



**ASSESSING STATE STRATEGIES
FOR HEALTH COVERAGE EXPANSION:
CASE STUDIES OF OREGON, RHODE ISLAND,
NEW JERSEY, AND GEORGIA**

Sharon Silow-Carroll, Emily K. Waldman,
Jack A. Meyer, and Claudia Williams
Economic and Social Research Institute

and

Kimberley Fox and Joel C. Cantor
Center for State Health Policy at Rutgers University

FIELD REPORT

November 2002

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and should not be attributed to The Commonwealth Fund or its directors, officers, or staff.

Copies of this report are available from The Commonwealth Fund by calling its toll-free publications line at **1-888-777-2744** and ordering publication number **565**. The complete report can also be found on the Fund's website at **www.cmwf.org**.

ACKNOWLEDGMENTS

The authors gratefully acknowledge the support of The Commonwealth Fund. They would like to thank the people with whom they met in each of the states profiled in this report who were generous with their time and provided valuable information about the state coverage programs.

About the Economic and Social Research Institute

The Economic and Social Research Institute (ESRI) is a nonprofit organization that conducts research and policy analysis in health care and in the reform of social services. ESRI specializes in studies aimed at enhancing the effectiveness of social programs, improving the way health care services are organized and delivered, and making quality health care accessible and affordable.

About the Center for State Health Policy

Rutgers Center for State Health Policy (CSHP) informs, supports, and stimulates sound and creative state health policy in New Jersey and around the nation. CSHP provides impartial policy analysis, research, training, facilitation, and consultation on important state health policy issues. Established in 1999, the Center is the newest research unit within the Institute for Health, Health Care Policy, and Aging Research at Rutgers University, New Brunswick, New Jersey.

ABOUT THE AUTHORS

Sharon Silow-Carroll, M.B.A., M.S.W., is a senior research manager at ESRI. Ms. Silow-Carroll's areas of expertise include health care reform strategies and meeting the needs of vulnerable populations. Her recent projects include: assessing state and local efforts to promote employment-based insurance; analyzing potential consequences of Internet-based tools for purchasing health insurance; reviewing community-based efforts to reduce financial and non-financial barriers to care; and developing a comprehensive strategy for expanding access to health care for at-risk populations. She is the author of an ESRI book analyzing the corporate/employer role in providing health care coverage to workers and families from economic, social, and cultural perspectives. She has also authored numerous reports and articles analyzing public- and private-sector initiatives aimed at enhancing access, containing costs, and improving quality of health care. Ms. Silow-Carroll received a master's degree in business administration from the Wharton School, University of Pennsylvania, and a master's degree in social work from the University of Pennsylvania School of Social Work.

Emily K. Waldman, M.H.S., is a senior policy analyst at ESRI. Most recently, Ms. Waldman has researched state and local initiatives to expand health coverage for the working uninsured. She also has evaluated public- and private-sector strategies to improve access to health insurance coverage and health care delivery for the District of Columbia Mayor's Health Care Systems Development Commission. Ms. Waldman also has conducted policy research and analysis on the issues confronting urban safety net institutions and academic medical centers, as well as studied the implications of managed care programs for people dually eligible for Medicare and Medicaid. Ms. Waldman received a master's degree in health sciences from the Johns Hopkins University School of Hygiene and Public Health.

Jack A. Meyer, Ph.D., is the founder and president of ESRI. Dr. Meyer has conducted policy analysis and directed research on health care access issues for several major foundations as well as federal and state government. He has led projects on community-wide reforms covering all regions of the U.S. Many of these projects have highlighted new strategies for overcoming barriers to health care access and innovative designs for extending health insurance coverage to the uninsured. Dr. Meyer is the author of numerous books, monographs, and articles on topics including health care, welfare reform, and policies to reduce poverty. Dr. Meyer has also directed recent studies on building quality improvements into employer purchasing, Medicaid managed care for people with disabilities, the State Children's Health Insurance Program to extend coverage to lower-income children, and assessments of reform proposals to extend health coverage to

workers in small firms. Dr. Meyer received a Ph.D. in economics from Ohio State University.

Claudia Williams, M.S., is president of AZA Consulting. She has research and policy development expertise on issues ranging from health coverage reform to Medicaid and CHIP policy and community health assessment. Prior to founding AZA Consulting, Ms. Williams worked as a senior policy analyst in the Office of the Assistant Secretary for Planning and Evaluation in the Department of Health and Human Services, where she co-led the development of the congressionally mandated CHIP evaluation, and as a senior manager at The Lewin Group.

Kimberley Fox, M.P.A., is a senior policy analyst at the Center for State Health Policy at Rutgers, where she currently directs projects related to pharmacy coverage, health insurance and access to care, and health care performance measurement. Prior to coming to CSHP, Ms. Fox was a senior research associate at Baruch College School of Public Affairs. She has extensive experience in health policy research and planning for at-risk populations, having worked as deputy director of planning at HIV CARE Services division of Medical and Health Research Association, deputy director of policy research at the Center on Addiction and Substance Abuse, and senior research analyst at the United Hospital Fund of New York City. Ms. Fox received her master's degree in public administration from the Maxwell School of Public Citizenship in 1986.

Joel C. Cantor, Sc.D., is the director of the Center for State Health Policy and professor of public policy at the Edward J. Bloustein School of Planning and Public Policy at Rutgers. Dr. Cantor's research focuses on issues of health care financing and delivery at the state and local levels. His recent work includes studies of the effect of health care market competition on access to care, the organization of the health care safety net for the uninsured, and the role of minority physicians in improving access to care of underserved populations. Dr. Cantor has published widely on health policy topics and serves on the editorial board of the policy journal *Inquiry*. Prior to joining the faculty at Rutgers, Dr. Cantor served as director of research at the United Hospital Fund of New York and director of evaluation research at the Robert Wood Johnson Foundation. He received his doctorate in health policy and management from the Johns Hopkins University School of Hygiene and Public Health in 1988, and was elected a fellow of the Academy for Health Services Research and Health Policy in 1996.

CONTACT INFORMATION FOR CASE STUDY STATES

Oregon

John Santa, M.D.
Administrator
Office for Oregon Health Plan Policy and Research
Telephone: 503/378-2422 ext. 401
E-mail: john.santa@state.or.us

Rhode Island

Tricia Leddy
Administrator
Center for Child and Family Health
Rhode Island Department of Human Services
Telephone: 401/462-2127
E-mail: tricial@gw.dhs.state.ri.us

New Jersey

Kimberley Fox
Senior Policy Analyst
Center for State Health Policy
Rutgers, The State University of New Jersey
Telephone: 732/932-3105 ext. 235
E-mail: kfox@cshp.rutgers.edu

Georgia

Sean Cucchi
Chief
Office of Planning and Fiscal Policy
Georgia Department of Community Health
Telephone: 404/656-0655
E-mail: scucchi@dch.state.ga.us

NEW JERSEY

The objective in studying New Jersey was to explore the factors and challenges related to the state's active involvement in health coverage initiatives. New Jersey has been at the forefront of insurance market reform, public subsidies for private insurance, and expansion of public coverage for children and adults. Some initiatives were more successful than others, but all provide valuable lessons to other states.

Summary

Over more than a decade, New Jersey has sought to expand health insurance affordability and accessibility, first through regulatory reforms in the private market and later through expansions in public coverage and subsidies to low-income families. In the early 1990s, New Jersey was one of the first states to introduce comprehensive reforms in the small-group and individual purchase insurance markets to promote access to affordable coverage regardless of health risk and to encourage price competition among carriers. Since the mid 1990s, the state has also been a leader in expanding publicly subsidized coverage. New Jersey's State Children's Health Insurance Programs (CHIP), including the NJ KidCare program, initiated in 1998, and the NJ FamilyCare program, initiated in 2001, have among the most generous eligibility criteria in the country, with more than 238,000 adults and children enrolled in 2001.²⁵ As a result of these programs, as well as a strong private coverage market, the uninsured rate among the nonelderly in the state declined to 14.4 percent in 2001 from a high of 19.1 percent in 1996 (Table 7).

Table 7. New Jersey State Profile and Overview, 1999–2000

New Jersey	
Total population	8,186,500
Nonelderly population	7,117,310
Total population under 200% FPL	2,218,490
Insurance status of nonelderly	
Employer	5,295,890
Individual	267,430
Medicaid	562,480
Uninsured	991,520
Insurance status of nonelderly under 200% FPL	
Employer	639,874
Medicaid	106,958
Uninsured	586,190
Percent of All Uninsured	59%

Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2000 and 2001 Current Population Surveys (www.statehealthfacts.kff.org).

²⁵ As of 12/3/01. Office of Statistical Analysis and Managed Care Reimbursement, Department of Human Services.

In contrast to some other states that have initiated comprehensive health care reform, New Jersey's coverage initiatives have been incremental and developed over time. The key features of New Jersey's health care access expansions include:

- a combined focus on stabilizing coverage in the private sector and expanding state-sponsored coverage;
- flexibility in its public coverage expansion in program design, outreach, and administration to improve enrollment of children, including a willingness to shift focus from solely covering children to covering parents and some childless adults; and
- consideration of the relationship of public programs to private coverage and an emphasis on maximizing private coverage through such efforts as an employer buy-in program.

Many factors contributed to the successful enactment of New Jersey's various initiatives. Individual (i.e., non-group) and small-group insurance market reforms were achieved, in large part, as a result of the need to avert collapse of the state's insurer of last resort, Blue Cross Blue Shield. The regulatory culture in the state and its history of engaging stakeholders in shaping policy solutions enabled a broad coalition to reach consensus rapidly on these reforms.

The successful enactment of the NJ KidCare and NJ FamilyCare programs can be attributed to the support of the governor and a favorable fiscal environment, stemming initially from the availability of federal CHIP dollars, a strong economy, and buoyant state tax receipts, and later from tobacco settlement funds. Strong entrepreneurial leadership from the governor's staff and creative state policy officials also contributed greatly to program development and enactment.

New Jersey overcame significant obstacles in creating its policy initiatives that may be instructive for other states considering similar initiatives. The insurance reforms enacted in 1993 and 1994 were among the most inclusive in the nation, with open enrollment and pure community rating.²⁶ However, resistance by small business interests to the breadth of these reforms led to significant softening of the rating regulations in the small-group market. While pure community rating in the individual market initially did not have the feared impact of rapid premium increases, over time prices have risen steadily, making

²⁶ Community rating requires that all purchasers be charged the same premium based on the experience of the entire group; premiums cannot vary by an individual's health status, age, gender, or geographic location.

direct purchase of insurance unaffordable for many. Since 1996, the number of individuals covered in this market has declined by about 3 percent per quarter. The state also learned some important lessons from its initial attempt to subsidize health insurance purchase in the individual market. The insurance reforms included the creation of the ACCESS program, a subsidy program for low-income persons wishing to purchase insurance directly through the individual market, which proved to be administratively complex and a costly mechanism for covering the uninsured. As a result, the ACCESS program was phased out and was eventually replaced by more comprehensive efforts to expand Medicaid and CHIP.

Like CHIP initiatives in most other states, the NJ KidCare program experienced early difficulties reaching enrollment targets. Program managers were quick to respond with aggressive outreach strategies. Enrollment eventually moved closer to expectations, but only after garnering considerable criticism from state legislators and the media. The state's enrollment experience in NJ FamilyCare was very different. After opening CHIP to parents and other adults, program enrollment reached its three-year target in just nine months. The extent of the response of adults to NJ FamilyCare, especially among parents earning between 134 percent and 200 percent FPL, who are required to pay monthly premiums, has been attributed to widespread awareness of the program resulting from a statewide multimedia campaign and the existing KidCare program, as well as to a significant unmet need for affordable health insurance in the adult population. The rapid enrollment of adults in NJ FamilyCare combined with the emergence of a significant state budget shortfall led to the need to control program growth. In response, the state closed enrollment to adults without children (with the exception of general assistance beneficiaries) in September 2001, stopped outreach and marketing, and allocated an additional \$25 million in fiscal year 2001 in order to maintain coverage for parents. Today, applications for NJ FamilyCare are still arriving in large numbers, and the state is considering additional strategies to contain costs. The state has also faced delays in its employer buy-in program under NJ FamilyCare and difficulty in demonstrating cost-effectiveness as defined by the CHIP federal waiver requirements. As a result, it is unlikely to reach its revenue target from this source.

The state faces even greater financial challenges ahead. Unrestrained state spending and tax cuts in recent years positioned New Jersey poorly for the economic shockwaves of September 11 and the national economic downturn. New Jersey faces one of the largest state budget deficits in the country. The slumping economy is likely to increase the number of uninsured in the state, while the capacity of the state to extend or even maintain its current coverage efforts is in doubt.

This case study presents a brief history of New Jersey’s health insurance coverage initiatives over the past decade, describes the elements that facilitated their success and the obstacles they have encountered, and discusses future challenges that the state faces in maintaining one of the most far-reaching coverage expansion programs in the nation.

Background: Development of New Jersey’s Coverage Initiatives

New Jersey’s health insurance coverage initiatives span more than a decade and cross the administrations of opposing political parties. During that time, access to affordable health insurance remained a top priority, although the focus shifted from the general adult population to achieving near-universal coverage for children.

Coverage initiatives in New Jersey generally fall into two periods: insurance market reforms in the early 1990s and child (and later family) subsidized coverage expansions in the late 1990s and early 2000s. These separate initiatives were not designed as a single, comprehensive strategy but instead represent an incremental approach to coverage expansion. In many ways, however, the experiences of earlier initiatives informed and facilitated subsequent coverage programs. The following discussion summarizes the key features of these initiatives.

Insurance Market Reforms of the Early 1990s

Individual and Small-Group Market Reforms

In 1992, the individual (i.e., nongroup) market in New Jersey was on the brink of collapse. Blue Cross Blue Shield (BCBS), which was subsidized by the state as the carrier of last resort, faced looming shortfalls and was near bankruptcy. The courts had ruled that the state’s hospital rate-setting mechanism, which was the primary mechanism for subsidizing BCBS, violated federal law. Although later overturned, the court decision catalyzed a sea change not only in hospital financing but also in the structure of insurance reforms in the state. To preserve the state’s individual market while unburdening BCBS, policymakers crafted a solution with the assistance of key industry and consumer representatives that provided guaranteed-issue, renewability, limits on preexisting conditions, and full community rating. Lauded as one of the most comprehensive reform packages in the country, the reforms included a unique “pay or play” requirement mandating that all health insurance carriers operating in the state either issue individual coverage or pay an assessment to cover a proportionate share of the reimbursable losses of those carriers that did sell in the individual market. Carriers that issued coverage also could choose to seek an “exemption” by agreeing not to seek reimbursement and by writing an assigned target of individuals. The reforms were generated, in large part, by the insurance industry itself. As a result, they included both stricter requirements on carriers and reduced

regulatory burdens. For example, the laws established an independent board to which carriers would submit premium change filings, replacing the existing prior approval required from the Department of Banking and Insurance.²⁷

At the same time as individual market reforms were unfolding, the state also enacted reforms in the small-group market, largely in response to pressure from the business community. Small employers, particularly the smallest firms, were being excluded from the market through medical underwriting practices. Many could not get coverage or were getting limited coverage because of exclusionary riders or preexisting condition exclusions. The difficulties of acquiring and maintaining health coverage in small businesses also were believed to limit job mobility among higher-risk employees. In addition, limitations in the small-group sector were reportedly leading excluded higher-risk workers to seek coverage in the individual market. Based on the same principles as the reforms in the individual market, small-group reforms required guaranteed issuance, guaranteed renewability, and limited exclusions for preexisting conditions in businesses with between two and 49²⁸ full-time employees. To be eligible to purchase the small-group coverage packages, small employers were required to pay at least 10 percent of premiums and achieve a minimum employee participation rate of 75 percent.

The original small-group coverage law also included rating restrictions. Ratings could be based only on age, gender, and geographic classifications and were not permitted to vary by more than a 3:1 ratio, which was to be gradually phased in to full community rating with at least 75 percent of premiums going toward medical expenses.²⁹ Under these rules, many employers experienced significant rate increases, and under political pressure, the state amended the rating reforms in 1996, freezing the premium variation ratio at 2:1, rather than moving to full community rating.

Another important feature of both the individual and small-group coverage reforms was standardization of benefit packages to simplify price comparison for purchasers (Figure 3, Table 8). The new laws required that no plans be sold in the individual market other than those approved by the state-appointed oversight board. This unique approach contrasts with most other states that either do not standardize plans or require that specific standard basic, standard, or catastrophic plans be offered, but permit the sale of other,

²⁷ Swartz, K. and Garnick, D., “Hidden Assets: Health Insurance Reform in New Jersey,” *Health Affairs*, Vol. 18, No. 4, 1999.

²⁸ With the passage of the Health Insurance Portability and Accountability Act, New Jersey modified its definition to two to 50 employees to comply with federal requirements.

²⁹ A 3:1 rating band meant that the highest-cost demographic/geographic rate cell could not be charged more than three times that which the lowest-cost cell is charged for the same product. Pure community rating permits no variation in price whatsoever for a given product.

nonstandard plans as well. Similarly, in the New Jersey small-group market, carriers are permitted to offer only standard benefit plans—including one managed care plan and five indemnity plans that may be offered also as a preferred provider organization or point-of-service plan. To stave off opposition by small employers with existing plans, the state allowed some such plans to be “grandfathered” and made available to new groups, albeit with significant limitations. The state also allowed for riders to add to the benefit package. But, in general, small businesses have bought the standard packages, with only 2 percent of the small-group market currently purchasing pre-reform plans.

Figure 3. New Jersey Individual and Small-Group Market Post-Reform Enrollment, 1993–2001

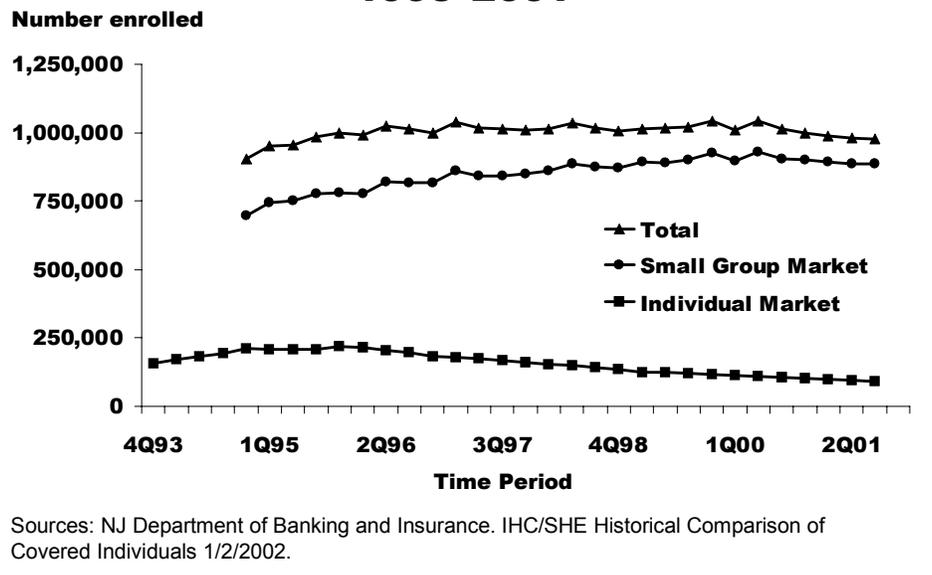


Table 8. New Jersey Standardized Individual Purchase and Small-Group Benefit Plans, 2002

Individual Plans	Co-insurance	Deductible/Copayment Options	Hospital Confinement Copay	Coverage Benefits
PLAN A/50	50%	\$1,000/\$2,500/\$5,000/ \$10,000 deductible	No	Office visits; hospital care; prenatal and maternity care; immunizations and well-child care; screenings, including mammography, pap smears and prostate examinations; x-ray and laboratory services; certain biologically based mental illness, alcoholism, and substance abuse services; prescription drugs. No deductible or coinsurance for routine physicals and other preventive care — up to \$300 per year per person and up to \$500 for newborns until the end of the calendar year in which the child attains age 1.
PLAN B	40%	\$1,000/\$2,500 deductible	Yes-In addition to deductible \$200 for up to 10 days per year.	Same covered benefits as Plan A/50.
PLAN C	30%	\$1,000/\$2,500 deductible	No	Same covered benefits as Plan A/50
PLAN D	20%	\$500/\$1,000 deductible	No	Same covered benefits as Plan A/50
HMO	Carriers have the option to cover drugs at 50%	\$10/\$15/\$20/\$30 copays	Yes	Same covered benefits as Plan A/50

Small-Group Plans	Co-insurance	Deductible/Copayment Options	Hospital Confinement Copay	Coverage Benefits
PLAN A	80% hospital 50% all other	\$250 deductible	\$250 for up to 10 days per year	Up to 30 days hospital, very limited coverage provided out of hospital
PLAN B	40%	\$250/\$500/\$1,000/\$2,500 deductible	Yes-In addition to deductible \$200 for up to 10 days per year.	Office visits; hospital care; prenatal and maternity care; immunizations and well-child care; screenings, including mammographies, pap smears and prostate examinations; x-ray and laboratory services; certain biologically based mental illness, alcoholism, and substance abuse services; prescription drugs. No deductible or coinsurance for routine physicals and other preventive care—up to \$300 per year per person and up to \$500 during the first year of a newborn's life.
PLAN C	30%	\$250/\$500/\$1,000/\$2,500 deductible	No	Same covered benefits as Plan B
PLAN D	20%	\$250/\$500/\$1,000/\$2,500 deductible	No	Same covered benefits as Plan B
PLAN E	10%	\$150 deductible	No	Same covered benefits as Plan B
HMO	Carriers have the option to cover drugs at 50%	\$5/\$10/\$15/\$20/\$30 copays	Yes	Same covered benefits as Plan B

Source: New Jersey Individual Health Coverage Program Board and Small Employer Health Coverage Board, NJ Department of Banking and Insurance.

Following small-group market reforms, enrollment in small-group plans increased continuously over the next six years, from approximately 690,000 individuals in 1994 to more than 930,000 in the second quarter of 2000 (Figure 3). In contrast, enrollment in nongroup plans rose initially fell from a peak of 220,000 in 1996 to only 90,000 in 2002, a steady decline of 3 percent per quarter.

State-Subsidized Coverage

At the same time that the state instituted reforms in the individual and small-group markets to make coverage more accessible for families of modest means, it also made its first foray into subsidizing coverage for low-income non-Medicaid-eligible people through the New Jersey ACCESS program. ACCESS provided sliding-scale subsidies to people with incomes under 250 percent of the federal poverty level, to help them purchase coverage in the individual market. Financed using surplus revenues in the unemployment compensation fund and without any federal financial participation, the program was created both to expand coverage and to provide an influx of covered individuals in a still unstable individual market. It was believed that ACCESS would help attract insurers to offer nongroup plans. The program, which began at the end of Governor James Florio's administration, was never fully funded by the subsequent administration of Governor Christine Todd Whitman, because the new administration felt that the individual market was an expensive vehicle through which to provide insurance coverage. The new administration felt that the Medicaid platform would be a better mechanism on which to base coverage expansions because of potential cost savings from managed care and the availability of federal matching funds. Because of its high per person costs to the state, the ACCESS program was eventually phased out and the remaining enrollees were eventually transferred to the NJ FamilyCare program.

Medicaid Expansions

Prior to the State Children's Health Insurance Program, New Jersey's Medicaid income eligibility levels were comparable to or lower than the national average for children,³⁰ although the state did elect to include optional Medicaid services targeted toward children and to expand coverage to optional populations in the late 1980s and early 1990s. In 1991, New Jersey extended coverage for children up to six years of age under 133 percent of the FPL and for pregnant women and children less than one year of age up to 185 percent of the FPL, prior to such coverage being federally mandated. The state also chose to cover the elderly, blind, and disabled populations, which are optional coverage groups under the Medicaid program. Although other states had sought Medicaid Section 1115 waivers to

³⁰ Cornell, E. *Maternal and Child Health Update: States Have Expanded Eligibility and Increased Access to Health Care for Pregnant Women and Children*. Health Policy Studies Division, National Governors Association, February 2001.

expand significantly eligibility in the mid-1990s, New Jersey initially began work in this area but then opted not to pursue this strategy, focusing instead on nonentitlement solutions to expand coverage for children.

Subsidized Expansions of Coverage for Children and Families in the Late 1990s and Early 2000s

Expanding Coverage for Children (NJ KidCare)

During her first campaign for governor in 1993, considerably before the passage of federal legislation creating the Children's Health Insurance Program, Governor Whitman made expansion of health insurance coverage for New Jersey's children a priority. In 1997, the growing national debate over coverage for children also advanced the issue in the state, particularly in a gubernatorial election year. Once elected, the governor established an interdepartmental working group to prepare a plan for covering all children in the state. Led by a senior policy adviser in the governor's office, the working group met on a weekly basis for many months.

The interagency group worked out myriad design details for a new child coverage strategy that would build on the existing Medicaid managed care program. After rejecting an initial proposal to subsidize child coverage through the individual market, Governor Whitman seized on the enactment of the federal CHIP legislation in 1997 to move ahead with implementation of the NJ KidCare program. NJ KidCare was financed with federal matching funds through Title XXI (Plans B and C, and later Plan D) and a Medicaid Section 1931 waiver (Plan A).³¹ The advanced planning that the state had already undertaken considerably shortened the waiver application and approval period.

The NJ KidCare program was designed with the philosophy that all children should have health insurance coverage but that higher-income families should bear some responsibility for the cost of coverage. Program design was premised on the theory that children in the lowest income group should receive the most comprehensive benefits because they are most likely to need services that their families cannot afford. Families with more resources should have benefits that more closely resemble plans available through employers. Thus, the state developed a tiered benefit approach that provided different levels of benefits to different income groups and imposed cost-sharing for the

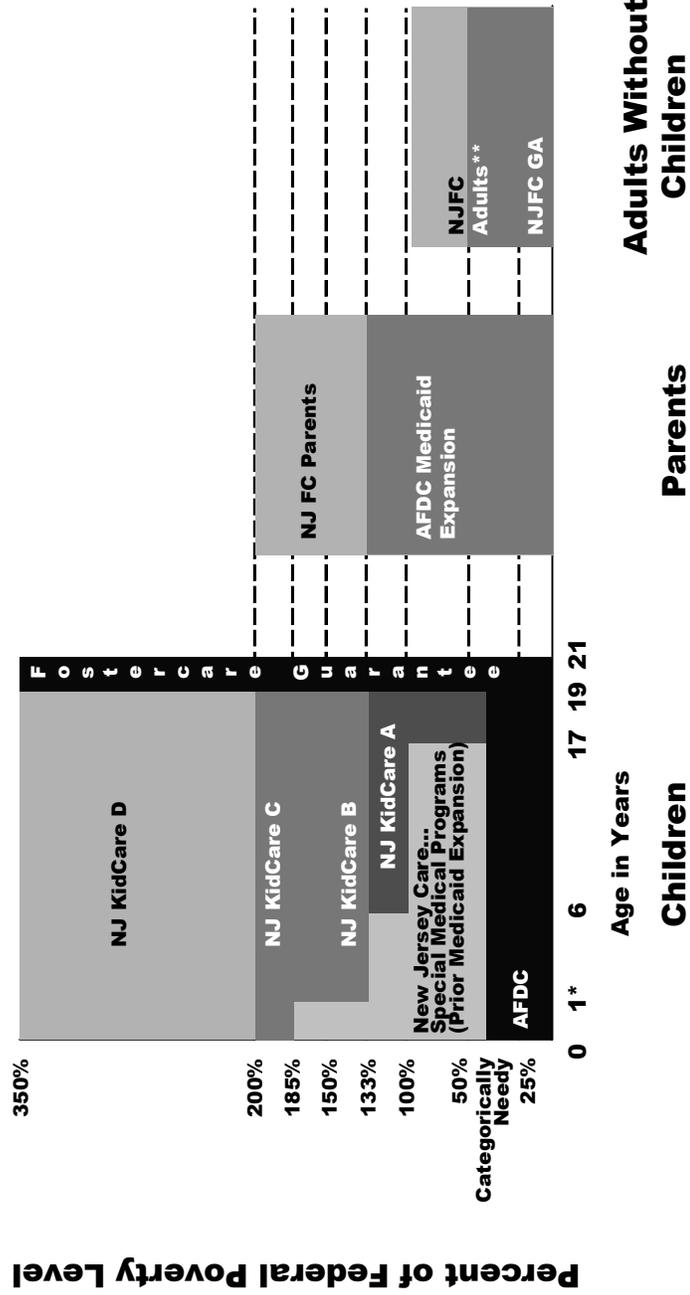
³¹ Section 1931 of the Social Security Act, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, allows states to expand coverage of low-income families through amendments to their Medicaid state plan without obtaining Federal waivers. Under Section 1931, states have great flexibility to cover more low-income families via income disregards, asset disregards, and increasing income and asset limits. (Birnbaum, M, *Expanding Coverage to Parents through Medicaid Section 1931*. State Coverage Initiatives Issue Brief, May 2000.)

highest income group (Figure 4). From the outset, program designers were concerned that publicly subsidized coverage would substitute for private coverage (a phenomenon known as “crowd-out”), and that coworkers of parents of NJ KidCare–eligible children would view a rich package with low cost-sharing as unfair. To address these concerns, the NJ KidCare plan for children in families between 151 percent and 200 percent of FPL was designed much like a standard employment-based plan, with the sole exception that, to promote child development, the state added some preventive and mental health services to the NJ KidCare benefit.

As was true for programs across the country, NJ KidCare experienced lower than expected enrollment and underspent allotted funds in its first year. In response, the state enacted legislation and submitted a series of state plan amendments for a second phase of the program. Through income disregards³² (which New Jersey learned about from Connecticut’s experience), the amended plan effectively expanded coverage under NJ KidCare to 350 percent of the FPL, potentially providing coverage for an additional 60,000 children (Figure 4). Other program amendments submitted and approved included reducing the period that children needed to be uninsured from one year to six months and exempting from the six-month rule children who were covered by COBRA and nongroup health plans or who became uninsured because of their parents’ job loss for families with incomes below 200 percent of FPL. To improve enrollment, the state also submitted an amendment to allow hospitals, federally qualified health centers, and public health clinics to provide services pending actual eligibility determination for children up to 200 percent of the FPL. As a result of these efforts, NJ KidCare enrollment improved significantly, particularly in Plans A and B, which required no participant cost-sharing.

³² Income or earnings disregards are allowed deductions that may be used in calculating income eligibility for applicants or recipients. Earnings disregards are frequently time sensitive, that is, the disregard becomes less generous over time. Income disregards vary significantly across states and are employed by most states that use net income, rather than gross income, to measure income eligibility. New Jersey disregards \$90 of earned income for applicants to its Medicaid and CHIP programs, and \$200 and 20 percent of the remainder for CHIP recipients. (Irvin, C., Czajka, J, *Simulation of Medicaid and SCHIP Eligibility: Implications of Findings from 10 States*. Final Report by Mathematica Policy Research, Inc. to Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, August 2000.

Figure 4. Eligibility for New Jersey Public Health Insurance Programs, 2002



* Includes pregnant women and children under age 1.

** Enrollment of non-General Assistance childless adults closed as of September 2001.

Source: State of New Jersey, Office of the Governor, 2000. Percentages still current for 2002.

In the second program phase, the state also had proposed vehicles for state-subsidized support of low-income families to purchase employer-based coverage. The program had two components. The first, the Partnership Assistance Program (which was later modified as the Premium Support Program) was similar to programs available elsewhere in that it was targeted to low-income individuals potentially eligible for employer-sponsored insurance who were not currently covered. The second component, the Equity Program, was a state-subsidized support program for currently covered low-income families. Under this program, proposed by policy staff within the governor's office, families above 133 percent and under 200 percent of the FPL who currently had a basic benefit package through their employer would be eligible for a state subsidy of up to \$45 per month. To be eligible, the employer would pay at least 50 percent of the premium, the employee would pay \$25 toward dependent coverage (compared with the \$15 per month in KidCare Plan C), and the state would pay the remainder up to \$45 per month. The intent of the program was to provide subsidies for low-income parents who had "done the right thing" in the past by purchasing insurance for their families, potentially at great sacrifice, rather than to extend subsidies only to those who had no coverage. The Equity Program was to be funded by state-only dollars, because no federal match was available, and was estimated to cost the state \$14 million to assist 55,000–57,000 eligible families. Proponents were unable to get sufficient support for the legislation, however. Because the program would not elicit federal matching funds, many felt that the limited state funds available should be targeted to those without insurance.

NJ FamilyCare and the Premium Support Program: Expanding Coverage to Parents and Childless Adults

The NJ FamilyCare initiative was developed in part as a further response to lagging enrollment in NJ KidCare but also as a result of the availability of new state funds through the tobacco settlement. Based on focus groups conducted with NJ KidCare parents, the state discovered that whole family coverage was preferred to child-only plans. State planners also were aware of research showing that children were more likely to get immunizations and regular checkups if their parents also were insured. As a result, the state developed a strategy for extending coverage to parents, with the goal of increasing the enrollment of children along with improving access to care for their parents.

At the same time, some policymakers were concerned that the welfare-to-work requirements under the state's welfare reforms would leave many former beneficiaries medically uninsured and felt that the state should protect single adults from losing health coverage. They argued that this population had the greatest health care needs and that, without coverage, they were relying on emergency rooms for basic health care or on

expensive hospital-based charity care. As a result, the NJ FamilyCare proposal expanded coverage not only to parents up to 200 percent of the FPL but also to the state's General Assistance population and low-income childless adults up to 100 percent of the FPL. The state also opted to use state-only funds to cover documented immigrants.

New Jersey also established the Premium Support Program to help families with incomes up to 200 percent of the FPL purchase employer-sponsored coverage in cases in which it would cost the state less to provide support than if such families were enrolled in FamilyCare. The program is mandatory for FamilyCare and voluntary for KidCare beneficiaries who have access to employer-sponsored coverage when the employer contributes at least 50 percent of the premium cost. This strategy was seen as having several advantages. It would avoid excluding workers from state help with health insurance costs simply because their employer offered health benefits; it would be less costly than providing a NJ FamilyCare plan; and it might reduce the incentive to substitute public for private coverage.

The state financed NJ FamilyCare with a combination of federal funds under a Section 1115 waiver, tobacco settlement funds, and expected employer funds from the Premium Support Program. New Jersey was one of the first states to apply for a Section 1115 waiver under CHIP. NJ FamilyCare enabling legislation, the Family Care Coverage Act, was enacted in July 2000 and called for \$100 million from the tobacco settlement funds, \$48 million from Section 1115 waiver federal matching funds, \$29 million from existing state General Assistance funds, and \$24 million from employer contributions through the Premium Support Program. Enrollment in NJ FamilyCare began in October 2000 and the Section 1115 waiver was approved in January 2001. Table 9 summarizes NJ FamilyCare for children and adults.

Table 9. New Jersey Publicly Subsidized Coverage Programs

Program Type	NJ FamilyCare for children (previously KidCare)/ Phase I & II	NJ FamilyCare/Premium Support Program for adults (plans A and D only)
Waivers/legislation required	Children’s Health Care Coverage Act. 12/97 (P.L.1997, c.272)/ 5 amendments 1999–2001 Medicaid 1931 waiver (Plan A) Title XXI State Plan (Plans B,C,D)	FamilyCare Health Coverage Act 7/00 (P.L.2000, c. 71) 1115 CHIP waiver
Time frame	Enrollment began Feb/March 1998 (Plans A, B, and C) Enrollment for Plan D - July 1999	Family Care Enrollment began October 2000. CHIP 1115 waiver approved 1/2001 Premium Support Enrollment began July 1, 2001/Outreach began in May
Benefits/subsidies	Benefits: Plan A—Same as Medicaid managed care Plans B & C—Modified commercial benefit package Plan D—Average commercial HMO benefit Subsidies: Plan A—No premium, no copays Plan B—No premium, copays for some services Plan C—\$15 premium per month, per family; copays \$5–\$10 Plan D—Premium based on sliding-scale ranges from \$30–\$100 per month, copays \$5–\$35	Family Care Benefits: Plan A—Same as Medicaid managed care Plan D—Average commercial HMO benefit Subsidies: Plan A—No premiums or copayments Plan D—Premium based on sliding-scale ranges from \$30–\$100 per month for families with children. Parents above 150% FPL pay an additional \$25 for one parent or \$35 for two parents. Childless adults pay no premiums, copays \$5–\$35. Premium Assistance Program—wrap around employer benefit to cover all Plan D benefits if deemed cost effective. Premium lower than for FamilyCare.
Eligibility Criteria	Children under 19 in families earning less than or equal to 350% FPL: Plan A—133% FPL or less Plan B—134%–150% FPL Plan C—151%–200% FPL Plan D—201%–350% FPL Six-month waiting period for Plans B, C and D. Exceptions allowed for waiting period in some cases.	Plan A: <ul style="list-style-type: none"> • Parents up to 133% FPL • Pregnant women up to 200% FPL • Single adults/childless couples up to 50% FPL • Individuals on General Assistance (GA) Plan D: <ul style="list-style-type: none"> • Parents who do not qualify for Medicaid up to 200% FPL • Single adults/childless couples from 51% to 100% FPL Six month waiting period for Plan D Premium Support Program: <ul style="list-style-type: none"> • FamilyCare eligible whose employer offers health insurance with comparable benefits and pays 50% of the premium.

Program Type	NJ FamilyCare for children (previously KidCare)/ Phase I & II	NJ FamilyCare/Premium Support Program for adults (plans A and D only)
Enrollment as of 12/01	Plan A—33,855	Single Adults
	Plan B—9,868	<ul style="list-style-type: none"> GA—24,495 0%–50% FPL—11,396 51%–100% FPL—6,858
	Plan C—27,741	Parents
	Plan D—15,008	<ul style="list-style-type: none"> TANF 0%–133% FPL—77,398 134%–150% FPL—13,772 151%–200% FPL—12,983
	TOTAL—86,472	Prior Health Access enrollees—1,306
		Other restricted aliens—3,616
		TOTAL FamilyCare Adults—151,824
		Premium Support Program—115 enrolled and 108 pending open enrollment.
Financing	Plan A B, C, and D—65% federal funds, 35% state (CHIP matching rate)	Plan A—50% federal, 50% state funds (Medicaid matching rate)
		Plan D: <ul style="list-style-type: none"> Parents—65% federal, 35% state (CHIP matching rate) GA, restricted aliens, childless adults—100% state funded

Source: Office of Statistical Analysis and Managed Care Reimbursement, NJ Department of Human Services, Enrollment as of December 2, 2001.

Elements that Facilitated Development

One of the key elements of success shared by all of the coverage initiatives in New Jersey has been the strong role played by the governor’s office. The administration of Democratic Governor Florio brokered the early individual and small-group coverage reforms; and the NJ KidCare and NJ FamilyCare initiatives benefited from the strong leadership of Governor Whitman, a Republican. There are also important differences in the factors that led to the successful implementation of the two waves of reform. The following discussion addresses these differences.

Individual and Small-Group Coverage Reforms

Regulation by Cooperation

The individual and small-group market reforms had significant support from the insurance industry. This reflects the general health policy culture in the state, which had long relied on stakeholder input to shape an active state regulatory role. The state had a history of regulating hospital reimbursement through its all-payer rate-setting system. This system was used not only to limit the growth of hospital expenditures but also to redistribute

resources within the market. Under one such redistributive mechanism, Blue Cross Blue Shield (BCBS) paid discounted rates to hospitals. BCBS was seen as providing a public good because it was the insurer of last resort, but by the early 1990s, the political coalition that supported rate-setting had evaporated, and BCBS was sinking into deep financial trouble. New Jersey responded to this crisis by bringing the insurers and other stakeholders to the table to hammer out a new system. The result was the inclusive regulatory scheme with community rating and guaranteed-issue and with requirements that insurers participate in the risky individual market or share in the losses of carriers that did.

NJ KidCare and NJ FamilyCare

A Program Champion

Even before Governor Whitman took office, she had decided to make near-universal coverage for children a legacy of her administration. In the governor's state-of-the-state messages at the outset of both her terms, the NJ KidCare and NJ FamilyCare programs were highlighted. Many attribute the success of the programs to her strong and consistent leadership. Her stewardship resulted in near-unanimous support from both legislative bodies for NJ KidCare and NJ FamilyCare legislation. The president of the senate was the prime sponsor for NJ KidCare and also testified in support of the bill, which according to at least one official interviewed occurs only rarely.

Program Development Leadership Came from Within Government

As a result of the high priority the governor had given to coverage of children, the state was able to "hit the ground running" when CHIP was enacted in Washington, in 1997. An interdepartmental working group had been developing a program long before the CHIP funds actually became available. The working group met from May to September in 1997. It stimulated cross-pollination of ideas and increased knowledge of and familiarity with issues in the insurance markets and Medicaid for those administering other programs, reducing some of the "silo effect" that plagues many state governments. The state also sought planning grant funds from the Robert Wood Johnson Foundation and assembled considerable data on the number and characteristics of the uninsured in the state, using Current Population Survey data and focus groups. Unlike many other states that relied heavily on external consultants, New Jersey relied largely on a homegrown plan created by a core group of state leaders. It appears that the principles and strategies developed by the working group were important to successful program start-up.

Decision to Build on Existing Infrastructure

Many state officials attributed the early successes of NJ KidCare and later NJ FamilyCare to the decision to build the programs on the state's Medicaid managed care platform.

Initially, some within the working group had proposed a program to cover children through the individual market, building on the ACCESS program and funding the initiative through assessments on insurers. Early in the process, however, this proposal was abandoned by the group because participants agreed that expanding coverage through the individual market would be too costly and too hard to control. The strategy of building on the Medicaid platform facilitated a rapid response to CHIP requirements and simplified program administration. For example, amending current Medicaid managed care plan contracts to include the NJ KidCare population eliminated a potentially lengthy procurement process.

Although the success of the state's Premium Support Program is far from assured, its initial design was facilitated by the earlier small-group market reforms. As in all states with similar programs, covering services not included in employer plans but covered by NJ FamilyCare (referred to as "wraparound" benefits) and assessing the cost effectiveness of doing so can be extremely complex. Although this was also true in New Jersey, the standardization of small-group benefit packages that was part of earlier small-group reforms significantly simplified the process. In fact, one official observed that without standardization in the small-group market, the wraparound would have been impossible.

Emphasis on Equity and Minimized Crowd-Out

Much of the early planning discussions focused on the need to treat families in similar economic situations fairly while avoiding giving currently covered individuals or employers incentives to drop private coverage. Program planners felt that if the state's coverage initiatives were seen as unfair or poorly targeted, it would lose political support from business. These concerns drove the decision to offer a benefit package for families above 133 percent of the FPL that was similar to the most widely sold policy in the private sector (then a U.S. Healthcare managed care product) rather than the Medicaid benefit package. Given the lack of discretionary funds in this income bracket, however, the state added some additional services that it believed would support child development, including preventive health, hearing, dental, vision, and some mental health services but excluding transportation, case management, and other benefits covered by the Medicaid program. These additional services were made available to children but not to adults in NJ FamilyCare. In addition, the decision to cap parental coverage at 200 percent of the FPL was driven by both crowd-out and budgetary concerns. As noted above, a separate policy initiative, called the Equity Program, would have offered state subsidies to families with access to private coverage but for whom the premiums were unaffordable. This program was driven by equity concerns, but it was not approved by the legislature.

Working with Stakeholders

State program planners working with key stakeholders contributed to successes in both the enactment and early implementation of NJ KidCare and NJ FamilyCare. From the outset, the state worked with children's advocacy groups and other groups in shaping NJ KidCare. This helped create a broad constituency for the program. Although local providers initially were not actively engaged in program design, over time the state developed strong working relationships with both the hospital association and community-based providers to help New Jersey respond rapidly to boost lagging enrollment (a problem that was experienced early on in CHIP programs across the country). Utilizing outreach funds from welfare reform, the state provided three-year, performance-based grants to community-based organizations [e.g., Federally Qualified Health Centers and Women, Infants, and Children program sites] to enroll low-income children. In addition to appropriating additional state funds for outreach, the state also sought private funding, in collaboration with the New Jersey Hospital Association, through Robert Wood Johnson's Covering Kids initiative.

Because Governor Whitman wanted to use tobacco settlement funds to support the NJ FamilyCare expansion, program planners had to negotiate with others who staked claims on that funding stream. The hospitals in the state, whose uncompensated care fund for charity cases had been cut substantially after earlier reforms abolished the hospital rate-setting system, were eager to use tobacco funds to restore charity care funding. To gain hospital support for the FamilyCare program, the state both earmarked some tobacco settlement funds for charity care and also extended presumptive eligibility under NJ FamilyCare for two years. Presumptive eligibility allowed hospitals and federally qualified health centers to receive reimbursement for adults before being deemed fully eligible, guaranteeing cash flow. Given the slow enrollment experience under NJ KidCare, the state also saw presumptive eligibility as a means of encouraging rapid take-up of NJ FamilyCare. (As discussed above, the rate of enrollment in NJ FamilyCare was much more rapid than anticipated, potentially because of the statewide multimedia outreach campaign and a ready market of adults seeking affordable health insurance coverage. Thus, presumptive eligibility was ended after just nine months.)

State planners also worked with the business community in developing coverage subsidy initiatives, including the Premium Support Program. Concerns of the business community encouraged a strong emphasis on equity and anti-crowd-out provisions in all the state's coverage initiatives.

Availability of New Funds

The healthy fiscal environment of New Jersey and the availability of federal CHIP dollars and tobacco settlement funds also were important catalytic factors in the enactment of both NJ KidCare and NJ FamilyCare. Indeed, many officials interviewed indicated that the replicability of New Jersey's programs is contingent on new funding streams becoming available, especially expansion of funds funneled through Title XXI or similar federal mechanisms.

Obstacles and Challenges: Individual and Small-Group Coverage Reforms

Rising Premiums and Declining Enrollment in the Individual Market

Initially, the individual market reforms had a positive effect on the market.³³ The number of carriers offering individual products rose from only one to more than 20 and by the fourth quarter of 1995, enrollment in the individual market had increased by 63 percent from the pre-reform period, covering over 220,000 individuals. In the first few years of operation, increases in the rates for the most popular individual plans remained consistent with medical inflation, and median rates for HMO coverage did not increase at all.³⁴ Individual reforms also introduced managed care into this market, which initially lowered the cost of coverage; however, over time, the prices of coverage in this market have risen dramatically. As of March 2002, the lowest cost for an HMO plan with a \$30 copayment was \$338 per month for single coverage and \$1,011 for family coverage. As discussed above, the number of individuals covered in this market has declined since 1996 by about 3 percent per quarter. By the third quarter of 2001, enrollment had declined to 91,433, a 32 percent decrease from the prereform period. Although some of this decline may have been caused by economic growth during this period and by people becoming eligible for employer-sponsored coverage, insurers attributed the decline to adverse selection and concomitant price increases resulting from pure community rating and guaranteed-issue. Community rating in the individual market is currently being reassessed and proposals have been introduced to allow modified community rating.

Small Employers Seeking Better Deals Challenge Stability of Small-Group Market

The small-group market has not exhibited the erosion in the number of covered individuals seen in the individual market, but attempts to avoid the regulations have challenged the stability of the reforms. After implementation of the regulations, insurance

³³ Swartz, K. and Garnick, D., "Lessons from New Jersey," *Journal of Health Politics, Policy and Law*, Vol. 25, No. 1, February 2000.

³⁴ New Jersey Small Employer Health Benefits Program Board. *The Effects on the Individual and Small Employer Health Coverage Markets of Permitting Individuals to Purchase Small Employer Health Benefits Plans*. September 1996.

carriers began offering stop-loss plans with low “attachment points”³⁵ that resembled high deductibles under traditional health insurance policies. For example, some stop-loss policies set the attachment point at \$1,000, reimbursing employers for claims paid over that amount. Because stop-loss policies were originally designed to reimburse self-funded employers for catastrophic or unexpected expenses, these policies were not considered to be health insurance and were not subject to health insurance reform laws. Policies with low attachment points permitted small businesses to avoid purchasing plans in the state-regulated program and thereby avoid paying higher health insurance rates. The state addressed this problem by increasing the permitted attachment point for stop-loss coverage to \$20,000 per year.³⁶

The small-group market has also been challenged by self-funded multiple employer welfare associations (MEWAs). These are arrangements that provide benefits to the employees of two or more employers. MEWAs were not previously subject to clear state regulatory oversight. Recently, the state enacted P.L. 2001, c. 352, which permits the establishment of MEWAs and provides for state oversight of the financial solvency of these entities. Although MEWAs may lower the price of coverage for small businesses, they may adversely affect the cost of coverage in the small-group marketplace to the extent that they offer different benefit packages or allow for rating of coverage that differs from the small-group market. Further, MEWAs are not subject to state guarantee funds. One recent high-profile MEWA failure highlighted the risks of these arrangements.³⁷ MEWAs also contribute to higher rates in the small-group market because groups with low-risk workers exit the regulated market, leaving higher-risk groups and increasing the overall cost of coverage. Although recent legislation introduced in the state supporting purchasing alliances may reduce the cost of coverage for some groups, such as MEWAs, the new entities also may have the unintended consequence of increasing rates for other groups.

Competition also has come from professional employer organizations (PEOs). These entities generally offer small businesses an array of services, including payroll and human resources administration, and may offer different types of insurance coverage including workers’ compensation and health benefits.

³⁵ An attachment point is the dollar amount of loss when an insurer begins to provide coverage. Stop-loss or excess risk insurance typically has two attachment points: the specific attachment point at which the employer is no longer required to self-fund the claims of an individual, and an aggregate attachment point at which the employer is not required to self-fund the claims for all covered individuals. O’Leary, K., Sanders, W., *Small Employer Health Insurance Reform: New Jersey’s Approach*.

³⁶ 1995 N.J. Laws 340, Section 1, definitions of “health benefits plan” and “stop loss or excess risk insurance.”

³⁷ Fitzgerald, E., “Car dealers’ health insurance trust goes under—Rising costs doomed NJ-CAR’s arrangement, which has \$13 million-plus in unpaid bills.” *Star Ledger*, Newark, N.J., February 24, 2002.

Pay or Play Difficult to Administer

The unique loss-sharing pay or play mechanism in the individual market, which was intended to encourage carriers to enter the market and offer coverage at competitive rates, has proven to be somewhat complicated to administer and has resulted in considerable litigation.

Initial Resistance from Businesses to Benefit Standardization

Because of strong opposition from some businesses that wanted to maintain their existing benefits, the small-group law was amended in 1996 to scale back a mandatory conversion to standard plans, thus allowing insurers to offer riders and grandfathering previously nonstandardized plans. Over time, however, businesses have increasingly opted to purchase one of the five standard plans, which today account for 98 percent of the plans purchased by small businesses.³⁸

Subsidizing Coverage in Individual Market Too Expensive

The ACCESS program, though innovative, proved to be an expensive approach to expanding coverage. The individual market is the most costly market segment because of its higher-risk enrollees and higher administrative costs. In addition, because ACCESS participants were a small fraction of individual market participants, state administrators could not realize economies of scale from negotiating with carriers or implementing cost-containment strategies. With a capped appropriation, the number of people who could enroll was limited. In fact, at its peak the program only enrolled 20,000 people, a tiny proportion of the uninsured. As the individual market became more costly, this strategy became increasingly unaffordable. As discussed above, the initial proposal to expand coverage to low-income children through ACCESS was abandoned by state officials when they saw the prospect of federal matching funds through CHIP. They also felt that it would be more efficient to manage the program through the existing Medicaid managed care infrastructure.

Small Employers Have Difficulty Meeting Employee Coverage Requirement

One of the requirements of the small-group coverage reform program was that, for a small business to be eligible, a minimum of 75 percent of the employer's workers must sign up for insurance. Business representatives have said that it is difficult to meet this requirement, in part because employees may be covered through other sources. Employees who had coverage through their spouse were counted toward the 75 percent requirement, but until recently other types of coverage were not similarly credited. A recent amendment to the

³⁸ Quarterly enrollment data for third quarter 2001. New Jersey Small Employer Health Benefit Program Historical Comparison of Covered Lives, January 2002.

small-group law, P.L. 2001, c. 346, now provides credit toward the participation requirement for persons covered under most public programs or by other group coverage. Employers still are not permitted to count an employee's participation in NJ FamilyCare toward the minimum participation requirement.

Obstacles and Challenges: NJ KidCare and NJ FamilyCare

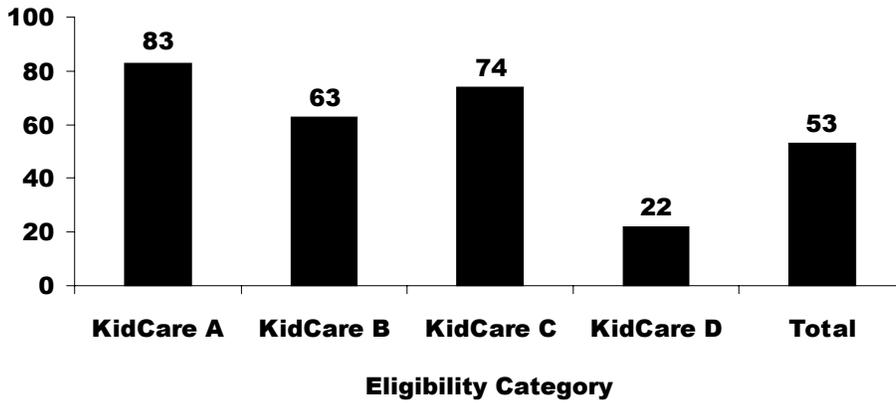
Low Enrollment of Children

As is true of most CHIP programs, NJ KidCare experienced lower than anticipated enrollment. Some attributed this to an unrealistic start-up period that assumed that the target population would be fully enrolled in one year. Others attributed it to the expected period needed to raise awareness of a new program and limited initial marketing of the program. The state has taken a series of steps to improve enrollment, including working with an advertising firm to develop a statewide multimedia outreach campaign to increase visibility, seeking external funding to support greater outreach efforts and engaging community-based organizations and the provider community to assist in enrollment.

After considerable investment in a variety of outreach methods, including grants to community-based providers and presumptive eligibility with respect to hospitals and community health centers, enrollment improved but remained below targets for the higher-income groups for whom premiums are required. Even with the expansion of coverage to parents, which was intended to increase the number of children covered, enrollment of children overall as of December 2001 was still only about half of the target (53%).³⁹ Enrollment varied considerably by type of plan, however. Plans A, B, and C, which were initiated in early 1998, enrolled an estimated 76 percent of eligible children as of December 2001, compared with 22 percent of eligible children enrolled in Plan D, which was initiated in mid-1999 (Figure 5). Plan D also has much higher cost-sharing requirements, with a \$30 to \$100 sliding-scale monthly premium and \$5 to \$35 copayments. Although premiums and cost-sharing are well below market rates, they may be a significant deterrent to enrollment.

³⁹ Office of Statistical Analysis and Managed Care Reimbursement, N.J. Department of Human Services, December 3, 2001.

Figure 5. NJ KidCare Enrollment as a Percentage of Qualifying Uninsured by Eligibility Category, December 2001



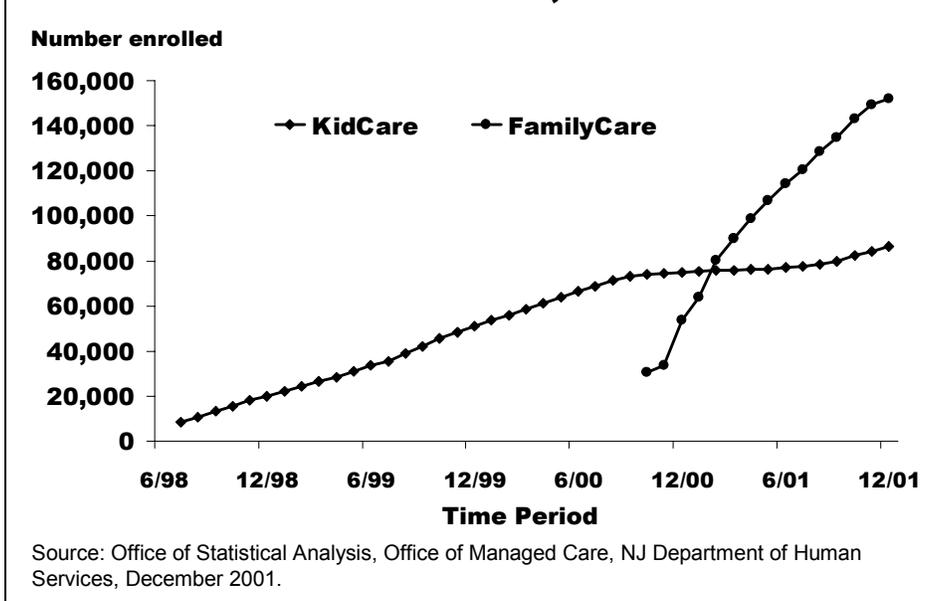
Source: Office of Statistical Analysis and Managed Care Reimbursement, NJ Department of Human Services, 12/3/01.

Faster than Expected Enrollment of Adults

State planners assumed that enrollment would occur more quickly in NJ FamilyCare than in NJ KidCare because of heavy outreach and marketing of NJ KidCare, the availability of contact information for parents of children enrolled in NJ KidCare, and the plan to automatically enroll the General Assistance population. Even so, planners did not anticipate how popular this program would be. In just nine months, NJ FamilyCare reached its three-year enrollment target. High demand led to stresses on the program as state program managers and their enrollment contractor struggled to catch up.

Enrollment of parents, particularly parents earning between 133 and 200 percent of the FPL who were eligible for Plan D, far exceeded expectations (Figure 6). Given the low enrollment of children in similar plans, this suggests that the willingness to pay premiums may differ when coverage is being purchased for adults compared with children.

Figure 6. NJ KidCare and FamilyCare Enrollment Trends, 1998–2001



To slow program enrollment, the state first curtailed its advertising campaign for NJ FamilyCare. In September 2001, it closed enrollment to non-general assistance childless adults and considered further cost-saving measures.

Budget Problems

In March 2001, only three months after NJ FamilyCare was initiated, managers projected a deficit in the program budget driven by greater than expected enrollment and higher than expected costs, particularly in the General Assistance program. This group, which is one of the neediest populations in the program, previously had access to emergency Medicaid and charity care services but had minimal access to preventive and mental health services. In retrospect, program managers felt that this population had pent-up demand for these services. Also, to accommodate quick rollover of this population to NJ FamilyCare, General Assistance recipients were covered on a fee-for-service basis, which also contributed to escalating costs. The state has since revised this policy, allowing a 30 to 60 day window to choose or be assigned to a managed care plan. At the same time, based on actuarial data for NJ FamilyCare single adults, plans are facing significant losses, particularly for adults with a history of chronic illness. Two plans threatened to pull out of the market because of low reimbursement rates. The state has since provided a rate increase from Medicaid surpluses, but plans are still concerned that costs will exceed reimbursement caps. Another step taken to support the program's growing costs has been an additional one-time allocation of \$25 million that the state was able to redirect from lower expenditures in the Medicaid budget, which was expected to cover 25,000 to 30,000 parents.

More recently, New Jersey has instituted additional measures in the FamilyCare program in order to control escalating costs and keep the program solvent. Before the last budget year expired on June 30, 2002, the state spent \$272 million of its own funds on the program—\$91 million more than had been planned. Facing a large state budget deficit, Governor James McGreevey has mandated that the state's share of spending on FamilyCare be held to \$229 million in fiscal year 2003, or \$43 million less than the state is currently spending.

In anticipation of these budget cuts, in addition to closing enrollment to childless adults in September 2001, the state stopped accepting applications from all parents as of June 15, 2002. This does not affect any current beneficiaries or applications received prior to June 15. NJ FamilyCare remains available to all eligible children with annual family incomes up to 250 percent of FPL and presumptive eligibility is still available for children in families with incomes at or below 200 percent of FPL and for pregnant women.

In addition, effective July 1, 2002, all general assistance beneficiaries are no longer enrolled in FamilyCare managed care plans. They receive a benefit package of community-based services provided on a fee-for-service basis. Hospital services, including hospital-based behavioral health services, are reimbursed through the state's charity care program and substance abuse services are provided through the Substance Abuse Initiative administered by the Division of Family Development.

Finally, in order to preserve the program for children, the state has scaled back the benefit package for some adults. Effective September 1, 2002, parents currently enrolled in Plan A (Medicaid package of services) will receive a benefit package comparable to Plans B and C that mirrors the most widely sold commercial HMO package in the state. For higher-income families who currently share some costs of the program, copayments and premiums increased effective September 2002.

Stumbling Blocks to Employer Initiatives

Governor Whitman's proposed Equity Program, designed to subsidize coverage for NJ KidCare-eligible children who had existing employer coverage, failed to get legislative support. Opponents of the program bill argued that scarce state resources, which would not be matched by federal funds, should be directed to cover those who were uninsured rather than to subsidize those who were already insured.

The Premium Support Program (PSP), which pays the worker's share of employer-sponsored plan premiums for previously uninsured NJ FamilyCare-eligible families with children, was approved by the legislature. However, technical and practical

considerations including contractual problems with managed care companies and a lack of employment information in the NJ FamilyCare database contributed to a six-month delay in the implementation of this initiative. Not wanting to delay enrollment in NJ FamilyCare, the state opted to initiate the program without PSP in place.

To improve participation in PSP, the state has conducted outreach through eligibility files. It also has attempted to identify employers with a number of FamilyCare enrollees to conduct outreach to businesses to encourage participation and assess whether they meet the employer eligibility and cost-effectiveness standards. Insurance underwriters also have marketed the program. Despite these efforts, enrollment has been slow, with only 150 individuals enrolled and 108 pending enrollment six months after the program started. State officials noted that if PSP had been in place when the FamilyCare program was initiated, some of these administrative problems could have been avoided by recording employment information at the time of enrollment.

Meeting federal requirements under the PSP waiver has been very challenging and costly. The state must demonstrate that it is cost effective to pay the employee's share of employer premiums compared with enrolling a family in NJ FamilyCare, and it must ensure that the scope of each subsidized employer plan meets minimum standards. This requires a benefit-for-benefit analysis, which was comparatively simple in the small-group market because of standardization of these plans. But the large-group market benefit plans are not standardized, making the scope-of-plan and cost-effectiveness certifications difficult. Industry representatives also raised concerns about the required 50 percent employer contribution, which is much higher than the minimum 10 percent contribution eligibility requirement in the small-group regulations. (Note that the Centers for Medicare and Medicaid Services originally wanted a 60 percent employer contribution and New Jersey submitted a waiver to require only 50 percent). The release of Health Insurance Flexibility and Accountability demonstration initiative guidelines⁴⁰ may allow states more flexibility in setting the employer contribution than in the past, and state officials are investigating the cost effectiveness of lower employer contribution percentages. Analysis commissioned by the state suggests that a minimum employer contribution of 35 percent would likely be cost effective.

Although business representatives give favorable reviews to PSP, they acknowledge that more needs to be done to promote it. They also report some potential barriers to program expansion. For instance, employers may be reluctant to participate for fear that

⁴⁰ Health Insurance Flexibility and Accountability is a newly developed Medicaid and CHIP Section 1115 waiver designed to encourage new approaches that maximize private health insurance coverage options for individuals below 200 percent of the FPL.

they will be required to pay worker premium shares if employees fail to do so, or because of a program requirement that employers inform the state if an employee receives reimbursement under PSP but does not purchase the company plan. Now that the initial administrative problems have been solved, the state has expanded program outreach. Managers acknowledge, however, that the potential pool of enrollees may be declining because of the softening economy.

Looking Ahead: Primary Challenges

New Jersey has been at the forefront of health care reform for over a decade. The state has not pursued a fully unified, comprehensive approach, but it has incrementally developed an integrated series of programs that build on each other and collectively form one of the broadest coverage programs in the country. Despite the fact that the state has developed strong platforms for both regulation of the private market and subsidies for low-income coverage, both policy arenas face significant challenges in the future.

In the private market, centrifugal forces threaten to undermine broad risk pooling in individual and small-group markets. Insurance carriers argue that the individual market, with open enrollment and pure community rating, is subject to cycles of serious adverse selection. Evidence on declining enrollment in the individual market supports this argument.

After six years of stability and steady growth, signs are appearing that New Jersey's small-group market may have begun to erode. Carriers in that market, which has been relatively stable, reported double-digit rate increases and declining enrollment as of 2000. These recent trends may be attributable to broader forces affecting all employer-based insurance, including the economic downturn and the general inflation of health care costs, but they will increase pressures to dismantle or modify the small-group market reforms. Even if the regulations are not changed, many small employers may leave the state-regulated system by forming self-funded Multiple Employer Welfare Associations or other kinds of group purchasing arrangements. Whatever the underlying forces, sustaining New Jersey's inclusive risk pooling in individual and small-group markets will become increasingly difficult in the coming years.

New Jersey has raised the bar for what states can do to cover the uninsured through public subsidies, but these initiatives also face serious challenges. NJ FamilyCare is threatened by the state's recent budget woes. As of February 2002, the state was predicting a budget deficit of nearly \$6 billion and the newly elected governor had already imposed 5 percent across-the-board spending reductions as well as additional cuts to some specific

health programs, including reductions in Medicaid reimbursement.⁴¹ NJ FamilyCare program officials are looking for ways to reduce costs; the state first will seek to save dollars without reducing program eligibility, but it might ultimately have to close enrollment for some eligibility categories (enrollment for adults not on General Assistance and without children has already been closed). By the end of the last gubernatorial administration, state officials were considering a number of cost-saving options including case management programs for high-cost enrollees, premium or copayment hikes, cuts in dental services in Plan D, prior authorization of some services, and closing enrollment for some groups. The new administration will face the same kinds of options. Even if the state fiscal environment improves, it is doubtful that New Jersey will be able to expand its CHIP initiatives to new populations unless the federal government significantly increases funding to states.

The coverage initiatives also face other ongoing challenges. NJ FamilyCare has experienced continuing problems recruiting and retaining children, especially in income categories in which families have to pay premiums. In contrast, adult enrollment, particularly among parents in eligibility categories in which family premiums are required, has been considerably higher than expected, suggesting that willingness to pay differs significantly when coverage is being purchased for adults rather than for children. Program managers are devoting considerable effort to enrolling and retaining children in the program even as they have reduced outreach to enroll parents.

Integrating public insurance with employer-sponsored coverage in ways that encourage a continued or even expanded private-sector role is another major challenge. Although the Premium Support Program is small, strategies like these theoretically offer considerable promise with respect to leveraging private funds. Recruiting and enrolling participants has been difficult, however. In a slumping economy, more workers, particularly those who qualify for PSP, are likely to lose coverage, and fewer employers may be willing or able to afford to buy in. It is too soon to tell whether these barriers will ultimately mean that this program cannot be brought to scale. Potentially greater flexibility in federal oversight of these strategies and state refinements in program design hold promise. In any case, if states are to attack the problem of the uninsured among moderate-income people, finding ways to coordinate with employer coverage without significant crowd-out will be important. New Jersey is a proving ground for employer premium support strategies.

⁴¹ Kocieniewski, D., "McGreevey's Budget Calls for Deep Cuts," *New York Times*, February 12, 2002, p. 6.

Finally, a continuing challenge heard in the political discussion of health coverage in the state is charity care, its interrelationship with coverage initiatives, and the investment required to preserve the safety net. Although coverage initiatives in the state have done a great deal to reach the uninsured, it is not yet known whether the NJ FamilyCare program has resulted in a reduction of charity care cases. The competing priorities of extending coverage while maintaining charity care funding for facilities serving those who do not have coverage will continue to remain in the forefront of political debate, particularly if economic conditions do not improve soon or if proposed federal funding cuts for health care facilities under Medicare and Medicaid are implemented.

Lessons for Other States

New Jersey's comprehensive yet incremental approach to health care coverage, focusing on maximizing access to private insurance while building a base of subsidies for public coverage, offers lessons for other states. By initiating market reforms early in the last decade, the state stabilized a faltering market. This may have resulted in a greater number of uninsured seeking public subsidies. Although the elements of the reforms may require reexamination, the state's initiation of a strategy that was accepted by the business and insurer communities positioned it well for subsequent expansion of public coverage. In particular, the standardization of benefit packages available in various markets helped simplify the establishment of cost effectiveness and of wraparound benefits for the state's employer-buy-in program.

Lessons also may be taken from New Jersey's experience with the expansion of public coverage. Through its experimental foray into subsidized coverage for low-income families through the individual direct purchase market, the state learned that existing state platforms that provide greater administrative efficiencies, lower per unit costs, and federal matching funds offer a more cost-effective public subsidy approach.

In expanding coverage to children, states should anticipate lower enrollment, in part because the perceived need for health care for children may not be as great. Because enrollment in the most expensive cost-sharing plan has been the lowest, other states may want to consider reducing cost-sharing requirements to attract more parents to purchase coverage for their children. Although New Jersey has experienced high demand for subsidized coverage for adults, it is not yet clear whether greater coverage of eligible children will follow.

Based on New Jersey's experience in expanding coverage to parents and other childless adults, states may wish to take a more gradual approach to assessing the unmet demand for affordable insurance among the low-income adult population and the capacity of budgetary resources to meet this demand.

GEORGIA

The objective in studying Georgia was to identify factors leading to the development of the state's integrated and flexible approach to child health coverage as implemented through the state's Medicaid program and its CHIP program, called PeachCare for Kids. Also explored was the state's experience in leveraging public funds to expand coverage for low-income people and in forging partnerships with business leaders, providers, and community representatives to develop Georgia's *Business Plan for Health*. The following summary describes the forces and ingredients leading to the development of these efforts and identifies reasons why certain components were successful while others stalled.

Summary

Georgia made a concerted effort to place all of the state's purchasing—under Medicaid, CHIP, and for its own employees—under one roof. It was successful in developing a streamlined public program enrollment system that substantially reduced the number of uninsured children. Georgia's consolidation and integration of diverse health programs have enabled the state to leverage its purchasing power to foster improvements in coverage and access in a state with rural access barriers, reluctance by some providers to participate in public programs, and few organized systems of care. State officials have also forged partnerships with business leaders, providers, and community representatives to develop Georgia's *Business Plan for Health*, a blueprint for coordinated public- and private-sector initiatives to improve access to health care. This plan brought together diverse stakeholders to develop a sweeping package of public, private, and community-based approaches to the problem of the uninsured. Central to the plan is the idea that public-sector expansions must go hand-in-hand with support for private-sector coverage.

Several factors have contributed to the Georgia's success in developing and expanding public coverage programs for children, leveraging public financing, and developing the state's *Business Plan for Health*. First, by focusing on children—a vulnerable population that generates public support—the state has maximized political support for comprehensively tackling a single task. Georgia has not only implemented effective outreach and enrollment policies to cover children, but has also created workable strategies to retain coverage for kids. Building on the existing Medicaid infrastructure, CHIP has served as a laboratory for the development of program improvements that are