



The Forums Institute for Public Policy

Reaching Out to the Uninsured: New Jersey's Initiatives to Expand Health Insurance Coverage

Background Information for...

THE NEW JERSEY POLICY FORUM
Wednesday, September 6, 2000
9:00 AM to 11:30 AM
Registration begins at 8:30 AM
The War Memorial
W. Lafayette Street
Trenton, New Jersey



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THE ISSUE: As the number of uninsured increase--even in the current climate of economic growth--how do state-level policymakers expand coverage to their uninsured adults and children?

POLICY IMPLICATIONS

- **Given that the acknowledged downside of incremental reform is the creation of a complex maze of programs each with individual eligibility requirements, how can access to insurance be facilitated?**

Health policy analyst Pamela Farley Short, in a research piece entitled, "Hitting a Moving Target: Income-Related Health Insurance Subsidies for the Uninsured," predicts that future state-level health care reforms will be incremental, as opposed to comprehensive and carefully targeted. She believes that the targeting of subsidies through new programs will be related to income.

- **How can states best approach the "limitations" set by the current public and private insurance system, when "even the most expansive [state] programs fail to reach substantial proportions of low-income adults who lack other coverage" (Spillman, 2000)?**

A study by Urban Institute researcher Brenda Spillman found substantial cross-state variation in adult access to

coverage and health care. In her conclusion, she comments that: "Barring a federal initiative to set and perhaps underwrite a higher income floor for Medicaid, expand or remove categorical requirements, or establish an adult counterpart to the State Children's Health Insurance Program (CHIP), it is unlikely that state efforts alone will be able to greatly expand coverage of adults (ibid.)."

- **What types of program design strategies can states use to address the various types of enrollment issues with which they are confronted?**

In a recent interview, Sarah Shuptrine, the director of *Covering Kids*--a national program designed to help state and local coalitions make health insurance accessible to eligible children--discussed issues related to the statistic that an estimated 7 million children are currently eligible for subsidized health care but are not enrolled in publicly or privately funded health plans (*Advances*, Issue 1, 2000). Shuptrine emphasized the need to design outreach plans for those eligible that offer accessible entry points, clear dissemination of information and consistent commitment to a simplified and dignified eligibility system.





INTRODUCTION

In the story of most heroic quests, there appears a crossroads, raising the question of which direction is the appropriate one to take in order to get to the next stage of the journey. A significant lesson learned when analyzing most of these stories is that often there is not only one "right" way; only after many roads have been traveled, sometimes more than once, is it then possible for the hero to find the most appropriate solution to the problem.

At present, one of the most complex — and most intractable — issues facing policymakers is that of the uninsured. An estimated 44 million non-elderly Americans (approximately 16.3 percent of the population) do not have health insurance coverage.¹ The uninsured are predominantly workers and their families; those who earn less than 200 percent of the federal poverty level (\$33,400 for a family of four in 1999) are at the highest risk of being uninsured (Kaiser Commission on Medicaid and the Uninsured, May 2000). Nationally, over 11 million (one in seven) children are uninsured, and two-thirds live in families with incomes below 200 percent of poverty (ibid.). Another recently documented trend is the rapid increase in the number of uninsured young adults: the 12 million uninsured adults between the ages of 19 and 29 account for more than 25 percent of the country's 44 million uninsured (The Commonwealth Fund, 2000). Both uninsured adults and children are less likely to receive preventive medical care and do not receive appropriate or timely treatment, making them vulnerable to more serious illnesses and poorer health outcomes.

For the past 25 years, state-level policy makers have implemented various types of insurance coverage initiatives aimed at providing access to health insurance for their uninsured residents;

some comprehensive, most incremental in nature. Health policy analysts and researchers at the National Academy for State Health Policy likened these activities to Shakespeare's flood tide, from which state policymakers "must take the current when it serves or lose our ventures" (Riley and Yondorf, 2000). They note that states -- through their roles as regulators, purchasers and providers -- have created a foundation of various types of insurance reforms in order to expand access to health care and provide coverage to the uninsured (ibid.). These insurance coverage initiatives include:

- Medicaid expansion programs
- Individual and small group reforms;
- Indigent care and high-risk pools;
- State-funded programs (some building on employer-based coverage); and,
- Children's health plans.

State-level efforts have focused on both private insurance market reforms and on expanding coverage in the public sector through a combination of federal and state initiatives. Following our April 2000 forum on the future of employer-based health insurance and private market reforms, the Forums Institute for Public Policy is now focusing on state-level activities to expand coverage to the uninsured in New Jersey via public sector programs and the foundation of the employer-based system.

NEW JERSEY — REACHING OUT TO ITS UNINSURED

New Jersey's approach has been to use several methods to address the issue of its uninsured, including Medicaid expansion programs, individual and small group reforms, children's health plans and a combination of national and state-funded programs. In a 1998 Urban Institute profile on health policy for low-income





people in New Jersey, policy analysts point out that: "New Jersey has a historic commitment to supporting health services for uninsured individuals. . . [The state] also has sought to promote private insurance coverage...and has been at the forefront in regulating managed care as well as the individual and small group health insurance markets" (Bovbjerg et al, 1998). When compared to other activities in other states, New Jersey has one of the most broad-sweeping individual insurance market reforms in the country, and it is also one of 30 states with a state-administered indigent/charity care program.

Based on 1996-98 data, New Jersey's uninsured non-elderly population numbered over 1 million; approximately 200,000 of this number are uninsured children (The Henry J. Kaiser Foundation, 2000). According to the Urban Institute's 1997 National Survey of America's Families, close to 120,000 of these children without insurance coverage live in low-income families (Almeida and Kenney, 2000).

Governor Christine Todd Whitman, through Executive Order No. 97, emphasized the state's commitment regarding the problem of the uninsured by establishing the Governor's Task Force on the Affordability and Accessibility of Health Care in New Jersey. Its primary charges are to compare New Jersey to other states in terms of affordability and accessibility of health care and to assess the impact of state and federal mandates on health care access and costs. Public hearings conducted by the Task Force were first held on May 30, 2000 and focused on the issue of mandated health care benefits in New Jersey.

NEW JERSEY KIDCARE

Through its Medicaid, Medicaid managed care (New Jersey Care 2000) and Medicaid expansion programs, New Jersey covers over 600,000 parents and children, and people who are aged, blind or disabled. New Jersey's CHIP-supported (Title XXI) KidCare program reaches out more broadly

to uninsured children 18 years of age and under. Maximum income eligibility ranges from \$28,840 for a family of two to \$78,190 for a family of six; income limits for a family of four are \$58,450 (1999 figures; NJ KidCare *Fact Sheet*). Based on income levels, the program may require premium payments and co-payments for certain services, such as prescriptions and lab services.² Most children will be eligible for NJ KidCare only if they have been uninsured for a period of six months or more. Enrollment since March 1998 for NJ KidCare is now at 70,000.

NEW JERSEY FAMILYCARE

Although the NJ KidCare program and Medicaid provide health care coverage for children, there is an absence of a health insurance safety net for their parents or for single adults and childless couples (FamilyCare *Fact Sheet*, 2000). The FamilyCare Health Coverage Act [A49](#) – Vandervalk/Thompson; [S1467](#) – Inverso/Vitale) was approved as P.L. 2000, c. 71 and signed by Governor Whitman on July 13, 2000.³ It is anticipated that enrollment for the program will begin in Fall 2000. Described as a program of affordable health insurance for 125,000 working New Jerseyans of moderate incomes, the FamilyCare program will provide free or low-cost health insurance to uninsured parents with income up to 200 percent of the federal poverty level (currently \$33,400 for a family of four) (*ibid.*). The need for such a program is based on recent census data showing that there are an estimated 210,000 adults who have been uninsured for more than a year whose incomes are under 200 percent of poverty (*ibid.*).

The FamilyCare program will be supported by New Jersey's share of tobacco settlement funds, as well as state and federal monies and contributions from employers and employees (Groves, 2000). Under the FamilyCare proposal, "in order to support the employer-based system of health insurance, where most New Jersey families obtain their health care coverage, any person





who is financially eligible for FamilyCare will be required to purchase their health insurance through their employer if their employer contributes at least 50 percent towards the cost of the insurance and their employer's benefits are similar to the benefits provided through FamilyCare" (FamilyCare *Fact Sheet*, 2000).

Still in proposal form is the New Jersey Equity Program, which would extend coverage to parents and would subsidize employer-sponsored health insurance premiums. Eligible working families would have to meet two criteria: (1) their incomes are between 133 and 200 percent of the federal poverty level, and (2) they currently made the choice to pay for health insurance that is ostensibly "unaffordable," as opposed to choosing not to purchase health insurance because of its cost (*State of the States*, 2000). It is expected to cost \$13.6 million per year, but has the potential to insure and sustain coverage for at least 50,000 low-income employees and their families.

THE 1990's — A DECADE OF NATIONAL AND STATE-LEVEL INITIATIVES

New Jersey has made its own state-level efforts in reaching out to the uninsured against the backdrop of a decade of federal and state activities. Medicaid program reforms represent one of the most influential public sector coverage changes during the past ten years. Using the Medicaid administrative structure and the federal cost-sharing benefits, states began to enroll Medicaid recipients into managed care plans in an effort to control costs and provide case management. Section 1115 Medicaid Research and Demonstration waivers are utilized by states to expand coverage to their uninsured; under these waivers categorical eligibility is restructured so that Medicaid enrollment is open to larger numbers of uninsured who meet specific income level requirements. In 1997, another landmark initiative -- this from the federal level after scores of states had established programs to expand insurance coverage to their

uninsured children -- came in the form of Title XXI of the Social Security Act, the State Children's Health Insurance Program, a federal-state partnership with enhanced federal matching funds.⁴ Prior to CHIP's enactment, 27 states had already established state-based programs. According to Riley and Yondorf: "As of January 1, 2000, HCFA had approved CHIP plans in all states and the territories. Nineteen expanded Medicaid, 15 created separate programs and 17 combined the two approaches." Although comprehensive initiatives like the State Children's Health Insurance Program (CHIP) have extended coverage to an additional 2 million children who do not qualify for Medicaid, millions more children are believed to be eligible for these programs but continue to be uninsured (Kaiser Commission on Medicaid and the Uninsured, January 2000).⁵ Barriers to enrollment include such problems as complex eligibility rules, difficult enrollment processes, perceived "stigma" attached to welfare and economic assistance, and obstacles related to language and cultural diversity.

NEW STRATEGIES, NEW CHALLENGES: WHAT ARE OTHER STATES DOING?

Health policy analysts have pointed out that state-level initiatives and activities related to insurance reform have foreshadowed federal actions: prior to the enactment of the Health Insurance Portability and Accountability Act in 1996 and the State Children's Health Insurance Program in 1997, states had already implemented insurance reforms and children's health initiatives (Riley and Yondorf, 2000). According to the State Coverage Initiatives program, the three major "vehicles" that states have used to expand coverage to families are the CHIP program, the Medicaid program (Section 1115 Research and Demonstration Waivers and Section 1931) and state-only programs, i.e., those funded without federal dollars (Wheatley, 2000).

Several states have developed comprehensive approaches in implementing access expansion





sions to establish state-administered health care insurance programs for their uninsured.⁶ Minnesota's MinnesotaCare program and Washington's Basic Health Plan are examples of two such state-subsidized programs. Funding for MinnesotaCare, which was created in 1992, is provided through premiums and tobacco and provider taxes and was implemented through a Medicaid 1115 waiver. Research analysis shows that the financing mechanism used for the program "gives MinnesotaCare financial stability since it is not financed from the state's general fund" (Riley and Yondorf, 2000). Recent studies regarding Minnesota's uninsured population have indicated that the number of uninsured in Minnesota has dropped from 6 percent in 1990 to 5.2 percent in 1999 (ibid.).

At present, if states wish to use CHIP funds to expand coverage to families and/or to subsidize employer-based coverage, they must obtain approval from the Health Care Financing Administration (HCFA).⁷ HCFA has set definitive standards to be met, and the focus is on deterring crowd-out. According to the National Conference of State Legislatures, only the states of Massachusetts, Wisconsin and Mississippi have been granted approval for using CHIP funds for covering parents by subsidizing employer-sponsored health insurance (2000). These subsidies must be "cost-effective," defined by HCFA as "family coverage that costs the state dollars equal to or less than what the state would pay to cover the family's eligible children under CHIP" (Cosgrove, 2000).

Wisconsin, for example, through its BadgerCare program, covers parents of CHIP-eligible kids using matching Medicaid funds. In the state of Massachusetts, MassHealth -- the state's combination Medicaid and CHIP program -- was expanded to cover parents in late 1997. Under the program, a family of four with an income of \$34,100 (200 percent of the federal poverty level) is automatically eligible. "If parents have access to an employer-sponsored plan but do not participate be-

cause the monthly premiums or payroll deductions are too high, the parents may join the employer-sponsored plan...and MassHealth covers the cost of the insurance using CHIP funds" (ibid.). At present, the Massachusetts program has covered several hundred people after two years of operation; the Wisconsin CHIP subsidy program has covered only a few families after one year and Mississippi is still in the implementation phase of its program (Polzer, 2000).

Regarding the use of CHIP funds to subsidize employment-based coverage, health policy analyst Karl Polzer points out that "programs merging federal and state funds to subsidize private health insurance coverage are a new concept posing a steep learning curve for policymakers at all levels of government" (2000). He adds that many state officials have expressed "frustration" with what they perceive as "federal barriers (either statutory or regulatory in origin) to implementing premium programs under CHIP"; many are taking a "wait-and-see attitude" towards such efforts (ibid.).

As a result of coverage expansions targeting children through Medicaid and the CHIP program, the ratio of adults lacking health insurance when compared to children has increased: in 1997, 37 percent of non-elderly, low-income adults were uninsured, compared with 21 percent of low-income children (Dubay et al, 2000; Zuckerman et al, 1999). Another incremental strategy of expanding Medicaid eligibility to the adult population (specifically, low-income parents) was made when the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) created Section 1931 of the Social Security Act (Birnbaum, 2000; Dubay et al, 2000). It requires states "to cover at least those parents with incomes below 1996 state Aid to Families with Dependent Children (AFDC) income thresholds, regardless of whether they receive cash assistance" (Birnbaum, 2000). Under Section 1931, states have flexibility to cover more low-income adults through tools used for assessing Medicaid





eligibility such as income disregards, asset disregards and by increasing income and asset limits. A significant policy implication related to coverage expansion under Section 1931 is that under it, eligibility applies to families and the parents "cannot be made eligible for Medicaid without the children" (Dubay et al.) Statistically, approximately two-thirds of uninsured non-elderly adults do not have children and this group of uninsured would not be affected by Section 1931 expansions (ibid.).

The March 2000 issue of the *State Coverage Initiatives* newsletter profiles several primary issues facing states in their insurance coverage expansions. These include the complications of accurately estimating the number of uninsured, the complexity of benefit package design and the logistics of conducting evaluation research. For example, the CHIP program requires states to submit an evaluation of their program by March 31, 2000, "to document program achievements and to assess program effectiveness in achieving the goals of CHIP" (*State Coverage Initiatives*, 2000).⁸ Although such evaluation research offers tremendous opportunities in establishing program success and merits, states are challenged with such questions as identifying funding for evaluation and the time to conduct it in an accurate and reliable manner.

CONCLUDING REMARKS

State Coverage Initiatives program director David Helms points out that: "Solving the ongoing challenges of expanding coverage availability -- and eventually reversing the trend in uninsurance rates -- involves not only determining how to maximize the reach of existing programs, but also finding ways to extend coverage to additional categories of the uninsured." In analyzing the national health reform activities during the past few decades, he further observed that health reform "is an evolutionary process of sequential steps building on the success and failures of prior steps" (*State Coverage Initiatives*, 2000). The insur-

ance coverage initiatives of state-level policymakers, including those in New Jersey, are representative of this type of evolutionary process. Each, whether comprehensive or incremental in scale, having the goal to extend the greatest level of coverage to their uninsured.





ENDNOTES

¹New Jersey's percentage of uninsured lives closely mirrors the national percentage and was 16.4 percent in 1998. Reference is made to Employee Benefit Research Institute (EBRI) *Facts* and to the Kaiser Family Foundation's Commission on Medicaid and the Uninsured, which offer comparative state-level data on sources of health insurance and characteristics of the uninsured population. (See: www.ebri.org and www.kff.org.) See also: "Health Insurance Access, and Use: New Jersey." Tabulations from the 1997 National Survey of America's Families. State Profiles. Assessing The new Federalism. The Urban Institute. July 2000.

²There are four plans in the NJ KidCare program, each with different premium and co-payment requirements for specific services. NJ KidCare Plan A has income limits at 133 percent of poverty; Plan B has a range of 134 to 150 percent of poverty; Plan C has a range of 151 to 200 percent of poverty and Plan D's range is from 201 to 350 percent of poverty.

³FamilyCare income qualifications for single adults or childless couples require that their income does not exceed 100 percent of the poverty level.

⁴Title XXI funding is a block grant to states and offers a higher share of federal financial participation than provided through Medicaid. States have been given discretion in designing their CHIP programs and have a choice of expanding their Medicaid programs or establishing/expanding state-only programs.

⁵The Health Care Financing Administration (HCFA) has taken the lead in directing states to reach out to women and children who no longer receive economic assistance because of welfare reform, but may still be eligible for Medicaid health benefits and food stamps. In New Jersey, the Association for Children estimates that this number is close to 25,000 (Leusner, 2000). New Jersey state officials have launched an outreach campaign to identify and inform these eligible individuals that they may be able to receive health and food stamp benefits, based on their current income levels.

⁶Reference is made to several research projects focusing on state-level insurance coverage initiatives, including: the National Academy for State Health Policy's comprehensive review --The Flood Tide Forum. Access for the Uninsured: Lessons from 25 Years of State Initiatives, January 2000; Gold, Marsha. Evaluating State Health Coverage Expansions. Tools for State Policymakers. *State Coverage Initiatives*. February 2000; The Urban Institute's Assessing the New Federalism -- National Survey of America's Families Reports (in which New Jersey is one of 13 selected states for comparative study); and the *State Coverage Initiatives* (SCI) program's *Issue Briefs* and research findings. The SCI program conducts regional workshops (most recently during May, June and July 2000) to bring together key policy and program officials to explore state options for expanding health care coverage.

⁷On the federal level, President Clinton in his Fiscal Year 2001 budget proposed extending CHIP eligibility to the parents of eligible children; over the next ten years, \$76 billion would be allocated to do so (Wheatley, 2000).

⁸*The State Coverage Initiatives Program* (as was its predecessor program, *State Initiatives in Health Care Reform*) is administered by the Academy for Health Services Research and Health Policy (formerly the Alpha Center) through funding by The Robert Wood Johnson Foundation.





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