



FORUMS INSTITUTE
For Public Policy

**The More Things Change,
The More They Stay the Same:
Fifteen Years of Issue Briefs
from New Jersey Policy Forums**

**New Jersey Policy Forum
on Health and Medical Care**

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BACKGROUND

The origins of Forums Institute and the New Jersey Policy Forums on Health and Medical Care (NJPF) trace back to the beginning of the 1990s, when health care reform was high on the country's agenda. That year, the New Jersey League of Women Voters convened a nonpartisan, off-the-record gathering of policymakers from across the state to discuss impending health care actions at the national level and how these developments might affect Garden State residents. The meeting focused on health care cost containment and implications for access. It was held in Trenton, New Jersey, and included presentations by invited national and state resource experts. An originally researched and written Issue Brief that presented various points of view on the issue of escalating health care costs and strategies for containment was distributed at the meeting. Based on audience attendance and evaluations, it was viewed as a resounding success. In 1993, the Robert Wood Johnson Foundation provided major funding to the New Jersey League of Women Voters' Education Fund to plan and conduct a series of forums on a variety of timely health policy issues in New Jersey. Four years later, Forums Institute for Public Policy was established as a 501(c)(3) organization to administer the successful New Jersey Policy Forums program.

Since then, with program support of more than \$2.5 million from the Robert Wood Johnson Foundation, the Institute has convened more than 60 health care policy forums in New Jersey. Forums Institute differs from other health-oriented organizations because of the breadth and diversity of its health forums topics. Rather than being single-subject focused, forum topic selection reflected the issues found to be significant to the health policy community.

The purpose of the NJPF program was to make available to New Jersey decision-makers at all levels of government, and within the private sector, balanced, nonpartisan information, research and analysis of key health care issues. The program also provided 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, could take place.

Over the past 15 years, an extraordinary number of legislators, legislative staff (both partisan and non-partisan), executive branch administrators and policy-makers, physicians, nurses, hospital administrators, other health care professionals and representatives of interested organizations and parties have participated in the Forums. They have touched on a great many subjects, and offered a wide variety of opinions and insights; they have shared information, aired their differences, found common ground and otherwise contributed to—and benefited from—the always lively discussion and debate.

What has emerged from this experience is a body of work that—both on paper, in the form of Issue Briefs accompanying each Forum, and in the collective memory of participants—shapes and defines this 15-year period of rapid and significant change in the delivery of health and medical care in New Jersey.

This transformation may best be summed up by the motto of New Jersey's state university, Rutgers: "Ever changing yet eternally the same."

Or, as the French are fond of saying, *Plus ça change, plus c'est la même chose*. The more things change, the more they remain the same.

THE UNINSURED AND HEALTH INSURANCE COVERAGE STRATEGIES

To say that issues related to access to health insurance coverage and hospital charity care have been a persistent theme throughout the years of the Policy Forums would be an understatement. The first Policy Forum in 1992 dealt with the topic: "Paying for Uncompensated Hospital Health Care." It focused on coverage and access issues related to New Jersey's uninsured population. These same issues were again a focus of a 2007 forum, "The Health Policy Landscape: 2007 and Beyond."





In between nine other Forums dealt with this topic: “The Uninsured: An Unresolved Problem” (1995); “How Will NJ Fund Charity Care and Subsidize Health Insurance After 12/31?” (1995); “The Uninsured: An Ongoing Unresolved Problem” (1997); “Reaching Out to the Uninsured: NJ’s Initiatives to Expand Coverage” (2000); “The Future of Employer-Based Health Insurance” (2000); “Coverage Initiatives and Programs for NJ’s Uninsured: Survival in the Time of Budget Deficits & Cutbacks” (2003); “The Status of NJ’s Employer-Based Health Insurance Coverage” (2003); “An Overview of Charity Care in NJ—Past, Present & Future” (2004); and “Universal Health Care in Massachusetts: Implications for New Jersey” (2006).

In 1992, passage of the New Jersey Health Care Reform Act made substantial changes in the way hospitals were reimbursed for providing charity care to patients without insurance. The Legislature also enacted health insurance reforms to increase coverage for individuals and small employers. The new law scrapped the old formula for reimbursing hospitals for charity care by dedicating surplus revenues from the state’s Unemployment Insurance Trust Fund to a new Health Care Subsidy Fund. Under the 1992 act, approximately \$1.6 billion was to be diverted from the UITF over the following three years: \$600 million in 1993, \$500 million in 1994 and \$500 million in 1995.

The new health insurance programs—the Individual Health Coverage (IHC) Program and the Small Employer Health Benefits (SEH) Program—were created to present coverage opportunities for the uninsured. Another program, Health Access, provided subsidies to bring payment of insurance premiums within the reach of low-income New Jerseyans.

By the end of 1995, however, the money for these programs ran out. A five-month stalemate over the mechanism to be used for hospital charity care funding was broken when lawmakers agreed to continue using funds from the UITC, augmented by general revenues. But the level of funding—\$310 million for 1996 and \$300 million for 1997—was sharply reduced. And the Legislature failed to fund continuation of the Health Access program,

The 1996 law directed that a new delivery system for charity care be developed by January 1, 1998, and a Charity Care Managed Care Advisory Committee came up with a set of guidelines to carry out this mandate. The managed care model was never implemented, however, as changes to the law made participation in the model voluntary. Meanwhile, charity care funding shifted away from the UITF and toward general revenues, placing additional strain on the state budget with each passing year.

In 2004, a new formula was adopted for charity care subsidies to provide a more equitable distribution of payments. The new formula ranks hospitals on their “relative charity care percentage,” and bases compensation on that percentage. Statewide, hospitals would be reimbursed for 75 percent of the cost of charity care, with no hospital receiving less than 43 percent and the top hospitals receiving 96 percent. For Fiscal Year 1995, a total of \$583 million was committed to charity care—\$50 million from the UITF, \$55 million from a new tax on Health Maintenance Organizations (HMOs), \$31 million from a new tax on certain non-hospital ambulatory medical facilities, and \$447 million from general revenues.

As each succeeding administration and Legislature grappled with problems associated with funding charity care, a larger issue of health insurance access and coverage emerged: the alarming growth in the number of uninsured. By 2007, this had become a dominant area of concern for policy-makers.

Approximately 46.6 million Americans—one in every seven—have no health insurance coverage. That number has grown steadily in recent years, and represents an increase of roughly 15 percent since 2000. An additional 16 million Americans are under-insured, meaning their coverage does not grant them access to necessary care or catastrophic protection.

The high cost of health insurance is one of the top reasons people lack coverage; although most uninsured people are part of working families, they tend to have limited incomes and employers that do not





offer health benefits. The increasing number of uninsured is due in part to scarcer availability of employer-based coverage and the failure of public “safety net” programs, such as Medicaid, to help compensate for this loss in coverage.

In New Jersey, an estimated 1.2 million to 1.3 million residents are uninsured. Employer-based insurance covers 63 percent of the state’s population, a full ten percent higher than the nation as a whole. Lawmakers are considering adopting a system of universal coverage, patterned after programs in Massachusetts, Vermont and Maine, which would require state residents who lack insurance coverage to obtain it; those who could not afford private insurance would enroll in a state subsidized plan. Employers who did not offer health insurance would be required to establish flexible spending accounts for workers to purchase coverage using pre-tax dollars.

A package of bills to adopt a system of universal coverage has failed to move in the Legislature. Its sponsors acknowledge that the legislation is unlikely to gain any momentum until the state’s ongoing fiscal problems are resolved.

In March of 2006 the Legislature enacted a law which partially addressed the growing number of young adults who were without health insurance coverage. Recognizing this need, the Legislature required health insurers to allow certain dependents to continue to be covered under their parents’ health insurance policy until they turn 30 years old. Assembly Bill No. 3759, by Assemblyman Cohen, provided this coverage option for persons under 30, who are unmarried, have no dependents of their own, are not provided coverage elsewhere, and are a resident of the state or a student.

MEDICAID AND MEDICARE

In 1992, New Jersey’s Medicaid program served about 697,000 people and cost approximately \$4.8 billion, of which roughly half, or \$2.4 billion, was state money. In 2006, the state’s Medicaid program served more than 900,000 people and cost approximately \$9 billion, of which \$3.2 billion was state money.

Medicaid is the second-largest component of total state spending (21 percent), trailing only state aid to education (24.2 percent) and as such has long been a subject of intense interest, not only to health care policy-makers, but to executive branch officials and legislators concerned about its budgetary impact. Efforts to impose cost-control measures on the Medicaid program, at both the federal and state levels, have been afforded considerable attention.

Since its inception in the 1960s, there has been almost continuous debate over the course and direction of the Medicaid program. By the early 1990s, this debate focused primarily on congressional 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.

Discussions about restraining the growth of Medicaid expenditures focused on increasing costs to beneficiaries, cutting provider rates, restructuring the programs, accelerating the shift toward managed care and changing the nature of the entitlement. At the same time, the federal and state governments were confronted with the challenge of ever-escalating costs for long-term care—a challenge that grew in direct proportion to the aging of the nation’s population.

This, in turn, led to overlap between Medicaid and Medicare, with many elderly and disabled citizens eligible for participation in both programs. Passage by the U.S. Congress of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) further complicated matters. In addition to offering Medicare Part D prescription drug coverage beginning January 1, 2006, the new law included





a “clawback” provision requiring states to pay the federal government for prescription drug coverage under Medicare for so-called “dual eligibles”—the estimated 6 million low-income seniors and people with disabilities who received prescription drug benefits through Medicaid.

In early 2006, New Jersey joined four other states in filing a lawsuit in the U.S. Supreme Court challenging the provision of the new federal prescription drug benefits plan governing prescription drug coverage for dual eligibles under Medicare. New Jersey argued that the “clawback” provision was an encroachment on state sovereignty. In June of that year, the high court upheld the provision and declined to hear the case.

New Jersey’s per-capita “clawback” obligation is the highest of any state. This is because it also has the highest monthly per-capita drug expenditures (\$144.18) for dual eligibles in the country. Dual eligibles represent 17 percent of New Jersey’s Medicaid enrollees, approximately 140,000 individuals, a greater proportion than the 14 percent of dual eligibles estimated for the entire country. New Jersey provides 42 percent of total Medicaid spending to dual eligibles, compared to the 40 percent average across all U.S. states.

New Jersey was among the majority of states that reported widespread problems affecting large numbers of dual eligibles in the beginning of the transition period. Dual eligibles had trouble obtaining needed medications, and reports of overcharging were prevalent. To ensure dual eligibles maintained coverage for needed medications during the transition period, many states, including New Jersey, implemented temporary assistance programs.

In the Issue Brief prepared for a 2007 Policy Forum, “The Health Policy Landscape: 2007 and Beyond,” several questions were raised regarding the future of Medicare and Medicaid, and their impact in New Jersey:

- How might changes to drug pricing regulations at the federal level affect New Jersey’s current assistance programs?
- How might drug price negotiation efforts potentially affect New Jersey’s seniors enrolled in the Medicare drug benefit?
- To what extent will Medicare physician payment rate reductions expected for future years affect New Jersey’s patients and providers?
- Given the documentation requirements for Medicaid participants, how can states work to ensure simplified enrollment and renewal systems are maintained?
- What are the best cost-containment measures to pursue or continue to pursue in New Jersey?
- What will be the effect of the “clawback” provision on state finances?
- What are projections for Medicaid costs in the coming decade for the state?
- Has the incentive to reduce the state’s clawback payments resulted in pressures to limit Medicaid enrollment for dual eligibles?
- Are early issues from the transition to Part D being resolved for the state’s dual eligibles?
- The federally determined clawback formula was intended to calculate payments representative of what states would have paid to fund prescription drugs for its own dual eligibles via Medicaid; does New Jersey consider its obligation to be accurate?





CHILDREN'S HEALTH

A two-part series of Policy Forums sought to answer the following in 1997: “Does New Jersey Need to Renew Its Commitment to the Health of Our Children and Adolescents?” Ten years later, the well-documented controversy over reauthorization of the federal State Children’s Health Insurance Program (SCHIP) that pitted congressional supporters against President George W. Bush makes clear that the commitment to the health of children and adolescents remains a topical issue.

The SCHIP program was authorized in 1997 in response to growing concern about the number of uninsured children—which, at the time, ranged from a low of 4.8 percent in Vermont to a high of 26.1 percent in New Mexico. (The corresponding number in New Jersey was 10.4 percent.) A 1997 report by the New York City Public Advocate found that the number of children and adolescents without health insurance had increased twice as fast as the number of adults.

New Jersey, like most states, offered many health and medical programs for children and adolescents. Programs and services offered by the Department of Health and Senior Services included: Newborn Screening Program; Birth Defects Registry; Maternal and Child Health Consortia; Head Start; Healthy Mother, Healthy Babies; Childhood Lead Poisoning Prevention; Special Supplemental Nutrition Program for Women, Infants and Children; Communicable Disease Control; and Prevention Oriented Health.

In addition, the Department of Human Services provided assistance through the regular Medicaid program; Medicaid Expansion programs; New Jersey Care (for pregnant women and children under 13); New Jersey Care 2000 (mandatory Medicaid managed care); Health Start (an enhanced package of Medicaid benefits); Medicaid Model Waiver Programs; ABC program (home and community-based services for medically fragile children); and School Based Youth Services, among other programs.

Of all these programs, however, only one—Health Access New Jersey—provided direct access to health insurance coverage for qualified uninsured children. And this program was rapidly losing participants. In 1995, enrollment stood at 22,000; however, by the end of 1996, it had dropped to 16,696.

With passage of the SCHIP program in 1997, the U.S. Congress authorized ten years of funding to cover children in families with incomes too high to qualify for Medicaid but too low to secure private health insurance. The joint state-federal program reached the point where it covered more than four million children (22 million more were covered through Medicaid) by the time funding was set for expiration or renewal in September 2007.

Between June 2004 and June 2005, New Jersey experienced a ten percent growth in SCHIP enrollment, one of the largest increases across the states, compared to a 2.2 percent increase for the entire nation over the same period. The state program extended to children with family incomes of up to 350 percent of poverty, one of the highest eligibility levels in the country, and also extended coverage to their parents through the NJ FamilyCare program.

Before the September 2007 reauthorization deadline was reached, both houses of Congress passed a bipartisan measure to continue—and expand—the SCHIP program. The measure would have expanded coverage to over four million more participants by 2012. It called for a budget increase for five years totaling \$35 billion, increasing total SCHIP spending to \$60 billion for the five-year period. The expansion was to have been funded by increasing the federal excise tax from 39 cents to one dollar per pack of cigarettes nationwide.

On Oct. 3, 2007, President Bush vetoed the bill, stating that he believed it would “federalize health care” and expand the scope of SCHIP much farther than its original intent. The president said he was open to a compromise that would entail more than the \$5 billion originally budgeted, but would not agree to





any proposal drastically expanding the number of children eligible for coverage. The House of Representatives subsequently fell 13 votes short of the two-thirds majority required to override the president's veto, and representatives of the administration and Congress are working on a compromise measure.

Even before vetoing the SCHIP expansion bill, the Bush administration issued a directive informing states they would no longer receive SCHIP reimbursements for children in families over 250 percent of the federal poverty level unless certain conditions were met—conditions New Jersey Governor Jon Corzine characterized as “onerous and unattainable.” As a result, New Jersey filed a lawsuit challenging the president’s authority to limit eligibility for the SCHIP program. The status and outcome of both the SCHIP reauthorization discussions and the New Jersey lawsuit are unclear at this time.

PUBLIC HEALTH

Certain key issues in public health have been recurring themes throughout the lifetime of the Policy Forums. The relationships among federal, state and local public health agencies; administration of immunization programs; communicable disease control; maintenance of public registries and records; private-sector partnerships in public health—all these issues and more have been the subject of intense policy discussion over the years.

It is hard to separate these public health issues from the topics already mentioned: the uninsured and health insurance coverage, Medicaid and Medicare, children’s health. The role of federal, state and local public health agencies in carrying out policies to provide insurance coverage, to address Medicaid and Medicare issues, to promote children’s health has been an integral component of each and every Forum devoted to these matters.

From 1992 to 2000, a dominant theme in these discussions was the extent to which the emergence of managed care would affect traditional public health activities. An Issue Brief prepared for the 1996 Forum “Public Health at the Crossroads: Past, Present and Future” put the question succinctly:

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?

With more and more public health agencies relying on Medicaid reimbursement for providing direct services to clients, their role as “provider of last resort” was seen to be in danger of disappearing—a casualty of reductions in Medicaid and other health care spending and an increase in the number of uninsured and medically indigent members of their communities.

Managed care was a recurrent theme not only in the context of public health, but as an issue in and of itself throughout the 1990s. At least a half-dozen Forums dealt directly with managed care, including “Managed Care: Keystone to the Health Care Delivery System of the 1990s?” (1994); “Medicaid Managed Care” (1994); “Public Oversight of Managed Care” (1994); “Mental Health Policy in a Managed Care Environment” (1997); “Free Market or Free for All: Regulation and Managed Care” (1998); and “Public Oversight of Managed Care Revisited” (1999).

The events of September 11, 2001, prompted a dramatic shift in public attention to emergency and bioterrorism preparedness, and the Policy Forums of the next three years reflected this shift. Two





Forums in 2002—“Domestic Preparedness in the Age of Terrorism: The Role of Public Health” and “Domestic Preparedness in the Age of Terrorism: The Role of Public Health and Emergency Response Systems”—focused the attention of policy-makers on this now-timely subject. In 2004, two more Forums—“Public Health & Emergency Preparedness Systems and Resources: Issues and Status in 2004” and “Public Health & Emergency Preparedness in New Jersey: Part II”—examined in detail the role public health agencies were increasingly expected to play in dealing with the threat of terrorism.

CONCLUSION

How can 63 roundtable policy discussions covering the full panoply of timely and topical issues in health and medical care over a period of fifteen years be summarized in a single paper? Superficially, at best. Beyond the broad subject areas already described, the New Jersey Policy Forums on Health and Medical Care have tackled such disparate topics as quality assurance, health care research and data, the nursing workforce shortage, confidentiality of health information, medical malpractice liability and the cost of prescription drugs—issues that are every bit as timely today as they were when an impressive group of interested and engaged New Jerseyans first convened to discuss them in Trenton.

The body of work that set the tone for discussion at each of these Forums is assembled in the compendium of issue briefs retained by the Forums Institute for Public Policy. The full text of the issue briefs prepared for Forums held since December 1997, and summaries of those accompanying Forums held between June 1996 and December 1997, may be found on line at www.forumsinstitute.org. Printed copies of earlier issue briefs may be requested by contacting Forums Institute at fippadmin@forumsinstitute.org.





APPENDIX I

POLICY IMPLICATIONS – THEN AND NOW

At the Policy Forums and in the Issue Briefs, we raised questions related to the policy implications of the health care topic. This is a snapshot of some of those questions that were posed over the years.

The Health Policy Landscape: 2007 and Beyond

What are the best cost-containment measures to pursue or continue to pursue in New Jersey?

Sustainable Communities for All Ages – 2006

How can states and communities respond to the development of policies and program that support an active and healthy lifestyle across the lifespan?

Long-Term Care in New Jersey – 2005

The Issue Brief ends with the statement, “although policymakers and stakeholders may have different approaches to address the issue, there is certain consensus that the growth of Medicaid long-term care expenditures must be slower and innovative options must be employed for the future.” Has that happened?

Public Health and Emergency Preparedness Systems and Resources – 2004

How are internal and jurisdictional challenges remedied in order to create a seamless system of response?

Quality – 2002

How should policy makers view the implications of the role of the consumer in making informed choices regarding health plans and health care?

How do these behaviors tie in with the design of patient protection laws and regulations?

Nursing Workforce Shortage – 2001

What strategies is New Jersey exploring to estimate and address shortages in other allied health professions in the state?

How can support for collaborative partnerships (which have had success) in nursing education and practice be sustained as potential long-term strategies?

Public Health Financing – 2000

Both national and state policy makers acknowledge the necessity for shifting towards collaboration and coordination of public health services. How can the move towards collaboration and coordination be achieved while preserving the integrity of each stakeholder?

In what ways and through what channels can “good information” be disseminated about the critical importance of public health in New Jersey?

How does leadership find identity in the public health environment?

Employer Based Health Plans – 2000

What are the implications for policy makers regarding health care coverage for retirees, particularly in New Jersey with its high percentage of elderly residents?





Public Oversight of Managed Health Care – 1999

How should state policy makers deal with disputes between patients and health plans over coverage decisions and claims of harm due to denials of coverage?

Demographics, Diversity and Accountability – 1999

What is the future of New Jersey's legislative vision to address issues related to cultural competency as its population continues to grow more racially and ethnically diverse?

In what ways do our general policies about end of life issues affect those from different cultural backgrounds?

Public Health at the Crossroads – 1996

How will the complex system of public health, whose structure is comprised of federal, 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?

Will the Business and Financial Realities of the 21st Century Eliminate the Role of State Government in Health Care Decision Making? – 1996

How do 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 Uninsured – An Unresolved Problem – 1995

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

National Initiatives and Implications for New Jersey Health Care Reform – 1994

Should anyone be in a position to monitor and comprehend the forces (market, regulatory, other) which are having such a dramatic impact on how and where we receive health care services?

Public Oversight of Managed Care – 1994

What are the pros and cons of over-regulation or relaxing regulation significantly?

Health Care Purchasing Power in New Jersey – 1993

What is the best format for an on-going analysis of the relationship between funding sources and health services?