THE CAPITOL FORUMS
On Health & Medical Care

DOES NEW JERSEY NEED TO RENEW ITS COMMITMENT TO THE HEALTH OF OUR CHILDREN?

PART I
0 - 10 YEARS OF AGE - SAFETY NET?

Background information
by:

Professor Michael Sparer
for

THE CAPITOL FORUM
on Tuesday, February 18, 1997
9:00 am - 1:00 pm
Masonic Temple Library
Trenton, New Jersey

Sponsored by
The League Of Women Voters of New Jersey

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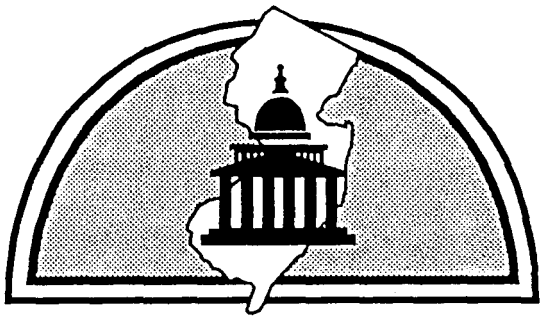

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equately-funded public insurance expansions.

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

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

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)].