive medical services.

Table 5

Medicaid Beneficiaries by State, 1994
Percent Distribution, by Beneficiary Group

	Total	Children	Adults	Blind & Disabled	Elderly
United States	**100.0%**	**50.1%**	**23.0%**	**16.7%**	**11.2%**
New England	**100.0%**	**46.5%**	**22.4%**	**17.8%**	**13.2%**
Connecticut	100.0	52.0	22.9	14.5	10.6
Maine	100.0	46.4	21.6	19.0	13.0
Massachusetts	100.0	43.5	22.5	19.5	14.6
New Hampshire	100.0	51.0	21.2	16.0	11.8
Rhode Island	100.0	42.7	21.9	19.7	15.8
Vermont	100.0	51.1	23.0	14.7	11.2
Middle Atlantic	**100.0%**	**48.7%**	**20.6%**	**17.7%**	**12.1%**
New Jersey	100.0	47.4	23.9	17.5	11.1
New York	100.0	50.7	20.4	16.2	12.6
Pennsylvania	100.0	48.7	19.0	21.0	11.4
South Atlantic	**100.0%**	**53.2%**	**19.5%**	**15.4%**	**12.0%**
Delaware	100.0	56.6	20.8	14.8	7.8
District of Columbia	100.0	53.0	22.6	17.0	7.4
Florida	100.0	60.3	13.3	14.5	11.8
Georgia	100.0	51.3	22.5	16.6	9.7
Maryland	100.0	49.9	19.3	19.6	11.2
North Carolina	100.0	50.0	24.5	11.5	14.0
South Carolina	100.0	48.2	17.8	18.1	15.8
Virginia	100.0	52.1	19.5	15.1	13.3
West Virginia	100.0	45.0	27.3	18.3	9.5
East South Central	**100.0%**	**44.5%**	**23.4%**	**20.5%**	**11.6%**
Alabama	100.0	45.9	17.5	23.3	13.3
Kentucky	100.0	44.9	21.5	23.4	10.2
Mississippi	100.0	49.5	15.9	22.3	12.4
Tennessee[1]	100.0	41.4	30.4	17.0	11.2
West South Central	**100.0%**	**53.2%**	**21.0%**	**13.1%**	**12.7%**
Arkansas	100.0	42.8	17.1	24.8	15.4
Louisiana	100.0	49.7	19.6	18.0	12.8
Oklahoma	100.0	51.1	22.1	13.5	13.3
Texas	100.0	56.0	21.8	10.0	12.3
East North Central	**100.0%**	**50.7%**	**23.1%**	**16.6%**	**9.6%**
Illinois	100.0	52.2	21.7	18.0	8.1
Indiana	100.0	53.5	23.8	11.2	11.6
Michigan	100.0	48.3	26.7	18.0	7.0
Ohio	100.0	51.7	22.8	14.7	10.8
Wisconsin	100.0	45.7	18.1	22.1	14.1
West North Central	**100.0%**	**50.0%**	**22.6%**	**14.6%**	**12.8%**
Iowa	100.0	46.9	24.9	15.7	12.5
Kansas	100.0	52.3	23.3	14.2	10.1
Minnesota	100.0	49.0	22.5	15.7	12.8
Missouri	100.0	49.2	23.6	13.8	13.4
Nebraska	100.0	58.2	15.4	13.6	12.8
North Dakota	100.0	49.0	20.0	13.5	17.5
South Dakota	100.0	51.2	18.8	17.4	12.7
Mountain	**100.0%**	**55.3%**	**24.0%**	**12.7%**	**8.1%**
Arizona	100.0	58.8	24.5	11.1	5.6
Colorado	100.0	50.4	23.3	13.4	12.8
Idaho	100.0	54.4	22.2	15.3	8.2
Montana	100.0	52.6	22.3	15.8	9.3
Nevada	100.0	50.5	23.4	15.0	11.1
New Mexico	100.0	56.6	23.2	13.3	6.8
Utah	100.0	55.1	28.0	10.9	6.0
Wyoming	100.0	58.0	21.7	11.0	9.3
Pacific	**100.0%**	**47.1%**	**29.2%**	**13.9%**	**9.8%**
Alaska	100.0	56.4	28.4	8.7	6.5
California	100.0	46.9	28.9	14.1	10.2
Hawaii	100.0	51.6	22.7	14.8	10.8
Oregon	100.0	41.9	39.2	10.8	8.2
Washington	100.0	50.2	26.7	15.1	8.0

Source: Urban Institute calculations based on HCFA 2082 data.
Does not include the US Territories. Totals may not add due to rounding.
[1] For Arizona and Tennessee, expenditure and beneficiary data are based on figures reported directly by the state; adjustments were made to categorize these numbers in the same manner as other states report to HCFA.

Table 6

Medicaid Beneficiaries by State, 1994

ALL Beneficiaries, by Beneficiary Group

(thousands of people)

	Total	Children	Adults	Blind & Disabled	Elderly
United States	**34,183**	**17,116**	**7,860**	**6,381**	**3,828**
New England	**1,525**	**710**	**342**	**272**	**202**
Connecticut	344	179	79	50	37
Maine	176	82	38	33	23
Massachusetts	704	306	158	137	103
New Hampshire	83	42	18	13	10
Rhode Island	126	54	28	25	20
Vermont	92	47	21	14	10
Middle Atlantic	**4,937**	**2,462**	**1,017**	**872**	**596**
New Jersey	779	369	186	137	87
New York	2,903	1,472	593	471	367
Pennsylvania	1,255	611	238	264	143
South Atlantic	**5,888**	**3,131**	**1,146**	**907**	**704**
Delaware	75	42	15	11	6
District of Columbia	127	67	29	22	9
Florida	1,727	1,042	229	251	204
Georgia	1,070	549	240	177	104
Maryland	415	207	80	81	46
North Carolina	983	491	241	113	138
South Carolina	483	233	86	88	76
Virginia	642	334	125	97	85
West Virginia	366	165	100	67	35
East South Central	**2,876**	**1,279**	**674**	**590**	**333**
Alabama	538	247	94	126	71
Kentucky	621	279	134	145	63
Mississippi	526	260	84	117	65
Tennessee[1]	1,191	493	363	203	133
West South Central	**3,997**	**2,126**	**839**	**523**	**509**
Arkansas	337	144	58	83	52
Louisiana	757	376	148	136	97
Oklahoma	388	198	86	52	52
Texas	2,514	1,407	547	251	309
East North Central	**5,195**	**2,635**	**1,199**	**884**	**497**
Illinois	1,441	752	313	260	116
Indiana	601	322	143	67	70
Michigan	1,187	573	317	213	84
Ohio	1,496	774	341	220	161
Wisconsin	470	215	85	104	66
West North Central	**1,928**	**964**	**436**	**283**	**246**
Iowa	302	142	75	47	38
Kansas	252	132	59	36	26
Minnesota	413	202	93	65	53
Missouri	669	329	158	92	90
Nebraska	159	93	24	22	20
North Dakota	62	31	12	8	11
South Dakota	72	37	13	12	9
Mountain	**1,560**	**883**	**374**	**198**	**126**
Arizona[1]	509	299	125	56	29
Colorado	287	145	67	39	37
Idaho	110	60	24	17	9
Montana	95	50	21	15	9
Nevada	96	48	22	14	11
New Mexico	258	146	60	34	18
Utah	157	87	44	17	9
Wyoming	50	29	11	5	5
Pacific	**6,275**	**2,955**	**1,833**	**873**	**615**
Alaska	69	39	20	6	4
California	5,008	2,346	1,447	704	510
Hawaii	119	62	27	18	13
Oregon	411	172	161	44	34
Washington	668	336	178	101	53

Source: Urban Institute calculations based on HCFA 2082 data.

Does not include the US Territories. Totals may not add due to rounding.

[1] For Arizona and Tennessee, expenditure and beneficiary data are based on figures reported directly by the state; adjustments were made to categorize these numbers in the same manner as other states report to HCFA.

Table 7

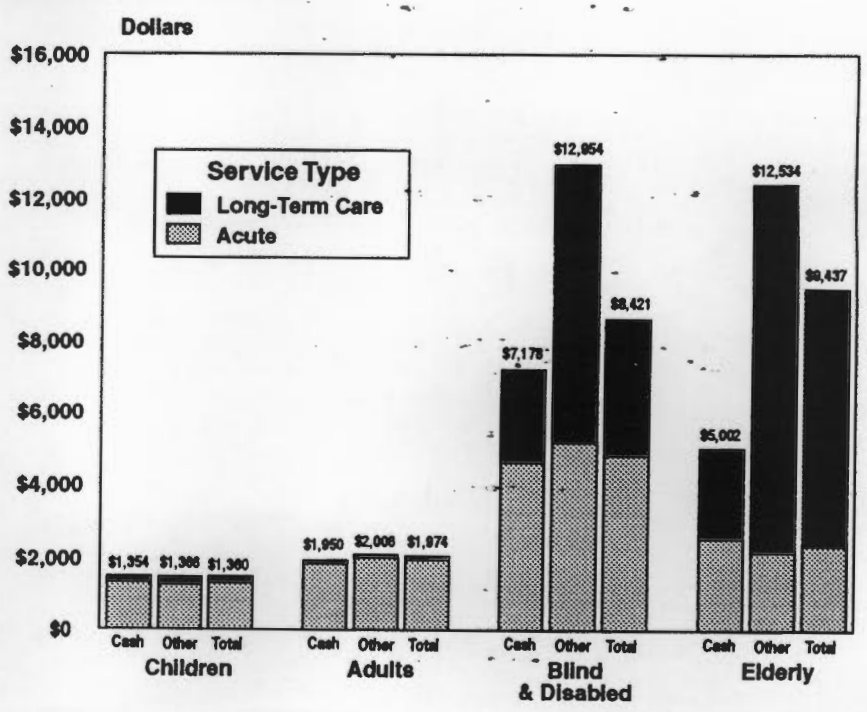
Federal Medicaid Expenditure and Beneficiary Projections, 1996-2002
By Eligibility Group and Type of Service Simulated[1] UI Baseline

	Simulated UI Baseline			
Expenditures (billions)	**1996**	**2002**	**Total 1996-2002**	**Ave. Annual Growth**
Totals	$95.8	$147.3	$839.1	7.4%
Benefits 81.0	127.0	717.4	7.8%	
Benefits by Service				
Acute Care	50.8	76.8	441.1	7.1%
Long-term Care	30.2	50.2	276.6	8.9%
Benefits by Group				
Elderly	25.7	41.3	231.0	8.2%
Blind and Disabled	29.1	48.7	267.6	8.9%
Families	26.1	36.9	218.8	6.0%
DSH 10.7	13.7	84.6	4.3%	
Administration	4.1	6.6	37.0	8.0%
Beneficiaries (millions)	**1996**	**2002**		
Totals	36.7	40.1		1.6%
By Group				
Elderly	4.3	5.0		2.5%
Blind and Disabled	6.0	7.4		3.5%
Families	26.4	28.0		1.0%
Benefits per Beneficiary	**1996**	**2002**		
Totals	$2,203	$3141		6.1%
By Group				
Elderly	5,976	8,286		5.6%
Blind and Disabled	4,830	6,571		5.3%
Families	988	1,318		4.9%

[1] The Urban Institute Medicaid Expenditure base line was modified to approximate 1996 expenditure and beneficiary levels reported in the April 1996 CBO baseline.

Table 8

Medicaid Expenditures per Beneficiary, 1994
by Beneficiary Group, Cash Assistance Status, & Service



Source: Urban Institute calculations based on HCFA and HCFA 2082.
Does not include Disproportionate Share Hospital payments. Payments to Medicare are included in spending for the cash assistance elderly. Payments to HMOs are included in spending for children and adults. Beneficiaries are defined as individuals enrolled in the Medicaid program who actually receive medical services. "Cash" refers to individuals who receive AFDC or SSI. "Other" groups include the medically needy poverty-related expansion groups and 1115 waiver eligibles (where defined). Does not include U.S. Territories, adjustments or administrative costs.

Table 8A

Federal and State Shares of Medicaid Expenditures by State, 1994 per Beneficiary

	Total			Federal			State		
	Total Expenditures	Non-DSH Expenditures	DSH	Total Federal Expenditures	Non-DSH Expenditures	DSH	Total State Expenditures	Non-DSH Expenditures	DSH
United States	**$4,011**	**$3,617**	**$494**	**$2,294**	**$2,009**	**$284**	**$1,717**	**$1,508**	**$210**
New England	**$6,524**	**$5,469**	**$1,055**	**$3,373**	**$2,829**	**$544**	**$3,151**	**$2,640**	**$511**
Connecticut	7,042	5,854	1,188	3,521	2,927	594	3,521	2,927	594
Maine	5,288	4,350	938	3,277	2,695	581	2,012	1,655	357
Massachusetts	6,672	5,903	769	3,336	2,951	384	3,336	2,951	384
New Hampshire	10,036	5,440	4,596	5,018	2,720	2,298	5,018	2,720	2,298
Rhode Island	6,224	5,474	750	3,353	2,949	404	2,871	2,525	346
Vermont	3,088	2,883	205	1,839	1,717	122	1,249	1,166	83
Middle Atlantic	**$6,572**	**$5,689**	**$882**	**$3,346**	**$2,897**	**$449**	**$3,226**	**$2,792**	**$434**
New Jersey	6,152	4,826	1,327	3,076	2,413	663	3,076	2,413	663
New York	7,311	6,447	863	3,655	3,224	432	3,655	3,224	432
Pennsylvania	5,123	4,473	650	2,798	2,443	355	2,325	2,030	295
South Atlantic	**$3,420**	**$3,087**	**$334**	**$2,027**	**$1,819**	**$208**	**$1,393**	**$1,268**	**$125**
Delaware	3,773	3,693	79	1,886	1,847	40	1,886	1,847	40
District of Columbia	6,214	5,794	420	3,107	2,897	210	3,107	2,897	210
Florida	3,096	2,931	165	1,696	1,606	90	1,400	1,325	75
Georgia	3,058	2,726	332	1,910	1,703	207	1,148	1,023	125
Maryland	5,414	5,051	363	2,707	2,526	181	2,707	2,526	181
North Carolina	3,230	2,833	396	2,104	1,846	258	1,126	988	138
South Carolina	3,932	2,936	996	2,795	2,087	708	1,137	849	288
Virginia	2,917	2,699	218	1,458	1,349	109	1,458	1,349	109
West Virginia	3,426	3,143	283	2,594	2,380	214	832	763	69
East South Central	**$2,663**	**$2,402**	**$261**	**$1,892**	**$1,703**	**$189**	**$771**	**$699**	**$73**
Alabama	3,287	2,512	776	2,341	1,789	552	946	723	223
Kentucky	3,007	2,898	108	2,132	2,055	77	875	843	32
Mississippi	2,529	2,228	301	1,994	1,757	237	535	471	64
Tennessee[1]	2,261	2,171	90	1,518	1,458	61	743	713	30
West South Central	**$3,582**	**$2,865**	**$717**	**$2,437**	**$1,946**	**$492**	**$1,145**	**$919**	**$226**
Arkansas	3,185	3,176	9	2,371	2,365	7	813	811	2
Louisiana	5,368	3,616	1,752	3,945	2,658	1,287	1,423	959	464
Oklahoma	2,680	2,619	61	1,886	1,844	43	793	775	18
Texas	3,237	2,635	602	2,077	1,691	386	1,159	944	216
East North Central	**$4,000**	**$3,669**	**$331**	**$2,294**	**$2,102**	**$191**	**$1,707**	**$1,567**	**$140**
Illinois	3,668	3,459	208	1,834	1,730	104	1,834	1,730	104
Indiana	4,676	4,186	490	2,969	2,658	311	1,707	1,528	179
Michigan	4,154	3,638	519	2,342	2,050	292	1,813	1,586	226
Ohio	3,676	3,343	333	2,236	2,033	202	1,440	1,309	130
Wisconsin	4,797	4,772	25	2,901	2,885	15	1,696	1,886	10
West North Central	**$4,282**	**$3,796**	**$486**	**$2,562**	**$2,269**	**$293**	**$1,720**	**$1,526**	**$194**
Iowa	3,609	3,589	20	2,286	2,273	13	1,323	1,316	7
Kansas	3,897	3,241	656	2,320	1,929	390	1,578	1,312	266
Minnesota	5,976	5,872	106	3,267	3,209	58	2,711	2,663	48
Missouri	3,788	2,721	1,066	2,297	1,650	647	1,491	1,071	420
Nebraska	3,867	3,812	55	2,397	2,363	34	1,470	1,449	21
North Dakota	4,469	4,451	19	3,179	3,166	13	1,290	1,285	5
South Dakota	4,063	4,059	4	2,824	2,821	3	1,239	1,238	1
Mountain	**$3,269**	**$3,077**	**$192**	**$2,114**	**$2,002**	**$112**	**$1,156**	**$1,076**	**$80**
Arizona	3,088	2,880	208	2,035	1,898	137	1,053	982	71
Colorado	3,904	3,533	371	2,120	1,918	201	1,784	1,614	170
Idaho	2,833	2,829	4	2,009	2,006	3	824	823	1
Montana	3,627	3,625	3	2,577	2,575	2	1,050	1,049	1
Nevada	4,374	3,604	770	2,201	1,813	388	2,174	1,791	383
New Mexico	2,581	2,551	31	1,915	1,892	23	667	659	8
Utah	3,268	3,238	31	2,430	2,407	23	838	830	8
Wyoming	3,186	3,186	0	2,091	2,091	0	1,095	1,095	0
Pacific	**$2,941**	**$2,561**	**$380**	**$1,509**	**$1,317**	**$193**	**$1,432**	**$1,245**	**$188**
Alaska	4,181	3,928	253	2,091	1,964	127	2,091	1,964	127
California	2,809	2,408	401	1,404	1,204	201	1,404	1,204	201
Hawaii	3,841	3,594	247	1,921	1,797	124	1,921	1,797	124
Oregon	2,686	2,634	52	1,689	1,656	32	1,017	998	20
Washington	3,805	3,342	462	2,064	1,813	251	1,741	1,529	211

Source: Urban Institute calculations based on HCFA 2082 and HCFA 64 data.
Does not include administrative costs, accounting adjustments, or the US Territories. Totals may not add due to rounding.
"DSH" refers to Disproportionate Share Hospital payments.

Medicaid expenditures for long-term care services are also expected to grow by 8.9 percent during the same period.

For 1994, national average Medicaid expenditures per beneficiary were approximately $9,437 per elderly beneficiary and $8,421 per blind and disabled beneficiary, compared to $1,974 per non-elderly adult and $1,360 per child beneficiary (See Table 8, "Medicaid Expenditures, per Beneficiary, 1994"). The higher per beneficiary expenditures for elderly, blind and disabled individuals reflect the expensive costs of acute and long-term care services. In general, spending per beneficiary was lowest in the South and highest in the Middle Atlantic States and New England, with New York showing the highest expenditure of $7,311 per beneficiary. New Jersey's 1994 Medicaid expenditures per beneficiary were reported at $6,152, compared to the national average of $4,011. (See Table 8A, "Federal and State Shares of Medicaid Expenditures by State, 1994, per Beneficiary").

Distribution of Medicaid Expenditures by Beneficiary Group

The distribution of expenditures remains the same as in the early 1990s: almost two-thirds of Medicaid expenditures are for the elderly and disabled populations, owing to their complex health care needs for acute and long-term care services (Ibid). Chart 9, "Medicaid Expenditures, 1994, by Beneficiary Group and Cash Assistance Status," shows that of total 1994 expenditures of $137.1 billion, expenditures for the blind and disabled equaled 33 percent; expenditures for the elderly represented 25 percent; expenditures for children represented 17 percent and expenditures for non-elderly adults represented just over 11 percent of total Medicaid expenditures. Disproportionate share hospital payments made up the remaining 12.3 percent of Medicaid expenditures for 1994.

Medicaid Program Services

Throughout the states, the Medicaid programs cover a wide range of acute and long-term care services. Regarding acute care services, the largest portion of Medicaid spending comprises several services: hospital inpatient care; physician, laboratory and X-ray services; outpatient and clinic services; early and periodic screening, diagnosis and treatment (EPSDT) and payment to HMOs, under Medicaid managed care. Medicaid long-term care services covers primarily institutional care — nursing facilities and intermediate care facilities for the mentally retarded. Although institutional care is the largest component of Medicaid long-term care spending, home and community-based services continue to "grow" in terms of enrollment and Medicaid expenditures (Holahan and Liska, 1996). In addition to financing acute and long-term care services, Medicaid also pays Medicare's cost sharing, premiums and deductibles for approximately 3.7 million low-income Medicare beneficiaries (*Policy Brief*, The Kaiser Commission on the Future of Medicaid, November 1996).

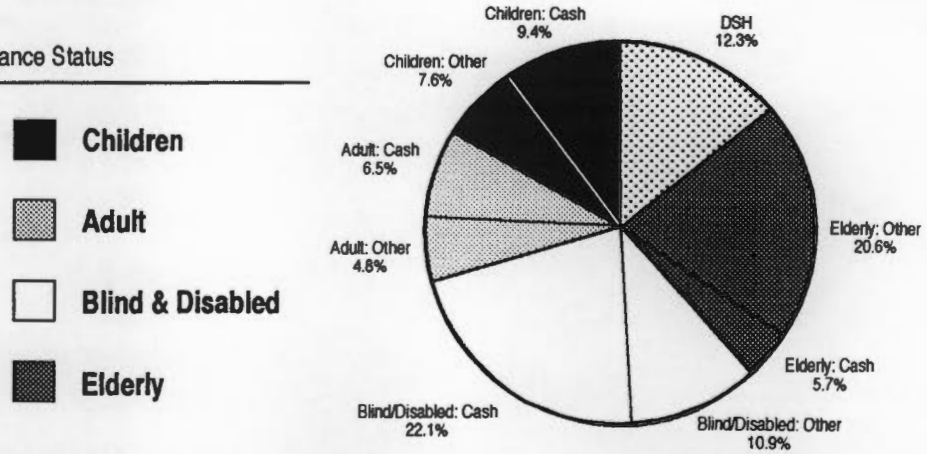
Chart 10, "Medicaid Expenditures, 1994, by Type of Service," and Table 11, "Medicaid Expenditures by Beneficiary Group and Type of Service, 1994," indicate the breadth of services provided by Medicaid and the expenditures for those services. When Medicaid payments for long-term care services (skilled nursing facilities, and intermediate care facilities for the mentally retarded) are factored into a percent distribution, they comprise 35.8 percent of Medicaid expenditures in 1994. Fifty-two percent, or slightly over half, of Medicaid spending on ser-

Chart 9

Medicaid Expenditures, 1994
by Beneficiary Group and Cash Assistance Status

Total Expenditures = $137.1 billion

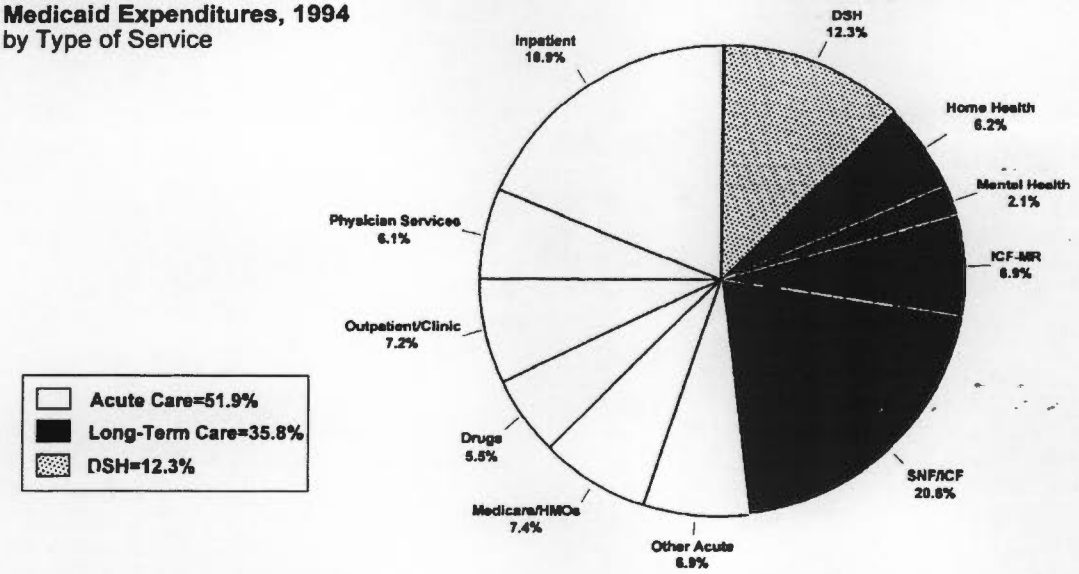
Source: Urban Institute calculations based on HCFA 2082 and HCFA 64 Data.
Does not include administrative costs, acounting adjustments, or the US territories; total spending for all categories in 1994 was approximatley $143.7 billion. Totals may not add due to rounding. "Cash" refers to beneficiary groups who receive AFDC or SSI. "Other" groups (non-cash, poverty-related) include the medically needy, poverty-related expansion groups, and 1115 waiver eligibles (where identifiable). States do not report payments to Medicare or HMOs by beneficiary group; payments to Medicare were distributed among aged, blind & disbled and payments to HMOs were distributed among adults and children as described in the data section of this report.



Kaiser Commission on the Future of Medicaid

Chart 10

Medicaid Expenditures, 1994
by Type of Service



Total Expenditures=
$137.1 billion

Source: Urban Institute calculations based on HCFA 64 data.
Does not include administrative costs, accounting adjustments, or the US Territories; total spending for all categories in 1994 was approximately $143.7 billion
Totals may not add due to rounding. "Other Acute" care services include case management, family planning, dental, EPSDT, vision, other practitioners' care, etc
"ICF/MR" refers to intermediate care facilities for the mentally retarded. "SNF/ICF" refers to skilled nursing facilities/other intermediate care facilities.

Table 11

Medicaid Expenditure by Beneficiary Group and Type of Service, 1994
United States

(Millions of dollars)

Beneficiary Group	Total	Acute Care: Total Acute	Inpatient	Physician Lab & X-Ray	Outpatient	Prescription Drugs	Other[1] Acute	Payments to Medicare/HMOs[2]
Total	**$137,112**	**$71,178**	**$25,862**	**$8,297**	**$9,910**	**$7,514**	**$9,416**	**$10,179**
Elderly	**$36,121**	**$8,447**	**$1,877**	**$568**	**$597**	**$2,226**	**$985**	**$2,194**
Cash Assistance	7,873	3,762	940	291	310	969	371	881
Other Beneficiaries	28,249	4,685	937	277	287	1,257	614	1,313
Blind and Disabled	**$45,318**	**$25,703**	**$10,859**	**$2,284**	**$4,159**	**$3,509**	**$3,710**	**$1,181**
Cash Assistance	30,311	19,879	8,082	1,848	3,362	2,724	2,938	925
Other beneficiaries	15,007	5,824	2,777	436	797	785	772	257
Adults	**$15,513**	**$15,309**	**$5,802**	**$2,821**	**$2,309**	**$820**	**$1,638**	**$1,920**
Cash Assistance	8,914	8,804	3,015	1,539	1,441	611	1,082	1,116
Other Beneficiaries	6,598	6,505	2,787	1,282	866	208	556	803
Children	**$23,270**	**$21,719**	**$7,324**	**$2,624**	**$2,845**	**$960**	**$3,083**	**$4,884**
Cash Assistance	12,838	12,146	3,173	1,295	1,646	525	1,841	3,666
Other Beneficiaries	10,431	9,573	4,151	1,329	1,199	434	1,241	1,218
DSH	**$16,890**	-	-	-	-	-	-	-

Source: Urban Institute calculations based on HCFA 2082 and HCFA 64 data.
Does not include administrative costs, accounting adjustments, or the US Territories: total spending for all categories in 1994 was approximately $143.7 billion. Totals may not add due to rounding. "DSH" refers Disproportionate Share Hospital payments. "Cash" refers to beneficiary groups who receive AFDC or SSI. "Other" groups (non-cash, poverty-related) include the medically needy, poverty-related expansion groups, and 1115 waiver eligibles (where identifiable).
[1]"Other Acute" care services include case management, family planning, dental, EPSDT, vision, other practitioners" care, etc.
[2]States do not report payments to Medicare or HMOs by beneficiary group: payments to Medicare were distributed among the aged, blind & disabled and payments to HMOs were distributed among adults & children as described in the data section of this report.

vices was for acute care, including inpatient hospital care, prescription drug payments, and physician and outpatient care services.

The Future of Medicaid

Since 1995, there continues to be a major debate over the future course of the Medicaid program. The debate in Congress is focusing on efforts to reduce Federal spending, the status of individual entitlement to benefits and the "devolution" of power and authority to the states to afford them flexibility and a greater degree of control over their Medicaid programs (Holahan and Liska, 1996). Discussions about restraining the growth of Medicaid expenditures (as well as Medicare expenditures) focus on several possibilities, including increasing costs to beneficiaries, cutting provider rates, restructuring the programs, accelerating the shift towards managed care and changing the nature of the entitlement (*National Health Policy Forum, Issue Brief No. 665,* 1995).

The National Governors' Association's (NGA) Task Force on Medicaid made recommendations in January 1997 to Congress and the Clinton Administration regarding their proposals on "re-structuring" the Medicaid program and the "devolution" of administrative authority to the states. The NGA recommendations differ significantly from those changes to the program proposed by the Clinton Administration; however, both plans are looking towards major restructuring of the program to achieve cost savings and provide greater flexibility to the states.

The NGA Task Force identified as its major priority to control Medicaid spending without shifting costs to the states and to reduce Federal statutory and regulatory micro-management. The NGA recommendations propose major programmatic changes, including giving states greater flexibility to design and implement waivers for managed care; eliminating administrative hearings for Medicaid beneficiaries enrolled in managed care and allowing states to limit EPSDT (early and periodic screening, diagnosis and treatment) services. On the Federal level, the debate over Medicaid will take place in two Congressional Committees: the Senate Finance Committee and the House Subcommittee on Health and Environment.

1992 -1996 — Emerging Trends: Reduction in Rate of Medicaid Spending Growth

Medicaid expenditures grew at an average annual rate of 22.4 percent between 1988 and 1992. In significant contrast, Medicaid expenditures increased by an average of 9.5 percent each year between 1992 and 1995. Spending increased from $119.9 billion in 1992 to $157.3 billion in 1995. Preliminary data from HCFA indicates that 1995-1996 spending growth for Medicaid is estimated at 3.2 percent (*Kaiser Commission Report,* November 1996).

Table 12, "Medicaid Expenditures by State, 1988-1994, Benefits Only, All Beneficiaries," sets forth the state-by-state Medicaid expenditures and average annual growth for the period from 1988 through 1994. During the period, the national average annual growth was 15.0 percent; in comparison, New Jersey's average annual growth was 13.9 percent.

The reduction in Medicaid expenditures since 1993 is attributable to a number of factors. First, their rapid growth during the 1988-1992 period has been slowed significantly because of Federal actions limiting the use of provider taxes and capping disproportionate share hospital (DSH) payments. DSH payments are made to hospitals serving disproportionate shares of low-income individuals. When DSH payments are factored into Medicaid expenditures, the national average annual growth for the period from 1988 through 1994 increases to 17.3 percent; New Jersey's average annual growth in Medicaid expenditures also increases to 18.4 percent for the same period. (See Table 13, "Medicaid Expenditures by State, 1988-1994, Benefits and DSH, All Beneficiaries.")

There is great variation across state-to-state Medicaid spending in the use of DSH payments. In Connecticut, Louisiana, New Hampshire and New Jersey, DSH payments amount to over $700 per low-income person. In comparison, large numbers of states, including Idaho and Arkansas, spend less than $10 per low-income resident on DSH payments (Hollahan and Liska, 1997; Table 14, "Medicaid Disproportionate Share Hospital Payments, 1994").

Medicaid enrollment growth has also slowed, contributing to a general slowing of any increases in Medicaid expenditures. Between 1988 and 1992, enrollment growth increased by 7.9 percent annually. In comparison, enrollment growth slowed to 5.3 percent per year in the following three years: 1993, 1994 and 1995. According to the Kaiser Commission on the Future of Medicaid, Medicaid enrollment growth has slowed for a number of reasons, which include that there is a general decline in the AFDC rolls (in part due to Federal and state welfare reform measures) and that the growth in coverage for pregnant women and children has slowed after significant expansions to cover this group occurred in the early 1990s.

Other factors involved with the reduction in Medicaid expenditures since 1993 are that general and medical price inflation are lower. Also, state cost containment efforts, most notably increased enrollment of Medicaid beneficiaries in managed care programs, have slowed the growth of

Table 12

Medicaid Expenditures by State, 1988-1994
Benefits Only, ALL Beneficiaries

Does not include Disproportionate Share Hospital payments, administration, or expenditure adjustments

	Expenditures (millions)				Average Annual Growth			
	1988	1990	1992	1994	1988-94	1988-90	1990-92	1992-94
United States	**$52,104**	**$69,131**	**$97,639**	**$120,222**	**15.0%**	**15.2%**	**18.8%**	**11.0%**
New England	**$3,761**	**$5,657**	**$7,430**	**$8,343**	**14.2%**	**22.7%**	**14.6%**	**6.0%**
Connecticut	840	1,237	1,717	2,015	15.7	21.4	17.8	8.3
Maine	326	436	609	767	15.3	15.6	18.2	12.2
Massachusetts	1,980	3,159	3,812	4,154	13.1	26.3	9.9	4.4
New Hampshire	169	226	369	450	17.7	15.7	27.7	10.4
Rhode Island	337	446	701	692	12.8	15.0	25.4	-0.6
Vermont	109	154	222	265	16.1	19.0	20.2	9.4
Middle Atlantic	**$13,632**	**$17,137**	**$23,062**	**$28,090**	**12.8%**	**12.1%**	**16.0%**	**10.4%**
New Jersey	1,721	2,339	3,085	3,759	13.9	16.6	14.8	10.4
New York	9,439	11,771	14,936	18,716	12.1	11.7	12.6	11.9
Pennsylvania	2,471	3,027	5,032	5,615	14.7	10.7	28.9	5.6
South Atlantic	**$6,648**	**$9,436**	**$14,239**	**$18,175**	**18.2%**	**19.1%**	**22.8%**	**13.0%**
Delaware	103	126	218	275	17.8	10.7	30.9	13.0
District of Columbia	387	406	567	737	11.3	2.4	18.2	14.0
Florida	1,526	2,491	3,958	5,062	22.1	27.7	26.1	13.1
Georgia	1,154	1,565	2,188	2,918	16.7	16.4	18.2	15.5
Maryland	918	1,182	1,777	2,096	14.7	13.5	22.6	8.6
North Carolina	988	1,434	2,149	2,785	18.9	20.5	22.4	13.9
South Carolina	470	795	1,111	1,419	20.2	30.0	18.2	13.0
Virginia	787	1,029	1,405	1,732	14.1	14.4	16.8	11.0
West Virginia	315	410	870	1,150	24.1	14.1	45.7	15.0
East South Central	**$2,645**	**$3,590**	**$5,591**	**$6,908**	**17.4%**	**16.5%**	**24.8%**	**11.2%**
Alabama	471	610	1,083	1,352	19.2	13.7	33.3	11.7
Kentucky	723	1,013	1,566	1,799	16.4	18.3	24.4	7.2
Mississippi	444	621	931	1,172	17.6	18.3	22.4	12.2
Tennessee[1]	1,007	1,347	2,011	2,586	17.0	15.7	22.2	13.4
West South Central	**$4,002**	**$5,700**	**$8,796**	**$11,460**	**19.1%**	**19.3%**	**24.2%**	**14.1%**
Arkansas	435	617	929	1,071	16.2	19.1	22.7	7.4
Louisiana	907	1,283	2,098	2,738	20.2	19.0	27.9	14.2
Oklahoma	602	720	1,022	1,017	9.1	9.3	19.2	-0.2
Texas	2,059	3,080	4,749	6,624	21.5	22.3	24.2	18.1
East North Central	**$8,838**	**$11,147**	**$15,868**	**$19,060**	**14.3%**	**14.3%**	**19.3%**	**9.8%**
Illinois	1,924	2,416	3,974	4,985	17.2	12.1	28.3	12.0
Indiana	1,052	1,482	2,284	2,516	15.6	18.7	24.1	5.0
Michigan	1,998	2,563	3,243	4,314	13.7	13.3	12.5	15.3
Ohio	2,394	3,205	4,365	5,001	13.1	15.7	16.7	7.0
Wisconsin	1,169	1,481	2,002	2,244	11.5	12.5	16.3	5.9
West North Central	**$3,297**	**$4,167**	**$5,988**	**$7,320**	**14.2%**	**12.3%**	**20.0%**	**10.5%**
Iowa	485	641	899	1,083	14.3	14.9	18.4	9.8
Kansas	336	458	610	818	15.9	16.8	15.4	15.7
Minnesota	1,208	1,464	1,899	2,426	12.3	10.1	13.9	13.0
Missouri	711	906	1,614	1,820	17.0	12.9	33.5	6.2
Nebraska	245	318	477	607	16.3	13.9	22.4	12.7
North Dakota	184	199	250	278	7.1	4.2	11.9	5.5
South Dakota	128	171	239	290	14.7	15.6	18.3	10.3
Mountain	**$1,481**	**$2,225**	**$3,877**	**$4,802**	**21.7%**	**22.6%**	**32.0%**	**11.3%**
Arizona[1,2]	n/a	553	1,138	1,466	n/a	n/a	43.4	13.5
Colorado	460	537	872	1,013	14.0	7.9	27.5	7.8
Idaho	119	157	266	311	17.3	14.6	30.4	8.1
Montana	155	193	270	344	14.3	11.8	18.3	12.9
Nevada	97	150	298	344	23.4	24.0	41.1	7.4
New Mexico	231	293	496	657	19.0	12.7	30.0	15.1
Utah	201	275	417	509	16.7	16.9	23.2	10.4
Wyoming	47	67	121	158	22.5	19.9	33.8	14.7
Pacific	**$8,102**	**$10,082**	**$12,796**	**$18,072**	**12.1%**	**11.6%**	**12.7%**	**12.1%**
Alaska	105	153	202	270	17.0	20.6	14.8	15.8
California	6,561	7,991	9,740	12,056	10.7	10.4	10.4	11.3
Hawaii	161	207	274	429	17.7	13.1	15.2	25.1
Oregon	376	532	787	1,083	19.3	18.9	21.6	17.3
Washington	898	1,199	1,792	2,234	16.4	15.5	22.3	11.6

Source. Urban Institute calculations based on HCFA 64 data.

Does not include Disproportionate Share Hospital payments, administrative costs, accounting adjustments, or the US Territories. Totals may not add due to rounding.

[1] For Arizona and Tennessee, expenditure and beneficiary data are based on figures reported directly by the state; adjustments were made to categorize these numbers in the same manner as other states report to HCFA.

[2] A large portion of expenditures for Arizona are reported as "other administrative / accounting" and are not included here.

Table 13

Medicaid Expenditures by State, 1988-1994
Benefits and DSH, ALL Beneficiaries

Does not include administration or expenditure adjustments

	Expenditures (millions)				Average Annual Growth			
	1988	1990	1992	1994	1988-94	1988-90	1990-92	1992-94
United States	**$62,554**	**$70,610**	**$115,164**	**$137,112**	**17.3%**	**15.8%**	**27.8%**	**9.1%**
New England	**$3,765**	**$5,661**	**$8,918**	**$9,952**	**17.6%**	**22.6%**	**25.8%**	**5.6%**
Connecticut	841	1,239	2,113	2,424	19.3	21.4	30.6	7.1
Maine	329	438	748	932	18.9	15.3	30.7	11.6
Massachusetts	1,980	3,159	4,269	4,696	15.5	26.3	16.2	4.9
New Hampshire	169	226	761	830	30.4	15.7	83.3	4.4
Rhode Island	337	446	782	787	15.2	15.0	32.4	0.3
Vermont	109	154	245	284	17.4	19.0	26.3	7.7
Middle Atlantic	**$13,818**	**$17,595**	**$28,233**	**$32,447**	**15.3%**	**12.8%**	**26.7%**	**7.2%**
New Jersey	1,740	2,374	4,179	4,793	18.4	16.8	32.7	7.1
New York	9,603	12,187	18,055	21,223	14.1	12.7	21.7	8.4
Pennsylvania	2,475	3,034	5,999	6,432	17.2	10.7	40.6	3.5
South Atlantic	**$6,709**	**$9,616**	**$15,881**	**$20,139**	**20.1%**	**19.7%**	**28.5%**	**12.6%**
Delaware	103	126	216	281	18.3	10.7	30.9	14.2
District of Columbia	387	406	600	790	12.6	2.4	21.5	14.8
Florida	1,570	2,535	4,150	5,347	22.7	27.0	27.9	13.5
Georgia	1,155	1,566	2,487	3,274	19.0	16.5	26.0	14.7
Maryland	918	1,182	1,890	2,246	16.1	13.5	26.5	9.0
North Carolina	991	1,499	2,481	3,175	21.4	23.0	28.7	13.1
South Carolina	480	857	1,551	1,900	25.8	33.6	34.5	10.7
Virginia	789	1,036	1,553	1,871	15.5	14.6	22.4	9.8
West Virginia	315	410	954	1,254	25.9	14.1	52.6	14.6
East South Central	**$2,675**	**$3,880**	**$6,856**	**$7,559**	**19.2%**	**20.4%**	**32.9%**	**5.7%**
Alabama	471	804	1,500	1,789	24.7	30.6	36.6	8.6
Kentucky	723	1,013	1,830	1,867	17.1	18.4	34.4	1.0
Mississippi	445	624	1,084	1,330	20.0	18.3	31.8	10.8
Tennessee[1]	1,035	1,439	2,442	2,694	17.3	17.9	30.2	5.0
West South Central	**$4,048**	**$5,829**	**$11,554**	**$14,317**	**23.4%**	**20.0%**	**40.8%**	**11.3%**
Arkansas	435	618	931	1,074	16.3	19.2	22.7	7.4
Louisiana	943	1,402	3,316	4,065	27.6	22.0	53.8	10.7
Oklahoma	607	723	1,044	1,041	9.4	9.2	20.2	-0.2
Texas	2,063	3,085	6,262	8,137	25.7	22.3	42.5	14.0
East North Central	**$8,604**	**$11,328**	**$17,398**	**$20,780**	**15.8%**	**14.7%**	**23.9%**	**9.3%**
Illinois	1,928	2,479	4,288	5,286	18.3	13.4	31.5	11.0
Indiana	1,052	1,487	2,495	2,811	17.8	18.9	29.5	6.1
Michigan	2,038	2,616	3,788	4,930	15.9	13.3	20.3	14.1
Ohio	2,415	3,262	4,816	5,499	14.7	16.2	21.5	6.8
Wisconsin	1,170	1,482	2,011	2,256	11.5	12.5	16.5	5.9
West North Central	**$3,329**	**$4,245**	**$6,958**	**$8,258**	**16.3%**	**12.9%**	**28.0%**	**8.9%**
Iowa	487	643	904	1,089	14.4	14.9	18.6	9.8
Kansas	339	493	799	981	19.4	20.5	27.4	10.8
Minnesota	1,214	1,472	1,941	2,470	12.8	10.1	14.8	12.8
Missouri	733	948	2,346	2,533	23.0	13.7	57.3	3.9
Nebraska	245	319	480	615	16.6	14.1	22.7	13.2
North Dakota	184	199	250	279	7.2	4.2	11.9	5.7
South Dakota	128	171	239	291	14.7	15.6	18.3	10.3
Mountain	**$1,484**	**$2,231**	**$4,090**	**$5,101**	**22.8%**	**22.6%**	**35.4%**	**11.7%**
Arizona[1,2]	n/a	553	1,138	1,571	n/a	n/a	43.4	17.5
Colorado	463	541	993	1,119	15.9	8.1	35.5	6.2
Idaho	119	157	268	312	17.3	14.6	30.7	7.9
Montana	155	193	270	344	14.3	11.8	18.2	12.9
Nevada	98	150	372	418	27.4	23.9	57.5	6.0
New Mexico	231	294	508	665	19.2	12.8	31.3	14.4
Utah	201	276	422	513	16.9	17.0	23.6	10.4
Wyoming	47	67	121	158	22.5	19.9	33.8	14.6
Pacific	**$8,122**	**$10,125**	**$15,276**	**$18,458**	**14.7%**	**11.7%**	**22.8%**	**9.9%**
Alaska	105	153	202	288	18.2	20.6	14.8	19.5
California	6,568	8,002	11,932	14,065	13.5	10.4	22.1	8.6
Hawaii	161	207	314	458	19.0	13.1	23.4	20.7
Oregon	377	537	805	1,105	19.6	19.3	22.5	17.2
Washington	910	1,227	2,023	2,543	18.7	16.1	28.4	12.1

Source: Urban Institute calculations based on HCFA 64 data.

Does not include administrative costs, accounting adjustments, or the US Territories. Totals may not add due to rounding.

[1] For Arizona and Tennessee, expenditure and beneficiary data are based on figures reported directly by the state, adjustments were made to categorize these numbers in the same manner as other states report to HCFA.

[2] A large portion of expenditures for Arizona are reported as "other administrative / accounting" and are not included here.

Table 14

Medicaid Disproportionate Share Hospital Payments, 1994 per Low-Income[1] Person, and per Uninsured Person, by Federal and State Shares

	Total			Federal			State		
	(millions)	per Low-Income Person	per Uninsured	(millions)	per Low-Income Person	per Uninsured	(millions)	per Low-Income Person	per Uninsured
United States	**$16,890.4**	**$251.4**	**$438.5**	**$9,722.0**	**$144.7**	**$252.4**	**$7,168.4**	**$106.7**	**$186.1**
New England	**$1,609.2**	**$658.7**	**$1,103.1**	**$829.9**	**$339.7**	**$568.9**	**$779.4**	**$319.0**	**$534.3**
Connecticut	408.9	822.4	1,357.2	204.5	411.2	678.6	204.5	411.2	678.6
Maine	165.3	477.0	1,093.1	102.4	295.5	677.3	62.9	181.5	415.8
Massachusetts	541.2	490.4	770.8	270.6	245.2	385.4	270.6	245.2	385.4
New Hampshire	380.1	2,048.0	2,808.6	190.1	1,024.0	1,403.3	190.1	1,024.0	1,403.3
Rhode Island	94.8	489.7	1,040.5	51.0	263.8	560.5	43.7	225.9	480.0
Vermont	18.9	162.1	243.3	11.2	96.6	144.9	7.6	65.6	98.4
Middle Atlantic	**$4,366.7**	**$493.6**	**$862.8**	**$2,216.0**	**$251.1**	**$438.9**	**$2,140.7**	**$242.5**	**$423.9**
New Jersey	1,033.6	702.2	929.6	516.6	351.1	464.6	516.8	351.1	464.6
New York	2,506.5	524.7	961.4	1,253.3	262.3	480.7	1,253.3	262.3	480.7
Pennsylvania	816.6	316.9	613.8	445.9	173.0	335.2	370.6	143.8	278.6
South Atlantic	**$1,964.3**	**$158.5**	**$274.5**	**$1,227.2**	**$99.0**	**$171.5**	**$737.1**	**$59.5**	**$103.0**
Delaware	5.9	39.0	60.6	3.0	19.5	30.3	3.0	19.5	30.3
District of Columbia	53.4	238.5	460.7	26.7	119.3	230.4	26.7	119.3	230.4
Florida	284.8	65.3	109.4	156.0	35.8	59.9	128.8	29.5	49.5
Georgia	355.5	194.0	309.5	222.1	121.2	193.4	133.4	72.8	116.2
Maryland	150.6	149.3	225.7	75.3	74.7	112.8	75.3	74.7	112.8
North Carolina	389.6	217.0	458.4	253.8	141.4	298.6	135.8	75.7	159.8
South Carolina	481.4	408.4	776.0	342.2	290.3	551.6	139.2	118.1	224.4
Virginia	139.7	114.8	178.4	89.8	57.3	89.2	89.8	57.3	89.2
West Virginia	103.4	166.2	385.5	78.3	125.8	291.9	25.1	40.3	93.8
East South Central	**$760.1**	**$147.7**	**$323.4**	**$542.2**	**$106.6**	**$233.5**	**$208.8**	**$41.0**	**$89.8**
Alabama	417.5	306.7	581.4	297.3	218.4	414.1	120.1	88.3	167.3
Kentucky	87.3	57.0	139.8	47.8	40.4	99.2	19.8	16.6	40.7
Mississippi	158.4	157.6	352.1	124.9	124.3	277.6	33.5	33.3	74.5
Tennessee[2]	107.6	70.0	160.1	72.3	47.0	107.5	35.3	23.0	52.6
West South Central	**$2,866.2**	**$316.1**	**$478.7**	**$1,964.8**	**$216.7**	**$328.1**	**$901.4**	**$99.4**	**$150.5**
Arkansas	3.0	3.5	6.3	2.3	2.6	4.7	.8	.9	1.6
Louisiana	1,326.4	846.0	1,331.6	974.8	621.7	978.6	351.6	224.3	353.0
Oklahoma	23.6	21.9	31.9	16.6	15.4	22.4	7.0	6.5	9.4
Texas	1,513.2	272.6	401.0	971.2	175.0	257.4	542.0	97.6	143.6
East North Central	**$1,720.0**	**$174.5**	**$343.5**	**$994.1**	**$100.9**	**$198.5**	**$725.9**	**$73.7**	**$145.0**
Illinois	300.4	110.3	209.7	150.2	55.2	104.8	150.2	55.2	104.8
Indiana	294.8	218.7	385.5	187.2	138.8	244.8	107.6	79.8	140.7
Michigan	615.4	280.0	539.6	346.9	157.8	304.2	268.5	122.1	235.4
Ohio	497.7	196.8	397.5	302.8	119.7	241.8	195.0	77.1	155.7
Wisconsin	11.7	11.0	28.0	7.1	6.7	16.9	4.6	4.4	11.1
West North Central	**$938.0**	**$228.7**	**$463.2**	**$564.7**	**$135.9**	**$276.9**	**$373.2**	**$89.8**	**$184.3**
Iowa	6.0	10.3	26.9	3.8	6.5	17.0	2.2	3.8	9.8
Kansas	165.1	302.6	538.6	98.3	180.1	320.6	66.9	122.5	218.0
Minnesota	43.7	49.8	86.8	23.9	27.2	47.4	19.8	22.6	39.3
Missouri	713.0	474.2	1,152.4	432.4	287.5	698.8	280.6	186.6	453.6
Nebraska	8.7	28.0	43.4	5.4	17.4	26.9	3.3	10.7	16.5
North Dakota	1.2	8.4	14.4	.8	5.9	10.3	.3	2.4	4.2
South Dakota	.3	1.4	2.9	.2	.9	2.0	.1	.4	.9
Mountain	**$299.1**	**$80.4**	**$121.1**	**$174.4**	**$46.9**	**$70.6**	**$124.7**	**$33.5**	**$50.5**
Arizona[2]	105.8	93.0	137.0	69.7	61.3	90.3	36.1	31.7	46.7
Colorado	106.4	152.2	217.2	57.8	82.7	118.0	48.6	69.6	99.3
Idaho	.4	1.5	2.4	.3	1.1	1.7	.1	.4	.7
Montana	.3	1.1	1.9	.2	.8	1.4	.1	.3	.6
Nevada	73.6	231.9	267.7	37.0	116.7	134.7	36.6	115.2	133.0
New Mexico	7.9	14.8	23.5	5.9	11.0	17.5	2.0	3.8	6.1
Utah	4.6	12.2	23.4	3.6	9.1	17.4	1.2	3.1	6.0
Wyoming[3]	.0	.0	.0	.0	.0	.0	.0	.0	.0
Pacific	**$2,366.1**	**$205.2**	**$338.6**	**$1,298.7**	**$183.9**	**$171.6**	**$1,177.4**	**$101.2**	**$167.1**
Alaska	17.4	126.2	190.6	8.7	63.1	95.3	8.7	63.1	95.3
California	2,008.9	210.8	345.7	1,004.4	105.4	172.8	1,004.4	105.4	172.8
Hawaii	29.5	115.2	254.0	14.8	57.8	127.0	14.8	57.8	127.0
Oregon	21.4	29.6	49.2	13.3	18.4	30.6	8.1	11.2	18.6
Washington	308.9	314.4	521.3	167.5	170.5	282.8	141.3	143.9	238.6

Source: Urban Institute calculations based on HCFA 64 data and projections from the March 1994 Current Population Survey.

Does not include administrative costs, accounting adjustments, or the US Territories. Totals may not add due to rounding.

[1] Low-income defined as under 150% of the federal poverty guideline, which was $12,320 for a family of three in 1994.

[2] For Arizona and Tennessee, expenditure and beneficiary data are based on figures reported directly by the state; adjustments were made to categorize these numbers in the same manner as other states report to HCFA.

[3] No DSH payments reported in 1994

expenditures (*Kaiser Commission Report*, 1996). Medicaid managed care enrollment has experienced an exponential increase — from 3.6 million beneficiaries in 1992 to 11.6 million in 1995 — a number representing one-third of Medicaid enrollment (Holahan and Liska, 1996) (See, Section V., "Medicaid Managed Care").

Medicaid Program Characteristics - State Variations

The following group of tables are provided to show the variation among states in Medicaid financial eligibility limits and the parameters of their program expansions, as well as to indicate how New Jersey compares to the rest of the country in terms of its program design. (Please refer to the Capitol Forums "Data Book on Medicaid Funding of Chronic and Long Term Care," May 4, 1994, for a specific overview of New Jersey Medicaid's program components). Each of the tables includes specific information for each state as follows: Table 15, "Annualized Medicaid Eligibility Thresholds for AFDC, Medically Needy, and Supplemental Security Income (SSI) 1995-1996"; Table 16, "Expanded Medicaid Coverage of Pregnant Women, Infants and Children, 1996"; and Table 17, "Status of Section 1115 Waivers as of November 1996"

Table 15

Annualized Medicaid Eligibility Thresholds for AFDC, Medically Needy, SSI, 1995-1996

	AFDC FAMILY OF 3, 1996		MEDICALLY NEEDY[1] FAMILY OF 3, 1996		Supplemental Security Income, 1996	
State	Payment Standard[2]	Percentage of Poverty[3] $12,980	Allowable Income	Percentage of Poverty[3] $12,980	Maximum Annual Income Limit	Income Limit as a Percent of Poverty
Alabama	$1,998	15%	n/a	n/a	5,352	75.2
Alaska[4]	$12,336	78%	n/a	n/a	5,352	75.2
Arizona	$4,164	32%	n/a	n/a	5,352	75.2
Arkansas	$2,448	19%	$3,300	25%	5,352	75.2
California	$7,284	56%	$11,208	86%	5,352	75.2
Colorado	$5,052	39%	n/a	n/a	5,352	75.2
Connecticut	$10,464	81%	$9,276	71%	5,352	75.2
Delaware	$4,056	31%	n/a	n/a	5,352	75.2
Florida	$3,636	28%	$3,636	28%	5,352	75.2
Georgia	$5,088	39%	$4,500	35%	5,352	75.2
Hawaii[4]	$8,544	57%	$8,544	57%	4,752	66.8
Idaho	$3,804	29%	n/a	n/a	5,352	75.2
Illinois	$4,524	35%	$5,904	45%	3,396	47.7
Indiana	$3,456	27%	n/a	n/a	5,208	73.2
Iowa	$5,112	39%	$6,792	52%	5,352	75.2
Kansas	$5,148	40%	$5,760	44%	5,352	75.2
Kentucky	$6,312	49%	$3,696	28%	5,352	75.2
Louisiana	$2,280	18%	n/a	n/a	5,352	75.2
Maine	$5,636	51%	$5,496	42%	5,352	75.2
Maryland	$4,476	34%	$5,208	40%	5,352	75.2
Massachusetts	$6,780	52%	$9,300	72%	5,352	75.2
Michigan	$5,868	45%	$8,004	62%	5,352	75.2
Minnesota	$6,384	49%	$8,508	66%	5,040	70.8
Mississippi	$4,416	34%	n/a	n/a	5,352	75.2
Missouri	$3,504	27%	n/a	n/a	5,064	71.2
Montana	$5,256	41%	$5,964	46%	5,352	75.2
Nebraska	$4,368	34%	$5,904	45%	5,352	75.2
Nevada	$4,176	32%	n/a	n/a	5,352	75.2
New Hampshire	$6,600	51%	$7,824	60%	5,232	73.5
→ New Jersey	$5,316	41%	$6,804	52%	5,352	75.2
New Mexico	$4,668	36%	n/a	n/a	5,352	75.2
New York[5]	$7,884	61%	$9,800	76%	5,352	75.2
North Carolina	$6,528	50%	$4,400	34%	2,904	40.8
North Dakota	$5,172	40%	$6,080	47%	4,428	62.2
Ohio	$4,092	32%	n/a	n/a	4,488	63.1
Oklahoma	$3,684	28%	$5,508	42%	5,352	75.2
Oregon	$5,520	43%	$7,356	57%	5,352	75.2
Pennsylvania	$5,052	39%	$5,804	43%	5,352	75.2
Rhode Island	$6,648	51%	$8,900	69%	5,352	75.2
South Carolina	$2,400	18%	n/a	n/a	5,352	75.2
South Dakota	$6,084	47%	n/a	n/a	5,352	75.2
Tennessee	$6,996	54%	$3,000	23%	5,352	75.2
Texas	$2,256	17%	$3,204	25%	5,352	75.2
Utah	$6,816	53%	$6,816	53%	5,352	75.2
Vermont	$7,632	59%	$10,500	81%	5,352	75.2
Virginia	$2,880	22%	$4,300	33%	5,352	75.2
Washington	$6,552	50%	$6,004	62%	5,352	75.2
West Virginia	$3,108	24%	$3,480	27%	5,352	75.2
Wisconsin	$6,204	48%	$8,268	64%	5,352	75.2
Wyoming	$7,080	55%	n/a	n/a	5,352	75.2

Source: National Governors' Association, August 1996.

[1] Medically needy programs target individuals who have large medical costs but have income too high to become Medicaid-eligible through the AFDC or SSI programs. States may establish higher income or resource standards for the medically needy. If states choose to establish a medically needy program, it must serve pregnant women and children below age 18.

[2] The payment standard is the sum from which countable income of a recipient is deducted to determine the AFDC payment for the family. In most states, the AFDC payment standard determines the earnings level at which AFDC eligibility ends. In Alaska, Colorado, Georgia, Kentucky, Maine, Michigan, Mississippi, Montana, North Carolina, Oklahoma, South Carolina, Tennessee, and Utah, the medically needy threshold is the state's need standard. State income or resource requirements for medically needy populations may be established at levels up to 133 1/3 percent of the maximum payment standard under a state's AFDC program.

[3] This poverty guideline became effective March 4, 1996.

[4] Poverty guidelines for Alaska and Hawaii differ from those of other states. Alaska (family of three) = $16,220; Hawaii (family of three) = $14,930.

[5] The payment standard in New York State varies among the counties within the state. The figures shown are for New York City.

Table 16

Expanded Medicaid Coverage of Pregnant Women, Infants and Children, 1996

State	Pregnant Women and Infants: Percentage of federal poverty guideline	Children Below Age Six: Percentage of federal poverty guideline	Children Ages Six and Older: Percentage of federal poverty guideline	Upper Age Limit[a]
Alabama	133%	133%	100%	13
Alaska	133%	133%	100%	13
Arizona	140%	133%	100%	14
Arkansas	133%	133%	100%	13
California	200%	133%	100%	19
Colorado	133%	133%	100%	13
Connecticut	185%	185%	185%	13
Delaware	185%	133%	100%	19
Florida	185%	133%	100%	13
Georgia	185%	133%	100%	19
Hawaii[1]	300%	300%	300%	19
Idaho	133%	133%	100%	13
Illinois	133%	133%	100%	13
Indiana	150%	133%	100%	13
Iowa	185%	133%	100%	13
Kansas	150%	133%	100%	17
Kentucky	185%	133%	100%	19
Louisiana	133%	133%	100%	13
Maine	185%	133%	125%	19
Maryland[4]	185%	185%	185%	13
Massachusetts	185%	133%	100%	13
Michigan	185%	150%	150%	15[5]
Minnesota	275%	133%	100%	13
Mississippi	185%	133%	100%	13
Missouri	185%	133%	100%	19
Montana	133%	133%	100%	13
Nebraska	150%	133%	100%	13
Nevada	133%	133%	100%	13
New Hampshire	185%	185%	185%	19
New Jersey	185%	133%	100%	13
New Mexico	185%	185%	185%	19
New York	185%	133%	100%	13
North Carolina	185%	133%	100%	19
North Dakota	133%	133%	100%	18
Ohio	133%	133%	100%	13
Oklahoma	150%	133%	100%	13
Oregon	133%	133%	100%	19
Pennsylvania	185%	133%	100%	13
Rhode Island[6]	250%	250%	[100%][5]	13
South Carolina	185%	133%	100%	13
South Dakota	133%	133%	100%	19
Tennessee[8]	185%	133%	100%	13
Texas	185%	133%	100%	13
Utah	133%	133%	100%	18
Vermont	[200%][7]	225%	225%	18
Virginia	133%	133%	100%	19
Washington	[185%][8]	200%	200%	19
West Virginia	150%	133%	100%	19
Wisconsin	185%	185%	100%	13
Wyoming	133%	133%	100%	13

Source: National Governors' Association, August 1995.

Table 17

Status of Section 1115 Waivers, as of November 1996

	Submitted	Approved	Under Review	Pre-Application	Denied
United States					
New England					
Connecticut					
Maine					
Massachusetts	√	√			
New Hampshire	√		√		
Rhode Island	√	√			
Vermont	√	√			
Middle Atlantic					
New Jersey				√	
New York	√		√		
Pennsylvania				√	
South Atlantic					
Delaware	√	√			
District of Columbia				√	
Florida	√	√			
Georgia	√		√		
Maryland	√	√			
North Carolina					
South Carolina[1]	√	√			
Virginia					
West Virginia					
East South Central					
Alabama	√		√		
Kentucky	√	√			
Mississippi					
Tennessee	√	√			
West South Central					
Arkansas					
Louisiana[2]	√				√
Oklahoma	√	√			
Texas	√		√		
East North Central					
Illinois	√	√			
Indiana					
Michigan					
Ohio	√	√			
Wisconsin					
West North Central					
Iowa					
Kansas	√		√		
Minnesota	√	√			
Missouri	√		√		
Nebraska					
North Dakota					
South Dakota					
Mountain					
Arizona	√	√			
Colorado					
Idaho					
Montana					√
Nevada					
New Mexico					
Utah	√		√		
Wyoming					
Pacific					
Alaska					
California					
Hawaii	√	√			
Oregon	√	√			
Washington	√		√		

Source: Health Care Financing Administration, As of November 1, 1996.

[1] *Suspended April 1995.*

[2] *Financial Proposal Disapproved June 1995.*

IV. THE STATUS OF MEDICAID FUNDING OF CHRONIC AND LONG-TERM CARE

Original Issue Brief May 4, 1994 • Update April 1997

As the Federal government and the states move forward with their efforts to control the growth of Medicaid spending, they are directly confronted with the challenge of reducing expenditures for chronic and long-term care (LTC). According to a 1996 Urban Institute study, approximately one-third of Medicaid expenditures in 1995 were for long-term care services — nursing facilities, personal care, home health, home and community-based services and intermediate care facilities for the mentally retarded (Weiner, 1996).

In the absence of any new initiatives for financing chronic and long-term care and the continued absence of any meaningful type of long-term care coverage under the Medicare program, Medicaid continues to be the dominant source of public funding for long-term care for the elderly. In 1993, it accounted for 62 percent of government spending for nursing home and home care services (Ibid). Table 18A shows the distribution of Medicaid spending on long-term care services across states. According to a recent report from the Kaiser Commission on the Future of Medicaid, for long-term care spending, 8 out of every 10 Medicaid dollars paid are for institutional services in skilled nursing facilities, or in intermediate care facilities for the mentally retarded. Medicaid also makes premium and cost-sharing payments to Medicare for low-income Medicare beneficiaries. Payments to Medicare in 1994-95 were largest for California and Florida, which are two states with large elderly populations (Kaiser Commission on the Future of Medicaid, 1996 Report).

Estimates for 1996 indicate that Medicaid expenditures for LTC will be $30.2 billion, or close to 33 percent of total Medicaid spending (See Table 7, "Federal Medicaid Expenditure and Beneficiary Projections, 1996-2002"). Projections for Medicaid spending for the period from 1996 to 2002 indicate that LTC expenditures for the elderly, blind and disabled will have the highest rate of average annual growth, when compared to other categories of Medicaid spending growth.

Chart 18 illustrates the growth in the number of individuals with chronic health conditions and the cost of providing their care. In 1990, the estimated direct cost of medical services and all institutional care for persons with chronic conditions was $425 billion . This amount represents some 70 percent of the country's total annual personal health care expenditures, which were $612 billion. By the year 2005 the numbers are projected to increase to 112 million individuals requiring chronic care services at an estimated cost of $539 billion.

Weiner (1996) identifies three broad strategies for states to control the rate of growth of Medicaid LTC expenditures: (1) to capture more private resources into the LTC system by encouraging private LTC insurance, enforcing transfer of assets prohibition and aggressively engaging in estate recovery; (2) re-structuring the LTC delivery system to offer a greater number of home and community-based services and reduce reliance on institutional care; and (3) to tighten eligibility rules and reduce provider payments and services. However, the first two of these strategies raise substantial questions regarding their viability and potential success in actually reducing Medicaid expenditures. In his final analysis, Weiner cautions that states may resort to the third alternative in order to reduce spending, which would have significant impact on beneficiaries and providers, in terms of access to services and quality of care. New Jersey, whose elderly population continues to grow and represent a significant portion of its population (13.8 percent of its total population), is a state which stands to be challenged to determine methods to reduce Medicaid LTC spending.

The elderly and disabled populations are also eligible for participation in the Medicare Program. Medicare provides limited coverage for short-term nursing facility care and for specific home care services; Medicaid still remains, by default, the primary payer for LTC services. Medicare's Part A Hospital Insurance Trust Fund (see Table 19) expenditures for home care and skilled nursing facilities are close to $30 billion per year (Reinhardt, 1997). Since 1995, annual deposits into the Part A Trust Fund account have been falling below annual withdrawals. As Table 19 indicates, this shortfall is projected to grow into the next century. The 105th Congress is currently debating solutions to the Part A Trust Fund problem, which include shifting home care expenditures to Medicare Part B Fund (which is funded from premiums paid by the elderly (about 25 percent) and general Federal revenues) (Ibid).

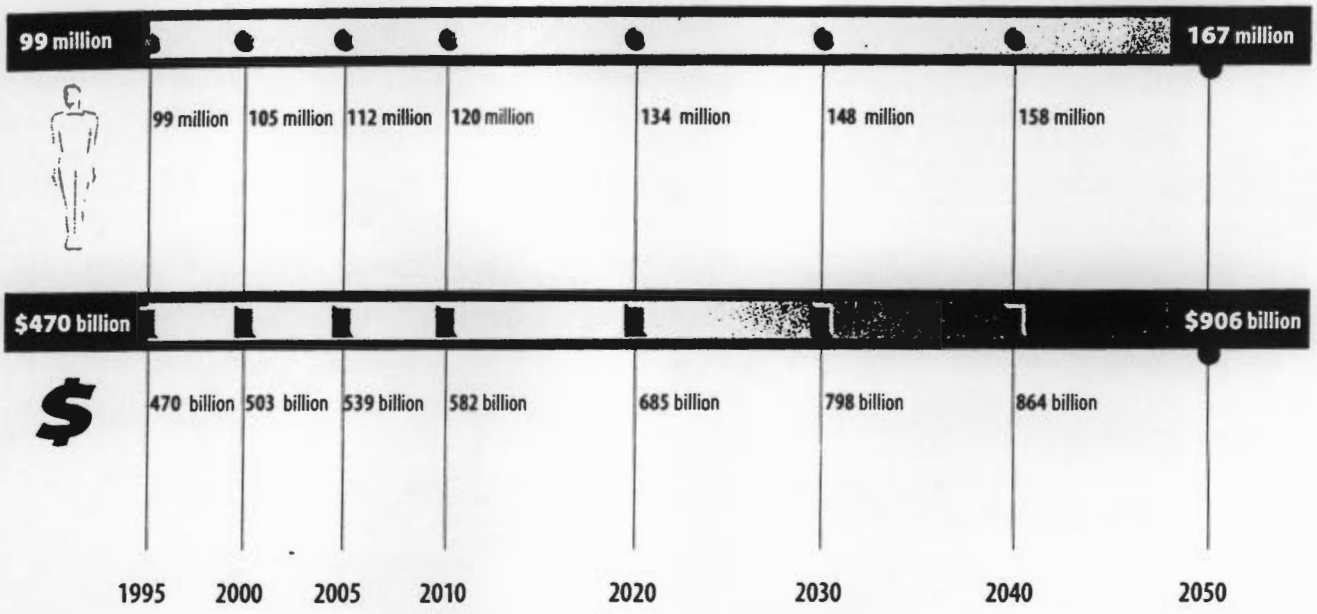
During the period from 1990 to 1995, Medicare enrollment grew approximately 1.8 percent per year. While this trend is expected to continue until 2010, it is then expected to increase sharply as the Baby Boom generation begins to age. Chart 20, illustrates Medicare as a percent of the Federal budget; in 1995, Medicare repre-

sented 12 percent of a $1.5 trillion budget, or approximately 2.6 percent of the gross domestic product. Medicaid, in comparison, represents 6 percent of the federal budget, or about half of the Medicare budget. By the year 2002, it is estimated that with a federal budget of $2.2 trillion, Medicare's percentage would increase 4 percent, to 16 percent of the Federal budget. During the same time, Medicaid's percentage would increase to 8 percent.

The financial characteristics of Medicare beneficiaries are represented in Chart 21: 83 percent of Medicare expenditures are for beneficiaries with annual incomes under $25,000, giving a clear picture of the general economic status of elderly and disabled beneficiaries . Overall, the Medicare program covers less than half of the total health spending of elderly Americans. Approximately 37 percent of total health spending by the elderly is financed from private sources, including out-of-pocket spending (Reinhardt, 1997).

Chart 18

Estimated Number of Persons with Chronic Conditions and Direct Medical Costs for Persons with Chronic Conditions, Selected Years, 1995-2050



Notes:

Chronic conditions is a general term that includes chronic illnesses and impairments.

Chronic illness: The presence of long-term disease or symptoms. (A common definition of "long-term" in population surveys is a duration of three or more months.)

Impairment: A physiological, psychological, or anatomical abnormality of bodily structure or function; includes all losses or abnormalities, not just those attributable to active pathology.

This estimate is of persons in the United States with chronic conditions characterized by persistent and recurring health consequences lasting for periods of years.

Costs are in 1990 dollars, estimated by applying the rates of chronic conditions and the per capita costs in 1990 dollars to the estimated projected population with chronic conditions by gender and age.

Source:

Hoffman, Catherine, and Rice, Dorothy P. Estimates based on the 1987 National Medical Expenditure Survey. University of California, San Francisco — Institute for Health & Aging, 1995.

Direct medical costs for persons with chronic conditions will nearly double by the year 2050.

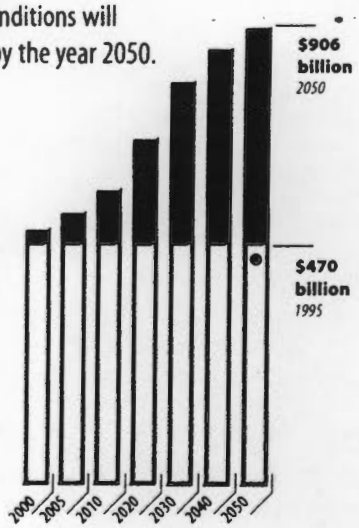


Table 18A

Medicaid LONG-TERM CARE Expenditures by State, 1994
ALL Beneficiaries, by Type of Service
(millions of dollars)

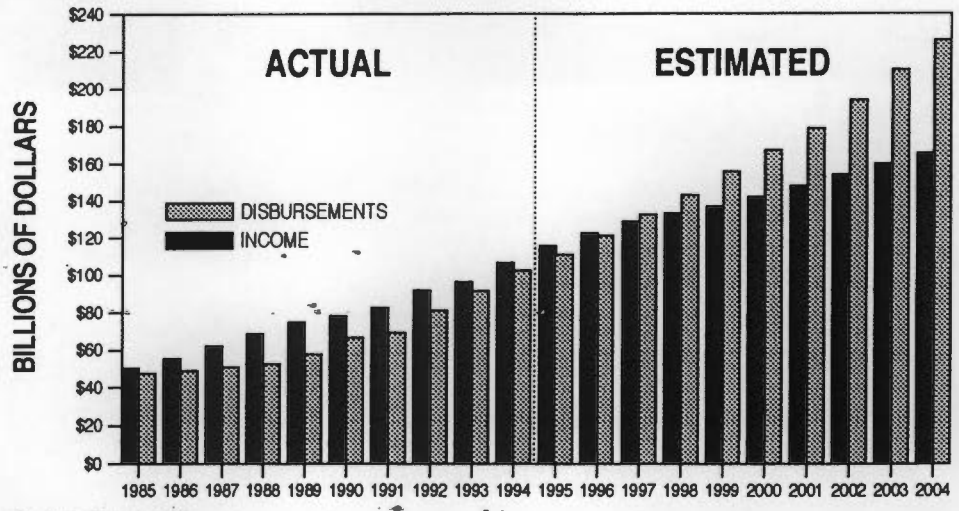
	Total Long-Term Care	SNF/ ICF-Other	ICF-MR	Mental Health	Home Health
United States	**$49,044**	**$28,253**	**$9,417**	**$2,869**	**$8,506**
New England	**$4,219**	**$2,687**	**$579**	**$106**	**$846**
Connecticut	1,204	768	180	32	225
Maine	364	238	55	15	55
Massachusetts	1,928	1,227	290	39	373
New Hampshire	271	180	6	10	74
Rhode Island	333	204	42	11	76
Vermont	119	70	6	0	43
Middle Atlantic	**$14,381**	**$7,199**	**$2,869**	**$964**	**$3,357**
→ New Jersey	1,822	1,052	357	64	349
New York	9,596	4,275	2,011	576	2,734
Pennsylvania	2,973	1,873	501	324	275
South Atlantic	**$8,205**	**$3,756**	**$1,155**	**$314**	**$980**
Delaware	120	80	27	6	27
District of Columbia	314	155	64	77	18
Florida	1,513	1,065	212	14	222
Georgia	808	572	120	16	101
Maryland	675	420	60	11	184
North Carolina	1,181	639	332	31	180
South Carolina	513	233	172	48	59
Virginia	710	379	154	87	90
West Virginia	371	231	14	25	100
East South Central	**$2,270**	**$1,551**	**$371**	**$141**	**$208**
Alabama	545	383	79	19	64
Kentucky	584	370	72	33	109
Mississippi	358	244	85	20	9
Tennessee[1]	783	553	136	69	26
West South Central	**$3,957**	**$2,180**	**$1,038**	**$173**	**$566**
Arkansas	497	273	94	51	79
Louisiana	969	514	300	95	60
Oklahoma	459	253	91	27	88
Texas	2,033	1,141	553	0	339
East North Central	**$7,978**	**$5,124**	**$1,597**	**$410**	**$848**
Illinois	1,833	1,145	489	43	156
Indiana	1,096	736	309	18	34
Michigan	1,546	954	157	142	292
Ohio	2,383	1,602	453	165	163
Wisconsin	1,120	687	188	41	203
West North Central	**$3,639**	**$2,102**	**$728**	**$107**	**$802**
Iowa	452	240	161	23	28
Kansas	409	202	105	25	77
Minnesota	1,331	864	212	26	229
Missouri	750	426	144	17	162
Nebraska	281	188	34	8	51
North Dakota	165	95	39	3	28
South Dakota	151	87	32	6	27
Mountain	**$1,650**	**$881**	**$268**	**$184**	**$318**
Arizona[1]	368	172	71	106	19
Colorado	424	239	39	20	126
Idaho	135	72	40	0	22
Montana	159	95	14	16	34
Nevada	123	73	20	17	12
New Mexico	203	107	38	19	39
Utah	163	83	38	6	36
Wyoming	76	40	7	0	29
Pacific	**$4,835**	**$2,772**	**$813**	**$469**	**$781**
Alaska	77	51	12	10	4
California	3,270	1,949	545	389	387
Hawaii	154	124	11	0	20
Oregon	444	157	79	23	185
Washington	889	491	167	47	185

Source: Urban Institute calculations based on HCFA 64 data.
Does not include Disproportionate Share Hospital payments, administrative costs, accounting adjustments, or the US Territories. Totals may not add due to rounding. "ICF/MR" refers to intermediate care facilities for the mentally retarded. "SNF/ICF" refers to skilled nursing facilities/other intermediate care facilities.
[1] For Arizona and Tennessee, expenditure and beneficiary data are based on figures reported directly by the state; adjustments were made to categorize these numbers in the same manner as other states report to HCFA.

Table 19

Operations of the Hospital Insurance "Trust Fund"

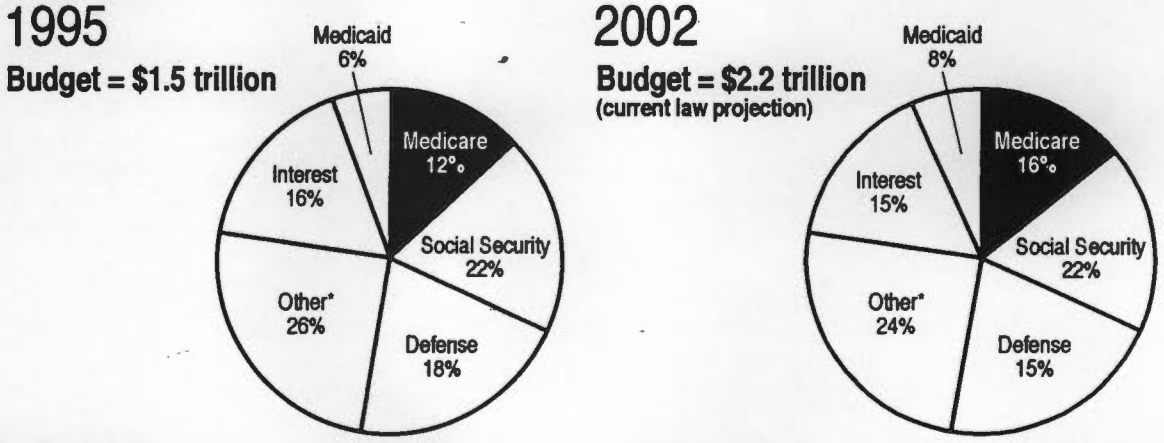
1985-2004



Source: Trustee's Report, 1995

Chart 20

Medicare as a Percent of the Federal Budget



* 'Other' includes a variety of programs such as domestic discretionary programs, family support, SSI, other means-tested programs, other mandatory programs, and international aid.
Source: Computed from CBO data in "The Economic and Budget Outlook," August 1995.

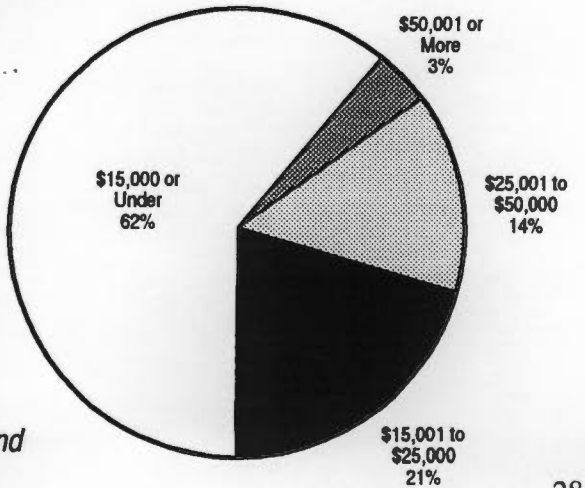
The Henry J. Kaiser Family Foundation

Chart 21

Medicare Expenditures by Beneficiaries' Income, 1992

83 % of Medicare Expenditures Are for Beneficiaries With Annual Incomes Under $25,000

Note: Excludes 2.2% Not Reporting Income and HMO Enrollees (6%).
Source: Health Care Financing Administration, Office of the Actuary, 1995.



Source: The Commonwealth Fund

V. MEDICAID MANAGED CARE

Original Issue Brief March 2, 1994 • Update April 1997

Throughout the country, Medicaid beneficiaries are being enrolled in managed care plans in an effort to create an efficient system of health care, to improve access to care and to reduce Medicaid expenditures. Enrollment trends across the country during the past two years indicate that initially, participation in Medicaid managed care was voluntary on the part of the enrollee. However, there has been a rapid expansion of mandatory managed care enrollment through both Section 1915(b) "Freedom of Choice" and Section 1115 "Research and Demonstrations" waiver programs (Holahan & Liska, 1996).

By the end of 1996, almost one-third of Medicaid beneficiaries were enrolled in Medicaid managed care programs throughout the country. Between 1993 and 1995, Medicaid managed care more than doubled, increasing from 4.8 million to 11.6 million. As of 1996, thirty-three states have obtained Section 1915(b) waivers for Medicaid managed care programs. These waivers are usually limited to a geographic area within a state and managed care can be made mandatory to Medicaid eligibles residing in that area. Section 1115 waiver programs allow states greater flexibility in expanding their Medicaid managed care programs as seen in states like Hawaii, Oregon and Tennessee. Each of these states extends coverage to uninsured individuals who would otherwise not be covered under traditional Medicaid eligibility standards. In 1996, 15 states have been approved for Section 1115 waivers, 11 of which have implemented programs (*Kaiser Commission Report*, 1996).

New Jersey's Medicaid Managed Care Program

By August 1996, New Jersey Care 2000, the state's mandatory managed care program, had enrolled more than 340,000 Medicaid beneficiaries in 13 commercial health maintenance organization's (HMOs) throughout the state and the state-operated Garden State Health Plan. The state's goal is to enroll all of its almost 450,000 Medicaid beneficiaries who receive Aid To Families with Dependent Children in HMOs during 1997. By January 1997, enrollment increased to 405,000 Medicaid beneficiaries who are receiving their care through HMOs. Medicaid will require participation of AFDC families in all counties where at least two HMOs are available; if only one HMO is available, those counties will remain voluntary. Table 1 lists the Medicaid managed care HMOs and their locations throughout New Jersey.

Table 1: Participating HMOs in New Jersey Care 2000 -- Medicaid Managed Care

- **Garden State Heath Plan** in Atlantic, Bergen, Burlington, Cumberland, Gloucester, Mercer, Middlesex, Monmouth, Morris, Salem, Somerset, Sussex and Warren counties.
- **HIP Health Plan of NJ** in Bergen, Burlington, Camden, Essex, Gloucester, Hudson, Mercer, Middlesex, and Union counties.
- **Medigroup South** on behalf of HMO Blue in Camden, Essex, Gloucester, Hudson, Mercer, Middlesex, Ocean and Union counties.
- **US Healthcare** in Camden, Cumberland, Essex, Gloucester and Hudson counties.
- **Liberty Health Plan** in Essex and Hudson counties.
- **Managed Health Care Systems** in Camden, Essex, Hudson, Passiac and Union counties.
- **University Health Plan** in Essex and Hudson counties.
- **First Option Health Plan** in Camden, Cumberland, Essex, Gloucester, Hudson, Mercer, Middlesex, Passaic, and Union counties.
- **Oxford Health Plan** in Atlantic, Bergen, Burlington, Camden, Essex, Gloucester, Hudson, Mercer, Middlesex, Monmouth, Passaic and Union counties.
- **Amerihealth** in Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Mercer, Ocean, and Salem counties.
- **Community Healthcare Systems** in Camden county.
- **American Preferred Provider** in Bergen, Essex, Hudson, Middlesex, Passaic and Union counties.
- **Amercaid** in Essex, Middlesex, Union and Passaic counties.
- **Harmony Health Plan** in Essex, Hudson, Middlesex, Passaic and Union counties.

The New Jersey Care 2000 program uses health benefits coordinators (Foundation Health Federal Services) to educate beneficiaries about managed health care and to assist them in selecting a plan. New Jersey 2000 has drawn national attention by its efforts of working with the state Division of Youth and Family Services (DYFS) and participating HMOs in order to enroll children who are under DYFS supervision in managed care plans. These children are often difficult to place in managed care plans as they live in foster homes and other out-of-home placements.

Regarding research on client satisfaction, New Jersey 2000 has put in place a system of tracking client attitudes about the program, which includes:

- A monthly in-house telephone survey of members;
- An annual statewide client satisfaction survey; and
- A requirement that each HMO must survey clients annually, correct any problems identified and turn over survey findings and corrective action plans to New Jersey's state Medicaid office.

A recent independent survey of 2,200 randomly selected Medicaid managed care beneficiaries in New Jersey 2000 found that in every area surveyed, respondents said their managed care coverage was the same or better than the services they received under fee-for-service Medicaid. One area of improvement was indicated in the response that one in four people had missed an appointment because they had no transportation to the physician's office (*New Jersey Care 2000,* Newsletter, January 1997).

The Status of Medicaid Managed Care Programs - Other States

In an effort to analyze states' experiences with Medicaid managed care enrollment, The Commonwealth Fund and the Henry J. Kaiser Family Foundation contracted with Mathematica Policy Research, Inc. to conduct in-depth studies of Medicaid managed care programs in Oregon, Tennessee, Minnesota and California. In general, researchers raised serious concerns about the absence of information on the quality of Medicaid managed care. The studies also underscored the importance that safety net providers, which serve both the uninsured and Medicaid populations, need to be "structured" into the Medicaid managed care expansion process. Regarding cost savings, researchers found that states had to set realistic objectives about the level of savings achievable under managed care.

Findings from specific states included:

Minnesota's Medicaid managed care program, which aims to have all of its 410,000 Medicaid beneficiaries enrolled by the end of 1997, benefitted from its well-developed managed care infrastructure. The state's gradual pace over a 10-year period allowed commercial plans to develop plans tailored to meet the needs of the Medicaid population. Also, safety net providers have competed successfully in the state's Medicaid managed care market. Study findings indicated that cost savings are not automatic, especially when special attention is given to ensure access. Even with enrollment in Medicaid managed care, the state's uninsured population remained constant.

California's experience to increase its Medi-Cal enrollment in managed care to almost 3 million by the end of 1996, up from less than 1 million as-of November 1994, has met obstacles related to the diversity of counties, fiscal constraints and administrative problems. Project researchers studied efforts in Sacramento, Los Angeles and Orange counties and found that more time was needed to ensure the setting of fair payment rates and to match beneficiaries with appropriate plans; and that low capitation rates like those paid in California may lead to poor quality of care and have a negative impact on the financial viability of managed care plans.

In a 1996 report on Medicaid managed care in American inner cities, researchers found that studies on Medicaid managed care in urban communities were indicating "pervasive underservice, inadequate access to primary and specialty care, and low-quality care" (Darnell et al, 1996). Other problems encountered include inadequate capacity, state inexperience in regulation of plans and lack of detailed data on managed care enrollment. In general, it is critical that monitoring and oversight of Medicaid managed care programs and accurate performance and outcomes research must be ongoing components of each state's efforts in reforming their Medicaid programs.

In May 1996, The Henry J. Kaiser Family Foundation released a report entitled, "Medicaid and Managed Care: Focus Group Studies of Low-Income Beneficiaries in Five States." The report was based on responses from 21 focus groups conducted in California, Minnesota, New York, Oregon and Tennessee. General findings indicated that when beneficiaries were given clear explanations of program requirements, were given access to conveniently located primary care physicians and when prior relationships with physicians and other providers were able to be maintained, they expressed satisfaction with the managed care plans (Frederick Schneiders Research, 1996 Report). Problematic areas included confusion about enrollment procedures, plan and provider selection and uncertainty about what to do if a client was dissatisfied and procedures as to how to rectify such situations.

According to report findings, access to care continued to be a problem as under the fee-for-service Medicaid program. Primary access problem areas were: lack of an easily accessible primary care physician; limited availability of care during the weekend or evening hours and difficulties in securing specialist care (Ibid).

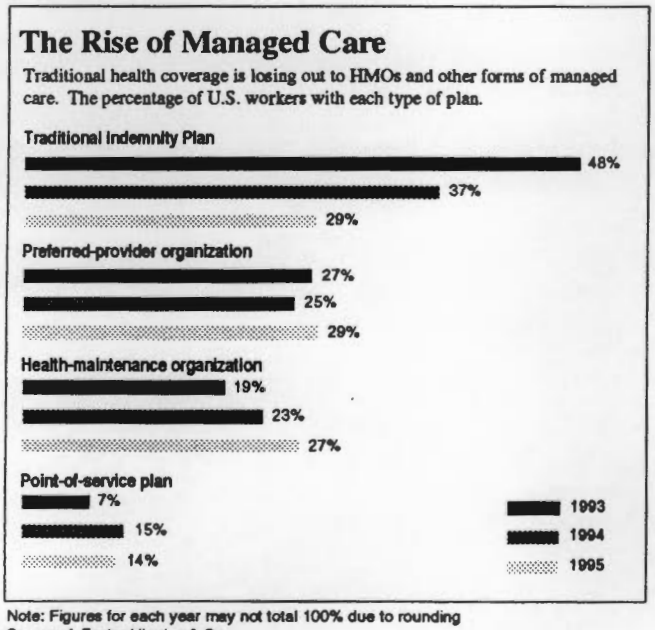
MANAGED CARE

VI. Managed Care - Oversight and Regulation

Original Issue Brief February 2, 1994 • October 19, 1994 • Update April 1997

An April 14, 1997 TIME magazine cover story profiles a "backlash" against managed care — in particular Health Maintenance Organizations (HMOs) — by reviewing criticism from all segments of the health care marketplace: doctors, patients, unions, and legislators (Federal and state). Criticism is focused on the belief that the country has moved too rapidly from a health care system that once had too few cost controls to one which is now being driven by too many, including rigid utilization reviews, gag orders restricting doctors to tell patients about expensive treatment alternatives and mandating time limits to reduce hospital stays to inappropriate lengths of time. In response, managed care advocates continue to assert that a managed care system is the only type of health care that can reduce health care costs, while providing appropriate health care and making it accessible and affordable to large numbers of individuals.

As the incursion of managed care plans continues at an exponential rate across the country — in both public and private market segments — cautionary reports and analyses about the changes in our health care system are numerous, whether they be in popular magazines (like Time and Newsweek), academic journals or conservative and liberal newspapers. On a national level, members of Congress have been introducing various bills to address different substantive areas of managed health care, such as lengths of stay for certain types of surgery and mandates regarding the terms of contracts between providers and managed care plans.



Note: Figures for each year may not total 100% due to rounding
Source: A Foster Higgins & Co.

In March 1997, President Clinton appointed a Commission to analyze and evaluate the delivery and quality of health care in a market-driven system, specifically consumer concerns. A New York Times editorial written in response to the President's appointment of the Commission called for national leadership to identify a defined role for government to address the complex issues emerging in a health care market dominated by managed care, cautioning about the continued introduction of "piecemeal" bills (March 29, 1997). The editorial emphasized the need for a governmental requirement that managed care plans disclose how effective a plan's medical care is. Such a requirement would necessitate the release of uniformly reported practice and medical outcomes data to be used to compare one plan to another. As the Federal government continues to address health care issues in various ways, on a practical level it is falling to the states to confront the complex issues raised as American health care "evolves" among their specific constituencies.

Certain trends have emerged as states are grappling with the new landscape of their individual health care delivery and financing systems. Across the country, while most states retreated from any-willing-provider legislation, which has been at the height of managed care legislative activity in 1994-1995, they aggressively moved in the direction of "patient protection" laws, covering such areas as minimum length-of-stay legislation for new mothers and adequate follow-up after outpatient surgery.

National Conference of State Legislatures health committee director Joy Johnson Wilson predicts that there will be more legislation on gag clauses in 1997, at both Federal and state levels. Response from the Federal side include President Clinton's appointment of a 34-member advisory committee to draft a patients' bill of rights and to study the appropriate type of legislation which would be needed to enforce it. Senator Edward Kennedy (D-Ma.) has introduced a comprehensive HMO reform bill to protect consumers and oversee that access to care and quality are not comprised in order to lower costs.

On the state level, in 1996, 35 states passed 56 laws to regulate HMOs. The American Medical Association's model Patient Protection Act was considered by state legislatures and portions of it passed in at least 20 states (*Modern Healthcare*, October 28, 1996). In all 20 states, the model act's provisions that require plans to provide

patients with information about contract terms and conditions were written into specific laws. New Jersey is one of several states to introduce a Managed Care Consumer Protection Bill, which includes such provisions as a ban on gag rules and easier access to specialist care.

As in the rest of the country, the citizens of New Jersey have increased their enrollment in various types of managed care plans, including HMOs, and Preferred Provider Organizations (PPOs) and Point-of-Service (POS) plans. In 1997, approximately 4 million people are enrolled in such plans, with 50 percent (2 million) enrolled in 21 HMO plans throughout the state, and the other half enrolled in other forms of managed care plans. In its HMO census, the Department of Insurance reports a steady increase in HMO membership between 1990 and 1994; while the annualized percent increase was 7.4 percent between 1991 and 1992 and 2.2 percent between 1992 and 1993. A significant 16.4 percent increase was reported between 1993 and 1994 (from 1,079,696 to 1,236,421 enrollees) and in 1995, enrollment increased to 1,591,578 (of which 158,348 were Medicaid managed care enrollees). (Table 1, lists New Jersey's HMO membership by category, including Medicaid, Medicare, Federal, state and group categories.) 1996 enrollment reached approximately 2 million, an approximate 25 percent increase from 1995. Medicaid managed care enrollment is attributable to a significant share of this increase.

New Jersey's new Health Maintenance Organization (HMO) rules became effective March 15, 1997; provisions contained in their new regulations include a ban on gag rules (which prevent doctors from discussing health care options not covered by their HMO); requirements that there be a choice of specialists; and allow for patients to appeal any decision to deny coverage. Enhanced consumer protections are the main features of the new regulations, including requirements that there be disclosure of financial incentives potentially impacting on member access to services.

A Health Data Committee(HeDaC) has been created to advise the Commissioner of Health and Senior Services on the development of a data reporting system that will collect standardized, reliable and, to the fullest extent possible, comparable information in a cost-effective manner from all HMOs in New Jersey. The data will be used to produce "report cards" which should enable consumers and payers to make informed choices among products.

HeDaC has collected 1995 information for nine selected HEDIS(Health Plan Employer Data and Information Set) quality measures such as childhood immunizations, cervical cancer screening, mammography, and diabetic retinal exams, from each HMO.

The Department will collect 1996 HEDIS 3.0 measures this summer and use that data to produce a report card later this year. The Department will also conduct and publish the results of an independent survey of HMO members this year.

At the present time there are several bills on managed care pending in the New Jersey Legislature which would expand regulatory oversight to forms of managed care other than HMOs, such as Preferred Provider Organizations and Provider Sponsored Organizations. The Department of Health and Senior Services has regulatory authority over HMOs but it does not currently have the statutory authority to regulate these other managed care entities; however, the bills pending would extend that authority to the Department.

In March 1997, a joint session of the New Jersey Legislature approved the Health Care Quality Act, which would strengthen the new HMO regulations and which extend those patient protection rights to the close to 2 million New Jerseyans enrolled in other forms of managed care plans (*The Star-Ledger*, March 11, 1997). The Health Care Quality Act, sponsored by State Senator Jack Sinagra and Assemblywoman Charlotte Vandervalk, has provisions which include barring managed care companies from paying doctors bonuses for restricting medically necessary treatment. Another bill sponsored by Assemblywoman Barbara Wright, would require disclosure of financial arrangements between the health carrier and its doctor (rather than banning bonuses), including any incentives for restricting care. Assemblywoman Wright's bill would also allow managed care patients to use a physician outside of the network if they pay an additional fee; it is co-sponsored by Assemblyman Paul Kramer and an identical bill by Senator Peter Inverson has been introduced in the Senate (*The Times*, February 21, 1997).

In general, legislation pending in New Jersey and several states throughout the country would bar "gag orders" that limit the kinds of information doctor can tell patients about their medical treatment; explain terms of the contracts, including services, restrictions and co-payments, in plain language; allow for the patient to appeal adverse decisions to a state-appointed outside panel of medical experts; explain to patients financial incentives between their doctors and the managed care plan; require that "report cards" be available on each plan and its operations and allow patients to see physicians outside of their plan for an additional fee.

Table 1

N.J. HMO Membership by Category

as of 12/31/95

	Medicare	% of Total	Medicaid	% of Total	State Local	% of Total	Federal	% of Total	Group	% of Total	Other*	% of Total	Total	% of Total
Aetna Health Plans	9,506	21.8%			46,335	20.2%	1,621	2.9%	61,913	6.0%	1,470	2.0%	120,845	7.6%
American Preferred			2,738	1.7%					0				2,738	0.2%
AmeriHealth					1,961	0.9%	496	0.9%	23,840	2.3%			26,297	1.7%
ChubbHealth									48	0.0%			48	0.0%
Cigna NJ					3,217	1.4%			6,517	0.6%	154	0.2%	9,888	0.6%
Cigna North/Comed					14,715	6.4%	2,741	5.0%	53,653	5.2%	1,159	1.6%	72,268	4.5%
First Option			5,431	3.4%	5,563	2.4%			71,904	7.0%	149	0.2%	83,047	5.2%
Garden State			33,299	21.0%					0				33,299	2.1%
Greater Atlantic							364	0.7%	1,338	0.1%	78	0.1%	1,780	0.1%
Harmony Health Plan			5,846	3.7%					0				5,846	0.4%
HIP Health Plan	8,859	20.3%	12,303	7.8%	23,007	10.0%	12,192	22.2%	72,829	7.1%	49,371	67.9%	178,561	11.2%
Liberty Health Plan			8,933	5.6%					0				8,933	0.6%
Medigroup of NJ			36,006	22.7%	34,141	14.9%	253	0.5%	103,224	10.0%	5,588	7.7%	179,212	11.3%
MetraHealth of NJ									23,447	2.3%	121	0.2%	23,568	1.5%
MetraHealth Upstate NY					250	0.1%			553	0.1%			803	0.1%
NYLCare Health Plans					4,449	1.9%	4,436	8.1%	30,233	2.9%	314	0.4%	39,432	2.5%
Oxford Health Plans	5,000	11.5%	4,266	2.7%	4,369	1.9%	1,922	3.5%	125,709	12.2%	5,200	7.1%	146,400	9.2%
Physician Healthcare Plan									17	0.0%			17	0.0%
PruCare of NJ					10,109	4.4%			77,800	7.5%	1,891	2.6%	89,800	5.6%
U.S. Healthcare	20,285	46.5%	41,609	26.3%	81,107	35.4%	31,009	56.3%	379,511	36.8%	7,244	10.0%	560,765	35.2%
University Health Plans			7,983		48	0.0%			0				8,031	0.5%
Totals	43,650	100.0%	158,348	100.0%	229,271	100.0%	55,034	100.0%	1,032,536	100.0%	72,739	100.0%	1,591,578	100.0%

* "Other" may include individual, group conversions and COBRA extensions. For HIP Health Plan, this also includes NJ members of out-of-state groups who have chosen to use the HIP NJ network.

THE CAPITOL FORUMS
On Health & Medical Care

Issue Briefs

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PUBLIC HEALTH AT THE CROSSROADS: PAST, PRESENT, FUTURE
PART I: NATIONAL, STATE, AND LOCAL OVERVIEW

Original Issue Brief June 21, 1996

ISSUE: How will the complex system of public health, whose structure is comprised of national, state, county and local municipality administrative units, negotiate the changes of the evolving health care system, with its call for efficiency, streamlining and elimination of administrative excess? In what ways with public health agencies balance core public health functions with the delivery of direct services?

Our evolving health care delivery system, with its emphasis on preventative care and case management, has as one of its primary goals improving the health of the public it serves. This goal has long been the cornerstone of America's public health system through its efforts at disease prevention and health promotion. As managed care organizations are fast becoming a primary source of health care for both private insurers and public programs (Medicaid and Medicare), how will the public health system be affected, especially in its role as provider of direct services? Should its primary function be framed by a population-based model to improve the health status of the overall population, should it be as a provider of direct services, or some combination of both functions?

INTRODUCTION

Ask an uninsured mother what she thinks public health is, and she will probably answer that it means a measles vaccine for her child; ask a chiropractor from Hunterdon County and she will probably talk about the deer tick she sent into the laboratory for Lyme disease analysis; ask a teacher from the inner city, and he may talk about the local board of health's lead screening program or asbestos abatement efforts in his school building; ask a local resident of Salem County and he may talk about well water testing.

Public health means many things to many people. Throughout history, from Old Testament edicts about the preparation of certain foods such as pork and dairy products, to Thomas Mann's novel *Death in Venice* (set in 19th century Italy during a cholera epidemic), when the Minister of Health assures the people and tourists in Venice that "nothing is wrong, the fever is just being caused by the warm winds blowing up from northern Africa," the public has believed that those in charge of public health will protect them from disease and illness, through surveillance, research, monitoring and public education and outreach. Historically, most times their beliefs were supported.

By the turn of the 20th century, with medical breakthroughs and understanding of the nexus of communicable and infectious diseases related to improving sanitary conditions and nutrition, a new era of disease surveillance and control was established in the American public health system. Public health has contributed to a majority of the major improvements in the health of the American public, through such public health activities as its control of epidemic diseases, the monitoring of safe water, food and sanitary conditions, and the oversight and provision of maternal and child health services. As we move toward the end of the 20th century, the traditional assertion that the "successes of the public health system are invisible, but its failures are not" continues to hold true, as exemplified by the re-emergence of medication resistant Tuberculosis (TB), the Cryptosporidiosis (caused by Cyptosporidium, an infectious organism found in water sources) outbreak in Milwaukee, Wisconsin, from which some 400,000 people became ill from the drinking water, and the cases of hantavirus (a virus that had not been found in the United States until the 1980s) in the Southwest in the 1990s (McGinnis, 1995).*

Since the 1960s when infectious diseases were believed to be all but eliminated in the United States and with the establishment of the Medicaid and Medicare pro-

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League of Women Voters of New Jersey Education Fund

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*The Appendix of this issue brief includes background information on the mission, structure and core functions of the public health system in the United States.

grams, the activities of public health agencies have shifted from providing core public health functions, such as surveillance of communicable and chronic diseases, environmental protection and public education, to providing clinical services to uninsured and other disadvantaged populations. Events during the 1980s and 1990s. with the emergence and proliferation of managed care organizations (MCOs) in the health care delivery system and the reduction in public health funding, have created a public health "identity" crisis. At the same time, between 1980 and 1992, age-adjusted mortality from infectious diseases (such as TB and pneumonia) increased by 39 percent, creating a need for more sophisticated active and passive surveillance by public health agencies (National Health Policy Forum, 1996). Currently, one quarter of all physician visits in the United States are related to infectious diseases, and antimicrobial medications (such as antibiotics) are the second most commonly prescribed type of drugs (Ibid).

CURRENT STATUS

The primary challenge facing public health officials on all levels is how public health activities should change in the context of a managed care environment. Specifically , should the provider of public health services continue to provide clinical services and contract as a provider with the managed care health plan; should it partner with the MCO, drop its clinical provider role and instead focus on delivering health promotion, prevention and surveillance activities; or should it provide some combination of both? Such decisions are further complicated when the issue of funding comes into play. The Institute of Medicine at the National Academy of Sciences reports that almost 75 percent of state and local health department funding goes to clinical care. While public health agencies have become reliant on Medicaid reimbursement for providing direct services to clients, their role as "provider of last resort" may disappear, in light of the likely reductions in Medicaid and other health care spending and the increase in numbers of uninsured and medically indigent members of their communities.

Core Functions of Public Health

- Surveillance of Communicable and Chronic Diseases (Data Collection)
- Control of Communicable Diseases and Injuries
- Environmental Protection
- Public Education and Community Mobilization
- Assurance of Quality and Accountability in the Delivery of Health Care
- Operation of Public Laboratory Services
- Training and Education of Public Health Professionals

In testimony before the U.S. Senate, the Assistant Secretary for Health, Dr. Philip R. Lee asserted that the "shift of public spending at the state and local level toward personal medical care has been at the expense of its essential role in keeping communities healthy" *(State Initiatives in Health Care Reform, 1994)*. The Committee for the Study of Future of Public Health at the Institute of Medicine is due to publish a progress report this summer (1996) as a follow-up to its 1988 report, "The Future of Public Health." The Committee found that American public health agencies are faced with the impossible responsibility, "to served as stewards of the basic health needs of entire populations, but at the same time avert impending health crisis, as well as provide health care services to persons who do not have access to health care by any other means." (Institute of Medicine Report at 2; 1988).

NATIONAL INITIATIVES-HEALTHY PEOPLE 2000

In 1990, the United States Department of Health and Human Services, through its U.S. Public Health Services, released *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*, a report which set forth the nation's health goals for the year 2000. The report was the result of cooperation among principal health officials of the 50 states, the National Academy of Sciences' Institute of Medicine and representatives from over 300 professional and voluntary national membership organizations. *Health People 2000* sets forth 300 measurable objectives in 22 areas of priority for health promotion, health protection and clinical prevention services to be accomplished by the year 2000. New Jersey is one of many states to develop state-specific goals and objectives for its individual needs and conditions. New Jersey's individual state document, *Healthy New Jersey 2000* and its 1996 update, monitor and assess New Jersey's status towards meeting the goals set forth in the national document regarding health status and preventive health services.

In a 1994 study conducted by the University of Illinois at Chicago School of Public Health, researchers looked at the objective set forth in both *Healthy People 2000* and *Healthy Communities 2000* (comprised of model standards at the community public health level) that 90 percent of the population be served by a local health department effectively carrying out the three core functions of public health; assessment, policy development, and assurance. Using a stratified random sample from the National Association of County Health Officials (NACHO) data base, the study group found that less than 40 percent of the U.S. population was served by a local health department effectively addressing the core functions of public health (Turnock et al, 1994). The group asserted that "considerable capacity building" within the public health system is needed to achieve the year 2000 target goal of 90 percent.

In a 1995 Journal of the American Medical Association (JAMA) article, Drs. J. Michael McGinnis and Philip Lee of the U.S. Public Health Services reported progress towards the goals and objectives of the national plan at mid-decade. One of the primary challenges of meeting the goals was identified as the erosion of the public health infrastructure at the community level; another

challenge was that critical obstacles to good health status remain for the most vulnerable populations, with an increase of financial barriers to medical care and preventive services for African-American, Latino and native American populations (JAMA, April 12, 1995).

In 1996 the New Jersey Department of Health published its *Healthy New Jersey 2000 Update, A public Health Agenda for the 1990's,* to report on " how the state is doing" in terms of goals and objectives of its plan developed in 1991. At the beginning of the 1990's, New Jersey set goals in eleven priority areas: access to health care; maternal and child health; adolescent health; cancer; cardiovascular disease; HIV/AIDS; sexually transmitted diseases (STD's); vaccine-preventable illnesses; injuries; occupational and environmental health; and substance addictions. In general, the state is following along the national lines in terms of grappling with the problem of closing the gap between minority and white health status. i.e., there continues to be substantial disparities in the health status between New Jersey's total population and its minorities. In its 1996 *Update,* the department analyzed these priority areas in terms of the likelihood of achievement of its Year 2000 objectives. The priority areas of public health in which the likelihood of achievement of goals was strong was in reducing the mortality rate for adolescents from motor vehicle accidents; in annual mammography screening; in the prevention, detection and control of cardiovascular diseases; and in the prevention and control of addictions. those areas in which the objectives are unlikely to be achieved are in the areas of health access; maternal and child health; cancer; AIDS and HIV and occupational and environmental health. Nutrition objectives for women and children, however, are likely to be met, via the accomplishments of the Women, Infants and Children (WIC) program.

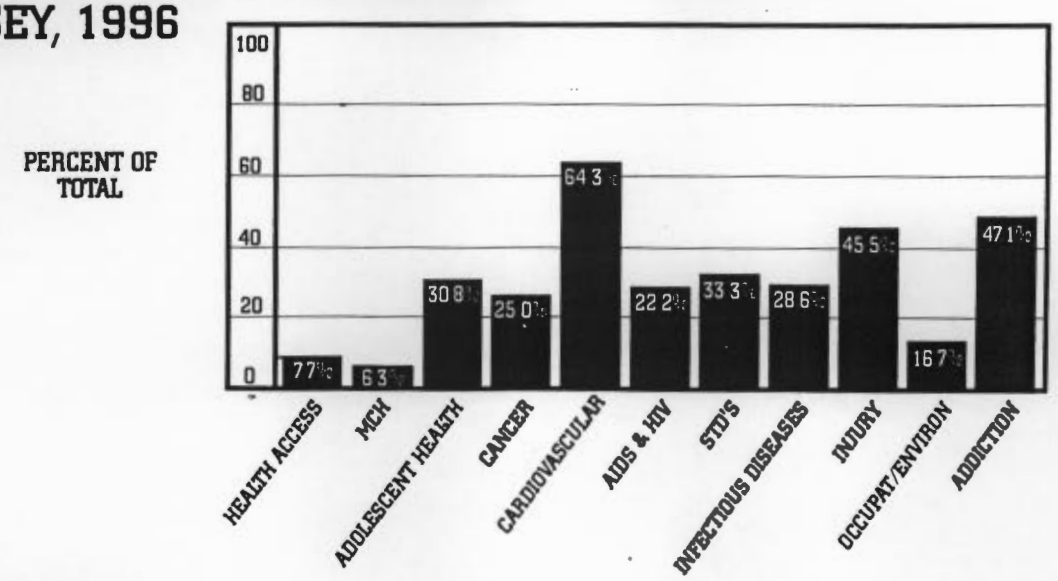
PUBLIC HEALTH IN NEW JERSEY-AN OVERVIEW

State Level

At present, the Department of Health in the state of New Jersey is itself "in transition"; as it brings "under one roof" services for New Jersey's senior citizens, the Department will become the Department of Health and Senior Services. Within the Department, Public Health Services is comprised of separate Divisions for AIDS Prevention and Control; Alcoholism, Drug Abuse and Addiction services, and Family Health Services. In further actions to improve its public health activities, the Department is in the process of re-organizing its epidemiology and public health laboratory activities into three divisions and two smaller programs. The three divisions will be: (1) Public Health and Environmental Laboratories; (2) Environmental and Occupational Health and (3) Epidemiology and Communicable Diseases. The two smaller programs are the Office of Cancer Epidemiology and the Office of Local Health.

While the Department does provide direct services through its Laboratories and is involved in four major data initiatives (Health Information Network (HINT) project; electronic birth certificate registry; the statewide immunization network project and the state cancer registry), its role is primarily as administrator. Through its labs, the

YEAR 2000 OBJECTIVES LIKELY TO BE ACHIEVED TOTAL STATE OBJECTIVES, BY PRIORITY AREA NEW JERSEY, 1996



Source: New Jersey Department of Health, 1996

Department provides an array of services to state and Federal agencies, physicians, clinics, hospitals and local health departments. Public health activities within the divisions include epidemiological research, the publication and dissemination of fact sheets and reports on diseases such as TB and Lyme disease, and environmental health problems such as mercury and hazardous chemicals. The Department is currently working with the Department of Environmental Protection to develop a statewide water system data base to ensure water safety.

Each division has its own fiscal and administrative units, which award Federal and state grants for public health activities to local health departments, hospitals, not-for-profit agencies and any other entity that provides public health systems. Federal block grants include the Maternal and Child Health Block Grant, the Preventive Health Block Grant and the Drug Abuse and Mental Health Block Grant. A number of other Federal grants for specific public health projects come into the Department and its Divisions. Through its Request for Proposals (RFP) process, the block grant funds are distributed to a variety of local agencies. In addition, the local public health agencies may also apply for and receive Federal funding support directly, without using the state Department as an administrator.

New Jersey Department of Health -Fiscal Year 1995 Expenditures

A recent report of the Department's Fiscal Year 1995 Expenditures in the area of public health breaks out expenditures including state funds, state appropriations, block grants, other Federal grants and contracts and private and other funds. Total expenditures from these areas was approximately $353 million. Public health categories include the following expenditure totals (from all sources):

•Family Health Services	$181,171,992
•Alcohol, Drug Abuse & Addictions	$90,424,706
•AIDS	$35,039,703
•Epidemiology, Environmental & Occ. Health	$32,671,774
•Public Health & Environmental Labs	$11,868,273
•Vital Statistics & Registration	$1,649,095
Total	$352,825,543

Within each of these budgets, various programs are operated and supported by multiple sources. For example, FY 1995 expenditures for the Prevention Services program within the Division of Alcohol, Drug Abuse and Addictions totaled $12,835,599. This total was comprised of $796,051 from State funds, $253,979 from the federal Preventive Health Block Grant, $10,822,219 from the federal Drug Abuse and Mental Health Block Grant and $963,350 from other federal grants and contracts.

As another example of the complicated funding streams involved in federal, state and local levels of public health, we can look to how the Federal Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990 funds are awarded and distributed. The Act makes funds available through four titles to states, eligible metropolitan areas (EMA) and nonprofit entities for developing, organizing, coordinating and operating service delivery systems for individuals and families with HIV disease. Nationally in FY 1994, over $579 million in CARE Act funds were appropriated. About 56 percent (or $326 million) of the funds were appropriated for Title I, which provides emergency assistance to EMAs, metropolitan areas disproportionately affected by the HIV epidemic. In New Jersey, approximately $5.5 million was awarded to Newark; approximately $2.4 million was awarded to Jersey City and $1.4 million was awarded to Bergen-Passaic counties directly fromm the Federal government.

Nationally, Title II of the CARE Act included $184 million in FY 1995, or approximately 32 percent of the total CARE Act funds. Title II provides funds to states to improve the quality, availability, and organization of health care and support services for people with HIV. New Jersey received approximately $8.9 million in FY 1995 for Title II public health activities. In Fy 1995, Titles III and IV monies were approximately $48 million and $22 million, respectively; Title III funds, which are awarded competitively, are intended for early intervention programs and Title IV funds are intended for pediatric AIDS programs. Tracking of such funds from the Federal, to the state, down through a multiple of local levels is a complicated task. And this represents just one single slice of a complex area of departments, divisions, and agencies on Federal, state, and local levels.

Local Public Health

Beginning in 1887, every municipality in New Jersey has been required to have a local board of health. According to the New Jersey State Health Plan, the boards of health have a statutory mandate "to provide policy direction for and oversee the operation of public health activities within the municipality." Departments of health at the local level, however, are not required under law; each municipality is free to contract with other health departments, join a county health department, or join with other municipalities to form a regional health commission.

In the mid-1970s, there were 291 local health departments in New Jersey. In 1975, when the state's Local Health Services Act was promulgated, it required that each local health department be administered by a full-time, licensed health officer. Consequently, the number of local health departments was significantly reduced; according to a 1994 Department of Health report on local health, there are now 115 local health departments in New Jersey. There are eleven Federally Qualified Health Centers located in medically underserved areas in New Jersey, which service approximately 40,000 beneficiaries by providing primary care and preventive services. Of this total, 55 are individual municipality health departments, and 15 are

county health departments. There are 39 contracting arrangements and six regional commissions. Under New Jersey's Health Care Cost Reduction Act of 1991, these six Local Advisory Boards (LABs) were established throughout the state to coordinate local health planning.

New Jersey's contribution equals approximately 20 percent of their total funding to local budgets, while the bulk of their funding comes from Federal grants and other public and private sources. In FY 1995, the state distributed approximately $3 million in these Public Health Priority Funds to the locals. New Jersey is one of several states (e.g., Connecticut, Iowa, Missouri and Wisconsin) with populations of under 8 million people, which have decentralized public health systems and low levels of state funding. According to 1991 figures from the Centers for Disease Control, per capita state funding in these states range from $0.53 in Wisconsin to $2.07 in New Jersey. New Jersey's decentralized public health system creates a wide range of variability in public health services and is supported by complex funding streams. The 1994 Report of "The Commissioner's Working Group on Public Health" strongly recommended that a more regional approach to the provision of local public health services be undertaken in New Jersey. Currently,the Department of Health is working to develop a public health infrastructure in new Jersey. The Department points to reduced funding and the growth of managed care as "forcing the issue" to develop a coordinated infrastructure of public health activities in the state.

The Commissioner's 1994 report cited the state of Georgia (with a population of approximately 6.5 million) as an example of successful regionalization in public health activities. While each of Georgia's 159 county-based local health departments are also decentralized, the primary difference between New Jersey and Georgia's public health system is that Georgia has Lead Districts throughout the state, which are compromised of between one to sixteen local health departments. These Lead Districts are responsible for coordinating surveillance and reporting activities, program development and service delivery. While the local departments still retain flexibility to design services appropriate to their communities, there is coordination of programs such as communicable disease surveillance at a regional level. The state contribution to Georgia's local health departments averages $7.10 per capita.

The state of Maryland has developed a strong relationship between its state and local health departments to provide coordinated health services at the community level *(Commissioner's Working Group on Local Health, 1994)* Support for local health varies; on average, the state and localities provide 50 percent of the funding to local health departments; wealthier counties contribute up to 80 percent to their departments, while poorer counties contribute as little as 20 percent (Ibid). The state provides an estimated $8.00 per capita to local health departments (Centers for Disease Control, 1991).

As an example of recent local planning efforts, the New Jersey Hospital Association has a Community Health Assessment Committee to assist members in administrating a community health needs assessment. Through a survey distributed to hospital's CEO's, local health departments, health planners, Local Advisory Boards and community agencies (e.g, Visiting Nurses; YMCAs; YWCAs) in order to gather information about current initiatives being undertaken by health care organizations concerned with improving the health status of the communities they serve. The 1995 survey found that community health Assessments were accomplished by organizations partnering with other organizations in order to obtain health and health status data. Based on responses, 53 percent of the hospitals, 28 percent of the local health departments, 11 percent of the LABs and 8 percent of the community agencies have conducted Community Health Assessments.

THE FUTURE OF PUBLIC HEALTH -CURRENT STRATEGIES

FEDERAL LEVEL ACTIVIES

Both the Clinton Administration and Republican leaders are in agreement that the maze of categorical public health grant programs should be simplified through consolidation and that the states should be given broader discretion as to how the funds are utilized. Currently, Senator Nancy Kassebuam (R.-Kans.) (Chair of the Senate Committee on Labor and Human Resources) has introduced a bill that would consolidate all 12 Centers for Disease Control (CDC) categorical funding streams into a single block grant, to be allocated among the states based on factors related to population, health status and financial capacity. A Clinton Administration proposal seeks to consolidate 32 separate CDC categorical grant programs into three areas: (1) immunization; (2) HIV/STDs/TB and (3) chronic diseases and disability. Both proposals are currently pending. While state and local public health officials generally support merging categorical public health grants, advocates are concerned that block grants may reduce appropriations.

In planning for the future of public health in a managed care environment, the CDC has created an agency-wide Managed Care Working Group, which believes that "managed care organizes health care into delivery systems with potential for prevention related surveillance, monitoring, intervention and health services research." The working group reports found that the electronic information systems being developed by MCOs may be utilized as sources of data for a new national health information system. Also, as enrollment of Medicaid and Medicare beneficiaries continues to grow in MCOs, there will be data collected on these two important high-risk groups. In other activitiés, a collaborative effort with the Group Health Association of America, the HMO national trade association and the CDC's National Immunization Program is the formation of a nationwide alliance to improve the vaccination status of preschool children. As a result, individual HMOs are working with public health agencies on local levels around the country.

STATE LEVEL ACTIVIES

Decisions concerning the future of public health within the states are inextricably tied in with health reform issues, in particular with initiatives concerning the uninsured population, insurance reform and managed care enrollment for Medicaid populations. As states continue with efforts to provide health coverage for uninsured and underinsured citizens, states like Washington are planning to enroll their uninsured population in managed health plans. As a consequence, public health agencies will be relieved from providing clinical services and will be freed up to focus on population-based prevention and health promotion and education. In the state of Florida's plans, local public health units will have the discretion to decide the best direction for their activities: they may work with Medicaid managed care providers, become HMOs themselves, or focus on population-based activities and core public health services, such as control of communicable diseases, environment protection and public education.

PRIVATE SECTOR PARTNERSHIPS IN PUBLIC HEALTH

A recent piece in *American Medical News* asserts that the long standing difficult relationship between public health and the private medical profession has contributed to the public health system's weakness *(American Medical News, 1996)*. It stresses that this rift has to be mended to facilitate consistent disease reporting, prevention and health education from private physicians and medical practitioners.

New potential partners in infectious disease surveillance and prevention are managed care organizations (MCOs), such as HMOs. While the traditional view of public health is that it is responsible for populations, not individuals and the traditional view of medical care is responsible for individuals and not populations, the emergence of managed care in the health care system is initiating a concern with the health of populations, in addition to the health of individuals. At the present time, concurrent functions of public health agencies and managed care organizations include: wellness and prevention programs, immunization, the identification and treatment of sexually transmitted diseases (STDs) and HIV/AIDS; case finding and surveillance; school-based health care; chronic mental illness, maternal and child health, case management, home health care and quality assurance.

In the most recent edition of *State Initiatives in Health Care Reform* (May-June 1996), discussion focused on the question of collaboration between public health and managed care organizations. Research has indicated that the likelihood of collaboration is "tied to market maturity and managed care penetration," putting Minnesota and West Coast locations in the forefront of such collaborations in areas such as preventive health. In Minneapolis-St. Paul, managed care organizations, public health agencies and other health care delivery organizations have formed the Center for Population Health to serve as a forum for developing public-private health promotion initiatives. In other activities, the state of Oregon is using school-based projects for public-private cooperation. While still in its planning stages, the plan would tie in Blue Cross-Blue Shield, the state's largest managed care organization, with establishing public health clinics in the schools. The report identified a trend that many public health agencies are responding to budget reductions and cutbacks "by focusing their resources on their traditional mission of overseeing the health of the whole community."

CONCLUSION

New Jersey is not alone in confronting the challenge of creating a public health infrastructure which can provide core public health functions in this era of dynamic changes within the entire health care delivery system. The direction which the state will take at the current crossroads is inextricably tied in with our policies and programs concerning the core functions of public health and its organization and funding. In addition, the corollary issues of insurance and welfare reform, and managed care delivery systems in both the public and private sectors must be addressed. Cooperation and coordination among all players and at all levels of public health are critical to its future.

PUBLIC HEALTH-ITS MISSION, STRUCTURE AND CORE FUNCTIONS

The development of public health activities in the U.S. evolved along with how the American people as a whole viewed social and health problems. Once poverty and disease were understood and accepted as societal as well as individual problems, both private and governmental interventions were implemented (Synder, 1994). In 1873, Stephen Smith, a physician and commissioner of the Metropolitan Board of Health in New York, founded the American Public Health Association as an organization for health officials and interested citizens. In the previous year, only three states and the District of Columbia had established boards of health and only two states had "accurate" registrations of birth, death and marriages.

THE MISSION AND CORE FUNCTIONS OF PUBLIC HEALTH

The Committee on the Future of Public Health found that while most agree that the overall mission of public health "is fulfilling the society's interest in assuring conditions in which people can be healthy," the implementation of that mission has broad variability across national, state and local lines. This variability is reflected by a "system" with extreme varieties of organizational arrangements, funding mechanisms and available services.

Historically, the core functions of public health have involved assessment, policy development and assurance. These functions include:

- Surveillance of Communicable and Chronic Diseases (Data Collection)
- Control of Communicable Diseases and Injuries
- Environmental Protection
- Public Education and Community Mobilization
- Assurance of Quality and Accountability in the Delivery of Health Care
- Operation of Public Laboratory Services
- Training and Education of Public Health Professionals

Public health experts agree that public health agencies, through inter-governmental and interagency cooperation, should collect, assemble, analyze and make available information on the health of the community, including statistics on health status, community health needs and epidemiologic and other health problems (Institute of Medicine Report, 1988). In addition, "agencies should be involved in the development of comprehensive health policies by using a coordinated scientific knowledge base to make appropriate decisions." Finally, public health agencies should be assure their constituents that services necessary to reach public health goals are provided, either by working with other agencies to provide such services, or providing them directly (Ibid). This assurance function means to assure access to environmental, educational and personal health services. The ways in which this last function are implemented are particularly dynamic, with the emergence of managed care organizations and their commitment to provide preventive care services.

Historically, disease surveillance, health assurance, health promotion and health policy development had been designated as core public health functions and were the primary functions of most public health agencies. With the "abeyance" of infectious and communicable diseases, especially during the period from 1970s to the 1990s, public health took on the expanded role of the direct delivery of services. Given the limited public health budgets, there is currently much debate as to whether or not both types of these functions can continue to be performed by agencies.

FEDERAL, STATE AND LOCAL GOVERNMENT ROLES IN PUBLIC HEALTH

FEDERAL GOVERNMENT'S ROLE

The Federal government's role in the public health system includes surveying the population's health status and health needs, setting policies and standards, helping states and local agencies to finance personal health services, delivering personal health services, providing technical assistance to state and local health systems, and supporting international efforts to ensure global health and protect against health threats. The primary Federal unit responsible for public health is the United States Public Health Service (in the Department of Health and Human Services). The administrator of the Medicaid and Medicare programs - the Health Care Financing Administration (HCFA) (in the Department of Health and Human Services) also has a significant role in national public health activities. The Food and Nutrition Service in the Department of Agriculture, and the Environmental Protection Agency are also involved in public health activities.

Organizationally, the U.S. Public Health Services is comprised of: (1) the Centers for the Disease Control (assessment and epidemiologic unit); (2) the National Institutes of Health; (3) the Food and Drug Administration; (4) the Health Resources and Services Administration; (5) the Alcohol, Drug Abuse and Mental Health Administration, and (6) the Agency for Toxic Substances and Disease Registry. In addition, the Office of Health Promotion and Disease Prevention and the Office of Planning and Evaluation are involved with health management, planning, education, and evaluation. For example, the Centers for Diseases Control provides technical support for disease prevention and control through approximately 800 public health advisors and other specialists who are assigned to state health departments, at an average yearly cost of $40 million dollars (United States General Accounting Office Report, January 1996). In recognition of the changing role of these advi-

sors, which continue to evolve, the evaluation of the role of public health advisors is one of over 25 "active" assignments that the General Accounting Office is investigating in the area of public health and health financing in the evolving national and state-based health care systems.

Technically, Federal public health activities fall into two broad categories: activities conducted directly by the Federal government, such as assessment, research and some delivery of personal health care, and activities contracted by the Federal government to states, localities and private organizations. These contracted activities represent the bulk of direct service programs and are through contracts and grants. For example, the Department of Health in the state of New Jersey receives block grants from the Federal government in such areas as maternal and child health, preventive health, drug abuse and mental health, and primary care. These grants are support for localities to provide such services as prenatal and obstetrical care, family planning, immunizations, mental health, alcohol and drug abuse care and services for chronic diseases.

STATE LEVEL RESPONSIBILITIES

The states carry the primary responsibility for ensuring the public health in this country. There are 55 state health agencies in the United States, each directed by a health commissioner or a secretary of health. Currently, there are two models by which state health agencies are organized: as a free-standing independent agency, or as a component of a "superagency". There is wide variation as to the oversight responsibilities of state health agencies throughout the country; some also are responsible for environmental concerns, mental health concerns and act as the state Medicaid agency.

Primary similarities among state health agencies are that most states have programs for vital statistics and epidemiology, conduct planning, have regulatory responsibilities (including inspection and licensing), conduct environmental safety programs (sanitation, air and water quality, occupational health, waste management) and are involved in personal health services. The resources for public health activities come from a variety of sources, including state funds, Federal contracts and grants, fees and reimbursements (e.g., state laboratory fees); local funds and other private sources.

LOCAL LEVEL RESPONSIBILITIES

Great variability exists at the local public health level. While there are an estimated 3,000 local health departments across the United States, most of them are county-based. In states like Pennsylvania and Nebraska, there are no local health agencies and reliance is upon state and federal government for public health support. States such as Maryland, Missouri and New Jersey have local health departments in every county. In each state, the number of local health departments varies from 0 in states like Rhode Island and Vermont, to close to 160 in the state of Georgia. New Jersey currently has 115 local health departments.

Local health departments across the country are in fact the "front line" agencies for public health activities. Activities in these local health departments may include the provision of screening and immunizations; the operation of communicable disease control programs; the collection of health statistics; direct services, such as maternal and child health services, mental health, public health nursing services and other ambulatory and home care services. The Committee for the Future of Public Health found that similarities among local health departments include that most are involved in providing health education, personal health services, environmental health services and conducting inspections. However, there remains significant variation in services rendered among the thousands of local health departments around the country and their capacity to provide services varies greatly. According to a recent Centers for Disease Control (CDC) survey, 42 percent of the nation's local health departments have fewer than 10 full-time staff members and 21 percent do not provide well-child clinic services.

PUBLIC HEALTH II
THE URBAN-SUBURBAN CONNECTION

Original Issue Brief July 31, 1996

ISSUE: The general health status of the public is not protected from illness and disease based on geographic location or socio-economic class. Epidemiologic research, the surveillance of communicable and infectious diseases, public education, and the operation of public laboratory services are among the essential functions of public health. How is New Jersey's public health system -- with shrinking funding and resources -- responding to increased cases of Tuberculosis (a re-emerging communicable disease) and newly emerging tick-borne infectious diseases (such as Lyme disease), whose incidence rates have been highest in different geographic and demographic areas?

Increases in infectious and communicable diseases are not only urban public health issues, but also have significant health, monetary and social impacts on New Jersey's suburban and rural populations. How can our state's decentralized public health system meet the challenge of increased cases and the demand of intense research to monitor and treat these two illnesses and similar threats?

INTRODUCTION

In his "Devotions upon Emergent Occasions" (1627), the 17th century writer John Donne describes illness as an enemy that may invade the "fortress" of the body at any time, despite our most sophisticated knowledge and intensive vigilance:

> We study Health, and we deliberate upon our meats, and drink, and ayre, and exercises, and we hew and we polish every stone, that goes to that building; and so our Health is a long and a regular work; But in a minute a Canon batters all, overthrows all, demolishes all; a Sickness unprevented for all our diligence, unsuspected for all our curiositie . . .
> (Sontag, 1989)

Donne's concerns still echo through the centuries as we, in 1996, confront the challenges of responding to relatively "new" illnesses -- like tick-borne diseases -- and communicable diseases believed to be almost eradicated some 30 years ago and now re-emerging, such as Tuberculosis (TB). While the highest TB prevalence rates are in New Jersey's urban centers, cases are increasing in communities outside of the inner cities. Conversely, cases of Lyme disease and other emerging tick-borne diseases originally were clustered in rural and coastal areas of the state, but Lyme disease is now endemic throughout all 21 counties. Both illnesses present complex public health problems at a time when the public health system is undergoing significant changes with the impact of managed care delivery systems (See, Capitol Forums Issue Brief, "Public Health at the Crossroads," June 26, 1996).

TUBERCULOSIS

History

Tuberculosis (TB), an upper-respiratory infection characterized by cough, weight loss, night sweats and low-grade fever, is caused by a bacillus: *Mycobacterium tuberculosis*. The disease is transmitted by inhaling airborne droplets expelled by the cough or sneeze of a person with infectious TB. For centuries the only "weapons" thought to conquer TB were environmental and behavioral: cleanliness, air, well-ventilated rooms, good hygiene, and bed rest. It was not until the mid-20th century when the true cure for TB -- antibiotics -- was discovered. The antibiotics kill the bacillus which causes TB.

Up until the mid-1980s, there had been an historical decline in TB morbidity and mortality in the United States. This was attributed to the result in improvements in nutrition and housing in the first half of the century, as well as specific public health interventions, such as education, isolation and quarantine, which contained the spread of the disease (Bayer and Dupuis, 1995). From 1953 - the

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year of the introduction of the anti-tuberculosis drug isoniazid - through 1984, the number of TB cases across the country decreased from 84,304 to 22,255 (an average decline of 5 percent per year) (Ibid). Yet, nationally, the disease continued to be a significant problem for non-white minorities and low-income communities, where TB prevalence rates ran almost 100 percent higher than in the general population.

While almost all cases of TB are curable through available and highly effective medications, the afflicted person must comply with his or her treatment plan. Most people with TB can be treated and cured with a six to twelve-month course of antibiotic therapy; their contacts can be tested and treated - all on an outpatient basis. It was with antibiotic medication that the care and treatment of TB shifted from an inpatient institutional setting, to an outpatient and community setting. For example, in New Jersey, hospitals for TB patients, which had a presence in the state since the late 1800s, began to disappear in the 1950s, when the disease was coming under control through antibiotic therapy. Outpatient TB care has a strong emphasis on education and communication between health care providers and patients. For outpatient treatment to be effective and to prevent the spread of TB, it is critical to manage and monitor the treatment of persons with active TB.

The Re-Emergence of Tuberculosis

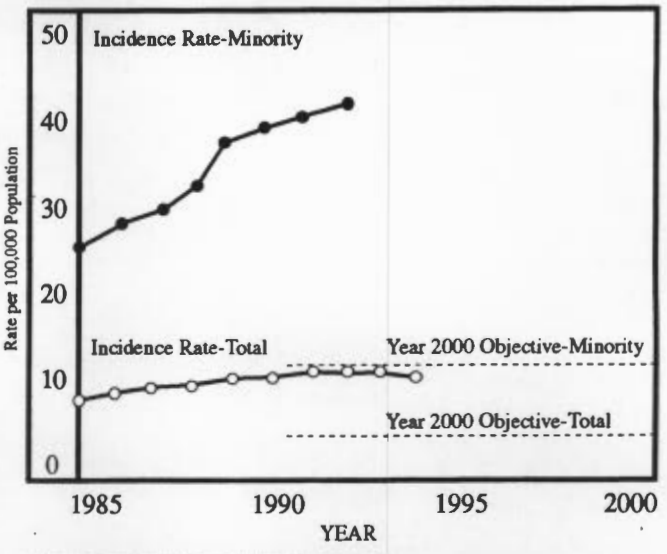
Beginning in 1985, the downward trend in TB cases began to reverse. Cases of TB increased more than 20 percent between 1985 and 1993 in the U.S. Since 1994, there have been small decreases (of 4-5 percent) in the number of TB cases nationally, reflecting the country's response to treat the disease and control its resurgence in the population.[1] What are the factors which are influencing the resurgence of TB at this time? New Jersey is one of many states which are grappling with the public health issue of TB, and the problem is global in breadth. The United States is experiencing an increase in re-emerging communicable diseases (once considered to be under control), such as TB and pneumococcal pneumonia, and in newly identified infectious diseases (including tick-borne diseases such as Lyme disease).

Researchers point to cutbacks in public funding (federal, state and local levels), reduction of facilities for TB control and treatment in the 1980s, and competition for public health monies at a time when TB cases were decreasing as significant policy factors in the re-emergence of TB. Identified high-risk factors for TB are: HIV infection, intravenous drug abuse, alcoholism, homelessness, poverty, malnutrition, institutionalization (such as in nursing facilities and long-term care facilities), foreign birth and contact with a person with active TB. Congregate settings, such as correctional facilities, homeless shelters, health-care facilities and drug-treatment centers, foster a high transmission rate for TB (*Morbidity and Mortality Weekly Report*, September 1995). The resurgence in TB cases is also related to the increased numbers of foreign-born persons from countries that have a high prevalence rate of TB. The Centers for Disease Control reported that while data indicates a decrease in the number of TB cases among U.S.-born persons, there are increased numbers of cases among foreign-born persons (*Journal of the American Medical Association*, June 5, 1996).

New Jersey

Since 1985, there has been a steady increase in cases of TB in New Jersey. In 1985, the state had 545 active cases of TB; ten years later in 1995, this number increased to 848 - a 56 percent increase. The greatest increase - 35 percent - occurred during the 8-year period between 1985 and 1993. Data on active cases of Tuberculosis in the state for the years 1994 and 1995 are showing a decrease in cases for those years. (See Appendix, "Active Cases of Tuberculosis in New Jersey 1986-1995"). The incidence rate of active TB among minorities in New Jersey increased between 1988 and 1992 and was more than three times the rate for the total population during that period (*Healthy New Jersey 2000 Update*, 1996).

ACTIVE TUBERCULOSIS INCIDENCE RATES
NEW JERSEY, 1985-1994 AND YEAR 2000 OBJECTIVES



Source: New Jersey Department of Health - 1996
Division of Epidemiology, Environmental and Occupational Health Services

[1] Between 1992 and the present, the U.S. Public Health Service increased funding to state and local health departments for TB prevention and TB control activities; in addition, some hospitals implemented practices to prevent nosocomial transmission of TB to visitors, workers and other patients within the facilities. Both activities may be connected to the decrease in reported TB cases in the period from 1993-1995.

This recent decrease in overall cases has largely been in urban areas; however, TB is now appearing in suburban and rural areas in such high-risk groups as health care workers, who have contracted it through their work in hospitals, clinics and community settings.

In 1995, the New Jersey State Department of Health's (now Health and Senior Services) expenditures for TB control, through its Division of Epidemiology, Environmental and Occupational Health Services, were approximately $8.4 million; state funds accounted for $2.9 million and Federal grants added $5.5 million. Current expenditures represent a significant increase from the $2.1 million that was expended on TB control in the state in 1986.

In 1993, the states of New York and New Jersey accounted for close to 21 percent of the country's active TB cases. The AIDS epidemic has exacerbated the problems with the resurgence of TB, because persons with AIDS are at a higher risk of becoming infected with and transmitting TB. States with high numbers of AIDS cases, including New York, California, Texas, Florida and New Jersey, are all struggling with the current resurgence of cases of TB.

The highest prevalence rates of cases of active TB are in three northeastern cities: Newark, Jersey City and Paterson.[2] For example, of the 848 new cases of active TB in 1995, 149 (or 18 percent) were located in Newark. These numbers translate to a case rate of 57.6 per 100,000 population in Newark, as compared to a case rate of 2.7 per 100,000 in Clifton (New Jersey Department of Health Report, 1996) (See Appendix, "Active Tuberculosis [by major city] - 1986-1995").

Medical and social researchers agree that the increase in active TB cases in New Jersey is not only an urban problem, because of the possible diffusion of infectious TB from the inner city to the suburbs. In a recent CDC study, it was reported that the five counties in New Jersey that reported more than one case of multiple drug-resistant TB (Essex, Union, Hudson, Passaic and Middlesex) are located closest to New York City, a place in which high percentages of TB patients (close to 20 percent) had multiple drug-resistant TB (*Journal of the American Medical Association*, July 1994).

MDR-TB Spreads to the Suburbs

Jane W., a highly trained RN, decided to return to the work force after her two daughters reached high school age. As she searched the classifieds, she realized that the competition was tough, even for a nurse with her credentials; she had worked in both hospitals and home care settings before she and her husband decided to raise a family in the suburbs outside of Camden. After several weeks, Jane responded to an advertisement that seemed perfect, as it combined her love of nursing with her commitment to public health issues. The position was part-time and the facility was close to her home. During her interview at the correctional facility, Jane felt confident that the medical staff administrator was quite interested in her as a potential candidate for the position. Soon they were discussing health risks for the workers. As Jane had been employed in hospital settings, she was knowledgeable about the risk of contracting certain infectious diseases, such as Tuberculosis. She was also aware that skin test screening was necessary and, if found positive, a regimen of antibiotics would be prescribed.

Jane's concerns were somewhat raised when the woman interviewing her began to speak about multiple drug-resistant TB. She explained that it was a form of TB that was much more difficult to treat and that there were increased cases of it within the correctional facility. The interview concluded, with Jane's feeling that she would be offered the job. The following week, Jane's hopes were confirmed and she began work at the facility almost immediately. Jane had close contact with many inmates for physical examinations and blood tests; however, she always wore the necessary masks, gowns and gloves when doing so. Although she knew the risks involved in her work, she felt that she was following every precaution. She had a lingering concern, however, about another nurse's raising the question of the poor ventilation and air filtration in the facility; she remarked that TB cases were on the increase in the prison and kept emphasizing that TB is an airborne disease.

Six months later, Jane began coughing and her TB skin test was positive. She has begun traditional antibiotic therapy, but her symptoms are persisting. Her physician has referred her to a pulmonary specialist, as he is uncertain as to whether or not Jane may have contracted MDR-TB. Last week, Jane's elderly mother called to say that Jane's father, who visits Jane's house regularly, had come down with the "flu" - a fever and cough. Jane's entire family and personal contacts are now being tested for TB.

[2] An individual with active TB experiences symptoms of the disease; the TB bacilli are multiplying and the disease can spread to other individuals. Inactive TB infection id latent in the body; the individual has been exposed to TB, but has no symptoms and cannot spread it to other individuals. The infection can become active when the immune system is suppressed, as with AIDS and long-term chemotherapy treatments.

The appearance of multiple drug resistant strains of TB has become a significant public health problem in the U.S., because the disease becomes even more difficult to treat if the patient does not complete a standard regimen of medication. Responses to antibiotics therapy are more difficult and longer courses of treatment are required in cases of multiple drug-resistant TB (MDR-TB). The fatality rate from multiple drug-resistant TB is high: it can be fatal in 50 to 80 percent of those who contract it.

Cases of multiple drug-resistant TB have created a strain on the outpatient care and treatment of TB, as well as a pressing demand for new and better TB drugs, diagnostics and preventive measures. These new forms of multiple drug-resistant TB are difficult and costly to treat. The total cost of treating one MDR-TB patient can reach $250,000 and some cases are not curable (27 *N.J.R.* 3659, October 1995).

Tuberculosis - Issues of Reporting and Compliance: National Overview

Infectious diseases are the third leading cause of death among Americans (National Institute of Allergy and Infectious Diseases [NIAID], 1996). TB is the world's leading cause of death from a single infectious organism, and kills more adults each year than AIDS, malaria and tropical diseases combined. An estimated 2 billion people - one-third of the world's population - are infected with the TB bacterium (Ibid).

On a national level, infectious disease reporting is decentralized, diffuse and discretionary on the part of many states. There is a National Notifiable Diseases Surveillance System (NNDSS), but reporting is voluntary. The Council of State and Territorial Epidemiologists, an association of state officials, designates diseases as nationally reportable. It is the states themselves, through legislatures, boards of health and local departments, that determine which diseases must be reported by physicians, laboratories, hospitals and other sources. Because the activity of surveillance is significantly labor-intensive and costly, most states rely primarily on passive surveillance, depending on these reports from health care providers. All states require the reporting of some important infectious diseases - AIDS, malaria, measles and TB; yet, the reporting of others, such as E. Coli, is not mandatory in many states. Given the de-centralized and under-funded nature of surveillance, there are major deficiencies in the infectious disease surveillance infrastructure throughout the country (Ibid). In late 1995, the Centers for Disease Control made ten awards (averaging about $200,000 each) to state or local health departments to enhance surveillance and response capacity for infectious diseases; New Jersey was one of the states receiving an award (National Health Policy Forum, June 1996).

Policy-makers grappling with the issues of the resurgence of tuberculosis are also confronted with difficult legal and ethical questions regarding the use of state power to promote public health (Bayer & Dupuis, 1996). The issue of compliance is significant in TB control and preventing transmission to others. Non-compliance with prescribed medication regimens and not finishing the course of medication are primary problems in treating TB. Non-compliance is high among the homeless and low-income populations for several reasons: long waiting times at public health clinics; stolen medications and more pressing immediate food and shelter concerns, once the individual symptoms are abated. The transient nature of the homeless population also impairs treatment regimens. The Centers for Disease Control report that within the homeless population, there is a compliance rate of approximately 55 percent regarding the completion of a medication regimen.

TB Control - The Complexity of Follow-up

Dr. S. is the pediatrician at a public health clinic serving the population of New Brunswick. Four weeks ago, he saw a new family who had emigrated from Pakistan the previous year. Their 6-year-old daughter, who had not yet been enrolled in school, was suffering from a fever, chills and persistent cough. Given the language problems, Dr. S. had difficulty learning how long the child had been sick before the family decided to stop using herbal remedies and to bring her into the clinic. Diagnostic tests indicated that the child had TB. Dr. S. prescribed antibiotic treatment and advised the parents to keep their daughter at home until she was no longer infectious; he informed the family that he wanted all individuals who had been in close contact with them to be tested and that he would send a social worker to their apartment to manage their case. At that time, the family indicated they wanted to cooperate with Dr. S.'s treatment regimen.

When the social worker tried to call the family, she could not get through to the individual answering the phone, who could not communicate in English. Her repeated attempts to stop by were thwarted as the family who had seen Dr. S. were never at home. Since their initial visit, the family has not been back to the clinic and at her last visit to their address, the social worker was told they had moved to a friend's home in Edison, where they were working in the friend's restaurant. At this point, follow-up with this family is not possible; they are lost to the public health system until the child enrolls in school at the end of the summer.

Members of this family, their friends and their daughter are coming in contact with the public every day, while their daughter's infectious TB remains untreated.

States are looking to coercive measures such as Directly Observed Therapy, or DOT (which requires that the patient take his/her medication in the presence of a health care worker or other responsible third party), involuntary detention of noncompliant patients and forced administration of medications, as solutions to ensure that those with TB are fully treated and to reduce the risk of transmission by infected individuals. Current bio-medical ethics stress the rights of the individual and the principles of autonomy and self-determination. Yet, in the context of public health, can the state remain silent if the exercise of an individual's personal freedom threatens the health of the public -- e.g., a 45-year-old man with active TB does not want to comply with his medication regimen over the required 9 months because he feels better, he has been taking antibiotics for 6 months and his symptoms have abated? An underlying ethical principle in the development of the American public health system requires those with communicable diseases to behave in ways that are likely to reduce the risk of disease transmission (Ibid).

The national Advisory Council for the Elimination of Tuberculosis calls for the practice of Directly-Observed Therapy in areas where treatment compliance falls below 90 percent. The Council also recommended the least restrictive alternative when addressing state tuberculosis control laws: "before committing TB patients for inpatient treatments, state should adopt step-by-step interventions beginning with Directly-Observed Therapy and supplemented by incentives and enablers."

Regarding other innovative programs for the prevention and control of TB, the Advisory Council for the Elimination of Tuberculosis also recommends the screening of high-risk populations (homeless; AIDS; inmates) to detect patients who are infected and who could benefit from treatment to prevent infection from progressing to TB disease. A recent longitudinal study of a Directly-Observed Therapy (DOT) program in Baltimore analyzed the program's effectiveness over 11 years (Chaulk, et al, 1995). The study, which compared TB rates from Baltimore with five other cities with high TB case rates (Miami, San Francisco, Newark, Atlanta and Washington) found that Baltimore's program facilitated high treatment completion rates and evidence of cure. The study found a decrease in active TB cases for the period, compared with increases in the five other cities. The success of this community-based, DOT program is an encouraging sign in the treatment and control of TB. The Baltimore program continued through multiple periods of political change (i.e., the terms of three governors, three mayors, four city health commissioners) and substantial Federal cuts in TB control.

Tuberculosis - Issues of Reporting and Compliance: New Jersey

The New Jersey State Department of Health has received a $6.6 million grant ($2.2 million annually for three years) to operate the New Jersey Medical School National Tuberculosis Center in Newark. The Center is a joint project of the medical school, UMDNJ-University Hospital and the New Jersey Department of Health. It is one of three model TB prevention, control and education centers in the country supported by the Centers for Disease Control. The goals of the Center are to curb the disease through diagnostic, treatment and prevention programs, such as Directly-Observed Therapy (DOT); to develop and apply new treatments through research and clinical drug trials, and to serve as an educational resource to healthcare professionals. The Medical School has long been involved in TB treatment and research and has had success with innovative programs such as its outreach program, which tracks down TB patients in their homes and on the streets, to ensure they take their medications.

According to New Jersey's *Healthy New Jersey 2000 Update*, the state is developing and implementing TB education and training programs for health care workers; policies for TB control in correctional facilities and Directly Observed Therapy and management programs. The Update recommends support for operational research to evaluate the most cost-effective and cost-efficient intervention strategies for controlling TB, including the development of a total management information system for TB, with access by provider of care (*Healthy New Jersey 2000 Update*, 1996).

Under the New Jersey Administrative Code at *N.J.A.C.* 8:57-1, Tuberculosis is a reportable disease in all health and medical care settings, such as hospitals, clinics, physician's offices and laboratories. A 1992 CDC review of state laws governing TB control found that 43 states provided for the quarantine of TB patients within their own homes, with 35 specifying that quarantine last until the person was no longer infectious (Bayer & Dupuis, 1995). Forty-two states allowed the commitment of TB patients to treatment facilities and 24 permitted such confinement until the person no longer posed a health threat to others.

At *N.J.A.C.* 8:57-5, the Department of Health re-proposed new rules in October 1995 regarding the detention of non-compliant persons with tuberculosis. Local health officers and health care providers who treat TB will have additional reporting requirements under these rules. Physicians are required to monitor patient appointment-keeping behavior, take various steps to enforce compliance with prescribed treatment regimens and contact the Department of Health and/or local health authorities with known or suspected cases of active TB.

In its responses to public comment which necessitated the re-proposal of the rules, the Department stated that the key to compliance in building a treatment system for TB

patients is to meet the individualized needs of many different patients. A system of this type requires maximum flexibility and responsiveness. The Division of Epidemiology advocates a team approach consisting of physicians, nurses, social workers and community outreach coordinated through a designated case manager. The Department's views on involuntary detention of non-compliant TB patients reflect that : "[I]nvoluntary detention and confinement have been narrowly circumscribed only for those patients who demonstrate a documented inability or unwillingness to complete their treatment through any other means" (27 *N.J.R.*3657). In its proposed rules, due process rights of these individuals are ensured. The proposed new rules are in response to the state's "attempting to strike a balance between [its] public health responsibility to control TB and to prevent its transmission, and the individual's right to freedom."

TICK-BORNE DISEASES

Ongoing research in the area of tick-borne infectious diseases is indicating the emergence of various infections, such as Lyme disease, ehrlichiosis and babesiosis. Lyme disease, which is transmitted by deer ticks, is now identified as the most common vector-borne disease[3] in the U.S. (National Health Policy Forum, June 1996). The identification of Lyme disease and the determination of its etiology was a coordinated effort among state and local surveillance actions to gather data and evidence about the disease and Federal support and research to discover its treatment. The Centers for Disease Control currently receives reports of 10,000 to 14,000 cases annually, and New Jersey is now surpassing Connecticut and New York in the number of reported cases. While funding and research for TB diagnosis, control and treatment have been re-established, the same is not true for Lyme disease. Funding and support for Lyme continue to be at lower rates than are necessary to launch a "full-scale" aggressive campaign against the disease. How does the public health system in New Jersey respond to a crisis like Lyme disease, when it is confronted by such "larger" public health problems as cancer, AIDS, heart disease and high rates of infant mortality?

Lyme disease is a multi-system inflammatory disease, which has progressive stages. It was first recognized approximately 20 years ago, when a clustering of rheumatoid arthritis-like cases among children in Old Lyme, Connecticut, was identified. Initially, it appeared that the source of the illness was unique to the town of Old Lyme. But within a few years, it became clear that people throughout the northeastern United States were being affected, primarily those living in places where housing had come to be developed in previously forested areas (Henig, 1994). It took close to ten years to determine that the infection was caused by a spirochete -- a type of infectious microorganism -- and was carried by deer ticks. Humans acquire the spirochete through the bite of freckle-sized ticks. These ticks and rodents -- usually white-footed mice, which pass the infection to feeding ticks -- are required to maintain the spirochete that causes Lyme disease in the natural environment. A regimen of antibiotics has been found to be most effective in the treatment of Lyme diseases, and work continues on the development of a vaccine.

The symptoms of the progressive stages of Lyme disease can range from mild to severely debilitating, depending upon the course of the disease and the stage when antibiotic treatments are initiated. The associated symptoms of Stage I, which occurs between one day and one month after a tick bite, are: fever, fatigue, malaise, stiff

Lyme Disease - A Family's Dilemma

Two years ago, A. and her husband and two children moved from Linden to a suburban home nestled on two acres in Belle Mead. Their first spring and summer at the house she was involved in a great deal of yard work. She and her husband were very concerned about ticks and the family did "tick checks every time the children had been playing out in the back yard. Although there were some close calls, neither child had been bitten by a tick.

During the past six months, A. has been feeling joint pain, muscle aches, headaches and extreme fatigue. She really began to worry when she could barely hold the steering wheel driving back home from work. Prior to that time, she had been a physically active 40-year-old working mother of two. Three months ago, her physician began testing for various illnesses; a blood test was negative for Lyme disease. He prescribed a 4-week course of antibiotic and warned her that she was going to "feel worse" before she felt better. He was also conducting diagnostic blood and urine tests during this period. A. did feel worse before she felt better; in fact, she did not feel better at all. She began having cog - nitive difficulties, could not concentrate and was extremely irritable. Her physician is now recommending intravenous antibiotic therapy. Yesterday, her supervisor called A. in to review her absenteeism during the past year and advised that it was not boding well for her continued position in the company. If she loses her job, she loses the family health insurance, because her husband is employed by a small business which does not carry him under its program.

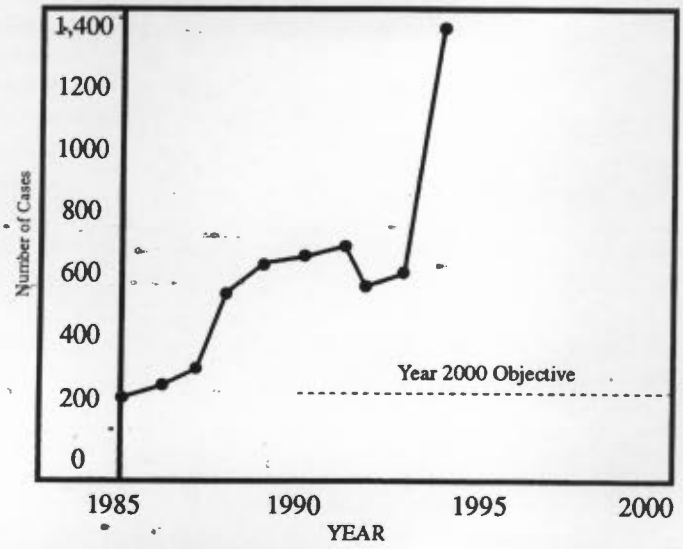
[3] Deer ticks are the "vector" for the transmission of Lyme disease in that through ticks, humans are infected by the infectious microorganism which cause Lyme.

neck and sore muscles. Stage II usually occurs two to three months after the initial infection and includes cardiac and/or neurologic disease. Stage III, which may occur years after the initial infection and my occur in the absence of any preceding history suggestive of Lyme disease, includes arthritis and/or chronic neurologic manifestations, such as sensitivity to light, headache, extreme fatigue, difficulty in concentration, and emotional irritability (Sigal, 1990). Many Lyme cases are further complicated by misdiagnosis and inconclusive laboratory blood test results, leaving the patient feeling even more hopeless in the absence of a definitive diagnosis and appropriate treatment plan. Individuals afflicted with Lyme disease are also grappling with the emerging trend among insurers who are scrutinizing reimbursement levels for medical procedures and treatments, especially those that are long-term, which is often the case with antibiotic therapy for Lyme disease treatment.

What are some of the causal factors associated with Lyme disease and why has it emerged at this time? The ecological changes that occur with land development put people in closer contact with microbes from which they were previously insulated. For example, changing land use patterns in the Northeast are favorable to deer -- new housing brings deer into the backyards of suburbanites -- and deer ticks are conjectured to be the primary reason for the emergence of Lyme disease (National Health Policy Forum, 1996). This trend, together with hunting restrictions, has caused a boom in the deer population, which has sustained an increased population of deer ticks.

As required under *N.J.A.C.* 8:57-1, Lyme disease is a reportable disease in the state. In New Jersey, between 1988 and 1994, the incidence of Lyme disease (with rash) has increased from 530 to 1,306 cases, up over 240 percent.

LYME DISEASE (WITH RASH)
NEW JERSEY, 1985-1994 AND YEAR 2000 OBJECTIVE



Source: New Jersey Department of Health - 1996
Division of Epidemiology, Environmental and Occupational Health Services

The state's Year 2000 objective for the annual Lyme Disease incidence is set at 275. The Department of Health reports that meeting this goal is unlikely, "without the resources to deal with this problem more aggressively" (*Healthy People 2000 Update*, 1996). New Jersey's infectious control division receives funding from the Federal Centers for Disease Control for Lyme disease. Over the past five years, this grant has been approximately $125,000, which is channeled to programs at the county level. Funding from the state of New Jersey supports staff and administrative expenses, such as the costs associated with the publication of Lyme disease information brochures.

The Department reports in its 1996 *Healthy New Jersey 2000 Update* that current strategies for Lyme disease include active research to identify the most cost-effective strategies for dealing with the vector tick population that carries the disease and direct work with affected communities to assist them with designing specific management strategies. Educational programs emphasizing prevention through personal protection are recommended for addressing the problems of Lyme disease. Public health education campaigns are critical in the prevention of Lyme disease as there is no safe, effective and practical method of large-scale tick control. Research is a key component of addressing the Lyme disease problem, as there currently are not available highly specific and sensitive diagnostic tests for the illness.

Surveillance and Reporting

At the annual New Jersey Public Health Association conference in May 1996, the New Jersey Department of Health reported on its objective to develop an epidemiologic database to study Lyme disease trends in New Jersey. From January through December 1995, 273 physicians from 6 counties were randomly selected and enlisted to report new diagnoses of Lyme disease. Results indicated that a total of 114 physicians (41 percent) reported 537 cases of Lyme disease. Of that total, 65 percent met the CDC case definition of Lyme disease. The Department noted that because only 41 percent of the physicians reported a case of Lyme disease in 1995, it may demonstrate that significant differences exist among participating physicians with regard to recognition and diagnosis of Lyme disease. An additional curious trend is that only two of every three cases of Lyme disease diagnosed in New Jersey fit the CDC's case definition (which sets the specific technical blood analysis parameters in order to make a Lyme diagnosis); further research is being conducted throughout 1996 on Lyme disease trends in the state in order to unravel the complicated epidemiologic, diagnosis and treatment problems associated with Lyme.

In June 1995, the New Jersey Department of Health made ehrlichiosis a reportable disease in the state, and active surveillance has been initiated. The disease, which is characterized by high fever, malaise, muscle pain, headache, nausea and other symptoms, is treatable by antibiotics. It is thought to be transmitted by tick bites, including dog and deer ticks. Two human tick-borne diseases caused by Ehrlichia are human granulocytic ehrlichiosis (HGE) and human monocytic ehrlichiosis (HME), which have been recognized in the U.S. since 1986.

Through its active surveillance efforts, the Department has identified at least 7 confirmed and 14 probable cases of ehrlichiosis in Atlantic, Ocean, Cape May, Essex, Burlington, Camden, Middlesex, Monmouth, Morris and Salem counties (Department of Health surveillance letter, April 1, 1996). The Department is in the process of continuing to define incidence, geographical distribution and clinical spectrum of the disease. A recent piece in *The New England Journal of Medicine* - "Ehrlichiosis -- In Pursuit of an Emerging Infection" -- cautioned about the increase of ehrlichiosis in the mid-Atlantic states and stressed the critical need for rigorous research for diagnosis and treatment of the disease, which has a fatality rate of 5 percent (January 1996).

THE URBAN-SUBURBAN CONNECTION

The outward suburban migrations from the central cities left behind poverty, social disintegration and extreme consequences for public health and order (Wallace, 1993). Three-quarters of the American population resides in a series of extended "urban-suburban complexes", which were created in the period of rapid suburbanization after World War II. By the mid-1980s, inner-city minority neighborhoods like Central Harlem were experiencing raised levels of contagious and chronic disease, substance abuse and violence, leading to life expectancies for adult males lower than those in Bangladesh (McCord and Freeman, 1990). Urban areas such as Central Harlem, Newark and south-central Los Angeles became "incubators" for contagious diseases, such as TB, which had been declining since the mid-1940s in this country.

There is more compelling evidence that shows that infectious diseases, new and old, cannot be left behind in the cities, keeping the suburbs invulnerable. Research on medical geography indicates that suburban isolation is "fragile", even if there is not forced displacement of populations from inner-city neighborhoods into adjacent suburbs (Gould, 1993). This is particularly true for infections like HIV or multiple drug-resistant TB. Challenges to public health in the suburbs will increase, as urban public health issues have reached a critical stage. Historically, great improvement in "the public health" was achieved in the population of the U.S. through an integrated series of programs, initiatives and policies that improved both living and working conditions in urban areas. Now, the political fragmentation, as well as de-centralized programs and funding sources, complicate the type of coordinated solution these public health and social problems demand.

CONCLUSION

In the sphere of public health, the goals of coordination among programs and equity in funding are complicated by several factors, which include multiple levels of administration and multiple, often co-mingled funding streams. The structure of New Jersey's decentralized public health system - - with 115 local health departments -- effects a wide range of variability in the types of services provided by the departments. The state plans to "re-structure" its public health system within the context of a dynamically changing health care delivery and financing system, which include managed health plans in both the public and private sector and new opportunities to explore public-private partnerships. This re-structuring requires sophisticated coordination and cooperation among all entities involved in order to meet the stated goals of public health and come closer to our Healthy New Jersey 2000 health status objectives. Our challenge continues to be one of meeting the primary public health goal to protect and promote the health of the public at a time when competition for public health funding and resources is strong and, as John Donne reminds us, our health remains more vulnerable than ever.

HIGHLIGHTS FROM THE ISSUE BRIEF PUBLIC HEALTH I & II

TUBERCULOSIS

• Recent studies have indicated that Directly-Observable Therapy, which requires extensive coordination between outpatient health care providers and outreach workers, can significantly decrease the number of TB cases in the population and reduce the risk of developing multiple drug-resistant TB. What is New Jersey's commitment to provide consistent funding and resources to develop and maintain these programs?

• Several states have found success in establishing school-based health clinics in order to monitor children and adolescents and to provide the appropriate screening tests. Where does New Jersey stand on establishing school-based programs that offer coordinated services such as annual TB skin tests?

• As the CDC has reported, the highest rates of TB in New Jersey are in the counties which are the closest to New York City, which is experiencing a significant public health crisis in cases of TB and multi-drug resistant TB. Is any cooperation among inter-state health departments planned in order to develop coordinated programs for TB control?

• Environmental control of TB can be effected by various technologies, including air filtration, improved ventilation of buildings and the use of ultra-violet light. The cities of Los Angeles and New York, with the support of local utility companies, have been installing UV lights near the ceilings of homeless shelters; UV light is known to have a deleterious effect on the TB bacillus. Ongoing research is indicating that there are fewer cases of TB in the shelters equipped with UV light, when compared to those that are not. Is New Jersey receptive to experimenting with such public-private partnerships in innovative ways to control TB?

• Hospitals, long-term-care facilities and prisons are "high-risk" places for the transmission of TB; often buildings do not have sophisticated air filtration or ventilation systems. The risks continue to increase that someone entering the hospital for routine gall bladder surgery may contract TB, especially if that individual is elderly or immune-suppressed. Does government have a role in establishing more stringent air filtration and ventilation system standards in these facilities?

• In April of 1994, a passenger with infectious multiple drug-resistant tuberculosis traveled on a commercial airline flight across the country (*New England Journal of Medicine*, April 11, 1996). A research study found evidence that transmission of MDR-TB from passenger to passenger and from passenger to flight crew was possible aboard a commercial airliner. While the CDC has now developed suggested criteria and procedures for notifying passengers and flight crews after exposure to TB, how is New Jersey equipped to handle such notification to residents of the state, where major air travel takes place on a daily basis?

LYME DISEASE

• Controversy surrounds the potentially costly antibiotic treatments being prescribed for individuals with Lyme disease. One issue in particular is whether or not to prescribe antibiotics for an individual who tests positive for Lyme via a blood test, but is asymptomatic. In this time of limited funds and the managing of health care to avoid "inappropriate" treatments, what is the role of the Departments of Health and Insurance regarding treatment of Lyme?

• The emergence of new tick-borne diseases, such as ehrlichiosis, continues in New Jersey. What is the state's commitment to provide funding and support in order to conduct research and surveillance of these "new" diseases that are affecting its residents?

• Should there be a specific line-item for Lyme disease in the budget for infectious diseases, as there is for TB control and AIDS, given that the disease, which can be physically devastating, is epidemic in the state?

EMERGING AND RE-EMERGING DISEASES

• The New Jersey State Department of Health has as one of its goals the establishment of an electronic information system for data collection in each county. How will this system improve that surveillance and monitoring of diseases such as Lyme and TB?

• How can public-private partnerships be utilized to enhance the technical capacity of New Jersey's state laboratories, which are a valuable resource in the state's research of infectious and communicable diseases?

• According to a National Health Policy Forum Issue Brief, it is conjectured that some states are reluctant to mandate the reporting of newly recognized diseases because budgets and staffing limit their capacity for surveillance, either active or passive, and response. What are the potential prices to be paid if we do not support our surveillance capacity in New Jersey to monitor and respond to public health emergencies, like an E. Coli outbreak in an amusement park?

• Dr. Anthony Fauci, director of the National Institute of Allergy and Infectious Diseases, speaking last month at a conference on new and re-emerging diseases, stressed that a strong commitment to basic and clinical research is critical to our preparedness for monitoring and controlling these diseases? What is New Jersey's commitment of funding and resources to state and local health departments for research and effective surveillance of infectious diseases? How much reliance can be kept on Federal funding for these activities?

• A recent Gallup poll found that 60 percent of patients use antibiotics inappropriately. For example, physicians are often pressured to prescribe antibiotics for the flu or colds, even though antibiotics have no effect on viruses. Such inappropriate usage may contribute to drug resistance on the part of the microbes, which have the ability to mutate to resist available drugs. What kind of public education campaign could be designed to educate patients and physicians about the risks associated with such practices?

PUBLIC HEALTH I

Organization and Funding

• Public health means many things to different people; how can a cohesive identity for public health be created so as to ensure adequate funding and resource allocation? Is the vision for public health in New Jersey one framed by a population-based model focused on providing core public health functions to the community, a direct services model, or a combination of both?

• The Department of Health at the state level is developing a public health infrastructure in the state to most effectively serve its constituents. How will the state handle the delicate task of "re-organizing" its de-centralized public health activities without alienating its local public health organizations which are critical in delivering community services?

• Managed care organizations are rapidly becoming major players in New Jersey's health care delivery system. How will New Jersey strategize working cooperatively with managed care organizations to effect public health activities in the state?

• In our evolving health care system, if New Jersey's public health officials decide to focus on population-based public health core function activities, and shift the provision of direct delivery services to managed care organizations and private health facilities, how will funding support be continued? In the current environment, much funding comes from Federal and state sources to support the provision of direct services. Will traditional funding sources continue to be supportive?

• What is the role of other executive departments within state government, such as the Departments of Insurance, Human Services, Environmental Protection and Community Affairs, in the evolving public health system?

AT-RISK GROUPS

• In a recent piece in The Milbank Quarterly, social researchers discuss the coming crisis of public health in the suburbs as a result of the deterioration of urban public health. By analyzing the social and health problems in neighborhoods such as the South Bronx and the central ward of Newark, they stress that the increase in communicable and infectious diseases in these communities are not only "inner-city" problems, but suburban problems as well, because of the likely diffusion of contagious diseases from inner city to suburbs. Only through an integrated system of initiatives, programs and policies can living and working conditions in urban areas be improved. What is New Jersey's commitment to funding such public health initiatives in inner cities, so as to enhance the quality of life for all of its citizens?

• All too often in the history of public health, political exigencies and interference have driven public health decision-making and strategies, often delaying actions which created serious health consequences. For example, the Federal government refused to act on urgings by the Centers for Disease Control in the early 1980s to act rapidly to deal with an emerging disease now known as AIDS. Such hesitancy, based on political conservatism, led to loss of lives and trust in the nation's blood supply. How do we in New Jersey guard against public health decisions being compromised by political agendas? How do we regain the loss of trust that the public holds in government to protect and ensure its health?

• In its report on the future of public health, the Institute of Medicine highlighted the weaknesses in public health activities concerning environmental health, mental health and the care of the indigent. Many states continue to administratively and programmatically isolate these services from general public health, creating fragmentation in services, policy development and fiscal accountability. The report calls on involvement at all governmental levels - national, state and local - to integrate services to these traditionally "isolated" population needs. What are New Jersey's plans in developing a public health infrastructure to integrate services to these populations?

• Across the country, states are challenged by the issue of whether or not to provide health care services for their "illegal alien" populations. While short-term savings may be accomplished by denying health services, such as immunizations, to this population, the long-term consequences, such as the re-emergence of infectious diseases

such as TB, will have considerably more significant health and monetary impacts. Where does New Jersey stand on such complex public health issues?

RESEARCH

• Disease surveillance is the basic public health strategy against infection. The activity of surveillance is a significantly labor-intensive and costly. As a result, most state and local public health agencies rely primarily on passive surveillance, depending on reports from physicians, community providers, hospitals, laboratories and other health care facilities. Infectious disease reporting is decentralized, diffuse and largely discretionary. The states are left on their own in paying for surveillance of other diseases. As a result, there are major deficiencies in the surveillance infrastructure. For example, 24 states had fewer than one staff person performing surveillance of food and waterborne disease per million citizens. Yet, there is growing evidence that public water supply infrastructure is deteriorating and that we are importing more foreign-produced foods, which is posing new threats. At the recent annual conference of the New Jersey Public Health Association, a paper was presented which identified weaknesses in surveillance capacity in New Jersey and point out that while the current infectious disease surveillance system is focused on known identified diseases, it is unprepared to identify and respond to emerging infections, similar to Hantavirus. What resources do New Jersey's state and local health departments have for effective surveillance of infectious diseases in New Jersey? Can continued reliance be kept on federal funds?

• The questions of data collection and the development of accurate, current and comprehensive health information databases are critical in the formulation of public health policy. Projects such as the birth certificate registry, the statewide immunization database and the cancer registry require consistent support, both fiscal and technical. How will New Jersey ensure continued support for these projects, which are so sensitive to changing political climates?

Active Tuberculosis 1986-1995

Cases/Case Rate* for Major Citites in New Jersey

City	1995	1994	1993	1992	1991	1990	1989	1988	1987	1986
Atlantic City	8/21.9	15/39.9	15/39.9	15/39.9	7/18.4	14/36.9	14/40.5	12/34.2	20/56.3	11/30.3
Camden	10/12.1	11/12.4	20/22.6	15/17.0	15/17.1	12/13.7	16/19.5	18/22.0	10/12.2	6/8.4
Clifton	2/2.7	2/2.9	3/4.3	8/11.4	7/9.8	7/9.7	6/7.8	4/5.2	4/5.2	7/9.1
East Orange	31/42.6	18/24.7	23/31.6	22/30.2	39/53.0	29/39.4	34/44.0	20/25.9	21/27.1	17/21.9
Edison	19/21.0	5/5.7	12/13.6	9/10.2	6/6.8	11/12.7	5/5.8	10/11.7	7/8.3	5/6.1
Elizabeth	28/26.3	19/17.0	18/16.1	26/23.3	14/12.6	28/25.5	32/30.5	29/27.5	33/30.9	36/32.6
Irvington	35/57.6	34/55.7	18/29.5	20/32.8	29/47.5	15/24.6	23/37.5	13/21.0	24/38.3	12/19.0
Jersey City	76/33.6	74/32.2	92/40.0	108/46.9	84/36.6	74/32.4	71/32.7	67/30.9	69/29.4	74/33.7
Newark	149/57.6	164/60.5	161/59.4	185/68.3	196/71.8	188/68.4	208/66.4	154/49.0	124/39.5	119/37.0
New Brunswick	5/12.1	6/14.0	4/9.3	5/11.6	11/26.0	3/7.1	6/15.2	13/32.5	8/20.2	4/10.0
Orange	14/48.7	14/47.1	11/37.0	18/60.6	9/30.1	9/30.1	13/41.3	14/44.3	9/28.2	6/28.1
Passiac	10/17.8	16/27.1	18/30.5	25/42.4	18/31.0	23/39.6	15/28.2	15/21.1	11/20.4	16/29.6
Paterson	43/31.1	90/63.1	85/59.6	95/66.6	69/48.7	81/57.5	73/52.5	81/58.0	54/38.7	53/38.5
Plainfield	10/22.3	11/23.9	4/8.7	3/6.5	10/21.5	8/17.2	10/22.4	4/8.9	5/10.9	6/13.0
Trenton	21/24.9	13/14.9	25/28.7	13/14.9	20/22.5	20/22.3	27/30.0	20/22.0	24/26.4	29/31.6
Union City	12/21.3	9/15.3	14/23.8	11/18.7	13/22.2	10/17.2	13/24.4	10/18.2	5/8.9	6/10.7
Union	2/3.9	4/8.2	5/10.2	3/6.1	7/14.1	4/8.0	7/13.7	5/9.7	3/5.9	6/11.8
Vineland	2/3.7	4/7.2	1/1.8	5/9.1	2/3.6	3/5.4	11/20.1	4/7.3	9/16.1	8/14.3
Woodbridge	7/7.4	6/6.4	6/6.4	7/7.5	8/8.5	10/10.7	6/6.4	8/8.5	7/7.4	2/2.1

*Rate Per 100,000 Population

Source: New Jersey Department of Health 1996

Active Tuberculosis-New Jersey 1986-1995

Counties Cases/Case Rate*

County	1995	1994	1993	1992	1991	1990	1989	1988	1987	1986
Atlantic	24/10.3	19/8.4	25/11.0	25/11.0	16/7.1	25/11.1	31/14.5	20/9.5	28/14.0	22/10.5
Bergen	37/4.4	49/5.9	56/6.7	58/6.9	54/6.6	66/8.0	43/5.2	42/5.0	38/4.5	42/5.0
Burlington	14/3.5	9/2.2	14/3.4	13/3.2	22/5.0	17/4.3	8/2.0	19/4.8	13/3.3	10/2.6
Camden	15/3.0	21/4.1	31/6.1	35/6.9	34/6.7	26/5.6	30/6.0	37/7.4	27/5.5	18/3.7
Cape May	3/3.1	1/1.0	5/5.2	9/9.3	3/2.9	17/17.0	10/10.4	9/9.4	6/6.4	11/12.0
Cumberland	7/5.1	9/6.5	5/3.6	8/5.8	4/2.9	6/4.3	20/14.4	7/5.1	10/7.3	11/8.1
Essex	251/33.1	257/37.4	23634.3	268/34.9	300/38.6	259/33.3	298/35.6	220/26.0	197/23.4	163/19.2
Gloucester	7/2.9	10/4.3	11/4.7	8/3.4	7/3.0	8/3.5	8/3.6	5/2.3	6/2.8	5/2.4
Hudson	127/23.1	121/21.9	137/24.8	156/28.2	134/24.2	108/19.5	114/21.1	99/18.3	92/16.7	111/20.0
Hunterdon	2/1.7	1/0.9	1/0.9	1/0.9	4/3.6	4/3.7	5/5.0	1/1.0	6/6.1	5/5.3
Mercer	30/9.1	24/7.4	27/8.3	13/4.0	27/8.3	25/7.7	36/10.8	24/7.2	30/9.2	32/9.9
Middlesex	64/9.2	39/5.7	63/9.2	50/7.3	62/9.1	57/8.5	47/7.2	68/10.3	55/8.5	38/5.9
Monmouth	27/4.6	27/4.9	34/6.2	28/5.1	35/6.3	33/6.0	41/7.3	20/3.5	43/7.8	27/5.0
Morris	16/3.6	23/4.9	15/3.2	24/5.7	17/4.0	25/5.9	15/3.6	11/2.6	18/4.3	8/1.9
Ocean	20/4.3	11/2.5	12/2.7	13/2.9	14/3.2	25/5.8	19/4.6	12/2.9	11/2.7	23/5.9
Passaic	64/13.8	114/25.1	112/24.7	137/30.2	100/22.0	120/26.5	103/22.2	108/23.2	71/15.3	83/17.8
Salem	2/3.1	1/1.6	4/6.2	2/3.1	4/6.1	4/6.1	1/1.5	1/1.5	3/4.5	4/6.0
Somerset	17/6.4	15/6.2	10/4.1	11/4.5	13/5.4	13/5.4	9/3.9	5/2.2	7/3.2	8/3.7
Sussex	0	2/1.9	10/9.5	2/1.5	2/1.5	6/4.6	5/3.9	8/6.4	2/1.6	4/3.3
Union	63/12.7	57/11.7	43/8.8	51/10.4	53/10.8	58/11.7	62/12.4	62/12.4	58/11.5	70/13.8
Warren	1/1.0	3/3.3	2/2.2	5/5.4	4/4.3	1/2.1	0/0	2/2.2	2/2.2	1/1.1
State at Large	57	42	59	67	74	67	44	13	25	29
New Jersey Total	848/10.7	855/11.0	912/11.7	984/12.6	983/12.7	970/12.5	949/12.3	793/10.3	748/9.7	724/9.5

*Cases Per 100,000 Population (NJ Pop.=7,945,298)

Source: New Jersey Department of Health 1996

WILL THE BUSINESS AND FINANCIAL REALITIES OF THE 21ST CENTURY ELMINATE THE ROLE OF STATE GOVERNMENT IN HEALTH CARE DECISION MAKING? PART I: NOT-FOR-PROFITS - VIABLE OR OBSOLETE?

Original Issue Brief October 23, 1996

ISSUE: We have a uniquely American institution — a group of nonprofit organizations which came into existence to serve a mission that was not being served by any other sector. We have funded these nonprofits via federal, state and local resources and through corporate giving and philanthropy. Reductions in funding support from both governmental and philanthropic sources seem to be suggesting that this "institution" is no longer necessary. **As the move towards acquisitions, mergers and conversions to for-profit status continues, will the original mission of the nonprofits be lost in this competitive health care arena? What impact will the business and financial realities of the 21st century have on the role of state government as policy maker, funder and regulator in our health care system, which is rapidly become a commercial enterprise?**

FOR-PROFIT AND NONPROFIT HEALTH CARE: NEGOTIATING THE TRANSITION

Throughout the country, a trend which began in California, Florida and Texas, is affecting many other states: the shifting of not-for-profit hospitals, health care providers and nonprofit health plans (such as health maintenance organizations and Blue Cross & Blue Shield plans) to for-profit status through mergers, partnerships, acquisitions and conversions.[1] It has been observed by both conservatives and liberals alike that the nonprofit sector in health care is dissolving across the country; its most rapid dissolution is taking place in California (Fox and Isenberg, 1996). This trend is driven by growing competition in the health care marketplace coupled with reductions in public support for nonprofit providers of health care. The primary players in this dynamic environment are the not-for-profit hospitals, Blue Cross and Blue Shield plans and nonprofit managed care health plans (under which insurance and service delivery are integrated). Although it is estimated that billions of dollars of charitable assets are at stake, up until this point there has been little input or oversight from federal or state governments (Alpha Center, 1996).[2]

A 1991 analysis of leveraged buy-outs, conversions and corporate reorganizations of nonprofit health care institutions to for-profit status enumerated several ways in which such transactions may take place: as a buyout by a business corporation; by amendment to the not-for-profit organizationís articles of incorporation; as a "spin-off" in a corporate re-structuring, or by merger with a for-profit entity, with only the for-profit entity remaining intact after the merger (Shields et al, 1991). Some more recent conversions of hospitals have taken yet another form — partnerships forming either a limited partnership or a limited liability company between the not-for-profit organization and the for-profit corporation (Challot et al., 1996).

Where do the imperatives of political responsiveness and public accountability, as well as the dictates of medical professional standards and personal principles, lead us when looking at the question of for-profit takeovers and mergers of nonprofit providers? Under the new Federalism, the Federal government continues to reduce its role as funder and regulator and shift more power and authority to state governmental levels. How will state governments — in the roles as regulators, policy makers and funders — respond to the changes in the free-market health care delivery and financing systems?

[1] For purposes of this brief, the term "nonprofit" will be used to refer generically to both not-for-profit and non-profit entities. In cases when each term is specifically used, it is done so to refer to the tax status of the organization being discussed.

[2] The December 11, 1996 Capitol Forum will analyze the issue of conversions against the background of government's role as regulator. Special attention will be given to the impact such conversions may have on the provision of charity care to uninsured and underinsured citizens.

ISSUE BRIEF No. 17

Capitol Forums on Health & Medical Care

League of Women Voters of New Jersey Education Fund

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The broad public policy question that may be asked is what does the public gain by having health care delivered by nonprofits. Historically, nonprofit organizations are driven by their mission; in most cases, to meet a need of society or its members. In contrast, the fundamental purpose and operating principle (both economic and legal) for for-profit business is the maximization of profit for the organization's owners, its shareholders. One important aspect of the nonprofit organization is that any surplus income that is generated is turned back to the organization, usually to improve or expand the services they provide. While for-profit conversions can offer the potential to increase access to capital and allow non-profit providers to be on "a level playing field" with for-profit competitors, will the missions, standards and values of the traditional nonprofit providers remain true? Historically, health care has been thought of as a charitable activity provided (except for physicians) by nonprofit providers (Friedman, 1996). Critics of for-profit health care argue that it is not strong in the areas of providing indigent care or of maintaining a commitment to teaching and research; advocates of for-profit health care assert that proprietary systems create a higher level of efficiency and accountability. In reality, there is little conclusive study to substantiate the validity of either claim (Challot et al, 1996; Friedman, 1996). The primary reason for the absence of rigorous study lies in the "newness" of the market. Further, there is great diversity among the types of nonprofits operating in the health care arena, as well as significant differences among the procedures through which for-profit mergers, acquisitions and conversions are taking place. How can government adequately regulate an industry in such a state of flux as the health care industry?

THE END OF NONPROFITS AS WE KNOW THEM?

How does this commercialization of health care, which appears to be an irreversible trend, affect the traditional role of nonprofit health care providers in their communities? The shift to a for-profit enterprise is a shift to a value ethic that is profit-driven, as the basic workings of charity and commerce are quite different. Will the demand and accountability to investors have a negative impact on the needs of the community served? The answers to these questions are not clear-cut, especially in the context of the health care industry, whose history includes shifts in the power structure between for-profit and nonprofit health care providers. In reality, the health care industry is one of the only industries in this country in which there is competition between large nonprofit and for-profit systems (Nudelman and Andrews, 1996). There are advocates and opponents on each side of the issue. Critics of for-profit health care organizations emphasize that their primary legal, fiduciary and ethical duty is to return a profit to the stockholders. Concern regarding this imperative arises out of the possibility that this duty puts patients and community health and welfare in second place. Nonprofit health care providers, whose mission is rooted in strong community service values, have incentives to provide health care not only to individuals entering their hospital or clinic, but also to monitor and preserve the public health of their communities.

While for-profit companies define their "products" by what the consumers are willing and able to pay for it, the nonprofit sector evolved in this country in response to societal needs that were not being met, or were not adequately met, by the for-profit sector (Miller 1996). The quandary that arises out of the health care nonprofit/for-profit struggle is rooted in the problem that it appears that American society does not view health care as a public good; consequently, it has not organized an incentive system and financial structures in order to deliver health care to all individuals. The private, voluntary sector of nonprofit health care providers have traditionally filled in the gaps left by the for-profit and public sectors — to provide care to the poor and vulnerable. It is anticipated that the nonprofit sector will bear much of the burden for developing new strategies to deal with health and social problems in communities after Federal downsizing of public programs and the implementation of block grants have occurred. (Weil, 1996).

HISTORY

In his 1982 work studying the history of medical practice in America, Paul Starr observed some 15 years ago:

> Profit-making enterprises are not interested in treating those who cannot pay. The voluntary hospital may not treat the poor as same as the rich, but they do treat them and often treat them well. A system in which the corporate enterprises play a larger part is likely to be more segmented and more stratified. With cutbacks in public financing coming at the same time, the two-class system in medical care is likely to become only more conspicuous.

And the cutbacks in public financing have continued. With the advent of managed care in the health care industry, nonprofit health care providers and health plans are confronted by questions of survival in an increasingly competitive health marketplace. The intersection of business ethics with medical ethics and social responsibility continue to clash as competitive market forces drive the health care delivery system.

Although there is great diversity among providers in the nonprofit sector, there are various factors that are

peculiar to all nonprofits: they are incorporated under state laws; most are governed by voluntary, self-perpetuating boards and do not have "owners"; nonprofits are chartered under state laws for several statutory purposes — charitable, religious, scientific, educational - and their assets and revenues must be used for those purposes; and they are prohibited from distributing surplus revenues (or assets, if the corporation is dissolved) to those who control the organization (Gray, 1991). The other primary distinctive element is that broad categories of nonprofit organizations, including hospitals, benefit from their tax exemptions and related public subsidies.

THE INTERNAL REVENUE SERVICE AS HEALTH POLICY MAKER?

Throughout the 20th century, the tax-exempt status enjoyed by nonprofits has been challenged; however, the 1990s may bring to bear the most difficult series of such challenges. A brief overview of amendments to Federal laws, regulations and Internal Revenue Service (IRS) rulings illustrates how the IRS, as compared to Federal and state regulatory agencies, has a primary role in shaping the identity of nonprofits.[3]

It was in 1913 that the income tax statutes exempted organizations that were operated for charitable purposes from taxation; donations to these organizations were made tax-deductible in 1917 (Ibid). Over the decades, amendments have been made to the tax exemption regulatory language, which most directly affected hospitals and the provision of charity care. Although a 1956 IRS revenue ruling (56-185) held a hospital to be charitable only "if operated to the extent of its financial ability for those not able to pay for services rendered and not exclusively for those able and expected to pay," the Treasury Department amended its Federal regulations in 1959 to define "charitable" as being "for the benefit of an indefinite number of people rather than for the relief of the poor (emphasis added) (Fox and Schaffer, 1991). Since the Federal requirement to provide charity care was ostensibly removed, the states have taken the lead in setting mandates regarding its provision.[4] A later 1968 revenue ruling by the IRS (69-545) again redefined the criteria for hospital tax exemptions as: providing a community benefit through the promotion of health, through participating in governmental programs such as Medicare, and by maintaining an emergency room open to the community (Gray 1991). Since 1985, there have been Federal, state and local governmental challenges to hospitals' tax exemption status throughout the country. These challenges have increased in number during the 1990s, as the documented numbers of uninsured Americans have increased.

SUPPORT FOR THE NONPROFIT SECTOR

Historically, over the past 60 years, a relationship has been sealed in which government raises the money to finance income transfers and basic welfare and charities deliver direct services (Wolpert, 1996). Between 1950 and 1980 a massive increase took place in the size and scope of Americaís nonprofit sector. By the late 1970s, the private nonprofit sector had become the principle vehicle for the delivery of government-financed health and human services, and government had become the principal source of nonprofit health and human services agency financing. As a result of massive reductions in Federal support for the nonprofit health care organizations during the 1980s and with the development of a competitive health care industry via deregulation and the emergence of managed care organizations, many believe the survival of nonprofits as we know them is threatened. In the current climate of mergers and conversions, nonprofit organizations are seeking investment capital in order to maintain and expand their services in a competitive marketplace.

THE SAFETY NET

The health care safety net concept refers to health care providers that are legally obligated to provide care to persons who cannot afford it. In actuality, the health care safety net is a loosely knit network of doctors, hospitals and clinics, both public and private, that provides services to the poor and the uninsured. These providers typically include public and teaching hospitals, federally funded community health centers and city and county health departments (Lipson, 1996). Also included in the definition of safety net providers are private, not-for-profit hospitals that provide uncompensated care to the community, and nonprofit organizations (such as Visiting Nurses Associations, Planned Parenthood, and religious organizations of every denomination and faith) and clinics who provide health care services at no charge or at discounted rates. Independent physicians who offer these services to vulnerable populations are also viewed as safety net providers (Ibid). These safety net providers are considered specialists at what they do, and most public hospitals, community health centers and nonprofit organization programs provide a wide range of medical and social services necessitated by the needs of their populations, including case management, patient education programs and home

[3] In 1985, John Simon, founding director of the Yale University Program on Nonprofit Organizations, estimated that between 1945 and 1985, there were at least eight congressional investigations and hearings on the tax treatment of nonprofits and six major statutes were passed (some 500 pages in the IRS Code and Regulations). The number of state and local conflicts over property tax exemptions were "beyond count" (Gray 1991).

[4] Reference is made to the 1995 Capitol Forums Issue Brief on Uncompensated Care.

visits (Rovner, 1996) [See Appendix, "Safety-Net Providers."]

Although many of the programs and services of safety net providers sustained the massive reduction of Federal support during the mid-1980s, many of them did not survive. Those most vulnerable were the small community-based programs funded primarily by Federal funds and a stream of mixed funding sources from foundations, religious organizations, the United Way and corporate and private donations.[5] These programs cover a wide range of public health and social problems, such as shelters for women who are victims of domestic violence, home health care for the vulnerable elderly and substance abuse outreach programs. At the present time, the nonprofit safety-net health care providers are facing major challenges for their future survival with funding cutbacks in Federal, state and local support, the diversion of Medicaid revenues to managed care organizations, the conversion of Medicaid from an entitlement program to a block grant and the pressures of a competitive marketplace (Davis, 1996).

HOW DEEP ARE THE FEDERAL CUT-BACKS TO NONPROFITS?

It is estimated that between 1997 and 2004, Federal budgetary changes will reduce spending on health, education, social services and housing and community development by $773 billion (Salamon, 1996). This set of programs — 38 percent of the current Federal budget — will absorb 55 percent of the budget cuts required to meet the goals of a balanced budget. Health care spending will be reduced by 25 percent over the next seven years; it is anticipated that the changes will cost nonprofit organizations over $263 billion in Federal funds. Private giving can not be expected to meet these reductions, as it would have to increase at 16 to 20 times its growth rate in recent years (Ibid). At the same time, the Federal move to establish block grants will have an impact on how health and social services programs on state and local levels will provide services to individuals and communities. As states and municipalities seek new revenue sources for their own survival, they are scrutinizing tax exemptions allowed for nonprofits in their communities and demanding greater effectiveness and accountability.

Equally as threatening to the future of the nonprofit sector in health care is the moral-political crisis affecting the public's perception of the nonprofit sector. Many critics view it as an extension of government in its role of provider of services to vulnerable populations. Much of the funding that nonprofits use to provide services comes directly from government grants and contracts. As characterized in a recent Twentieth Century Fund report on "What Charity Can and Cannot Do," a massive shift from government support into a greatly enhanced role for charities ignores this historical relationship: it is a "sizable leap" into the unknown, advocated by those who are questioning the merits of social programs and their beneficiaries (Ibid). The report states that charitable, nonprofit organizations lack the resources to sustain the nation's poorest residents even at minimal safety-net levels. It estimates that by the year 2002, charitable nonprofits in the United States would have to more than double their private contributions to make up for cutbacks being proposed by advocates of a sharply reduced government role providing assistance to those in need. In reality, the report cautions, decreases (not increases) can be expected in charitable contributions and volunteerism during the next five years.

In a move to strengthen its members' ability to survive in an ever-more competitive marketplace, the National Association of Community Health Centers is encouraging safety net providers to form networks of their own in order to attract bids for contracts as providers of care. In similar moves, Planned Parenthood affiliates are exploring mergers across the country in order to cope with competition for private funding, a changing patient base as a result of managed care and rising operational costs. For example, in the Charlotte, North Carolina area, two affiliates are merging to create a larger organization to provide more efficient service delivery and increased fundraising power.

Catholic charities have long been players in the health care and social services arena. In speaking at an Alpha Center meeting this year, venture capitalist Paul Queally predicted that Catholic charities would be out of the health care marketplace in the next century, primarily because of lack of capital to compete in the new competitive health care market (Hiebert-White, 1996). In response, William Cox of the Catholic Health Association asserted that the challenge to his members is to compete successfully but in a way that does not undermine their values and identity as Catholic, religious organizations.

A recent survey conducted by the Home News and Tribune found that New Jersey-based corporations are committed to maintaining their current level of philanthropic commitment to nonprofit organizations in the

[5] Foundations play a significant role in nonprofit support to fill in where government cannot or will not. Foundations also traditionally meet the needs of small groups, institutions and organizations which are under-represented in the health care arena and those which may provide "politically sensitive" services, such as family planning.

state, even in light of downsizing and restructurings. Responses from corporate sponsors indicated that the two leading factors in determining which nonprofits receive funding are the change to improve the quality of life in local communities and to associate the firm with a project that spreads good will. Nonprofit fund-raisers in New Jersey point out that the greatest challenge to them this past year has been mergers. For example, where they might have had five or six banks in their region that gave corporate gifts in 1994, there may be only two banks in 1996.

STILL, THE FOR-PROFIT/NONPROFIT DEBATE CONTINUES

At this point in time, against the backdrop of reduced funding support, nonprofits continue to play a major role in the provision of health care, as do their growing for-profit competitors. Who can provide the best level of access and quality health care — a for-profit or nonprofit provider? This question is by no means easily answered and the environment in which both exist is rapidly changing. In 1994, 21 for-profit and nonprofit managed care health plans across the country participated in the National Committee for Quality Assurance's (NCQA) Report Card Pilot Project. This study indicated that there is no correlation between profit status of a health plan and the level of preventive care services; some nonprofits scored below the mean, while some for-profits scored above it.

The Alpha Center, at the request of the Commonwealth Fund, is involved in analyzing the various public policy issues and concerns related to the for-profit conversion of public hospitals, not-for-profit hospitals and health plans (Blue Cross and Blue Shield plans; managed care health plans) since 1980. In their 1996 working paper, the researchers noted that "despite growing levels of conversion activity and public concern in many states, available information about conversions by not-for-profit hospitals and health plans to for-profit is extremely limited" (Id.). As to the question as to whether or not and how well vulnerable populations continue to be served after conversion, available information precludes a fair assessment. Across the states, financial arrangements that are made to support indigent care differ, as do the terms regarding how the new for-profit entity will provide such care.

IT'S THE ACCOUNTABILITY ISSUE

The question of accountability is primary in a discussion of nonprofit as compared to for-profit health care organizations. Advocates of nonprofit health care delivery assert that their organizations are accountable to the patient and the public — not the shareholder. Their net income does not go to shareholders but is (in theory) retained for the benefit of members and the public. For-profit advocates argue that historically, nonprofits have not lived up to their community benefit claims; they argue that nonprofit health providers should enjoy tax subsidies only if their contributions to society equal or exceed the value of the subsidy (Heibert-White,-White 1996). This clash of views will require that both nonprofit and for-profit health care organizations evaluate, study and assess their contributions to their community in a rigorous, empirical manner.

Community benefit from nonprofit providers cuts across many dimensions: the provision of charitable services and of essential (yet in most cases, unprofitable) services; and in maintaining a research and advocacy role in the public health of the community. Dimensions of accountability in the health care sector include political accountability (especially regarding the retention of tax-exemption status); commercial accountability; community accountability in maintaining appropriate services and overseeing community health status, and clinical/patient accountability in terms of access and quality outcomes (Gamm, 1996).

The effects of conversions on community benefit are complex and raise multiple public policy issues. For example, when a for-profit health care provider such as Columbia/HCA dominates a community market, what entity subsidizes trauma units and indigent care if the for-profit provider does not make a commitment to do so? This type of question is embedded in the accountability issue — when necessary, is the for-profit hospital or health care provider willing to provide the "safety net" function traditionally filled by nonprofit health care providers? With close to 45 million uninsured individuals in this country — an estimated 1 million in New Jersey — will for-profits make a commitment to provide health care to these citizens?

What is the role of public policy makers regarding such issues? As responsibility falls to the state governmental level to respond to these market trends in the rapidly changing health care arena, policy makers are challenged to require accountability from nonprofit and for-profit organizations alike.

CURRENT STATUS: MERGERS, ACQUISITIONS AND CONVERSIONS

A brief overview follows of current trends in the national health care arena regarding the shifting of nonprofits to for-profit status. It is offered to put the role of nonprofits within a context of the competitive health care

market. As the trend continues in mergers, acquisitions, and conversions, it is estimated that billions of dollars of charitable assets are at risk unless state regulators and policy makers work with the organizations involved in the conversion transaction (Bell 1996). Many states are looking to the National Association of Insurance Commissioners (NAIC) which continues to develop guidelines regarding the reorganizations or conversions of not-for-profit health plans in areas such as operational structure, valuation of assets, the regulatory authority of the states and how to decide on the distribution of assets. In the absence of Federal guidelines, states are working to oversee such transactions.

Hospitals

At this time in health care, every aspect of health care — including managed care organizations, nursing homes, pharmaceutical manufacturers and home care — except hospitals, is dominated by proprietary, for-profit enterprises. Bradford Gray, in a commentary entitled "Why Nonprofits? Hospitals and the Future of American Health Care," asserted that the future of the nonprofit hospital, more than any other nonprofit, is affected by the changes in the business and governmental sectors (Gray 1991). He notes that governmental tax subsidies "may well be larger for hospitals than for any other type of nonprofit organization because of the amount of revenue they generate and the aggregate value of their capital assets" (Ibid). Further, government not only plays regulatory roles, but it is also the largest purchaser of hospital services through its Medicare and Medicaid programs.

Historically, between 1980 and 1990, almost one-third of all general hospital conversions involved a conversion to for-profit status (Challot et al., 1996). In the early 1980s, there emerged a growing presence of for-profit health care and investor-owned hospital companies, such as Humana, Inc. and the Hospital Corporation of America (which only came into existence in 1968). These companies initially purchased existing, independent for-profit hospitals and by the early 1980s, after they had been successful in purchasing most smaller, for-profit hospitals, their acquisition activities turned towards not-for-profit hospitals (Gray, 1991).

By the mid-1980s, acquisitions and mergers of not-for-profit community hospitals and public hospitals by for-profit "megasystems" began to accelerate. As of summer 1996, Columbia/HCA, the largest for-profit chain in the country, owned 340 hospitals, 135 outpatient-surgery offices, and 200 home health agencies in 38 states, controlling almost 50 percent of the for-profit hospital beds and 7 percent of all hospital beds in the country (Kuttner, 1996). In 1994, Columbia/HCA Healthcare announced plans of acquiring as many as 500 more hospitals before the end of the decade (Bell, 1996). During 1995, Columbia purchased or became involved in joint ventures with 41 nonprofit hospitals. Across the country, the number of nonprofit hospitals merging with or being acquired by for-profit businesses increased from 18 in 1993 to 176 in 1994. The Chronicle of Philanthropy found in a 1995 survey at least 65 conversions of nonprofit health care institutions pending throughout the country.

These mergers and acquisitions have significant impact on the policy and legal questions regarding the protection of charitable assets; the value of a nonprofit hospital, in many cases, can exceed $100 million (Bell, 1996). While research indicates that it is common practice that for-profit corporations initiate hospital conversions, there are many cases were communities in fiscal trouble have proactively sought hospital conversions as a means to survive in the community (Bell 1996; Challot et al., 1996). What happens to the public resources that have contributed to building these nonprofits? And whose role is it to decide? Currently, there appears that there is not a consistent public oversight procedure in place regarding hospital conversions.

Last year, speaking before the National Association of Attorneys General, the Volunteer Trustees Foundation for Research and Education urged state attorney generals to assert authority over conversions of nonprofit hospital assets to for-profit use. The Foundation encourages the use of existing laws that require directors of nonprofit charitable corporations to obtain prior court approval for any fundamental change in corporate purposes and recommends a set of actions to protect public interest and avoid changes being made for self-interest of for-profit purchasers, which include the holding of public hearings on nonprofit asset conversions; the protection of the community from the loss of essential health care services, such as emergency room care; and the proactive involvement of the state attorney general in any transactions under which the use of charitable assets is being changed (Miller, 1995).

In recent news, a Michigan trial court judge ruled in early September 1996 that a proposed 50-50 joint venture between Michigan Capital Medical center — a not-for-profit hospital system — and Columbia/HCA Healthcare violated the Michigan laws governing public charities. The proposed merger would have made Michigan Capital the first for-profit hospital in the state. In the case, which was initiated by the state attorney general's office, the judge asserted that Michigan law does not permit assets of a not-for-profit hospital legally formed for charitable purposes to be transferred to a for-profit joint venture. Michigan Capital announced that it will appeal the state court ruling which blocked its proposed 50-50 joint ven-

ture with Columbia/HCA.

Blue Cross and Blue Shield Plan Conversions

Blue Cross plans were organized in the 1930s as not-for-profit, community-based entities that accepted all members of the community, regardless of health status. Emerging from the Depression and the American Hospital Association's move for legislation to create a special class of nonprofit corporations and hospital insurance, the first Hospital Service Plan enabling act was adopted by the New York state legislature in 1934. By 1938, 1.4 million people had enrolled in 38 Blue Cross plans across the country (one of which was Blue Cross and Blue Shield of New Jersey). Two major characteristics that have distinguished Blue Cross from most commercial insurance companies are: payment of service benefits to hospitals rather than of cash benefits to the individual insured and community rating.

In June 1994, the National Association of Blue Cross and Blue Shield plans voted to amend its rules to allow plans to convert to for-profit status, after 60 years of requiring that plans be not-for-profit. The changes were spurred by the evolving health care marketplace, growing increasingly more competitive by the market penetration of managed care, and the individual plan needs to raise capital. By early 1991, three Blue Cross plans had filed for bankruptcy (Miller 1995). At present, only 12 of the 63 Blues plans across the country are designated as "insurers of last resort" for those individuals who cannot obtain insurance on the market. It is estimated that nationally, the asset value of the Blues' plans is approximately $60 billion.

Blue Cross of California was the first state Blue Cross plan to convert after the national association amended its rules in June 1994 to allow for conversion of plans to for-profit status. Currently, Blue Cross and Blue Shield in at least 17 other states, including Colorado, Maine, New York, Missouri, Maryland, Georgia and Virginia, are in the midst of considering such conversions (Ibid). As case examples, conversion transactions in California and Georgia are illustrative of two contrasting outcomes. In California, where consumer advocacy and state oversight was strong, two grant-making foundations focused on improving health care and public health in the state, were created with a total endowment of $3.3 billion, as a result of the conversion of nonprofit Blue Cross of California to a for-profit entity. The state of Georgia enacted legislation in 1995 to simplify the conversion of its Blue Cross and Blue Shield plan to for-profit status. Such legislation may result in the state's losing access to any charitable assets.

In other states, such as New Jersey, Maine and Colorado, Blue Cross plans are involved in advocating for change of state laws, as was accomplished in Georgia, to facilitate conversions. Such negotiations are currently in process. In the state of Maine, most recently the proposed conversion of Blue Cross of Maine was not passed by the Legislature because of questions about the ownership of the company's assets. Empire Blue Cross in New York is planning the creation of for-profit managed care units in 1997-98; the state's regulatory entities are working on how to address the plan's reorganization, in which the plan would establish a for-profit subsidiary instead of converting their entire operation. In January 1995, Maryland Insurance Commissioner Dwight Bartlett rejected a similar proposal from Blue Cross and Blue Shield of Maryland. In his decision, the Commissioner wrote that the proposal to set up a for-profit subsidiary created an inherent conflict of interest between policyholders and stockholders and with the pressure to satisfy investors: "...the interests of the subscribers of Blue Cross and Blue Shield of Maryland would be secondary to the for-profit enterprise."

Another emerging trend (most recently seen in Ohio, Georgia and North Dakota) is the conversion of Blue Cross plans to mutual insurance companies and merging with larger, for-profit firms. In New Jersey last year, under P.L. 1995, Chapter 196, procedures were established for a health service corporation to convert to a mutual insurance company. Blue Cross and Blue Shield of New Jersey's plans include converting to a mutual insurance company and merging with Anthem, Inc., a for-profit mutual insurance company. The merger, scheduled to be finalized by the end of 1996, must be approved by insurance commissioners in New Jersey and Indiana (Anthem's home state). One significant issue for New Jersey regards the question of whether or not the plan is required to establish a charitable foundation under the terms of its conversion to a mutual insurance company. In some cases, such as in Virginia, the Virginia Blues initially converted to a nonprofit mutual insurance company and is now proposing to convert to full for-profit status. In the intermediate step of mutual insurance company conversion, the plan was not required to transfer charitable assets.

Health Maintenance Organizations and For-Profit Conversions

The evolution of health maintenance organizations (HMOs) is illustrative of an industry-wide shift from nonprofit to for-profit status. The majority of HMOs began as not-for profits; the Federal HMO Act of 1973 provided grants only to nonprofit HMOs. The government invested in the HMOs to support health care that was lower in costs and increased access to health care and preventive care. In early 1982, federal support of not-for-profit HMOs was significantly reduced as the Reagan administration encour-

aged the HMOs to convert to for-profit status (Challot et al., 1996 et al). By the mid-1980s, most state legislatures passed laws allowing for HMOs to be for-profit businesses and to allow for conversions of nonprofit HMOs (Bell 1996). In the state of California, with its mature market penetration of managed care organizations, the percentage of for-profit HMOs increased from 16 percent to 65 percent of the HMO market during the period between 1980 and 1994. Currently, all but two of the state's largest HMOs are for-profit.

While the issue of community benefit is not as significant regarding conversion of nonprofit managed health plans as it is with the conversion of not-for-profit hospitals and other health care providers, the issues of access and quality remain strong (Challot et al., 1996). In the current environment, the for-profit sector in managed health plans is under scrutiny to ensure that quality and access are not compromised for the sake of profit. Conversions to for-profit status will raise the same issues regarding the monitoring of services delivered to specific populations. Public oversight responsibilities to monitor not-for-profit health plan conversions vary greatly between states. In most states, authority rests with the Department of Insurance; in New Jersey, both the Departments of Health and Insurance are involved in such transactions.

State Oversight of Conversions

Under almost all state laws, the assets of nonprofit organizations must be "permanently dedicated to charitable purposes" (Bell 1996). Most nonprofit health care organizations were created and evolved through tax-exempt status and publicly supported funds, including tax-free bonds. Volunteer time and charitable contributions also form a large part of the assets over time. Under, section 501(c)(3)(of the Internal Revenue Code) not-for-profit organizations — which are entities organized for religious, charitable, educational or scientific purposes — are required to show that no part of net earnings go to the benefit of private individuals (Chollet et al., 1996). Further, the governing board must represent the community being served by the organization (Ibid). Although there are no Federal laws that require not-for-profit hospitals or other not-for-profit health organizations to support indigent or charity care in order to retain their tax-exempt status, some states have obligated not-for-profit hospitals to provide such care in order to retain their not-for-profit status.

Under most state laws, when a nonprofit makes the decision to convert to for-profit status, merge, or to be acquired by a for-profit company, it is required to transfer the value of its assets to another nonprofit organization or charitable foundation pursuing "similar charitable goals" of the converting nonprofit (Bell 1996). Oversight authority for these activities at the state government level varies across states: usually the insurance commissioner oversees nonprofit HMO and insurance company conversions and the attorney general monitors hospital and nursing home activities (Ibid). In California — now a precedent-setting state in terms of acquisitions and conversions — the Department of Corporations oversees the conversions of health plans. In 1995, legislation was enacted in California regarding the review of conversions to ensure that nonprofit HMO assets are reserved for charitable purposes (Ibid). Across the country, however, given the complexity and "newness" of these transactions, many regulatory agencies are struggling with the staff resources and expertise to take a lead in monitoring such conversions. Their efforts are framed by existing state laws, articles of incorporation of the nonprofit entities, and the current political environment in the state.

The 1996 Alpha Center survey of such transactions in the states of California, Florida, Texas and Georgia found that even when it was required by regulators that assets be transferred to a new charitable foundation, the assets have been undervalued; specifically, the valuation of health plan assets at the time of conversion "is likely to be substantially less than the value Wall Street places on the successor for-profit organization" (Challot et al., 1996). The fair market value of the assets are extremely difficult to evaluate, appraise and transfer at the time of conversion. In many cases, state regulators valued only tangible property; yet such things as name recognition, good will and provider contracts are not included in the valuation. In California, during the 1980s, the value of not-for-profit HMOs offered and retained as a charitable contribution at conversion was less than one fourth of the value of the plan when measured in terms of its publicly traded stock soon after conversion (Hamburger et al. 1992; Challot et al., 1996).

Consumer Groups

Regarding the conversions of hospitals and health plans, policy makers and regulators in the state of California expressed a need to focus on the issues raised by conversions and acquisitions, based on their experiences with the conversion of Blue Cross and HealthNet (a for-profit HMO conversion) (Challot et al., 1996). Specifically, state policy makers emphasized the importance of public hearings and consumer involvement throughout the transaction process. Consumers groups such as the Consumers Union are instrumental in monitoring the converting of nonprofit health care companies in California. Their advocacy activities in working with state regulators in California influenced the valuation of HealthNet (a for-profit HMO) and increased the transfer of its charitable assets to endow a new foundation — the Wellness Foundation — in the state. Consumers Union is working jointly with Families USA to monitor these conversions as they are taking place across the country.

CONCLUSION

As the commercialization of health care continues, the issue of public benefit is paramount in the realm of public policy making regarding mergers, acquisitions and conversions among for-profit and nonprofit health care organizations. Without the support of state and local government working in tandem with them, nonprofit health care entities will have great difficulty surviving in a profit-driven economy. Is there a place for both nonprofit and for-profit entities in the new health care arena? The jury is still out. Public policy makers and governmental leaders are confronted by the challenges of creating an environment in which decisions about health care are made from the perspective of protecting the public good and keeping the public interest as the central focus. The overall goal is to create a health care system that affords accessible, quality health care in an cost-effective manner, whether it be for-profit, nonprofit or a balanced combination of both. The challenge to public policy makers and legislators is not to have the issue obscured by either side, but to keep the public interest as the central focus in making decisions.

QUESTIONS FOR DISCUSSION

Health policy analysts predict that state and local governments, rather than picking up the slack, will effect spending cuts in safety net and other programs, as those benefiting from these programs have little political clout. This prediction is based on the experience of the cuts during the 1980s and the current propensity of many states to cut revenues and spending. What is New Jersey's commitment to preserve its safety net providers and ensure access to health care for its vulnerable populations?

In the mid-1980s throughout the country, community-based shelters for women and children who were victims of domestic violence developed a revenue-raising strategy to keep their programs in operation. A surcharge was placed on marriage license fees at the state level to provide funding for domestic abuse. In the state of California alone in one year's time, $1.2 million was raised through the surcharge. In the current climate when surcharges are not favorably viewed as an alternative owing to their perception as "another form of taxes," how can nonprofits work with state and local government for creative revenue-raising strategies to support their community programs?

In a recent trend, managed care organizations are interested in working with community health centers, as they have established relationships in their communities and high clinical standards imposed by Federal requirements. However, a National Association of Community Health Centers study of some 200 national managed care contracts found that reimbursement was extremely low — in some cases 50 percent lower than Medicaid reimbursement for health center services. What role do public policy makers have in monitoring the managed care contracts with providers such as the community health centers?

In an August issue of the New England Journal of Medicine, a physician writing from Germany in response to an earlier article about the positive aspects of the rapidly changing for-profit health care sector, notes that the problem with a fully privatized for-profit medical system is that it will ultimately "create a pyramid of medical care modeled after the pyramid of income distribution." Under this pyramid, those at the top will enjoy access to quality health care, while those at the bottom will continue to struggle. He asserts that this is the reason no "civilized" nation has chosen to open medicine to full-scale competition. While acknowledging that nonprofit and public sector health care need rigorous reform, he makes a plea that the system not be altogether abandoned to market forces. How do public policy makers continue to focus on the values inherent in nonprofit health care and an increasingly profit-driven market focused on the "bottom line"?

The most recent issue of Competitive Healthcare Market Report, a publication dedicated to tracking mergers, acquisitions and conversions in the health care industry, included eight, single-spaced pages reporting on such business transactions around the country. As the commercialization of health care continues to expand, how does government "keep up" with industry changes that affect the public?

SAFETY-NET PROVIDERS[6]

The following are some key elements in the health care safety net. While a formal definition of the safety net providers encompasses only those who are legally required to provide health care for free or at reduced rates, on a practical level, the net is much broader. (Robert Wood Johnson Foundation Advances, 1996).

Public Hospitals

Competition puts public hospitals at risk. Of the nation's 6,500 community hospitals, about 1,400 are "public" — they are owned and operated by states, cities and counties. Funding sources include Medicare, Medicaid, insurance companies and patients themselves, as well as direct subsidies from state and local tax monies. These hospitals provide services to the community that are typically under-funded by insurance, such as trauma care, burn centers, neonatal intensive care units and emergency psychiatric care.[7]

Private Hospitals

These are private hospitals, both nonprofit and for-profit. In a competitive market, even nonprofit private hospitals are likely to decrease their levels of charity care. Using California hospitals as an example, when hospitals discounted their charges to managed care organizations in order to be competitive when they were sustaining Medicaid and Medicare cutbacks, the private hospitals reduced their provision of uncompensated care by 36 percent.

Community Health Centers/Migrant Health Centers

Located primarily in inner-city and rural areas with shortages of health care providers, there are approximately 600 community and migrant health centers throughout the country, offering some 2,500 delivery sites. Approximately 9 million individuals are served each year via comprehensive, case-managed primary and preventive care. The centers are involved in working with managed care organizations and exploring capitation as ways to remain competitive in the current health care environment.

Public Health Agencies

Supported by federal, state, county and local sources, public health agencies act as both providers and planners of community health. Services range from child immunizations, home health care and the monitoring and prevention of the spread of communicable diseases. The advent of managed care is having a significant affect on the public health activities of these agencies.

Family Planning Clinics

There are over 4,000 clinics in this federally funded program and an estimated 4 million women and teenagers receive primary care, cancer screening and disease prevention services.

Health Care for the Homeless

A federal program that funds 129 projects that offer primary care health services to approximately 420,000 individuals. Almost half the projects are administered by community health centers; the other are operated by nonprofit coalitions, nonprofit urban hospitals and local public health departments.

Ryan White AIDS Program

The Ryan White CARE Act provides health care and social services to an estimated 80,000 patients with AIDS or who are HIV-positive. The program is federally funded and last year served approximately 80,000 patients.

Rural Health Clinics

There are approximately 2,500 federally designated Rural Health Clinics which are mostly privately owned and operated. These clinics provide access to health care for almost 4 million patients each year. Approximately 70 percent of their clients are either Medicaid or Medicare beneficiaries.

Privatization

An emerging trend among financially strapped counties, states and municipalities is to contract with private nonprofit or for-profit organizations to provide public health services. Such contractual relationships have been expanding since the mid-1980s, especially in the area of social service programs, such as child day care and maternal and child health programs.

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[6] Definitions and terms are derived from many sources; two primary sources are: a Supplement to *Advances*, 1996, a publication of the Robert Wood Johnson Foundation; and *States of Health*, December 1995, from Families USA Foundation.

[7] In New Jersey, under state law all hospitals are required to provide indigent care. Reference is made to the Capital Forums Issue Brief on Uncompensated Care (1995).

WILL THE BUSINESS AND FINANCIAL REALITIES OF THE 21ST CENTURY ELIMINATE THE ROLE OF STATE GOVERNMENT IN HEALTH CARE DECISION MAKING?
PART II: CONVERSIONS — PROCESS, PROTECTION, PROFIT

Original Issue Brief December 11, 1996

ISSUE: The health care marketplace continues to change at an unprecedented pace. Competition is the definitive driving force behind the changes. It still waits to be seen what combination of nonprofit and for-profit providers and insurers will survive the changes and rise to the challenge of meeting the country's health care needs in this new landscape.

Traditionally, not-for-profit community hospitals and nonprofit health plans (such as Blue Cross and Blue Shield plans) have formed a significant part of the American health care system's infrastructure.[1] As the trend towards the converting of these health care entities to for-profit status continues, how will the health care system be affected in terms of access, quality and costs? What role will government have in this new environment of conversions, mergers and consolidations? How will New Jersey protect the public interest?

INTRODUCTION

In a scene from Milan Kundera's contemporary novel, *The Unbearable Lightness of Being,* the protagonist — a young Prague physician — is discussing with his friends the political and socio-economic changes that have occurred in eastern Europe during the 20th century. As the group ponders how the various leaders differ — whether communists, socialists or capitalists — they unanimously reach the same conclusion: they are all scoundrels, no matter what "label" they are wearing. And in many cases, they are the same people; they are just wearing different hats.

In today's current health care environment, critics from all sides are quick to point to the "scoundrels." But the solutions are more complicated than that. And it behooves all players to take the time to ascertain how the new landscape of the health care industry will be laid out, while retaining quality health care that is cost-efficient and equitably accessible. This issue brief is the second part of a discussion on nonprofit health care and the national trend of the shifting of not-for-profit hospitals, health care providers and nonprofit health plans (such as health maintenance organizations (HMOs) and Blue Cross & Blue Shield plans) to for-profit status through mergers, partnerships, acquisitions and conversions.

FOR-PROFIT VS. NONPROFIT HEALTH CARE - IS THERE THAT MUCH OF A DIFFERENCE?

As discussed in the October 23, 1996 Issue Brief, nonprofits are re-structuring and consolidating in several different ways: as a buyout by a business corporation; by amendment to the not-for-profit organization's articles of incorporation; as a "spin-off" in a corporate re-structuring and by merger with a for-profit entity, with only the for-profit entity remaining intact after the merger (Shields et al, 1991). Some recent conversions of hospitals have taken the form of partnerships, either a limited partnership or a limited liability company between the not-for-profit entity and the for-profit corporation (Challot 1996). The recent trend of joint ventures or 50-50 partnerships is of concern because of the question as to whether or not the investment is an appropriate use of charitable assets and/or a good risk for the community. Each variation in the merger and acquisition activity creates another set of pub-

[1]For purposes of this brief, the term "nonprofit" will be used as a generic reference to both not-for-profit and non-profit entities.

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Capitol Forums on Health & Medical Care

League of Women Voters of New Jersey Education Fund

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lic policy issues regarding oversight and monitoring of these transactions, which involve significant amounts of charitable assets.

The practice of conversions forces the issue of the very nature of the health care system, which has long been the only enterprise that has large numbers of nonprofit and for-profit entities operating within its parameters. Several public policy questions are raised by the conversion activities: do nonprofit providers offer more charity care and community benefits than for-profits; should there be requirements to do so for both nonprofits and for-profits; what would be the nature of a market dominated by for-profit providers; are communities "better off" after conversions; and should the conversion process be regulated and if so, to what extent (Shactman & Altman, 1996). Each of these questions is comprised of complex contingency questions; and there are no easy answers. At present, there is little standardization regarding oversight of conversion activities, and the responsibility for rising to the challenge of these issues falls to the state level of governance.

Supporters of for-profit conversion contend that it will create a more efficient and market-oriented system, resulting in more affordable health care (Shactman & Altman, 1996). They commend the formation of charitable foundations, targeted for health care needs specific to states and regions. Critics of the conversions have great concerns that for-profits will not provide necessary health care services to their communities, will reduce charity care and will not support graduate medical education. Further concerns are that in the absence of strict monitoring and oversight, conversions will result in the loss of charitable assets. Federal and state laws require that charitable assets must be used for the same "charitable" mission or purpose as the nonprofit entity. The assets may go either to an existing 501(c)3 organization, or to a newly created foundation.

Two 1996 studies in progress (being conducted by the Alpha Center and the Council on the Economic Impact of Health System Change) are looking at the effects of conversions on nonprofit hospitals and health plans, and the regulatory environment in which they are taking place. Both research groups point out the importance of ongoing, empirical research on the impact on communities when a nonprofit hospital is converted to a for-profit hospital and a charitable foundation. It is also noted that while research regarding the measurement of charity care and community benefit is riddled with methodological differences, some preliminary findings indicate that nonprofits do provide significantly more charity care than their for-profit counterparts. The authors cautioned that national aggregate data regarding the for-profits' commitment to charity care was statistically unreliable because most for-profit hospitals are located in areas that have low needs for the provision of charity care. For-profit hospitals were found to be more aggressive in seeking operating efficiencies, especially in the area of staffing levels (Shactman & Altman, 1996).

In the 1996 Alpha Center working paper, the researchers noted that "despite growing levels of conversion activity and public concern in many states, available information about conversions by not-for-profit hospitals and health plans to for-profit is extremely limited" (Challot et al., 1996). As to the question of whether or not and how well vulnerable populations continue to be served after conversion, available information precludes a fair assessment. Across the states, financial arrangements that are made to support indigent care differ, as do the terms regarding how the new for-profit entity will provide such care.

FOR-PROFIT CONVERSIONS - WHY NOW?

While the mergers and takeovers in the late 1980s and early 1990s primarily involved large for-profit hospital chains acquiring for-profit hospitals, the mid-1990s have seen the acceleration of takeovers of nonprofit hospitals by the for-profit chains. In 1995, 59 nonprofit hospitals were sold or joint-ventured to for-profit organizations (Ibid). By the end of 1996, it is expected that more than 100 hospitals once controlled by state and local government, religious organizations or community boards will have been purchased by for-profit investors (*The Wall Street Journal*, October 18, 1996).

The trend of for-profit hospital chains looking to nonprofits has been triggered by many inter-related factors: consolidation has already occurred amongst the country's for-profit hospitals (which number over 700); the approximately 4,500 nonprofit hospitals have billions of dollars of assets, are valued in the community and often have teaching hospital affiliations already established (Ibid). These nonprofits are experiencing reduced funding from governmental sources, aggressive competition from managed care entities, and are in need of access to capital in order to survive and compete in a deregulated marketplace. They contend that increased capital will allow them to compete on a level playing field; it would be used to develop new products and services, such as information systems. Both nonprofit providers and health plans assert that health care "giants" like Humana, Aetna, Tenet Healthcare and Columbia/HCA have the ability to raise capital and gain greater market share, which they do not have under their current nonprofit status (Ibid).

OVERSIGHT AND MONITORING - WHO'S IN CHARGE?

The conversion process is extremely complex and rife with technical details, such as asset valuation, transaction analysis, structure, issues of private inurement and conflict of interest (Miller, 1996). In most states, oversight authority of conversions from nonprofit to for-profit status (whether providers or insurers) rests with the attorney general, who technically is the only party in the state legally empowered to represent the public interest (Ibid). Since 1995, when more than $1.6 billion of community hospital assets were sold, attorneys general throughout the country have been confronted with the challenges of identifying their roles in the process and applying appropriate legal tools in the oversight process. The conversions of the nonprofit entities is a "new phenomenon" on many levels: the sheer number of conversions, their scope and the resulting new structures (Ibid).

The attorney general's responsibilities in assets sales are driven by legal authorization under common law. Specifically, the doctrine of *cy pres* (regarding the re-formation of a charitable trust or foundation); the doctrine of *parens patria* (that the attorney general, as the officer of the sovereign, represents the people and the public interest); and the writ of *quo warranto* (which relates to nonprofit corporations and the attorney general's right to take action on proposed changes given to an original charter granted by the state to the nonprofit) (Cambridge Partners *Brief*, 1996)

How broad or how narrow the role of the attorney general is to be has varied from state to state. In a recent talk in Washington, DC, California Deputy Attorney General Jim Schwartz discussed the attorney general's role in conversion transactions (Council on the Economic Impact of Health System Change, October 1996, meeting). He emphasized that the role is one of enforcement and protection of the public good and interest; it is not a role of regulator. The transaction is reviewed within the parameters of trust law. Oversight by state attorneys general may require that the parties submit proposed transactions for advance review and approval, and the attorney general has the authority to impose requirements as conditions for approval.

As a result of the great number of conversion transactions (Deputy Attorney General Schwartz estimated five transactions involving thirteen hospitals in the last year, as well as the conversion of California Blue Cross), legislation was passed setting forth requirements for conversions in California. The California law requires that public meetings be held and that procedures of the attorney general's office are a matter of public record. Financial details of the conversion transaction are also public information, because the assets being valued and transferred are public assets.

ACCOUNTABILITY AND COMMUNITY BENEFIT

Hospital and health plan conversions raise a number of issues for communities regarding community benefit. Answering the questions of how community benefit is defined and the ways in which it is measured once a definition is agreed upon is a complex process. The answers are critical, however, in order to evaluate accurately the performance of nonprofit and for-profit health care providers. Community benefit involves looking at several activities, including the provision of charity care in the community; the level of access to care; support in research, education and training; the provision of unprofitable but essential health care services, such as emergency room and trauma units, and the entity's participation in maintaining and ensuring the public health of the community. (See table in Appendix 1.)

According to a recent Alpha Center research analysis of conversion activity throughout the country, "available information does not allow a careful assessment of how well vulnerable populations continue to be served when public or nonprofit hospitals convert to for-profit ownership or management" (Challot, 1996). Further, fragmented and unreliable data make it difficult to track whether or not communities experience any change in essential (but unprofitable) services. In some cases, however, when there was active community involvement in establishing the terms of the conversion and the ongoing management of the for-profit hospital, the community's interest in maintaining these services appeared to be protected (Ibid).

CONVERSIONS IN OTHER STATES - LESSONS LEARNED

Across the country in 1996, states actively promulgated legislation regulating managed care entities and providing patient protection. Analysts are predicting that 1997 will see the emergence of legislation to tighten state oversight of conversions (*Modern Healthcare*, October 14, 1996; *The Wall Street Journal*, October 18, 1996). In the absence of any standardized Federal guidance regarding conversion issues, significant public policy issues such as regulation and oversight are falling to the states to undertake. At present, only the states of Nebraska and California have laws specifically focused on conversions. Nebraska's law requires full public disclosure, an independent valuation process supported by a buyer and a monitoring process assuring future compliance. It also gives broad powers to the attorney general and state regulators to act in the public interest (Miller, 1996).

In Ohio, two Republican state legislators (Representative Van Wyven and Senator Drake) and the Ohio Attorney General Betty Montgomery recently introduced legislation requiring that nonprofit health care entities need state attorney general's approval to transfer assets to for-profit companies. The Ohio bill would require a provider or health plan that wishes to transfer 20 percent or more of its assets to notify the attorney general's office; it would also require public hearings to allow the community to determine how the transfer's proceeds would be used for the provision of charitable health care. Ohio has seen a significant increase in conversion activity since the beginning of 1995. Attorney General Montgomery, who reviewed five of the transactions, asserted that the charitable assets involved were accumulated over decades but had been converted to for-profit assets "in just days —without any public input" (*Modern Healthcare,* October 21, 1996). It is anticipated that the new law will allow for greater scrutiny of the conversion process, by both the Attorney General's office and the public.

ONGOING OVERSIGHT

Some states are also considering mandating the creation of monitoring mechanisms once the sale has been effected, in order to ensure that the for-profit entity does not discontinue providing essential health services, such as neonatal care or trauma units. Historically, for-profit chains have not invested in providing services such as indigent care, medical education and research, or burn units and other high technology services (Challot, 1996; Friedman, 1995; Miller, 1996). Ongoing oversight of hospital and foundation activities is also critical to monitor such trends as the cost shifting of certain services, e.g., cases in which it was found that charity care services in the community were being paid for by the foundation formed by the transfer of charitable assets, rather than being contributed to by the converted for-profit hospital (Miller, Council on the Economic Impact of Health System Change, October 6, 1996 meeting).

THE ISSUE OF VALUATION

The trend of converting health plans and managed care organizations began in the state of California in the 1980s. During the early transactions, when there was little if any oversight, billions of dollars of charitable assets were lost to the public. A recent analysis in the *Chronicle of Philanthropy* evaluated five nonprofit HMO conversions in the mid-1980s and found that as much as $212 million that might have gone to health care charities or other community uses was lost to under-valuation.

The issue of valuation of assets is one of great debate, with much disagreement as to the most appropriate and reliable way to do so. Approaches for the valuation of assets range from the amount the plan could be sold for on the open market; to valuing the physical plant and other tangible assets; or to establishing the total of taxes not paid (which varies from state to state).

The 1996 Alpha Center survey of such transactions in the states of California, Florida, Texas and Georgia found that even when it was required by regulators that assets be transferred to a new charitable foundation, the assets have been undervalued; specifically, the valuation of health plan assets at the time of conversion "is likely to be substantially less than the value Wall Street places on the successor for-profit organization" (Challot, 1996). The fair market value of the assets are extremely difficult to evaluate, appraise and transfer at the time of conversion. In many cases, state regulators valued only tangible property; yet such things as name recognition, good will and provider contracts are not included in the valuation. In California, during the 1980s, the value of not-for-profit HMOs offered and retained as a charitable contribution at conversion was less than one fourth of the value of the plan when measured in terms of its publicly traded stock soon after conversion (Hamburger et al. 1992; Challot 1996).

GUIDELINES FOR REGULATION

Shactman and Altman (1996) describe two levels of regulatory measures that may be considered in states regarding conversions:

- Level 1: Regulate conversions to safeguard and conserve the full value of the nonprofit assets and insure that all proceeds from the conversion are used for appropriate charitable purposes.

- Level 2: Regulate conversions to ensure that the community continues to have access to needed amounts of health care services and that the community is satisfied with the degree of local control over its health care delivery system.

The authors caution that "too much regulation" could be counter-productive and may increase prices. Yet, their findings indicated that when states did not have specific conversion laws, the full value of charitable assets was not protected. In the absence of legislation, there is no clear structured administrative process for conversions.

The Volunteer Trustees Foundation for Research and Education has set forth guidelines for state regulators' oversight of the sale and joint venture transactions in which the assets of nonprofit hospitals or health maintenance organizations are transferred to for-profit enterprises. These guidelines set forth that the primary objectives of the state regulator's oversight should be: (1) safeguard-

ing the value of the charitable assets; (2) safeguarding the community from loss of essential health care services and (3) ensuring that the proceeds of the transaction are used for appropriate charitable purposes (Boisture et al, 1995). The Foundation sets out various procedures in order to accomplish the three primary objectives, including conducting an independent review of the fairness of the transaction, assessing the degree of risk to charitable assets; requiring the disclosure of conflicts of interest; determining appropriate safeguards for the continuation of essential health services; implementing public hearings and soliciting public comments; determining that sale proceeds are not used for the private benefit of the for-profit purchaser and providing governance and oversight of the nonprofit entity that receives the sale proceeds (*Guidelines*, 1995).

BLUE CROSS AND BLUE SHIELD PLANS - A TRADITION IN TRANSITION

The evolution of the "Blues" is a significant national and local discussion point regarding the complex issues raised by conversion. The Blue Cross and Blue Shield Plans were originally organized in the 1930s as not-for-profit, community-based entities that accepted all members of the community, regardless of health status. For several decades, community rating prevailed among the Blues, which operated under their nonprofit social mission. Changes in the evolving health care marketplace in the 1980s, including increased competition from managed care entities, led to the national association's June 1994 decision to allow plans to convert to for-profit status. The plans pushing for for-profit conversion argue that to survive in a marketplace with for-profit competitors, they need access to capital in order to expand, increase market share and continue to provide affordable coverage (*Modern Healthcare*, October 14, 1996).

Currently, there are 62 independent Blues plans operating in the competitive health care marketplace. Across the country, the plans, which serve 66.3 million people in mixed markets, are merging, affiliating in consortia, creating for-profit subsidiaries and converting to for-profit status. Industry analysts contend that plans engaged in activities such as creating for-profit subsidiaries, affiliations and mergers may be taking initial steps towards conversions. Although consolidating brings some efficiencies, if there are a number of entities pursuing the same market, it may be that some find it necessary to convert to for-profit status so as to have access to capital in order to invest in more competitive new products and services and to offer competitive discounts based on volume (*Modern Healthcare*, October 14, 1996).

There are currently several mergers pending across the country, such as the Illinois Blues with the Texas Blues; the Colorado Blues with the Nevada Blues; and the Connecticut Blues with Anthem, Inc., based in Indiana and one of the country's major health care management companies. Health industry analysts predict that the future of competitive health care will have only 10 to 20 major integrated health care management companies serving the majority of the U.S. health care market.

According to the national Blue Cross and Blue Shield Association president Pat Hays, although five Blues plans have converted to for-profit status or announced conversion plans, it is expected that most others will not. He pointed out that the majority of the Blues plans are committed to their nonprofit heritage and are involved with innovative strategies "to preserve that heritage" (*Modern Healthcare*, October 14, 1996). Consumer advocates contend that the Blues are distancing themselves from their original social mission.

Among the 62 plans, only two have completed conversion to for-profit status and issued stock - Blue Cross of California and Blue Cross and Blue Shield of Georgia. Plans in Colorado, New York, Virginia and New Jersey have started the conversion process. Three other plans own publicly traded subsidiaries: in Wisconsin (1991); Indiana (1992) and Missouri (1994). Empire Blue Cross and Blue Shield of New York points to two significant 1996 state laws affecting its decision to convert to a for-profit entity: the first mandated that every managed care plan enroll chronically ill patients and the second ended Empire's discounts for hospital fees (*The New York Times*, September 1996).

Blue Cross and Blue Shield of Ohio's decision to transfer most of its business to Columbia/HCA Healthcare Corporation is raising many issues. The $300 million deal would provide an almost $15 million "windfall" to Blues executives (*Modern Healthcare*, October 14, 1996). The national Blue Cross and Blue Shield Association reports that it will revoke the Ohio Blues license if it goes through with its proposed sell-off to Columbia. In the beginning of November, US District Court Judge Wells enjoined Ohio Blue Cross from using the Blues names and trademarks pending a final decision in the lawsuit between the plan and the national Association.

TWO CONVERSIONS AND TWO OUTCOMES: CALIFORNIA AND GEORGIA

Because each case is unique, states are settling conversion transactions in a variety of ways. In California, after lengthy negotiation and public pressure, two charitable foundations dedicated to health care were created. In very distinct contrast, the Georgia insurance commissioner ruled that the Blue Cross was not a charity and therefore, owed none of its assets to the public.

Blue Cross of California's conversions took three years and involved an active battle with state regulators and legislators. It was only after pressure from legislators that Blue Cross established two charitable foundations worth $3 billion; it had initially maintained that creating the WellPoint Health Networks for-profit subsidiary was a restructuring and not a conversion, and therefore, the public was not owed anything by the company. California law requires converting companies to donate their fair value to charity. WellPoint is currently engaged in acquisition and growth in out-of-state health insurance companies.

By contrast, Georgia Blues went through a process over the course of one year. In 1995, the Legislature passed a law allowing the plan to convert to for-profit and the state insurance department authorized the re-structuring. In February, Cerulean Co., the holding company for the Blues, secured an initial private investment of $49.9 million and issued stock. The Georgia plan was not required to establish a charitable foundation because the state Supreme Court in 1960 ruled that the company was taxable. The plan's assets are not public and paid taxes in 1995. Consumer advocates believe that Georgia is an example of what an insurance commissioner should not do in reviewing a conversion plan and stress the importance of a lengthy and thorough review for such transactions (Id.).

NEW JERSEY BLUE CROSS AND BLUE SHIELD - A CASE IN PROGRESS

Negotiations continue regarding the conversion of Blue Cross and Blue Shield of New Jersey to a mutual insurance company and its proposed merger with Anthem, Inc., a for-profit mutual insurance company based in Indiana. The merger, scheduled to be finalized at the beginning of 1997, would create Anthem East, with its corporate headquarters in Newark overseeing operations for Anthem on the East Coast.

Other aspects of the proposed merger plans involved regional mergers, under which New Jersey Blues will purchase Delaware Blues and Anthem would later buy the combination (*Modern Healthcare,* 1996). $103 million would be earmarked for a charitable foundation by conversion in the state of Delaware. A significant issue for New Jersey involves the question of whether or not the plan is required to establish a charitable foundation under the terms of its conversion to a mutual insurance company. P.L. 1995, c. 1996, the bill which provided for a health services corporation to convert to a domestic mutual insurance company, does not have specific requirements for the establishment of a charitable foundation as "all assets and liabilities of the health service corporation would become the assets and liabilities of the new domestic insurer" at the time of conversion (Kane, 1996). As with most other states, New Jersey currently has no specific law regarding conversions; all transactions are reviewed under the doctrines of common law by the Attorney General. A.2368, introduced in September 1996, addresses the issue of conversion and the government's role in the process.

At the same time, a merger plan in Connecticut — scheduled to be finalized in early 1997 — comprises the formation of a multi-regional health care company, including New Jersey and Delaware Blues. Operating companies will be present in all three states and administratively coordinated through the new holding company, Anthem East. When these pending mergers with Blue Cross & Blue Shield of New Jersey and Connecticut are finalized, Anthem will rank among the top 5 health care management companies in the country. Its consolidated revenues will exceed $11.5 billion, and combined assets will equal more than $7.5 billion (*Blue Cross & Blue Shield Report,* October 1996).

The ongoing conversion process in Virginia with Trigon Blue Cross Blue Shield is illustrative of some potential issues when a Blues plan has already converted to a mutual insurance company and parallels similar issues confronting the state of New Jersey. The two primary questions raised by Trigon's conversion were: what portion (if any) of Trigon's value should go to taxpayers to make up for 50 years of nonprofit status and what amount of its stock should go to policyholders. Because Trigon became a mutual company in 1991 and mutual companies, by definition, belong to their policyholders, Trigon executives initially argued that all of its stock should go to policyholders, none to charity or to the state. Two Virginia laws made an interesting counterpoint: the state law governing mutual nonprofits declares that if the business liquidates, the policyholders are entitled to its shares; however, because Trigon had been a nonprofit company in the state for some 56 years before it became a mutual company, another law states that nonprofits wishing to change their status should liquidate and use their assets to form a charitable foundation with a similar mission - health care for Virginia's citizens and support of medical education in the state. Strong consumer activism in Virginia from its Citizens Consumer Council and Virginia Common Cause is helping to focus the issue of the fair valuation of Trigon's assets.

GREATER SCRUTINY OF CONVERSIONS BEGINS

Although earlier transactions were accomplished outside of the view of public scrutiny, through the activities of state attorneys general, volunteer boards, consumer advocacy groups (national and local) and increased media attention, the transactions are being held to more intensive

analysis and oversight. According to monitoring by the Volunteer Trustees Foundation for Research and Education, many of the buy-outs and joint ventures creating for-profit hospitals are part of a highly confidential negotiation process. Confidentiality agreements are signed early on by the parties involved; consequently, the community is left out of the process by which "community-owned" hospitals and health plans are being converted. The investor-owned companies argue that disclosure of terms of the sale may "hurt" their competitive positions in negotiations. However, advocates for the nonprofits assert that in the absence of disclosure, there are no mechanisms to ensure that the interests of the community are being served, or that the long-term assets and attributes of the nonprofit are being protected (Ibid).

It is anticipated that greater public scrutiny will open the acquisitions to a competitive bidding process and allow for fairer valuation of the hospital itself and its charitable assets. A recent Wall Street Journal article on the subject of conversions notes that in two recent transactions — one done quietly and the other with competitive bidding — the "quiet" sale hospital sold for $30 million; the competitive bidding transaction resulted in a $50 million sale. Both hospitals were of similar size and had a local near-monopoly (Id.).

The Internal Revenue Service has reported that it is increasing its scrutiny of such transactions based on the change in tax status. It is currently developing guidelines and planning an intensive audit program on health care transactions to ensure that no institution or individual unduly benefits from the transaction and transfer of charitable assets.

On the Congressional level, the Government Accounting Office (GAO) is involved in what is expected to be a year-long study on the trend in nonprofit hospital conversions and the potential loss of charity care and other essential health services. The study will also look at the mission and control of charitable foundations that result from nonprofit conversions to for-profit and the use of the funds designated for charitable purposes (*Modern Healthcare*, 10/28/96).

CONCLUSION

The health care system in New Jersey, as throughout all of the states, continues to be rapidly evolving. In this dynamic environment, every individual change affects and has an impact on every other part of the system: some traditional structures are being irrevocably changed, while new entities are coming onto the scene with the promise of bettering the entire health care system. Much remains unknown, but lessons can be learned from the experiences of other states. In this time of change, the state leaders and policy makers have various issues to balance for New Jersey: the future of its non-profit hospital system; the protection of its vulnerable populations; the integrity of its communities and their public health and its regulator role in health care.

XI. CONVERSIONS - UPDATE

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Our Capitol Forum on Conversions of Non-Profits this past year focused, in part, on the conversion activity surrounding Blue Cross and Blue Shield of New Jersey. At the time of its publication, New Jersey Attorney General Peter Verniero was reviewing the terms of the conversion and Blue Cross' plans to merge with Anthem Inc.

In a January 1997 decision, the Attorney General found that Blue Cross "satisfies the requirements" as a charity. In that case, it must be determined what amount of its charitable assets it would be required to donate to a charitable foundation. In response to the Attorney General's decision, Blue Cross and Blue Shield has filed suit in state Superior Court in Essex County, asking for the courts to decide whether or not it is a charity. Proceedings continue at the present time.

QUESTIONS FOR DISCUSSION

Administrative Law vs. Contracts Law: In a de-regulated health care arena, where many aspects of corporate transactions and activities fall under the purview of contracts law, what happens to the regulatory and monitoring role of state government and administrative rulemaking? What are the limits of regulation?

A 1996 study by the California Office of Statewide Planning and Development focused on hospital mergers in the state and their effect on competition and health care delivery. The researchers assessed the hospitals' finances, payer mix and services before and after the mergers. While study findings were inconclusive, they did show that mergers appear to increase efficiency, but they may also compromise competition. For example, in Northern and Southern California, three integrated health care systems are becoming dominant in two markets. Are three players enough to insure competition and preserve quality? Regarding charity care, the study found that levels of charity care were already so low that no drastic reduction in care was evident.

The impact of managed care entities on New Jersey's hospitals (some 85 acute care facilities in the state) has led to outright mergers and partnerships which are critical to economic survival. Through these consolidations, hospitals can take advantage of the efficiency of specialization and can offer managed care companies a full range of medical services, from walk-in clinics to nursing home care. In New Jersey, these transactions are nonprofit with nonprofit. Is the degree of oversight currently in place for mergers between nonprofit hospitals sufficient? Should there be a more aggressive governmental role in the process?

Non-profit hospital systems throughout the country are strategizing to remain viable competitors in the health care arena. In Texas and New Mexico, VHA Southwest Community Corporation was formed, a new company dedicated to preserving a not-for-profit hospital presence in Texas and New Mexico; its goal is also to take over not-for-profit hospitals in the region who are considering converting to for-profit status. In New Jersey, where currently all hospitals are not-for-profit, will recent mergers and consolidations to form large not-for-profit hospital systems throughout the state work to strengthen the position of the not-for-profit hospitals and block the entry of for-profit players?

Representative Stark (D-Calif.) is calling for investigation of changes in physician referral patterns after nonprofit hospitals are taken over by for-profit hospital chains and physician investors. His concern is based on reports that physician groups are referring the healthiest and best insured patients to the for-profit hospitals with which they have financial ties, while referring uninsured and expensive patients to public or other hospitals in the community (Modern Healthcare, October 28, 1996). Such referrals would violate federal physician self-referral laws. As changes in the economic relationships between physicians, hospitals and provider groups continue, how will New Jersey monitor the market environment for such trends that have significant impact on "the public welfare"?

When "mega" for-profit hospital chains purchase nonprofit community hospitals, localities are confronted with the "absentee landlord" syndrome and fears that the new owners will have little knowledge or concern about the community in which their hospital is located. Should incentives be given to owners in order to ensure they "do the right thing" for their communities? What level of responsibility to the community is appropriate? A recent California Medical Association study found that for-profit HMOs in California use more of their revenues on administration than nonprofits: in fiscal year 1994-95, nonprofit Blue Cross of California spent 93.4 percent of its revenues on patient care; in comparison, for-profit Aetna health plans of California spent 77.4 percent on patient care. What are the implications for access to health care based on these figures?

As the changing market and health care environment, as well as reductions in the traditional revenue streams of Medicaid and Medicare, are driving the ways in which medical residents are trains, states are confronted with deciding on how to address the problem. Throughout the country, they are evaluating options that include seeking new mechanisms for graduate medical education to replace lost revenues at teaching hospitals, developing incentives to induce managed care companies to contribute to medical education, and taking a "wait and see" position for guidance from the Federal government. (This past year Senator Moynihan (D-NY) introduced S. 1870, the Medical Education Trust Fund Act of 1996. The purpose of the trust fund is defined "to assist medical schools in maintaining and developing quality educational programs in an increasingly competitive health care system" (Kane, 1996)). What ways is New Jersey exploring to address this pressing problem?

The debate regarding nonprofit vs. for-profit health care providers is just beginning. Accurate comparisons along the dimensions of quality, access, efficiency and community benefit cannot be made without solid research. Once again, the lack of reliable data, as well as fragmentation of data sources, thwarts the goal of validly measuring the performance and outcomes of either system. What is New Jersey's commitment to proactively standardize health data for evaluation and analysis purposes?

APPENDIX 1

Selected Conversions of Not-For-Profit Health Organizations: Charitable Beneficiaries and Amount of Assets Transferred

Health Organization	Name of Foundation Created or Charitable beneficiaries	Year of Conversion	Asset Value Transferred	Current Value of For-Profit Asset (Date of Valuation)
Hospitals and other medical facilities				
Anciote Psychiatric Center (Tarpon Springs, FL)	Anciote Manor Hospital	1984	$6.9 million	29.6 million (1985)
Northwest Area Community Hospital	Mid-Iowa Health Foundation	1984	$8 million	$14.5 million (12/31/93)
Ridgeway Hospital (DesPlaines, IL)	Blowitz-Ridgeway Foundation	1984	$10.5 million	$16.8 million (9/30/92)
Eastmoreland Hospital (Portland, OR)	Northwest Osteopathic Foundation	1984	$6.3 million	
Davenport Osteopathic (IA)	Quad City Osteopathic Foundation	1984	$4.5 million	
Portsmouth Hospital (NH)	Foundation for Sea Coast Health	1984	$45 million	
Eisenhower Osteopathic Hospital (Colorado Springs, CO)	Colorado Springs Osteopathic Foundation	1984	$13.8 million	
St. Joseph Hospital (Omaha, NE)	Health Future Foundation	1984	$70 million	
Presbyterian/St. Luke's Healthcare Corporation (Denver, CO)	Colorado Trust	1985	$123 million	$259.8 million (12/31/93)
North Miami General (Miami, FL)	Modern Health Care Services	1985	$.25 million	
Presbyterian Hospital (Oklahoma City, OK)	Presbyterian Health Foundation	1985	$110 million	
Wesley Medical Center (Wichita, KS)	Kansas Health Foundation	1985	$200 million	$332.8 million (12/31/93)
Greater Bridgeport Foundation (Trumbull, CT)	University of Connecticut Foundation	1986		
Tucson Osteopathic (Tucson, AZ)	Tucson Osteopathic Medical Foundation	1986	$9 million	
Georgia Osteopathic Hospital (Tucker, GE)	Georgia Osteopathic Institute	1986	$5 million	
Irvine Medical Center (Irvine, CA)	Irvine Health Foundation	1986	$15 million	$22.25 million (12/31/93)
St-Marks Hospital (Salt Lake City, UT)	Episcopal Church Trust Fund	1987	NA	
Flow Regional Medical Center (Denton, TX)	Flow Health Care Foundation	1989	$1.2 million	
Montefiore Hospital (Pittsburgh, PA)	Jewish Health Care Foundation of Pittsburgh	1989	$75 million	$88.8 million (1993)
Michael Reese Medical Center (Chicago, IL)	The Michael Reese Foundation	1991	$2 million	
Cedars Medical Center (Miami, FL)	Health Foundation of South Florida	1993	$50 million	
Hilton Head Hospital (Hilton Head, SC)	Hilton Head Foundation	1994	$12 million	
Helen Ellis Memorial Hospital (Tarpon Springs, FL)	Tarpon Springs Hospital Foundation	1994	NA	
Nashville Memorial Hospital (Nashville, TN)	Nashville Memorial Foundation	1994	$108 million	$100-$108 million (1994)
St. Francis Hospital (Memphis, TN)	Primary Corp./Assisi Foundation of Memphis	1994	$130 million	
University of Louisville Hospital (Louisville, KY)	Columbia/HCA Healthcare Foundation	1994		
Southwest Texas Methodist Hospital (STMH) (San Antonio, TX)	Methodist Healthcare Ministries of South Texas	1994	$27 million, plus about $47.7 million in retired hospital debt. STMH retains 50% ownership & remains not-for-profit.	
Winter Park Memorial Hospital	Winter Park Health Foundation	1994	$29 million, plus future earnings from WPMH/Columbia/HCA for-profit partnership	$47 million (1995)
Tulane University Medical Center (New Orleans, LA)	Tulane University	1994	$130 million; plus 20% of future distributions from Columbia HCA/Tulane's health care system, $20 million/year to the University's medical education and research, and up to $75 million in loans and guarantees for 11 new centers of excellence.	
Heartland Medical Center	Dakota Medical Foundation	1995	50% ownership of Dakota Heartland Health Care System plus 50% of system's annual earnings	

Rapides Regional Medical Center (Alexandria, LA)	Rapides Foundation	1995	$66 million, plus 50% ownership and half of distributions from new Central Louisiana Healthcare Corporation	
St.Joseph's Hospital and St. Joseph Center for Mental Health (Omaha, NE)	Creighton University	1995	Reorganization of 1984 sale to AMI (now Tenet Healthcare Corporation). Creighton received $100 million for 1984 sale and in reorganization received 26% ownership of new limited liability company holding both hospitals.	
Memorial Hospital (Jacksonville, FL)	Genesis Health Foundation	1995	$5 million	
Rose Medical Center (Denver, CO)	Rose Foundation	1995	NA	
LaGrange Memorial Hospital (Chicago, IL)	Community Memorial Foundation (LaGrange, IL)	1995	$50 million	
Chicago Osteopathic Hospital (Chicago, IL)	Not Named	1995	NA	
JFK Medical Center (Atlantis, FL)	JFK Medical Center Foundation	1995	$275 million	
Bishop Clarkson Memorial	Clarkson Foundation	1995	NA	
Olympia Fields Osteopathic (IL)	Not Named	1995	NA	
	Academy of Medicine of Columbus and Franklin County Foundation (Dublin, OH)			
	Drs. Bruce and Lee Foundation (Florence, SC)			
	Dr. John T. MacDonald Foundation, Inc, (Coral Gales, FL)			
	The Memorial Foundation (Goodlettsville, TN)			
	Mercy Hospital Foundation (Charlotte, NC)			
	Donald W. Reynolds Foundation (Tulsa, OK)			
	Springs Foundation (Lancaster, SC)			
	St. Luke's Charitable Trust (Phoenix, AZ)			
	St. Luke's Foundation (Bellingham, WA)			
	Tri-State Health Foundation (Cincinnati, OH)			
	Paso del Norte Health Foundation (El Paso, TX)			
	Good Samaritan Health System (San Jose, CA)			
	Daughters of Charity National Health Systems (St. Louis, MO))			
Health Care Financing Organizations:				
Family Health Plan(Sacramento, CA)	Sierra Health Foundation	1984	$38.3 million	$1.7 billion (6/30/95)
	Foundation Health	1984	$78 million	$1.9 billion (6/30/95)
Greater Delaware Valley Health Care/Del Val HMO (Concordville, PA)	3 not-for-profit hospitals	1984		
Pacific Health Systems (Cypress, CA)	PacifiCare Charitable Dedication Irrevocable Trust	1984	$360,000, plus $1 million non-interest-bearing promissory note	$2.2 million (6/30/95)
FHP, Inc. (Long Beach, CA)	FHP Foundation	1985		$69.6 million (1994)
Group Health Association (Washington, D.C.)	Consumer Health Foundation			$5-$10 million (4/15/94)
Group Health Plan of Greater St. Louis (St. Louis, MO)	Group Health Foundation, sold to Coventry Corporation	1985		$4 million (10/31/92)
Inland Health Care (Loma Linda, CA)	Various charities in San Bernardino and Riverside Counties, CA.	1985		
HEALS (Herrick Alta Bates Study) Pueblo, CO)	East Bay Community Foundation, Easter Seals, General Foundation for Medicine, Planned Parenthood	1987		
Health Net (Woodland Hills, CA)	California Wellness Foundation	1992	$300 million	
	Allina Foundation (Minneapolis, MN)			
	Blue Cross of CA (Woodland Hills, CA)			
	Blue Cross/Blue Shield of Colorado (Denver, CO)			
	Blue Cross/Blue Shield Community Foundation of Maryland (Owings Mills, MD)			

See References for Source

DOES NEW JERSEY NEED TO RENEW ITS COMMITMENT TO THE HEALTH OF ITS CHILDREN?
PART 1: 0 - 10 YEARS OF AGE - SAFETY NET?

Original Issue Brief February 18, 1997

ISSUE: Over the next year, state governments will have an unprecedented opportunity to set social policy for needy children. One reason for the change is that federal officials have delegated to the states increased authority over both Medicaid and welfare. Here in New Jersey, for example, state Medicaid officials are using their increased discretion to require most child beneficiaries to enroll in managed care. At the same time, state welfare officials are requiring adults on welfare to move quickly into the job market, an effort that has a profound impact on every child on welfare.

The focus on the states is due to more, however, than the so-called "devolution revolution": it is due also to the perception that state policymakers are more likely than their federal counterparts to enact new initiatives for needy children. After all, several states have already enacted state-funded programs to provide insurance coverage to previously uninsured youngsters, and other states may well follow this model. Perhaps innovative states will accomplish what federal officials cannot.

Given this trend toward increased state authority, the debate over U.S. social welfare policy is increasingly taking place in state legislatures. This is especially so for child health and child welfare policy. In this Capitol Forum, we consider the implication of this trend. We focus on young children, those below the age of ten. How will the "new Medicaid" affect children in this age bracket? Should states expand their Medicaid programs, either to cover more children or to provide more services to youngsters already covered? Should states enact some other program to reduce the number of uninsured children? Are insurance expansions the best way to improve the health of the uninsured? What are the alternatives? How will young children fare under the new welfare? What are the limits (if any) of state reform activity? What role (if any) does the federal government need to play?

Introduction

Following the defeat of the various national health insurance proposals, in 1993/94, many liberals looked to the states as the source of health policy innovation. After all, there are a handful of states engaged in comprehensive insurance expansions. Minnesota provides state-subsidized insurance to families with incomes below 275 percent of poverty. Tennessee provides a choice of state-subsidized managed care plans to nearly 1.5 million low-income persons, one-third of whom were previously uninsured. Hawaii requires most employers to provide health insurance to their employees. Reformers hoped these models would be emulated and replicated (Sparer, 1996). This seemed plausible, particularly after Washington state and Oregon enacted employer mandates, to be phased in by the end of the century, based on the Hawaii model. Similarly, several states proposed managed care initiatives modeled on the Tennessee initiative.

Three years later, liberal reformers are less optimistic. The obstacles to state-led reform are more apparent. Many states have retreated. Washington state repealed its employer mandate. Minnesota abandoned its goal of 100 percent universal coverage. Other states repealed or inad-

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Capitol Forums on Health & Medical Care

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equately-funded public insurance expansions.

Even with these retreats, however, many universal insurance advocates still pin their hopes on the states. These advocates now focus on more incremental expansions, hoping to build slowly toward universal insurance. In nearly every state, for example, advocates will seek legislation that would provide insurance coverage for many of the nation's 10 million uninsured children (GAO, June 1996). Similarly, reform-minded legislators in nearly every state continue with efforts to make health insurance more available and affordable for the small business community (Morrisey and Jensen, 1996).

Universal insurance advocates are not the only ones, however, who look to the states for innovation. National leaders (including President Clinton and the Republican Congressional leadership) have joined with most of the nation's governors to support federal legislation that delegates to the states increased authority to run health and welfare programs. This bipartisan coalition hopes that the so-called devolution revolution will reduce federal spending. Supporters also argue that the delegation of authority will enable states to innovate and contain costs. This argument is the main draw for the governors.

The devolution coalition last year persuaded Congress to replace the nation's main cash assistance welfare program, Aid to Families with Dependent Children (AFDC), with a new program entitled Temporary Assistance for Needy Families (TANF). The change simultaneously capped federal welfare spending and delegated increased authority to the states. Under the new system, welfare is no longer an entitlement program (providing federally-protected coverage to any person who meets basic eligibility standards) but is instead a block grant (which provides states with a fixed amount of federal dollars, which delegates to the states significant discretion in spending those dollars, and which significantly reduces the federal role as protector of individual beneficiaries).

The effort to convert Medicaid into a block grant was more controversial and was defeated. Interestingly, however, while President Clinton opposed the Medicaid block grant proposal, he supported other legislation that would increase state authority over Medicaid policy. For example, the President proposed legislation that would make it easier for states to require Medicaid beneficiaries to enroll in managed care. The President also proposed expanding state authority to determine Medicaid reimbursement levels. While defeated in 1996, these proposals may well be revived in 1997. Importantly, however, even without new federal legislation, federal regulators are already expanding state authority over Medicaid, approving numerous state requests for waivers and exemptions.

The Medicaid Program: An Overview

Enacted in 1965, Medicaid is a publicly-funded health insurance program for the poor. In 1995, the program covered approximately 35 million persons, at a cost of just under $160 billion (Holahan and Liska, 1996). The cost is divided between the states and the federal government: the federal government pays between 50 and 80 percent, the poorer the state, the higher the federal contribution (here in New Jersey, the state and the federal government each pay 50 percent). The different levels of government also divide responsibility for setting Medicaid policy. The inter-governmental balance-of-power has shifted over time.

The First Medicaid Era (1965-1983): State Discretion and Interstate Variation

Between 1965 and the early 1980s, states had enormous discretion to set eligibility policy, benefit coverage policy, and reimbursement policy. For example, while federal law required states to cover all persons receiving AFDC, states largely determined which persons received AFDC. Similarly, while federal law required states to provide beneficiaries with a basic benefit package, states could choose between two dozen other optional benefits. States also had significant discretion in setting provider reimbursement (especially for nursing homes and office-based providers).

States exercised their policy discretion in very different ways. No two states have identical programs. Even states that seem similarly situated have developed dissimilar programs. Income eligibility levels in Vermont are far higher than in Maine. New Jersey pays hospitals more generously than does Pennsylvania. Every state offers a different benefit package. California's program spends approximately $2,801 per beneficiary; New York spends almost three times as much ($7,286), while New Jersey spends $5930 (GAO, 1995).

The Second Medicaid Era, 1984-1992: Federal Mandates and Rising Costs

Beginning in the mid-1980s, federal policymakers imposed numerous Medicaid mandates, thereby shifting significantly the intergovernmental balance-of-power. The new mandates focused on two areas: first, increased eligibility for pregnant women and children, and second, increased reimbursement for the medical safety net. These mandates contributed to a sharp rise in Medicaid expenditures. The level of intergovernmental tension increased sharply as well.

A Focus on Kids

While a program for the poor, Medicaid has never covered all of the poor. For example, a family of three

with monthly income below $1,082 is considered to be living in poverty. Here in New Jersey, however, a mother of two with income above $567 earns too much to receive a Medicaid card. The story in other states is similar. Indeed, by the late 1980s, Medicaid covered less than 50 percent of the nation's poor.

During the early 1980s, several southern governors (including then-Governor Bill Clinton) began campaigns to encourage pregnant women to obtain prenatal care and to thereby reduce the number of low birth-weight babies. One obstacle was a federal law which prohibited states from significantly increasing their Medicaid eligibility levels unless they also raised cash assistance welfare levels. The governors, along with a coalition of child health advocates and provider organizations, persuaded Congress to change this rule and to allow states to provide Medicaid to pregnant women and infants well above the poverty level. As a result, states today can cover pregnant women and infants in families with income up to 185 percent of the federal poverty level. New Jersey has adopted this option: pregnant women in a three person family can have up to $2002 in monthly income and still qualify for Medicaid.

During the late 1980s, Congress converted some of the eligibility options into eligibility mandates. In 1989, for example, Congress declared that states must cover children below the age of six in families with income below 133 percent of the federal poverty level. The next year, older children in families with income below 100 percent of the federal poverty level were also given Medicaid eligibility, though this mandate will not be fully implemented until the year 2002. As a result of these mandates, the number of children on Medicaid nearly doubled between 1989 and 1994, growing from 8.9 million to 16.1 million. At the same time, Congress also required the states to provide child beneficiaries with all needed medical services, even if such services are not available to adults.

More Money for the Medical Safety Net

During the 1980s, Congress required the states to increase the Medicaid reimbursement paid to many safety net providers. Three examples illustrate the point. First, Congress required that Medicaid provide supplemental payments to hospitals that serve a disproportionate number of low-income patients. By 1992, safety net hospitals were receiving over $17 billion annually from the so-called disproportionate share program. Hospitals in New Jersey receive approximately $900 million of these supplemental funds.

Second, Congress also required that Medicaid reimburse federally-funded community health centers for 100 percent of their actual costs. Previously, states had had nearly complete discretion in determining health center reimbursement. The result was another dramatic increase in Medicaid spending. Finally, Congress also required Medicaid to increase the payment paid to most obstetricians and pediatricians. The goal was to encourage greater participation from a sector that had previously underserved the Medicaid population.

The federal courts also contributed to the rising Medicaid bill. In 1990, the Supreme Court held that federal courts could evaluate the reasonableness and adequacy of hospital and nursing home payment rates. By 1991, more than two dozen states were defending their rates in court. Medicaid directors sometimes raised rates to settle cases. Other times rates were increased by the courts.

The new federal mandates, along with the growing judicial scrutiny, enabled hospitals, community health centers and other safety net providers to cope (more or less) with the rising number of uninsured. This pattern continues today: Medicaid revenue subsidizes much of the care rendered to the uninsured.

The new mandates also contributed to a rise in program costs. Between 1988 and 1993, annual Medicaid costs rose from $54.1 billion to $131 billion. Here in New Jersey, Medicaid costs grew 19.65 percent in 1990, 18.57 percent in 1991, and 44.26 percent in 1992. State officials in New Jersey and elsewhere blamed the trend on the federal mandates. Federal regulators denied the charge, noting, for example, that the newly-eligible pregnant women and children accounted for only 9.3 percent of the actual spending growth (Holahan, 1993).

Federal officials also pointed to illusory financing schemes developed by states to generate billions in additional federal dollars. One state strategy was to convert programs previously funded exclusively with state dollars into Medicaid services with significant federal participation. A second strategy is illustrated by the following hypothetical. Assume that Medicaid in New Jersey pays hospitals $100 for each emergency room service. The federal government and the state would each pay $50. Assume further that the state increases reimbursement to $110, but receives a $5 donation from the hospital. The hospital would end up with a $5 increase ($100 to $105) funded entirely with federal dollars.

The Third Medicaid Era, 1993-present: State Authority and Managed Care

By the mid-1990s, Medicaid had entered a third era. The effort now is to return policymaking authority to the states. Congress is wary of new Medicaid mandates. Federal regulators are inclined to approve state requests

for waivers. Courts are deferential to Medicaid bureaucrats. There is even a bipartisan coalition that favors repealing many of the mandates now in place.

At the same time, states increasingly are using their expanded authority to encourage or require Medicaid beneficiaries to enroll in managed care. Between 1983 and 1995 Medicaid managed care enrollment grew from 750,000 (3 percent of all enrollees) to 11.6 million (36 percent). The policy assumption is that managed care simultaneously will encourage lower costs and better care. Indeed, the managed care poster child is the youngster whose sore throat was previously treated, if at all, in the emergency room of the local safety net hospital. In a managed care environment, that child would (or should) have access to a primary care provider, and should receive better care, more appropriate care, and less expensive care.

Not surprisingly, there is significant interstate variation in the Medicaid managed care initiatives (Sparer, 1997). In some states managed care enrollment is mandatory, in others it is optional. Some states include nearly all Medicaid-covered services in the managed care benefit package, others keep certain services (like mental health coverage) in the fee-for-service system. Some states use an enrollment contractor to conduct marketing and enrollment, others rely on county welfare workers, and still others permit direct enrollment by managed care plans. Some states set statewide capitation rates, others rely on competitive bidding. Some states micro-manage the performance of managed care plans, others have a more laissez-faire approach. Some states have policies designed to protect the medical safety net during the transition to managed care, others rely more on the market itself.

Here in New Jersey, the transition to managed care is proceeding incrementally. In 1995, the state received permission to require those beneficiaries also on AFDC to enroll in managed care. The strategy is to begin with this population, comprised primarily of women and children, and then to add the Medicaid-eligible aged and disabled at a later date. Moreover, the state phased in mandatory managed care on a county-by-county basis: enrollment did not begin until there was an adequate managed care infrastructure in place. As of early 1997, mandatory managed care is in place in all but six counties, and approximately 410,000 of the states 440,000 AFDC-related beneficiaries have enrolled.

The transition to managed care, in New Jersey and around the nation, is one reason that Medicaid spending growth has declined from 22.5 percent in 1992 to 3 percent in 1996 (Holahan and Liska, 1996). Interestingly, however, Medicaid costs for populations generally not covered by managed care (such as the aged and disabled) are declining at a faster rate than are costs for managed care enrollees (Holahan and Liska, 1996). This suggests other factors are also at work. First is federal legislation which limited the use of provider tax and provider donation programs. Second is a decline in enrollment growth. Third is the declining rate of health care inflation.

Medicaid: The Impact of Welfare Reform

The recent changes to the U.S. welfare system are best understood if placed in historical context. That context begins with the ongoing influence of the English Poor Law tradition, under which local governments (not the states or the federal government) are responsible for providing assistance to the so-called "deserving poor" (those outside of the job market through no fault of their own). Under this tradition, local governments have historically provided aid to children, and to the aged, blind and disabled.

In response to the economic depression of the 1930s, however, the national government established a national social welfare system. There are two components to this New Deal welfare system. First are the so-called social insurance programs, such as Social Security. These programs are quite popular, in large part because of the perception that benefits are "earned" by virtue of contributions made (even though most beneficiaries receive back far more than they put in). These programs are administered by the federal government in a relatively uniform manner around the country. The states neither contribute to the cost of such programs nor play any other significant role.

The second component to the New Deal welfare system are the so-called welfare programs, such as the recently abolished Aid to Families With Dependent Children (AFDC). AFDC provided cash assistance to the "deserving poor". The program was financed jointly by the federal and state governments, and was administered by state bureaucrats. State officials also had significant policy discretion. There thus was significant interstate variation in program coverage. In 1992, for example, a three-person family living in California with monthly income below $694 could receive AFDC; that same family living in New Jersey needed income below $424 to qualify; that same family living in Alabama needed income below $149 (Sparer, 1996). Nonetheless, state discretion was not limitless. For example, federal law controlled the process states had to follow before cutting someone off the roles. Federal law also provided beneficiaries with various other rights and protections.

During the early 1990s, several states sought more authority to set welfare policy. The goal was to use welfare to induce certain forms of behavior. In order to

implement these initiatives, however, the states needed waivers from various federal requirements. Federal officials were happy to comply. Between 1992 and 1995, 31 states received welfare waivers: 24 states imposed work requirements; 23 implemented time limits on the receipt of welfare; and 13 instituted family caps (GAO, July 1996). Wisconsin's waiver permits it to reduce payments to parents when kids miss school. Ohio provides a bonus to families if the kids attend school, and makes a deduction if they don't. New Jersey refuses to supply cash benefits to children born more than ten months after their family first receives AFDC.

Even with the increasing number of waivers, AFDC remained a federal entitlement program: if you met the basic program requirements, federal law protected your right to receive coverage. This programmatic underpinning is what Congress changed in 1996. The individual entitlement is eliminated. Moreover, the role of federal law has changed. Instead of protecting individual rights, federal law now imposes limits on the use of federal funds. For example, new immigrants are prohibited from receiving coverage for five years after arrival. Beneficiaries are also generally prohibited from receiving benefits for more than five years.

The 1996 welfare reforms also made changes in various other federal welfare programs. Food stamp funding between 1997 and 2002 is cut by $23 billion. The Social Services Block Grant is cut from $2.8 billion to $2.35 billion. The Supplemental Security Income program (SSI) has in place a more restrictive definition for determining if a child is disabled, and thus entitled to benefits.

Despite these cutbacks, the overall impact of welfare reform on child health is far from clear. For example, it was initially estimated that the various changes could force as many as one million additional youngsters into poverty. This estimate may turn out to be too high. One reason is that the dollar amount of the welfare block grant is determined by welfare enrollment as of 1994. Since enrollment in most states is lower today than it was in 1994, the states will receive more federal money under the block grant initiative than they would have received under AFDC. Here in New Jersey, welfare officials hope to use the supplemental federal funds to expand job support programs and child care initiatives. These expansions, part of the state's new WorkFirst welfare program, could well ease the impact of cuts in other programs.[1]

Importantly, however, the welfare windfall will end when the next recession forces a rise in the number of enrollees. At that point, the number of children in poverty could well rise significantly, though the amount of such rise will be influenced by how successful states are in finding jobs for welfare recipients.

The impact of welfare reform on Medicaid is also unclear. For example, individuals who were eligible for AFDC as of July 1996 are still eligible for Medicaid, even if they are ineligible for the state's new welfare program. It is unclear, however, what percentage of this population actually will remain on Medicaid. It is also unclear whether these beneficiaries will enroll while they are healthy (and hopefully receive good primary care) or if they will enroll only when sick (perhaps with the application filed by a hospital administrator).

The Medicaid status of legal immigrants is also unclear. States have the option of covering legal immigrants who were in the country prior to the enactment of reform. New Jersey has adopted this option. At the same time, however, newly arriving immigrants are barred from receiving coverage for five years (though providers can be reimbursed for emergency services provided to such immigrants).

Should New Jersey Adopt A New Child Health Initiative?

There is growing support for an effort to provide health insurance to some or all of the nation's ten million uninsured children. There are several reasons for the support. First, children, especially young children, are considered a deserving group. Second, child health care is relatively inexpensive. Third, focusing on kids is an incremental approach. Finally, the ongoing erosion of the private insurance market has led to a growing number of uninsured children. For all of these reasons, a number of states have enacted child insurance expansions. New York subsidies the cost of insurance for youngsters in families with income below 222 percent of poverty. Minnesota has a similar program for children in families with income below 275 percent of poverty. In July 1996, Massachusetts lawmakers repealed an employer mandate enacted in 1988, which was never implemented. At the same time, they introduced a law aimed at expanding coverage to reach low-income children who are currently not covered by Medicaid. The new law expands eligibility for the Children's Medical Security Plan (CMSP) (the state-funded children's health insurance program) and expands Medicaid eligibility through its Section 1115 waiver. The

[1] New Jersey's State Welfare reform plan was submitted to the Federal Government to comply with the "Personal Responsibility and Work Opportunities Reconciliation Act of 1996" and its Temporary Assistance for Needy Families program. Known as Work First New Jersey, the plan overhauls New Jersey's welfare system and makes changes that include a five year lifetime limit clock on assistance benefits and establishing unified work program and career centers to facilitate helping former AFDC recipients to find employment.

CMSP is now extending its age limit to children up to age 18. The new measures are to be funded by a 25 cent per pack increase in the cigarette tax and other tobacco products. It is estimated that currently 130,000 to 160,000 children lack health insurance in Massachusetts. Here in New Jersey, state officials hope soon to implement the Children First initiative, which would subsidize kids in families up to 250 percent of poverty.[2]

At the same time, however, there are significant obstacles to the enactment of new child insurance initiatives. The first problem is cost: in addition to the cost of insurance for the uninsured, there is also the so-called "crowding out" effect, under which children now with private insurance could be dumped into the new public program. Several states deal with the cost problem by enacting new taxes, typically tobacco or other so-called sin taxes. California, Massachusetts, and Minnesota have all followed this model. It is quite difficult, however, to enact any new taxes in the current anti-tax environment. The second obstacle is political: the nation's anti-government sentiment reduces the likelihood of a major new governmental program. Finally, the diversity of insurance expansion options make it difficult for reformers to coalesce around any particular approach. The lack of consensus makes it difficult to build a coalition for particular legislation.

In weighing the alternatives, legislators must also consider one other factor: the Medicaid expansions already in place undermine the need for a new initiative. For example, only 7 percent of poor children below the age of five are uninsured (Davis, 1996), and nearly all of these youngsters are eligible for Medicaid though not enrolled in the program. Similarly, while 26 percent of poor children between the ages of 13 and 18 are uninsured (Davis, 1996), this group will become Medicaid eligible between 1997 and 2002. This data suggests that child health advocates may want to focus on initiatives other than expanded insurance (such as expanding benefits or subsidizing providers).

The limits of health insurance are illustrated also by studies of the impact of the recent Medicaid expansions. The evidence suggests, for example, that increased Medicaid eligibility for pregnant women does not automatically produce an equivalent increase in the use of prenatal care (Piper, 1994; Haas, 1993). One explanation is that persons eligible for public insurance sometimes do not enroll. For example, nearly 30 percent of the nation's uninsured children are eligible for Medicaid but are not enrolled (GAO, June 1996).

A second explanation is that some beneficiaries, especially those that suffer from mental illness or substance abuse, do not seek needed care. Finally, the geographic maldistribution of providers makes it difficult for many of the poor to receive care. There are simply too few primary care providers in many low-income communities.

The limits of health insurance suggest other policy approaches, some of which New Jersey policymakers are already pursuing. Other alternatives are programs like HealthStart, which provide an expanded benefit package to Medicaid-eligible pregnant women and infants. The program provides nutritional counseling, health education, outreach and follow-up, and other similar services. The program now serves approximately 85,000 beneficiaries: with increased funding, the effort could be expanded.

A second alternative is to provide additional funding to safety net providers that care for the poor and the uninsured. For example, state officials have proposed that hospitals develop managed care networks to serve the poor and uninsured. These networks would receive the funds now spent under a state program that reimburses hospitals for bad debt and charity care. The state could decide, however, to increase the level of such funding from the $310 million now in place. The state also could add to the initiative an effort to expand the supply of health care providers in low-income communities.

A third alternative is to focus greater efforts on outreach and enrollment. One model is the Florida Healthy Kids program, now in place in 16 of the Florida's 67 counties. This program provides state-funded health insurance to children in families with income below 185 percent of poverty. More importantly, however, the program uses the schools to enroll uninsured youngsters, thereby capturing a far larger percentage of the uninsured population than state-funded programs in other states.

In the end, the policy debate is over how best to improve the health of New Jersey's children. There is no simple answer to this question. It is this question, however, which will inform the Capitol Forum to be held on February 18, 1997.

[2]Given reduced funding levels for Health Access New Jersey, the Department of Health has shifted the focus of the program and its subsidy monies to the purchase of health insurance for children (rather than both children and adults as was originally intended with Health Access). The new initiative, known as Children First, will provide access to affordable health care for qualified uninsured children. According to the Department, there are approximately 200,000 uninsured children in New Jersey and more than 80 percent of those children live in families where at least one parent is employed. In the restructuring of Health Access there will be two programs: The Access Program and Children First. The Access program will exist for current enrollees, but applications for new enrollment that were received on and after December 31, 1995 will not be processed. [Reference is made to "Summary" -- Health Access New Jersey -- at 28 N.J.R. 4202 (September 16 1996)].

QUESTIONS FOR DISCUSSION

1. Should the state either expand Medicaid, or develop some other program, in an effort to provide health insurance to the state's uninsured children? Are insurance expansions the best way to improve the health needs of the uninsured?

2. Should the state provide more services to youngsters already covered by Medicaid? For example, should the state expand the HealthStart program?

3. Is the movement to Medicaid managed care improving the health of low-income youngsters?

4. When should the state include disabled youngsters in the managed care initiative?

5. What is the connection, if any, between the survival of the medical safety net and the health care received by young children? Would child health needs be best served by a vigorous effort to help safety net providers survive in the emerging health care marketplace?

6. How will welfare reform impact on the health of New Jersey's children?

7. Do the health needs of young children and their older counterparts require separate strategies? If so, what are the relevant differences?

DOES NEW JERSEY NEED TO RENEW ITS COMMITMENT TO THE HEALTH OF OUR CHILDREN AND ADOLESCENTS? PART II - 10 TO 18 YEARS OF AGE - SAFETY NET?

Original Issue Brief March 26, 1997

ISSUE: Is there need to renew our commitment to the health care safety net for all — particularly children and adolescents — or are the changes that are taking place as a result of market forces sufficient to provide health care to New Jersey's citizens? Should the recommitment (if any) come in the form of a subsidized insurance program for kids or as a tax dollar initiative to "beef up" the service delivery capacity of community-based agencies? Or, should there be a coordinated combination of both subsidies and increased funding?

Health care for adolescents is the focus of this second part of the Capitol Forums series on health care issues for children and adolescents in New Jersey. There is growing support for an effort to provide health insurance to some or all of the nation's ten million uninsured children. It is estimated that over three million of these children are eligible for, but are not receiving Medicaid, and seven million are from families in which one or both parents work. With the changes to Supplemental Security Insurance (SSI) through welfare reform, children taken off the SSI rolls will also lose their Medicaid eligibility. Many of these children, who are at high-risk for physical and emotional disorders, comprise some of the most vulnerable members of our society and depend upon "safety net" providers for their health care. Who should take the leadership to ensure that the safety net — threatened by funding cutbacks, reduced support from the Federal government and a disadvantaged position in competitive health care marketplace — remains intact?

INTRODUCTION

The subject of adolescent health care is one which is broad in scope and complex in nature. Historically, there is no "system," per se, of health care for adolescents. Health care to adolescents is delivered through a network of various categorical programs — some community-based, some school-based; some preventive care, some primary medical care; some education-oriented, others designed for outreach; some focused on a "single-issue," such as teen violence, others on a cluster of mental health issues (depression; eating disorders) — which form a type of patchwork. The lack of coordination and service integration among these programs raises access issues for adolescents, whose health needs are varied and cut across health, mental health, health education and social welfare issues.

This issue brief will continue our analysis of access to health care to our children and youth by focusing on adolescents. It will identify the factors which make adolescent health care needs "different" from those of younger children and adults and discuss barriers to care and strategies to improve access to care for New Jersey's almost 1.9 million (1995) children and adolescents under the age of 18.

OVERVIEW: NATIONAL PROPOSALS AND STATE RESPONSES

In a recent report released by the New York City Public Advocate, it was found that the number of children and adolescents without health insurance has increased twice as fast as the number of adults (*The New York Times*, February 25, 1997). Public Advocate Mark Green

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Capitol Forums on Health & Medical Care

League of Women Voters of New Jersey Education Fund

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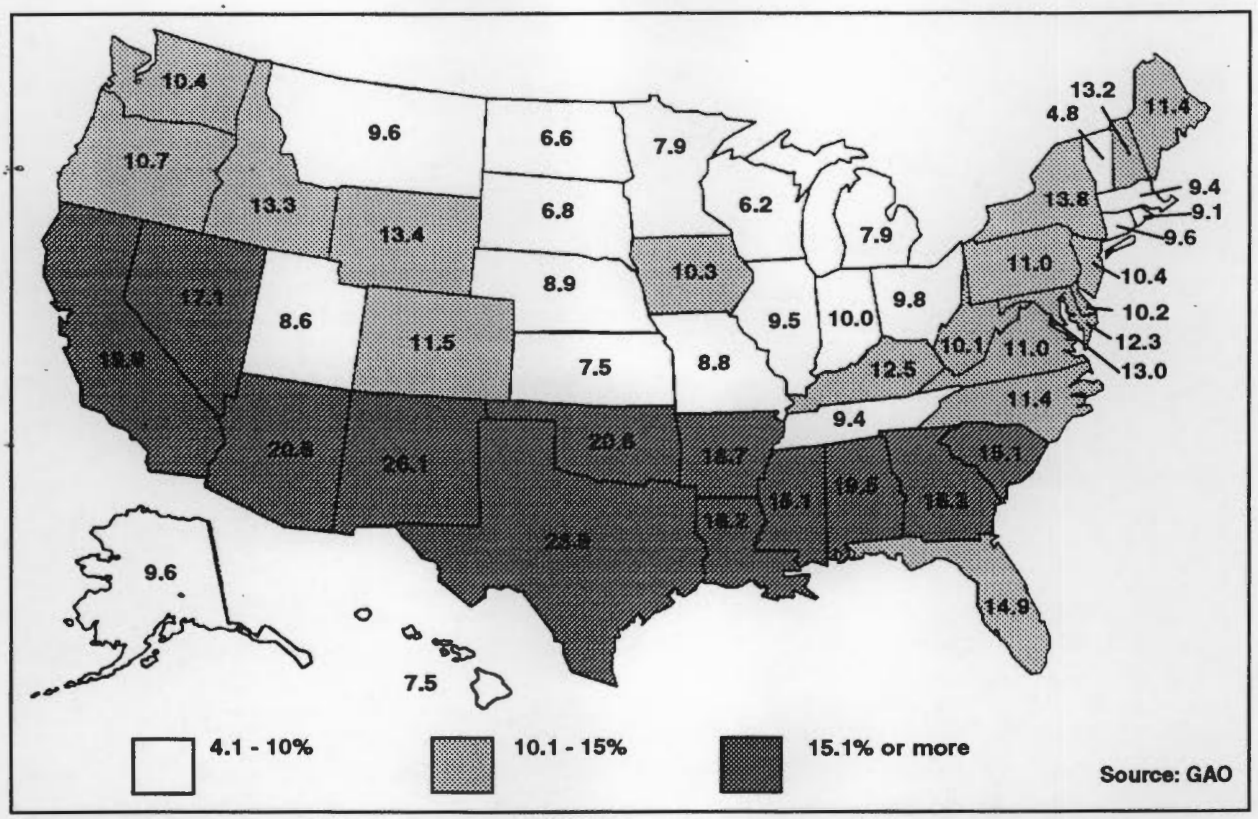
observed: "This is a crisis that is growing exponentially. But unlike kids being shot on the streets, the rising uninsured rates among kids and working families is a quiet crisis that is too easy to overlook."

The issue of providing adequate health care for our children and adolescents is being addressed across the country. National proposals range from Senators Kennedy and Kerry's proposal to establish a subsidy program to help working families purchase private health insurance for their children to the far-reaching goal of Representative Stark's proposal to mandate all group health plans and insurers to make coverage available for dependents and other individuals under the age of 21. A group led by Senator Thomas Daschle and Representative Richard Gephardt is sponsoring "Families First," a broad proposal

PERCENTAGE OF UNINSURED CHILDREN, BY STATE, 1994



The chances of being uninsured are about 40 percent higher for a person under the age of 18 than for an adult. Nationally, research indicates that children were less likely to be covered by insurance as they got older. Table 2 shows that in 1993, rates of non-coverage increased from 12 percent for children under age 6, to 17 percent for children between the ages of 12-17.

Table 2: PERCENT OF CHILDREN NOT COVERED BY HEALTH INSURANCE

	1987	1988	1989	1990	1991	1992	1993	1994
All Children	13	13	13	13	13	12	14	14
Age 0-5	-	-	13	-	-	-	12	-
Age 6-11	-	-	13	-	-	-	13	-
Age 12-17	-	-	14	-	-	-	17	-
Race/Ethnicity								
White	-	-	13	-	-	-	13	13
Black	-	-	17	-	-	-	16	17
Hispanic	-	-	30	-	-	-	26	28
Family Structure								
Two Parent	-	-	11	-	-	-	12	-
Single Female Headed	-	-	16	-	-	-	14	-
Single Male Headed	-	-	24	-	-	-	22	-

Source: Data for 1989 and 1993 produced by Child Trends, Inc., based on data from the March 1990 and current Population Surveys. Data for 1994 produced by Child Tends, Inc., based on unpublished tables supplied by the U.S. Bureau of the Census. Data for other years provided by U.S. Bureau of the Census based on analyses of March Current Population Surveys for 1988, 1989, 1991, 1992, and 1993.

aimed at families and children that also includes "kids-only" health insurance to create access for all children and youth to affordable health insurance. Currently, the Republican side has not offered any alternative plans (*George Washington University Newsletter*, January 1997).

On the federal level, the insurance model — offering subsidies to families to purchase health insurance — is the more favored model than the model to increase expansion or eligibility in already-established programs, such as Medicaid. Retiring Senator Sam Gibbons of Florida, however, has introduced such a bill, which would create a Children's Health Insurance Trust Fund that would be patterned after the Medicare Insurance Trust Fund.

In many ways, these Federal plans resemble the types of plans states have been experimenting with and developing over the past several years, partly because of the absence of direction offered by the Federal side.

The February 1997 Capitol Forums Issue Brief on children's health care discussed how as a matter of the "Devolution Revolution," it has fallen to the states to develop plans to meet the health care needs of their growing numbers of children and adolescents who experience multiple barriers to affordable and appropriate health care. By 1995, some 14 states had already established state-funded children's health insurance programs to subsidize the purchase of private insurance policies that generally offer more limited benefits than Medicaid (Ibid). In 24 states, it is the strategy to encourage public-private partnerships, with private sector organizations offering children-only insurance policies to some 250,000 children across the country (Ibid).

In analyzing the trend in several states to address the problem by enacting child insurance expansions, the February 1997 Issue Brief presented different models, including insurance subsidy models (such as Children First in New Jersey); the provision of additional funding to safety net providers that care for the poor and uninsured; or expanding programs by extending eligibility limits such as Medicaid expansion models or like HealthStart in New Jersey, which provides an expanded benefits package to Medicaid-eligible pregnant women and infants. Florida's Healthy Kids program provides another model which approaches the problems of access to health care by making greater efforts on outreach and enrollment — the program uses schools to enroll uninsured children. Each of these models affects the health care of our "older" children, aged 10 to 18, in different ways.

The state of New York has implemented an expansion of its Child Health Plus (CHPP) to cover children up to age 19. The CHPP expansion, which is expected to cover a total of 251,000 children (somewhat less than half of the state's uninsured children and youth), will be financed by a new 18.8 percent private payer surcharge (*George Washington University Newsletter*, January 1997). Although in-patient benefits will be added to this program which already provides out-patient benefits, the CHPP excludes mental health, substance abuse and alcohol treatment services.

In the state of Wisconsin, Governor Tommy Thompson proposed his Wisconsin Works program as part of the state's efforts towards implementing welfare reform. In working with the Hudson Institute, a nonprofit public policy think tank in Indiana, Thompson and a team of welfare reform staff built in child and health care subsidies to families earning up to 165 percent of the federal poverty level into the Wisconsin Works program. The subsidies will no longer be connected to public assistance but will be treated as "employment-supporting" programs for low-income working parents. The program's child and health care subsidies do not have time limits attached to them (*Public Welfare*, Spring 1996).

ADOLESCENT HEALTH ISSUES

In the February 1997 Issue Brief on children's health care, Professor Sparer noted that one of the reasons that there is growing support for providing health insurance to our nation's children is that "children, especially young children, are a deserving group". This statement is particularly significant when adolescent health and health care is added to the equation. Culturally, adolescents are not viewed, for the most part, as a "deserving" group; their transition to adulthood is often rife with "behavior" problems which are categorized as "rebellious, non-compliant and attention-seeking." Meeting their health and mental health care needs poses a set of complex problems.

The Children's Medical Security Plan (CMSP) in Massachusetts — the state-funded children's health insurance program — expanded in 1996 to include children up to age 18. While costs for Fiscal Year 1997 were projected at $40.96 per child per month, the program's health benefit coordinator acknowledged that "the expansion will drive up costs because adolescents have different health care needs" (Id).

The health care needs of adolescents **do** differ from those of children and adults. Many adolescents engage in risky behaviors that may have "harmful, even fatal, consequences for themselves and others" (Harvey and Rauch, 1996). The major causes of adolescent mortality (injury, homicide and suicide) have a behavioral basis, which require preventive health services. Currently, adolescent health care is crisis-oriented; yet, research continues to

find that in order to be effective, programs for adolescents must provide comprehensive coordinated care, available at a single site, which focuses on health promotion, illness and injury prevention and education about good health habits. In general, adolescents do not seek out health care services; consequently, provision of preventive and educational services must be through consistent outreach and coordinated information and referral services.

While the commonly held belief is that adolescence is a time of good health, the U.S. Office of Technology Assessment estimates that one in five adolescents suffers from at least one serious health problem (1995). In an analysis of adolescent health care, Dr. Gail Slap at the University of Pennsylvania summarized that adolescents are at particularly high risk for unintentional pregnancy, sexually transmitted diseases (STDs), injury, violence, suicidal behavior and substance abuse (1995). In the age group ranging from 15-24 years of age, injury causes 4 million person-years of lost work - the single-most costly American health problem. Similarly, injury and violence cause 76 percent of deaths and account for a significant share of chronic illness and disability in adolescents (Ibid).

The Child Welfare League of America, using data looking at indicators of health, sketched a portrait of a high school graduating class of 40 students in the year 2000 : thirty-six would have used alcohol, eight tried cocaine, seventeen marijuana, eleven would be unemployed, fifteen living in poverty, six would have run away from home, eight would not even have graduated, but dropped out, two would have given birth and one would have committed suicide (Hein, 1993).

According to the Department of Health and Senior Services' 1996 *Healthy New Jersey 2000 Update*, the leading problems influencing the health and well-being of adolescents in New Jersey are: unintentional injury, sexual and physical abuse, violence, homicide, suicide, unintended pregnancy, sexually transmitted diseases and addiction (alcohol, tobacco, marijuana and cocaine). Adolescent pregnancy is a primary public health issue that affects the health, educational, social and economic future of both mother and child.

Adolescent Pregnancy - A Complex Problem with No Easy Answers

Adolescent pregnancy rates are 3 to 10 times higher in the United States than those documented among industrialized nations of Western Europe. This health problem among our young girls is associated with a high number of individual and societal costs. However, recent studies have shown that the root causes for adolescent pregnancy cut across many issues, and the reduction of adolescent pregnancy cannot be limited to family planning education. The foremost factor affecting adolescent pregnancy is poverty: forty percent of American teenage girls live near or below poverty income levels, and these individuals account for 6 of 7 births to teenage mothers (Journal of the American Medical Association, July 24/31, 1996). At the same time, access to contraceptives remains limited. Only 15 percent of health insurance plans cover the most effective contraceptive methods and two-thirds do not cover birth control pills (Ibid). Another disturbing statistic that emerges when the issue of adolescent pregnancy is scrutinized is the role played by adult males in childbearing by adolescents. In a 1995 study, it was found that of 46,511 marital and unwed births to school-aged girls in California, 71 percent were fathered by men whose mean age was almost 23 years of age (almost five years older than the mother). These and other statistics are sobering and underscore the challenge and complexity of remedying just one of countless adolescent health problems. Cooperative strategies must be developed with families, communities, health care providers, policy makers and politicians to target the root causes of the social problem to reach a viable solution. An example of a successful coordinated program is the adolescent services program at New Jersey's Pinelands Regional High School. The state is currently exploring replicating the program in other schools based on the decline in adolescent pregnancy rates at the school. The Pinelands program documented a decline in adolescent pregnancy from 20 per year prior to the program to 2 per year post-program (Healthy New Jersey 2000 Update, 1996).

The *Healthy New Jersey 2000 Update* identifies as a significant barrier to its goal of improving the health of New Jersey's adolescents the fact that many adolescents do not have health insurance and do not have access to appropriate and regular sources of primary health care. New Jersey mirrors the national problem that economically disadvantaged urban minority and rural adolescents are at highest risk for hurting themselves and others by engaging in risk-taking behaviors (*Healthy New Jersey 2000 Update* 1996; Harvey and Rauch, 1996; Durlak 1995). Poverty is directly related to the growing rates of teen pregnancy, sexually transmitted diseases, addiction, violence-related injuries and deaths, and contact with the criminal justice system (Ibid).

DELIVERY SYSTEM AND ACCESS ISSUES FOR ADOLESCENTS

The provision of adolescent health care is fragmented and not well-coordinated: state programs are administered across several Departments — including Health, Human Services, Education; and community-based services are offered through various private and public provider orga-

nizations (Reference is made to Appendix II, "Overview of New Jersey's Health and Medical Programs for Children and Adolescents"). The primary reasons for this fragmentation include that historically, there were financial disincentives to provide preventive care; categorical funding sources created "single problem" programs, such as alcohol abuse or teen pregnancy, rather than integrated services, leaving already resource-drained safety net providers competing for reduced dollars; adolescent discomfort and mistrust with the health care system and provider inexperience with working with adolescents.

Although research study after study indicates that a comprehensive, integrated approach has the best chance of helping youth avoid negative behaviors and outcomes, administrative and fiscal barriers act as blocks to such coordinated programs. When is the "right time" to consider re-structuring the service delivery system to allow for access to appropriate services for this vulnerable population? In the current environment in which funding reductions are threatening the existence of our community providers, many of whom are providers of last resort, should change be considered at the delivery system level, rather than at the insurance subsidy level? Just as in New Jersey, state government leaders recognized the detrimental effects a fragmented delivery system was having on the senior population and has now "put under one roof" programs for its elderly, is the same restructuring necessary for programs for children and adolescents, which currently cut across the Departments of Health; Human Services (including Divisions of Mental Health and Hospitals; Youth and Family Services; Medicaid; Family Development; Developmental Disabilities); Education, Labor, Insurance and various components of the juvenile justice system?

Research on adolescents indicates that early intervention is critical in working with at-risk adolescents. Early adolescence — that is, between the ages of 10 and 15 — is a formative time in the development of positive behaviors and activities. There appear to be three critical risk antecedents for early adolescents: poverty, neighborhood environment and family environment. Two risk markers — or warning signals for more significant problem behaviors in adolescence — are poor school performance and involvement with child protective services and foster care systems (Resnick and Matheson, 1992). Problem behaviors in this population include: early practice of sexual behavior; truancy from school; running away from home; early use of tobacco, alcohol and other drugs. Risk outcomes which may extend from these behaviors are teen pregnancy and teen parenthood; school dropout; criminal behavior; AIDS and other sexually transmitted diseases (STDs); physical and sexual abuse and various morbidity and mortality conditions, such as accidents, suicide and homicide. It is estimated that as many as half of today's adolescents run a moderate to high risk of experiencing school failures or participating in early sexual activity, alcohol and drug use and criminal behaviors (Id).

Traditional services for at-risk adolescents often address only a single risk marker or outcome, such as teen pregnancy, substance abuse or school failure (Id.) The single-problem focus has limitations: the programs focus only on the problem, rather than the "whole person"; it is difficult to coordinate with other agencies when the single-problem program does not have the resources to address the other problems being experienced by the client; the adolescent client gets "lost" in the system, which s/he is not skilled at negotiating in the first place and also may be resistant to cooperating with.

A service integration model is one in which several service agencies coordinate their efforts to address the full range of service needs presented by youth and families in an efficient manner. The model would include case intake and evaluation, a coordinated service plan based on the needs identified; institutionalized interagency linkages that ensure referrals and follow-up on service referrals. Barriers to service integration for adolescents are significant. They include professional orientation, administrative procedures, eligibility rules and the categorical nature of funding. Service agency staff are trained in narrow, specialized traditions (such as mental health or criminal justice services) and do not move easily into interagency coordination. Categorical public and private funding also drives single-issue programs, as legislatures and policy makers structure programs to address specific problem areas (Id.)

In an Urban Institute study focused on service integration program models, nine programs across the country were evaluated. They included one mentoring program (using positive adult role models in working with at-risk youth); one focused on a geographically defined community; one operating exclusively in the schools; three operating in the schools and community and three that were community-based. Although study findings showed that service integration models best served the adolescent population, whether they were school-based or community-based, or a combination of both, all of the programs continue to struggle for their existence and with the problems of categorical funding and with the fact that several agencies were competing for the same dollars to develop similar programs.

SCHOOL-BASED PROGRAMS — INSURANCE AND SERVICES

The model of Florida's Healthy Kids program enhances access to insurance for this vulnerable popula-

tion by offering School Enrollment Based Health Insurance. The goals of the program are to create a comprehensive insurance product for school children and to facilitate the provision of preventive care for children. Coverage is offered to families with children enrolled in schools, since research indicates that about two-thirds of the uninsured are in households with children of school age. The model is based on the traditional employer-based insurance model, where the employer is the policy holder and the employee as certificate holder can cover spouse and children; with school enrollment based health insurance, the school district is the policy holder, the student is the certificate holder and parents and siblings are covered under his/her insurance plan. A sliding scale is used to identify the family's contribution towards premium payments. Currently, families are contributing 37 percent of the medical costs for the program. Co-pays are also required for some services, such as prescriptions and glasses. The balance of funding comes from local funding sources (18 percent) and state appropriations (45 percent). While the current enrollment is at approximately 20,000 children in nine counties, 1997 plans include expansion into seven new counties and 47,520 children (Healthy Kids - Florida. Annual Report. 1996). One expansion also being considered is to include over 100,000 preschool children throughout the state.

The role of the schools is critical in this model. They serve as the central institution within communities, creating relationships between the local project, community leaders and area business groups. The school-based health center (SBHC) model, which is in place throughout the country, offers a multi-disciplinary team to provide a full array of health services, including primary and acute care, psychological services and treatment for substance abuse. Located on-site in the schools themselves, SBHCs aim to increase access to health care services for students, which is a critical issue for adolescent health care. For example, in 1990, the American Medical Association found that at least 7.5 million youths under age 18 needed mental health services, but fewer than one-third will receive treatment (*Advances*, Fall 1996). When counseling services such as groups on depression or self-harm are made available in school settings, adolescents are more likely to attend because the setting is familiar and non-threatening (Durlak, 1995).

Typically, adolescents under-utilize primary preventive health care services; therefore, outreach is a critical component of any coordinated adolescent health care system. In a recent longitudinal study of school-based programs, it was found that voluntary, in-school groups covering a variety of issues — including depression, substance abuse and addiction, physical abuse, STDs and HIV/AIDS — had a significant positive impact on the adolescents who attended. Concurrent research found that the most effective type of program involved school-based program services, extracurricular activities and corollary programs to educate and engage parents and the community (*Journal of the American Medical Association*, August 21, 1996). The Robert Wood Johnson Foundation's national program "Making the Grade," focuses on helping state-community partnerships increase the availability of school-based health services. In their outcome studies, all evaluations agree in the area of access, school-based centers have a positive impact and do increase access to health care (Advances, Fall 1996).

The New Jersey School-Based Program (SBYSP), implemented over 10 years ago, is an example of a state wide effort to place comprehensive services for adolescents in or near secondary schools. The program is administered and funded through the Department of Human Services, and it is currently in operation in 30 school districts (with 42 program sites). While most of the programs offer primarily supportive services, mental health, employment training and substance abuse couseling, there are a few cases where the program includes primary medical care services, such as the program in operation at the high school in Plainfield, New Jersey

NEW JERSEY - CURRENT STATUS, FUTURE DIRECTIONS

As part of its public health agenda, the state of New Jersey recognizes the need: "to enhance adolescents' access to health services; to strengthen the linkages and infrastructure among the Departments of Education, Human Services and Health to increase the effectiveness of existing primary and preventive health services and the School Based Youth Services Programs; and to collaborate to develop models of health care delivery that include school-based and community-linked approaches." (*Healthy New Jersey 2000 Update*). (Reference is made to Appendix II, "Overview of New Jersey's Health and Medical Programs for Children and Adolescents.")

During the past year, the Department of Health and Senior Services (DHSS) has brought together all of the players at the state governmental level who are involved in programs for adolescents. As with almost every state across the country, New Jersey's programs are shaped by categorical funding sources so that most are focused on single problem issues - such as teenage pregnancy, substance abuse, or AIDS. As a means to "coordinate" health and social services for adolescents, DHSS has organized a working team, beginning with its intra-departmental programs such as Substance Abuse, STDs, AIDS; suicide; homicide; violence; teen parenting; and communicable diseases, and branching out to include advisors from the other Departments, including Human Services (DYFS,

Medicaid, Mental Health), Education, Labor, and representatives from the juvenile justice system.

The Department of Health and Senior Services is also currently completing a profile of New Jersey's adolescents, which assesses their health and mental health status and identifies issues associated with providing primary and supportive services to adolescents. The state is looking at ways to incorporate Service Integration models for adolescent services, in order to remedy access problems that exist in the fragmented delivery system.

In an effort to coordinate adolescent health care services statewide, the Division of Medical Assistance and Health Services (Medicaid), in consultation with the Department of Health and Senior Services, implemented teen-directed family planning services in July 1995. The program offers a separately reimbursed package of services to Medicaid recipients under the age of 21 years old who are served through Family Planning Clinics and Federally Qualified Health Centers in the state. The teen-directed services include an intake process, risk behavior assessment and evaluation, preventive health education and counseling services covering a broad range of issues, from contraception to violence prevention, and case management services including referral to other appropriate services. The service package incorporates the recommended clinical preventive services for adolescents included in the American Medical Association's "Guidelines for Adolescent Services" and the Maternal and Child Health Bureau's "Bright Futures: National Guidelines for Health Supervision of Infants, Children and Adolescents." In a period of just over a year, approximately 5,000 teens were served through the program.

The program works on the model of reaching the teenage client when s/he makes contact with a service agency for medical assistance. The service package "is intended to reduce the number of adolescent pregnancies. . .to diminish risk-taking behaviors and to improve adolescent health outcomes" (*Newsletter*, Department of Human Services, August 1995). DHSS is also implementing a tracking system to collect and analyze outcome data to evaluate the effectiveness of the program.

CONCLUSION

The transition from childhood to adulthood — from dependence to autonomy — is marked with challenges and frustrations. In the current environment of the health care "revolution," the status of adolescents, whose health care services have traditionally been crisis-oriented and rife with barriers to access, is most vulnerable. While there are countless programs throughout the state which provide much-needed services in a effective and efficient manner, their existence is threatened based on the realities of a competitive market and reduced public funding support. As with our children, we must remember that with our adolescents, when we ensure their health and safety, we are ensuring the future for everyone.

QUESTIONS FOR DISCUSSION

• Should the state either expand Medicaid, or develop some other program, in an effort to provide health insurance to the state's uninsured children and adolescents? Are insurance expansions the best way to improve the health needs of the uninsured?

• How will welfare reform impact on the health of New Jersey's children and adolescents?

• Do the health needs of young children and their older counterparts require separate strategies? If so, what are the relevant differences?

• Across the country, several states have scaled-down their once-ambitious health reform plans--whether in the form of insurance expansions, employer mandates, managed care iniatives or universal coverage--and have shifted to an incremental approach. What is New Jersey's position regarding its responsibility, during this time of dynamic transition in the health care environment, to assure a minimun level of health care to its citizens, especially children and adolescents?

• According to a recent U.S. General Accounting Office study of six state-and privately-funded children's health insurance programs, **limited** evidence was found to suggest that such programs "increase the likelihood that children would get the care that they needed; reduced inappropriate emergency room use in some cases; and/or increased children's use of preventive services." Is it too soon to tell, or are early indicators suggesting that the insurance subsidy model is not an appropriate strategy in handling the problem of the enormous numbers of uninsured children and youth?

• The health care revolution — with its emphasis on reduced spending and the spirit of competition — may well have a negative effect on the health care safety net, a significant piece of which is the Medicaid program. What are New Jersey's strategies for supporting its safety net providers who meet the health care needs of its high-risk and vulnerable adolescents?

• As the loosely-knit "safety net" grows thinner, what are the options regarding "who pays?" for care. Throughout the country, the safety net providers themselves are paying for some portion of the care provided to those who are uninsured and under-insured. The Congressional Budget Office reported that in 1995 hospitals and physicians provided an estimated $28 billion in uncompensated care, up from $20 billion in 1991 (Rovner, 1996). With limitations on cost-shifting and competitive market practices such as discounting, hospitals will find it more difficult in the future to provide such levels of uncompensated care. How will these gaps be filled?

• Across the country, states are expanding their Medicaid eligibility limits to provide services to children. As states move towards expanding these programs to the adolescent population up to age 18, policymakers raise concerns about increase costs associated with serving this population based on the reality that their health care needs are different from those of children and adults. How will we balance the great need to serve our adolescents and the drive to reduce health care spending?

• Preventive health care and health education are prominent features of an adolescent health care system, both of which are at the core of population-based public health activities. What priority will New Jersey, which is in the process of "re-structuring" its public health system, place on adolescent health care?

• In the field of mental health, it is well-established that mental illnesses are treatable, and with successful diagnosis and treatment, most children and adolescents with mental illnesses can lead productive lives. Positive outcomes result from early intervention and well-coordinated treatment plans. What is New Jersey's commitment to develop outreach to ensure that its children and adolescents are evaluated and treated at the onset of mental illness, rather than to delay treatment and intervention until the care becomes much more costly?

• Under Title IV-B of the Social Security Act, new legislation was introduced to promote family strength and stability, enhance parental functioning and to improve the delivery of preservation and support services to vulnerable children and families. New Jersey's five-year plan for its Family Preservation and Support Services (FPSS) Initiative, developed and coordinated through the Department of Human Services, includes a commitment to coordinate supportive services for families, which are community-based, in areas outside the traditional child welfare system — housing, mental health, health, education, job training, substance abuse treatment and child care. How will the FPSS affect New Jersey's high-risk adolescents?

• Healthy New Jersey 2000 Update includes in its recommendations to "evaluate managed care trends and their impact on adolescent health outcomes." How can we best use managed care's emphasis on preventive medicine with our adolescents, who so require comprehensive, coordinated preventive care to identify potential problems before they develop into full-blown health problems or self-destructive behaviors?

• The issue of "aging-out" of programs when an individual reaches age 19 raises multiple problems. How do we deal with "transitioning" these individuals from health and human services programs once they chronologically pass the age limit set for program participation?

• Demographers project that by 2020, the growing population of the elderly in our country will be paralleled by the shrinking population of adolescents. In 1980, the percentage of children under 17 years of age was estimated at 30 percent of the total U.S. population, and will be less than 20 percent by the year 2020, when the percentage of elderly population will far exceed it. What are the public policy implications of this skewed balance, especially when our country's youth are confronted with such complex health, mental health and employment problems?

• Program evaluation research, supported by reliable data, is critical in identifying which program models for adolescents "work" and which do not. As with most health care issues, the collection and analysis of reliable data is, at best, fragmented and must be pieced together from different data sources. What is New Jersey's commitment to establishing empirical data sources to best evaluate the programs and collect and analyze outcome data for state-funded adolescent health care?

APPENDIX I

NEW JERSEY HEALTH AND MEDICAL PROGRAMS FOR CHILDREN AND ADOLESCENTS

This overview summarizes the key health and medical programs for children and adolescents administered by the state of New Jersey. Included are various "cross-over" programs that offer social support, mental health, nutritional services and insurance coverage to these groups.

State-wide, there are a multitude of outreach, intervention and prevention programs and services for children and adolescents (with varying levels of service needs) at regional, county and local levels. These services are provided in communities through publicly and privately funded agencies, religious and civic organizations (such as Catholic Charities; Jewish Family Service; Planned Parenthood; Red Cross; United Ways); county and local health departments, local family service agencies, community nursing services, community mental health centers and special education programs in the school districts. For example, county and local health departments may provide a broad range of services such as childhood immunization clinics, dental health services, lead screening and sexually transmitted disease (STD) clinics to members of their communities. A Department-by-Department summary follows.

DEPARTMENT OF HEALTH AND SENIOR SERVICES

• Newborn Screening Program (hearing/biochemical, i.e., sickle cell, PKU)

• Birth Defects Registry: State law mandates reporting of children, birth to age one, with a birth defect to Special Child and Adult Health Services.

• Maternal and Child Health Consortia Oversees and monitors regional maternal, perinatal and child health service delivery networks. Provides education and promotes total quality improvement.

• HealthStart [in conjunction with Medicaid] Pregnant women and children - provides an enhanced package of Medicaid benefits to eligible pregnant women during pregnancy and for 60 days following delivery or the date the pregnancy ends. Children up to the age of two are also eligible for enhanced health services.

• Healthy Mother, Healthy Babies Initiatives in cities with high rates of infant mortality, adolescent pregnancy, including special outreach programs to adolescents.

• Childhood Lead Poisoning Prevention. Provides screening, follow up and education, medical referral and environmental investigation services.

• Special Supplemental Nutrition Program for Women, Infants and Children (WIC) Provides monthly vouchers to purchase food. 1997 budget book indicates that approx. 260,000 pregnant women and children were served under WIC in 1995.

• Communicable Disease Control for infants and children entering school (Rubella; Measles; Mumps; Polio, Diphtheria), provides immunizations for low income uninsured and underinsured children.

• Health Access New Jersey: The Access Program and Children First For access to health insurance coverage for qualified uninsured children. 1995 enrollment for Health Access reached 22,000; by the end of 1996, through attrition, enrollment was at 16,696. Currently, there are 1,548 children under the age of five (5) who are covered and 4,120 covered children between the ages of 6 and eighteen (6 - 18). In the FY 1997-98 proposed budget, $5 million is dedicated to the Children First program. It is estimated that 5,000 children will be covered by the program and an estimated 2,300 children will be from families transitioning from the AFDC economic assistance program.

• Prevention Oriented Health Program provides home visiting services through local health departments for at risk families to promote wellness, safety and parenting skills.

Funding sources for programs include various Federal block grants: Maternal and Child Health Block Grant; Preventive Health Block Grant; Drug Abuse and Mental Health Block Grant; as well as other state and Federal funds.

Within the Department of Health, the key programs for children and youth are situated in various Divisions and Offices. For example, the Division of Family Health Services is comprised of Community Health Services (administers state and federal funding support and technical assistance for the provision of preventive and primary health care services); the Early Intervention Program (EIP) (maintains system of services for infants and toddlers (birth to age 3) with developmental delays or disabilities offering comprehensive coordinated multidisciplinary services); Maternal and Child Health and Regional Services provide Maternal and Child Health Consortia oversight and primary and specialized perinatal services.

Specific programs and services are administered through discrete units. Special Child and Adult Health Services through the Specialized Pediatric Services Program supports a network of providers for access to quality, multidisplinary comprehensive health/medical care for children with disabilities, birth defects and chronic illness. Special Child and Adult Health Services, in cooperation with the local Boards of County Freeholders, funds 21 county based case management units. Their mission is to assist families of children with special health care needs identify and access comprehensive services needed by their child. Each year, more than 10,000 children with special needs are identified through the SCAHS Special Needs and Birth Defects Registries. More than 15,000 families receive SCAHS case management services.

In January 1997 the Department announced the formation of a 31-member Blue Ribbon Panel on Black Infant Mortality, comprised of community members, health experts and social services representatives, to examine the problem of black infant mortality and to find ways to reduce the state's high rate of black infant deaths. In 1994, New Jersey's state-wide infant mortality rate was 7.7 deaths for every 1,000 live births; the rate for blacks was 16.6, which is 2.8 times higher than the rate of 5.9 for whites. The national black infant mortality rate was 15.8 in 1994. Healthy New Jersey 2000's goal is a black mortality rate of 11.0 by the end of the decade.

The Department's programs for children and adolescents also include immunization programs; Sexually Transmitted Disease Control program; Alcohol, Drug Abuse and Addiction Prevention Services; Alcohol and Drug Treatment and Rehabilitation Services. Grants provided for violence-prevention, family counseling (for adolescents), rape prevention education and date/acquaintance rape (with hotlines and counseling services.)

There are 20 state-funded agencies that provide confidential family planning health and education services to adolescents at 60 sites throughout the state.

DEPARTMENT OF HUMAN SERVICES

Division of Medical Assistance and Health Services (Medicaid)

• "Regular" Medicaid Program (health program for the poor whose incomes and resourcesare equal to or below the limits established for the program)
• Medically Needy Program (for pregnant women and children; aged blind and disabled. For individuals whose incomes are too high to qualify for the regular Medicaid program.)

• New Jersey Care (for pregnant women and children under age 13; also aged, blind and disabled eligibles)

• Medicaid Expansion Programs, including: Maternal and Child Health Expansion to Age 6 and 133 percent of poverty.
Expansion to Age 13 and 100 percent of poverty
Expansion to 185 percent of poverty for infants birth-one year and pregnant women.

'• New Jersey Care 2000 - the state's mandatory Medicaid managed care program. Has enrolled more than 340,000 Medicaid beneficiaries in 13 commercial HMOs and the state's Garden State Health Plan.

• HealthStart — Since 1987, in conjunction with the Department of Health and Senior Services, provides an enhanced package of Medicaid benefits (including case management services) to eligible pregnant women and children (up to two years of age).

• Medicaid Model Waiver Programs I, II and III - home and community-based waivers for blind or disabled children and adults.

• ABC Program - home and community-based services for medically fragile children under the care and supervision of the Division of Youth and Family Services (which administers the program).

• Home and Community-Based Services Waiver for Persons with Traumatic Brain Injuries To provide community alternatives for brain injured individuals currently in nursing facilities. Client population to be served is primarily young adult and ambulatory, with cognitive, behavioral and physical deficits which require supervised and supported care.

• AIDS Community Care Alternatives Program (ACCAP) Designed for individuals who are diagnosed as having AIDS or children under five (5 years of age) diagnosed as HIV positive who, without home services, would need institutional care.

DEPARTMENT OF HUMAN SERVICES

School Based Youth Services (SBYSP)

In Healthy New Jersey 2000, the goals for the end of the decade include "strengthen the linkages and infrastructure among the Departments of Education, Human Services and Health for primary and preventive health services and comprehensive school health education."

School Based Youth Services (SBYSP), currently in 42 sites state-wide, are coordinated through a collarborative partnership between the Department of Human Services, local school boards and their communities. The program links the education and human services systems together in a "one-stop shopping" site for youth. Currently, over 20,000 students are served annually through the programs.

SBYSP operates in urban, rural and suburban school districts with at least one site per county; the program is expanded from secondary school settings to elementary and middle schools. Each site provides health care, mental health and family counseling, job and employment training and substance abuse counseling. Additional services may include teen parenting education, day care, tutoring and family planning hotlines.

DEPARTMENT OF HUMAN SERVICES

Division of Youth and Family Services (DYFS)

The primary responsibility of DFYS is receiving, responding to and investigating allegations of suspected child abuse and neglect. DYFS also provides preventive and supportive social services to families where child maltreatment has been substantiated and/or where family disorganization requires intervention, either by direct provision of services or through referral to community providers. Protective services and family support services are delivered by a state-wide network of 32 local District Offices. DYFS provides assessment and evaluation of families to determine appropriate services, foster care placements, adoption services and case management. The Division also operates a 24-hour hotline to receive reports of suspected child abuse and neglect.

Child care programs coordinated through DYFS and the Division of Family Development (DFD):

1. Title IV-A At-Risk Child Care Program.

At-risk is defined as working low-income families whose income is at or below 200 percent of the FPL. This program provides child care assistance to low-income working families who might otherwise be vulnerable to welfare dependency.

2. Child Care and Development Block Grant Program - provides low and moderate income families with child care assistance.

Division of Family Development (DFD)

The Division of Family Development administers various programs including: Aid to Families with Dependent Children (AFDC) - Temporary Assistance to Needy Families (TANF); Work First NJ; General Assistance; Food Stamps; Supplemental Security Income Program; JOBS; Child Support Enforcement; Home Energy Assistance and Emergency Assistance. Recent federal legislation under Title IV-B of the Social Security Act — Family Preservation and Support Services — aims to promote family strength and stability, enhance parental functioning and protect children through a program providing family preservation and support services. In recognition of a fragmented delivery system of services in child welfare and the vulnerability of high-risk families, DFD has designed a five-year plan to implement the Family Preservation and Support Services Initiative, taking into consideration the broader factors of poverty, unemployment and homelessness as threats to the integrity of the family.

Division of Mental Health and Hospitals

The Division of Mental Health and Hospitals oversees, monitors and administers mental health services for New Jersey citizens, including children and youth, through the state and country psychiatric hospital systems and through community mental health centers. The Division purchases community mental health services through contracts with 127 not-for-profit provider corporations, which provide 575 discrete mental health programs. Program services include: outpatient, group home services, case management and family support services.

Division of Developmental Disabilities

The Division of Developmental Disabilities oversees, monitors and administers programs and services, both institutional and community-based, for children, youth and adults with developmental disabilities. Under the Family Support Act (1993), the Division developed the Family Support Program to create a system of family support to serve the individual with a disability and the individual's family. Program services include: cash subsidies, counseling and crisis intervention, day care and personal assistance services.

DEPARTMENT OF HUMAN SERVICES

Catastrophic Illness in Children Relief Fund

The Catastrophic Illness in Children Relief Fund was established by legislation to provide financial assistance for families whose children have experienced an illness or condition which is not otherwise covered by insurance, State or Federal programs, or other source. The Commission which administers this dedicated trust fund operates from the Office of the Commissioner of Human Services.

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