THE CAPITOL FORUMS
On Health and Medical Care

The Uninsured - An Unresolved Problem

background information for the discussion at the

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THE UNINSURED -- AN UNRESOLVED PROBLEM

An issue brief prepared for discussion at the April 5, 1995 Capitol Forum

The Issue:

How is New Jersey addressing the complex public policy issue of financing health insurance and providing health services to the individuals and families who are unable to afford health insurance, whose numbers are now estimated to be over 1,100,000?

Numbering more than 1.1 million in 1993 -- in excess of 16 percent of the state's under-65 population -- New Jersey's uninsured population continues to grow despite the state's efforts to extend health care coverage to all state residents. Some progress has been made since the arrival of new coverage opportunities for individuals and those working for small companies, options created by the Health Care Reform Act of 1992. Yet the cost of coverage under those new private plans remains expensive, and the vast majority of people who were uninsured before the reforms remain uninsured today. In the meantime, new people join the ranks of the uninsured each year. For them, the emergency room too often remains the sole gateway to health care. Who are the New Jersey's uninsured?

What follows is a demographic profile of the uninsured and a review of New Jersey's past and current efforts to resolve the problem.

The Uninsured Population - A Demographic Profile

The uninsured population grew steadily in New Jersey throughout the late 1980s and early 1990s. According to census data compiled by the Employment Benefit Research Institute (EBRI), there were 697,000 uninsured people in New Jersey in 1988, representing 10.5 percent of the under-65 population. By 1993, the last year for which data are available, the figure had grown to 1,126,000 -- 16.2 percent of the under-65 population.

New Jersey's Uninsured, by Year

Year	Number Uninsured	% under-65 Population
1988	697,000	10.5
1989	820,000	12.3
1990	800,000	11.9
1991	857,000	12.7
1992	1,060,000	15.6
1993	1,126,000	16.2

source: Employment Benefit Research Institute

To put the New Jersey figure in perspective, it is useful to look at the state's neighbors and the rest of the nation. According to the 1993 EBRI data, 40.9 million under-65 Americans had no health coverage, 18.1 percent of the non-elderly population of 226.2 million. Uninsured rates were particularly high in the West and South, ranging as high as 27.4 percent in Oklahoma, 27 percent in Louisiana, and 26 percent in New Mexico. Closer to home, 15.5 percent of the under-65 population in the Middle Atlantic states -- New Jersey, New York, and Pennsylvania -- had no health insurance. In 1993, the rate was at 13.4 percent in Pennsylvania and 16.5 percent in New York.

New Jersey's Uninsured by County

The proportion of uninsured people varies greatly from county to county in New Jersey. According to estimates based on 1991 data, 20.2 percent of Hudson County residents lacked coverage, in contrast with 7.4 percent in Somerset County and 7.5 percent in Hunterdon County. In 1991 the county break down of the uninsured population was: Atlantic, 27,750 (12.2 percent of the non-elderly population); Bergen, 87,521 (10.6 percent); Burlington, 32,590 (8.2 percent); Camden, 51,649 (10.2 percent); Cape May, 11,438 (11.9 percent); Cumberland, 14,177 (10.2 percent); Essex, 115,123 (14.9 percent); Gloucester, 25,582 (11 percent);

Hudson, 111,910 (20.2 percent); Hunterdon, 8,167 (7.5 percent); Mercer, 29,703 (9.1 percent); Middlesex, 57,939 (8.6 percent); Monmouth, 48,714 (8.7 percent); Morris, 32,256 (7.6 percent); Ocean, 27,269 (6.2 percent); Passaic, 74,949 (16.5 percent); Salem, 5,477 (8.4 percent); Somerset, 17,952 (7.4 percent); Sussex, 10,970 (8.3 percent); Union, 45,719 (9.3 percent); Warren, 8,240 (8.9 percent).

New Jersey's Uninsured by Employment Status

The striking characteristic of New Jersey's uninsured residents is that most of them -- an estimated 90 percent -- are employed or are members of families with at least one employed person. These are often the people who earn too much money to qualify for Medicaid, but too little to buy coverage in the open market. New Jersey's uninsured workers are disproportionately employed by themselves or by small companies; nearly two-thirds of the state's uninsured workers are self-employed or work for companies with fewer than 100 employees. Nearly a quarter of self-employed workers in the state -- 23.5 percent -- are uninsured, accounting for 9 percent of uninsured workers. Some 18.6 percent of workers in firms with fewer than 100 employees lack coverage, making up 53 percent -- by far the biggest share -- of the state's uninsured worker population.

At bigger companies, smaller proportions of workers are uninsured. Just 8.5 percent of workers employed by firms with 100 to 999 employees are uninsured; that group accounts for 16 percent of uninsured workers in the state. At firms with 1,000 or more employees, 7.9 percent of workers lack health insurance coverage, making up 23 percent of New Jersey's uninsured worker population.

New Jersey Workers Without Insurance, By Size of Company 1991

Number of Employees	Percent Uninsured	Share of total Uninsured Workers
self-employed	23.5	9.0
<100	18.6	53.0
100-999	8.5	16.0
>1000	7.9	23.0

source: March 1992 Current Population Survey

Coverage Rates For Full-time and Part-time Workers

Full-time workers have better access to health care coverage than people working part-time. According to data from the 1992 Current Population Survey, 9.5 percent of full-time New Jersey workers were uninsured, in contrast with 23.9 percent of part-time workers with more than 1,500 hours a year and 23.2 percent of those with fewer than 1,500 hours. The rate stood at 19.1 percent among non-workers.

New Jersey's Uninsured by Age Groups

As they do by income and employment, coverage rates vary significantly between age groups. According to the 1992 Current Population Survey, more than 22 percent of the 18-24 category lacks health coverage, whereas just 7.8 percent of those in the 55-64 group are uninsured. In the Medicare-eligible 65-and-older group, the rate is just 1 percent.

New Jersey's Uninsured By Age Group, 1991

Age Group	Number of Residents (000's)	% Uninsured
0-17	1,869	9.1
18-24	797	22.6
25-34	1,281	15.6
35-44	1,246	11.8
45-54	905	9.0
55-64	645	7.8
under-65 total	6,743	12.3

source: March 1992 Current Population Survey

New Jersey Uninsured by Race/Ethnic Group

One's racial or ethnic group also influences the likelihood of success in obtaining insurance coverage. A white person in New Jersey is less than half as likely as a Hispanic person to go without coverage. According to the 1992 Current Population Survey, 9.8 percent of the state's 4.9 million non-elderly whites were uninsured. Among the 931,161 blacks, the uninsured rate was 15.9 percent; and among the 609,734 Hispanics, it was 21.9 percent.

The high rate among Hispanics is, in part, a result of the low coverage rates among non-citizens. This is a significant factor in New Jersey, a state with one of the highest proportions of non-citizen residents in the country. Roughly half of the approximately 400,000 non-citizen under-65 residents of New Jersey are without insurance. According to the 1994 Current Population Survey, non-citizens make up 20.8 percent -- more than one-fifth -- of the state's uninsured. Nationwide, 15.1 percent of non-elderly uninsured people are non-citizens.

The History of New Jersey Health Insurance Reform

It was nearly two decades ago, in 1978, that New Jersey began its commitment to broaden health care coverage. New Jersey's hospital industry became one of the most closely regulated in the nation, setting a national standard for reimbursement rates and methodologies. Through legislation and regulations, the state aimed to control the growth of health care facilities, programs and costs in the hope of containing costs and, thus, assuring access. A key component of the cost-containment was the Diagnostic Related Group (DRG) reimbursement method, which based reimbursements on the nature of a condition and treatment in the hope of discouraging unnecessary costs associated with inappropriate utilization.

The efforts were, to a large extent, successful. Cost increases remained below regional averages, and the poor and uninsured enjoyed improved access to acute health care. The foundation of this approach was a requirement that private and third-party payers cover the cost of charity care.

By the mid-1980s, however, some of New Jersey's hospitals were straining under the ever-increasing burden of uncompensated care. Lawmakers in 1987 created the New Jersey Uncompensated Care Trust Fund with the aim of more equitable reimbursement for unpaid care. The primary vehicle to do this was a surcharge on hospital bills. The surcharge supported the fund, which then paid for hospital bills incurred by the uninsured. But as the cost of care continued its rapid rise in New Jersey and nationwide, the fund had to grow rapidly. It doubled in size by 1992, reaching a point where it accounted for 19.1 percent of every hospital bill.

A legal challenge by a self-insured union prompted a crisis. In federal court, the union contended that the surcharge violated provisions of the Employee Retirement Income Security Act (ERISA) forbidding state infringement on employee benefits. U.S. District Judge Wolin ruled in favor of the union, declaring the uncompensated care financing method in violation of federal law. The decision was ultimately overturned, but not before the wheels of reform were turning again.

The Health Care Reform Act of 1992 -- A Summary

In response to the Court decision, to the mounting dissatisfaction over the cost of charity care, and to a growing national sentiment for health care financing methods based on competition, the state Legislature enacted the Health Reform Act of 1992 and two related health care laws -- the basis for today's system. A departure from the old approach, the new system eases regulation in the hope of setting loose market forces and creating competitive incentives for providers to hold the line on costs. The law requires hospitals to provide necessary services to all New Jersey citizens; to compensate them, the Legislature created the Health Care Subsidy Fund, which is supported by the transfer of employer and employee contributions to the state's Unemployment Compensation Fund. DRGs which had become the object of payer and consumer dissatisfaction, were eliminated by the act.

Individual, Small Group and Subsidized Programs

Two key components of the 1992 effort to recreate New Jersey's health care system are the Individual Health Insurance Reform Act and the Small Group Insurance Reform Act, which were enacted along with the Health Care Reform Act. The legislation attempted to address the lower rates of coverage among New Jerseyans who don't work for large companies and, thus, do not have the easier access to health care that comes with employment in a large firm. The legislation also attempted to provide subsidies to bring payment of insurance premiums within the reach of more lower-income New Jersey residents.

Individual Health Coverage Program

To assist those who cannot access health insurance through their workplaces, the Act created the New Jersey Individual Health Coverage Program. Under terms of the program, all insurers must participate in the program as a condition of doing

business in New Jersey. That participation consists of providing individual policies on a community-rated basis. (Community-rating protects against higher rates for some people by basing rates not on an individual's health status and experience, but on the pooled risk represented by the entire group.)

Some rate differentials were allowed to remain in place if the policy was issued before the act went into effect, but all new and renewed policies are to employ community rating by July 1, 1995.

In addition to community-rated policies, the act requires participants to provide open enrollment periods and to allow renewal at the policy-holder's option unless there has been non-payment of premium, fraud, misrepresentation, termination of eligibility or cancellation of the plan, whether by the carrier or the board appointed to oversee the program. Among other key requirements, participants must offer five standard plans established by the board, including a basic or "bare-bones" policy, a managed-care option, and three additional policies of escalating actuarial value.

Rates for the individual policies vary widely from company to company and plan to plan. The monthly rate for the bare-bones Plan A policy ranges from $113 to $247 for a single, and from $290 to $680 for a family. A single buying the richest coverage option -- Plan E, with the $150 deductible --faces monthly rates ranging from $372 to $713. The same coverage for a family would cost $948 to $1,598 per month. Monthly rates are considerably lower, however, for families opting to purchase Plan E with the $1,000 deductible; those range from $362 to $1,076.

In March, the program announced that the new individual policies were covering 113,535 people in New Jersey, about 49,000 of whom had no health coverage before buying one of the state-designed policies. The most popular policy was Plan D, the second-most generous and expensive of the five options. The rates for this plan for a family range from $786 to $1,342 per month with a $250 deductible or $317 to $939 per month with a $1,000 deductible. For a single, the rates range from $305 to $572 per month with a $250 deductible or from $134 to $322 per month with a $1,000 deductible. According to statistics released by the board, 54 percent of those covered under the program's policies are female, and 46 percent male; about 48 percent of those covered by the policies are under age 40.

The board's report included some discouraging news as well. Forty-three percent of the program's policies were bought by previously uninsured individuals in 1994, but in the fourth quarter, that target population accounted for only 36 percent of those acquiring coverage under the plan.

Small Employer Program

The state's new small group policies, which first hit the market in January 1994, are aimed at extending the coverage umbrella to small companies -- those employing two to 49 people. The New Jersey Small Employer Health Excess Reinsurance Program requires all carriers selling small-group insurance in the state to meet conditions including the following:

- a successful transition to community rating for small group plans by 1997; rates for holders of identical policies may vary by no more than 300 percent in 1994 and 1995, and by no more than 200 percent in 1996;

- the commitment, beginning in 1995, to issue dividends or credits to policyholders if premiums exceed payments by more than 25 percent; requests for premium increases will be denied if they would result in total premiums exceeding total payments by more than 25 percent; and,

- the provision of five standard plans to be developed by the program; similar to the program for individuals, the five plans must include a basic policy, a managed-care option, and three additional plans of increasing value.

The Essential Health Services Commission

The eleven member independent New Jersey Essential Health Services Commission was created to administer the Health Care Subsidy Fund. Its responsibilities include: developing and implementing systems to disperse the fund's monies; monitoring hospital rates and contracting practices; reviewing Medicare hospital rates and Medicaid provider rates; assessing hospital charges; studying managed care options for charity care services, and establishing the New Jersey Shield Program, now called New Jersey Access. Described only in rough sketches in the legislation, the Shield Program was created to provide subsidies for health services

delivered in "disproportionate share" hospitals and other community-based care providers. The commission is not funded in the Whitman administration's proposed 1995-96 budget.

Health Access New Jersey

To bring health care closer within reach of lower-income New Jerseyans, the Legislature enacted a subsidy program, Health Access New Jersey. Debuting in April 1995, the program subsidizes participants' premium payments, with the level of one's own contribution towards the premium based on income. Eligibility is restricted to individuals and families with gross incomes up to 250 percent of the federal poverty level ($18,675 for individuals and $37,875 for a family of four). Participants use the subsidies to buy into one of three coverage plans offered under the state's individual insurance program. They may opt for Plan D, Plan E or the HMO option. (In Plan D & Plan E, the choice is restricted to the lower deductible.) A principal target of the program are families leaving welfare to return to the work force, who have no other access to health insurance. These families are guaranteed coverage subsidy funds are made available to other uninsured individuals and families on a first-come, first-served basis. Eligible residents already insured will have the opportunity once a year to join the program during an open-enrollment period. A total of $50 million is allocated this year for the Access Program, which will cover an estimated 30,000 people.

The Conclusion

New Jersey has been a model for other states. For almost twenty years it has maintained its commitment to assure access to hospital care for all residents. This commitment in fiscal terms has taken various forms and combinations.

In the 1980s, a regulated system based on the DRGs (a prospective determination of charges) and a surcharge on hospital bills kept costs lower than others in the region, and provided a means for financing care for the uninsured. Now, despite significantly reformed insurance availability (the individual and small group programs) and assurance (Medicaid and Medicare), the number of residents without insurance has increased.

New Jersey is not alone in experiencing the mounting numbers of residents without health insurance. The answer for each state will depend on its history and its commitment to assure health care for all residents.

Questions for Discussion

1. How will New Jersey provide, maintain and evaluate access to high-quality health care for the uninsured population?

2. Given the striking characteristic that an estimated 90% of New Jersey's uninsured residents are employed, or are members of families with at least one employed person, what is New Jersey's commitment to provide coverage?

3. Non-citizen tax paying residents comprise over 20% of the state's uninsured population. What is New Jersey's commitment to remediating this low coverage situation?

4. How is New Jersey's uninsured population affected by a rapidly evolving managed-care system in the state? What form of coverage makes the most sense for today's uninsured? Will they -- should they -- have free or limited provider choice?

5. How does the issue of health care and health insurance for the uninsured tie in with New Jersey's Medicaid population, and with the state's Medicaid managed care program?

6. Regulation vs. deregulation: Can cost containment work in the deregulated environment that exists today in New Jersey's health care and health insurance marketplace?

7. The "woodwork effect": Will aggressive outreach backfire? How should New Jersey address the policy implications of this complex issue?

8. Data collection and coordination revisited: The statistical data on the uninsured population cut across the department lines of the departments of Health, Human Services, Insurance, and Labor. What is New Jersey's commitment to establish a coordinated system of data collection and analysis?

Appendix

The Health Care Dollar

Health care expenditures, in New Jersey and the rest of the country, exploded during the 1980s. Nationally, less than $160 billion was spent on hospital care, physician services and prescription drugs in 1980, according to figures compiled by the federal Health Care Financing Administration (HCFA). The sum reached a total of $473 billion by 1991, the latest year for which figures are available. In New Jersey, the expenditure more than tripled between 1980 and 1991 -- from $4.5 billion to $14.6 billion.

New Jersey Health Care Expenditures, by Category (1991)

Category	Amount	% of Total
hospital care	$8.83 billion	60.3
physician services	$4.57 billion	31.2
prescription drugs	$1.25 billion	8.5

source: Health Care Finance Administration

The National Health Care Dollar, by Source (1990)

Source	% of Total Expenditure
private health insurance	33
Medicare	17
Medicaid	11
Other government programs	14
out-of-pocket payments	20
other private	5

source: Health Care Financing Review, Fall 1991

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