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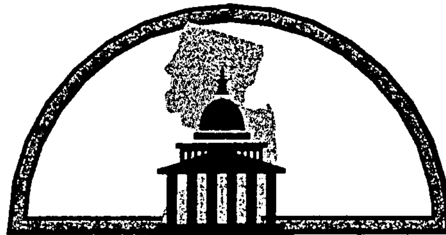

National Initiatives and Implications for New Jersey Health Care Reform: An Unfolding Saga

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An issue brief prepared by Howard S. Berliner, Sc.D.
for discussion at the September 21, 1994 Capitol Forum.

The Issue:

Independent of any action in Congress, New Jersey will have to continue to make changes in its health care system in order to improve quality, reduce costs, and increase the numbers of residents with adequate health insurance and with access to preventive, primary care, and specialty services. What role will the state of New Jersey play as its health care system continues to develop?

The National Context

For the past year and a half, the attention of the nation has been focused on proposals for health care reform. Beginning with the Clinton Health Care Task Force that emerged with the Health Security Act, introduced into Congress in November 1993 and continuing with several other pieces of legislation. As of late August 1994 there are two health reform bills in front of Congress: the House Leadership bill (Gephardt) and the Senate Leadership bill (Mitchell) that may be debated. The Clinton timetable called for passage of bills in each house by the end of August, conference committee work to reconcile the differences by the end of September and final votes on the legislation in each house in October allowing for the President to sign the emerging legislation before the mid-term elections in November. This timetable was optimistic at best, and there is a growing likelihood that either no legislation will emerge or that Congress will delay the passage of any bills until after the elections or later.

The questions of how national health care reform will affect New Jersey is obviously one of great concern to the state. In this light, in May 1994, Health Commissioner designate Fishman established an Advisory Panel on Federal Health Care Reform charged with advising him on the impact of federal proposals on New Jersey in the areas of: business and industry, public programs, consumers, providers, and the uninsured. The purpose of this panel was to assemble data that could guide the Commissioner as well as the Congressional delegation on the impact of specific health reform proposals on New Jersey. The Panel looked at the impact of three (then) current bills before Congress: Health Security Act (Clinton plan), Managed Competition Act (Cooper), and the Chafee bill. None of these bills remain as contenders for national health reform as of today, although pieces of each of them still exist in the legislation before Congress.

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Deregulation of Hospital Rate Setting

In less than ten years, New Jersey has gone from a completely all-payer system (with all hospital reimbursement rates virtually the same), to a quasi all-payer system (with Medicare, the largest payer for hospital services paying a separate rate), and finally to an unregulated payment system with some allowances made for charity care. Hospitals are now allowed to charge patients whatever rate they want and payers can seek discounts from those rates.

Insurance Reform

Two state insurance panels, one for individual coverage, and one for small group coverage authorized by the Health Care Reform Act of 1992 developed five standard health insurance plans (plus an HMO plan) of increasing coverage to be offered by all carriers wishing to do business in the state. New Jersey also mandated community rating for individual and will phase it in over 2 years for small group health insurance. It places limits on medical underwriting and pre-existing conditions. The reform has allowed 72,000 new individual policies to be issued within the past year with indications of greater growth in the future. The New Jersey Access program, developed by the Essential Health Services Commission, will begin to subsidize the purchase of health insurance by the unemployed and the working poor.

Growth of Managed Care

Managed care has grown rapidly in New Jersey as more employers switch from traditional indemnity insurance to HMOs and PPOs of various types. Managed care serves to lower hospital use rates and to stress ambulatory care, thus forcing a change in the way that health services are delivered. As of July 1993, New Jersey had 991,986 residents enrolled in managed care plans ranking it 11th in the U.S. for enrollment with 12.7% of its resident population enrolled. This does not count the increasing number of Medicaid recipients in managed care programs.

Role of the Market

As health care has become more expensive, employers are becoming more involved in efforts to reduce or constrain costs. This has prompted the growth of managed care and other cost containment mechanisms. Whether the changes that are occurring in the health system are permanent or merely represent the efforts of providers to reduce the focus on costs remains to be seen.

The Interim Period - Issues

Given the current uncertainty surrounding national health reform, it is critical that the health care system continue to develop in New Jersey in order to improve quality, reduce costs and increase access. In many ways the system that New Jersey

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Managed Care

The growth of managed care noted above has taken place in a largely young, healthy population. How will New Jersey deal with the growth of managed care among special populations such as the disabled, those in need of chronic long term care, and those with special health problems (such as mental health and substance abuse)? How will plans be prevented from "creaming" and how will an equitable distribution of these patients to HMOs around the state be guaranteed?

Uninsured Citizens

New Jersey has over 800,000 residents who lack health insurance at any given time, over 12.3% of its under-65 population. The state has attempted to provide health care for the uninsured population by providing hospitals with funds to enhance their care for needy patients, and by establishing a system of subsidies to make the cost of health insurance less expensive. It is fair to say that New Jersey is well in front of most other states in the country in its provision of such services, and as a result, the implications of universal coverage (or some variant of that concept) will not be as important to New Jersey as it will be to other states.

Undocumented Residents

New Jersey has a substantial number of undocumented residents living within the state. Because these individuals cannot provide the necessary documentation to receive charity care, hospitals which provide services to them will generate bad debt for which they will not be reimbursed. Moreover there is some concern over the ability of the undocumented to receive adequate primary and preventive care services. There is also concern about their health with respect to contagious disease. How can the state ensure that the undocumented will receive adequate care and where will the funds to reimburse hospitals and providers come from for this purpose?

The Re-Forming System: Economic Consequences

The delivery of health care is currently in transition and this will continue independent of any national reform. There will be a substantial change in the way the health system looks and it will differ greatly from its present configuration. A reformed health system is predicated on the transition from a hospital centered system to one which is ambulatory care centered. The speed at which this transition takes place is difficult to measure but it involves two complementary processes: downsizing hospitals and establishing primary care centers. For the process to work correctly the two must occur in tandem, but this is far easier to say than to put into practice.

Shift from Hospitals to Ambulatory Care Centers

Hospitals are the most expensive component of the health care system, nationally responsible for over 40% of total health care costs. To lower the cost of health care,

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reforms include limiting the numbers of residency positions to 110% of the domestic medical school graduating class, requiring 50% of residency positions to be in primary care medicine, and reducing Medicare payments for indirect medical education expenses. The resistance to these reforms from states that do substantial residency training (such as New York) has been intense and may block such changes. Since the medical schools in New Jersey are state institutions, there is a far greater possibility of change in this state than in many others.

Impact on Workers and Facilities

It has been estimated that the number of acute care hospitals nationally will be reduced by 15-20% as a result of health reforms such as the transition to managed care. For the approximately 29,000 acute care beds in New Jersey this could amount to between 4,500 and 6,000 acute care beds lost. The inability to close or substantially downsize hospitals in the state will need to change, but exactly what are the new forces that will accomplish this? Assuming 5,000 beds are taken out of the system over the next few years, and assuming there are 3.1 full time equivalent health care workers per bed, what will happen to the 15,000 hospital health workers who will lose their jobs? Can they be retrained to take on other positions within the health field and if so what would these positions be and what would the retraining programs look like? What new jobs will they be eligible for and where will they be located?

Health care is assumed to have a high economic multiplier effect (each health dollar causes the spending of other dollars) and for areas which have a large number of health facilities the impact of downsizing on overall employment and overall economic development could be severe (e.g., Newark, New Brunswick, Camden). What will the impact of closing hospitals be on spin-off and related economic activities? National projections suggest that the health industry as a whole will continue to grow, but the actual configuration and location of jobs within smaller areas has yet to be satisfactorily determined.

Since the passage of Medicare and Medicaid in the mid-1960s, we have used the health care system as a jobs program. The costs were spread over a large base and hospital employment tended to give many low and unskilled people career paths, institutional employment, and fringe benefits. We can easily reduce the cost of health care by eliminating these jobs but will the overall cost to society be lower if the displaced people go on Medicaid, receive Welfare and collect unemployment checks? How can New Jersey redirect its health worker training programs so that current students will learn skills that will not leave them at the mercy of restructuring forces that will keep them from working in chosen fields? Who will coordinate these efforts at a state level?

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tial commitment to the provision of care for New Jersey residents through the use of the teaching hospitals of UMDNJ. Will there still be the need to perform that service if there is universal access to care? How can legislators be assured that there will be an equity in the distribution of health care services to all communities within the state?

In part because health care was thought to be best left to local communities, and in part because it was perceived as ethically wrong to profit from people's illness, proprietary health care has never been a central feature of the U.S. system, particularly in the Northeast where there has been a long tradition of organized voluntary community hospitals. If all people in the U.S. have guaranteed access to care, as could happen under national health reform, much of this issue fades away. If for-profit institutions can provide care in a cost-effective and cost-efficient manner and can attract patients, it will be difficult to argue against them. At the same time, the concept of charity care begins to fade away as everyone is now covered for their health care. What then is the need for tax-exemption of not-for-profit hospitals? What will be the implications of the (anticipated) expansion of for-profit companies? What should the role of the state be in the provision of care in an era of universal access?

Regulation of Managed Care

The growth of managed care in all its different entities (i.e. HMOs, PPOs, PHOs etc.) has both been both an outcome of previous health reform strategies as well as a response to new health system problems. All of the bills under consideration in Congress would promote the growth of managed care. It is not uncommon to find estimates of managed care growth of from its current 18% of the national population in 1993 to 25-30% by the year 2000. Much of the new growth of managed care is coming from Medicaid Managed Care programs that have been springing up across the country (36 states now have Medicaid Managed Care programs). To what extent will "caveat emptor" apply in the managed care field and to what extent will New Jersey take responsibility for the regulation of HMOs and other managed care entities. How will the state interface with operational activities and how will it deal with financial problems, consumer complaints, and other potential issues? How will the state ensure that managed care companies provide service to poor communities and have a distribution of providers that is beneficial to all residents of the state?

Conclusion

The health care system in New Jersey, as in the rest of the country, is in a state of flux. The changes currently underway may seem mild compared with those changes that are expected in the near future. The question of what the health care system in New Jersey should look like is important but is secondary to the larger

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Questions

1. If there is national health reform and if it is different from the way that services are currently provided in New Jersey, should the state attempt to keep its own system or should it adapt to a national model? Should the New Jersey Congressional delegation fight to allow states to waiver out of a national system to protect what is currently in place?

2. The regulation of health care services in New Jersey is currently split between several governmental departments including Department of Health, Department of Human Services, Department of Treasury, Department of Community Affairs. Given that the cost of transforming the New Jersey health care system will be expensive and will require a considerable amount of money and coordination, where will the funds come from and who will be responsible for the organization of services? Should a new department be established that will be better able to coordinate services?

3. What role will the public play in a reformed health care system? How will insurance companies, health care systems and networks, and government meet the needs of the public and be responsive to the residents of the state? What entity will assure that there are no gaps in the system and that access to care is equitable to all residents of New Jersey? Where does responsibility for access to care end and public health start?

4. Should the state of New Jersey continue to play a role in the assurance of and upgrading of the quality of health care? If not, who should play that role?

5. It is clear that there will be a need for substantial amounts of current data about the extent of insurance coverage, current business practices, current costs of health care. Can the state ensure that this data will be collected and analyzed in a timely fashion? What new processes and mechanisms are necessary for this data to be made available? Who should coordinate the collection, analysis and dissemination of the data?