Access to Affordable Health Insurance:
New Jersey
State Planning Grant

Interim Report

September 2003

State of New Jersey
Department of Human Services

In Collaboration with
Rutgers Center for State Health Policy

Project funded by the U.S. Department of Health & Human Services, Health Resources and Services Administration,
State Planning Grant # 1 P09 OA 00040-01

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New Jersey Department of Human Services (NJDHS)

In Collaboration with
Rutgers Center for State Health Policy

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EXECUTIVE SUMMARY

In July 2002, New Jersey was awarded a HRSA State Planning Grant to conduct multiple research projects to study the issue of the uninsured. The New Jersey Department of Human Services, the lead agency for this project, was recently given a one-year no-cost extension, and all project activities will be completed by June 30, 2004.

While premature to assess the policy impact of the research completed thus far, we have identified several key lessons and preliminary findings that will help to inform our remaining project activities. To summarize:

? Approximately 1.08 million residents (15% of the non-elderly population) in NJ were uninsured in 2001-2002. Households with annual income below $20,000 are most likely to be uninsured, while most uninsured households have annual income between $20,000 and $50,000. Hispanic households are most likely to be uninsured, followed by other minorities. One quarter of those in fair or poor health report being uninsured. Finally, non-elderly adults are most likely to be uninsured and also make up the greatest proportion of New Jersey's uninsured population.

? In an effort to improve employment-based health insurance, the New Jersey Premium Support Program subsidizes the employee portion of the health insurance premium for qualified applicants who are enrolled in New Jersey FamilyCare. Under the State Planning Grant, New Jersey interviewed state officials of similar programs in Illinois, Iowa, Maryland, Massachusetts, Oregon, Pennsylvania, and Rhode Island and found that many states with high enrollment in their subsidy programs have passed legislation requiring insurers to recognize enrollment in the subsidy program as a qualifying event for enrollment in the employer plan.

? Data collection from New Jersey employers proved to be a significant challenge. New Jersey had originally planned to conduct three two-hour employer focus groups to discuss health insurance offering decisions in an effort to identify ways to maximize employment-based health insurance coverage in the state. However, focus groups proved to be too burdensome for New Jersey employers who did not have time to participate and were hesitant to discuss personal information about their company and their opinions regarding health insurance offerings. As a result, New Jersey changed the focus group data collection strategy to short telephone interviews instead. Twenty-six employers participated in the telephone interviews including those who offer health insurance as an employee benefit and those who do not, as well as both small and larger employers.

Although other New Jersey State Planning Grant activities have not yet produced results, these projects are also progressing well. The following briefly summarizes on-going project work under this grant:

? Simulation and analysis to identify possible design improvements for the New Jersey Premium Support Program is underway. Work currently underway involves linking data on employer health plans with data from the New Jersey Family Health Survey, and analyzing the linked data set.

- Field work for the New Jersey Family Health Survey, Supplemental Survey of NJ FamilyCare enrollees is nearly complete. Enrollment and retention in NJ FamilyCare will be analyzed using these data.
- Work on a detailed profile of the uninsured and analysis of the affordability of health insurance coverage in New Jersey is continuing.
- Results of each NJ SPG project will be reviewed with project advisory groups and implications will be discussed.

Finally, on June 10, 2003, Governor McGreevey hosted the *Conference on Healthcare Coverage* to accelerate the process of engaging experts and stakeholders from both the public and private sectors in the policy debate. Working collaboratively with members of his cabinet, including the Commissioners of the Departments of Banking and Insurance, Human Services and Health and Senior Services, the Governor positioned this Conference as the first in a continuum of activities designed to inform the health policy discussion. There is considerable synergy between the State Planning Grant projects and the activities planned following the Governor's Conference. We hope to receive supplemental funding from HRSA to support specific post-conference initiatives outlined by Governor McGreevey.

INTRODUCTION

In July 2002, the State of New Jersey was awarded a $982,075 HRSA State Planning Grant (SPG). Governor James E. McGreevey designated the New Jersey Department of Human Services (DHS) the lead agency for project activities and Deborah C. Bradley Kilstein, then Acting Deputy Commissioner and current Chief of Staff at DHS, assumed the role of Project Director. When Ms. Bradley Kilstein took on her current position as Chief of Staff of the Department in October 2002, Matt D'Oria, Acting Director in the Division of Medical Assistance and Health Services (DHS), was named SPG Project Director. Ms. Bradley Kilstein remains involved in all strategic decisions related to the SPG and is an active member of the interdepartmental Steering Committee which functions as the governance body for this grant. Additional details about the role and composition of the Steering Committee will be described below.

Throughout the past year, the Department of Human Services has successfully partnered and worked closely with Rutgers Center for State Health Policy (CSHP or "Center") to pursue the project goals outlined in the 2002 grant application. They include: (1) optimizing the effectiveness of New Jersey's current innovative and substantial coverage initiatives and, (2) describing remaining gaps in access and affordable coverage and exploring policy approaches to addressing these gaps. This collaboration continues to provide the opportunity for policymakers to call upon the expertise and academic rigor of one of the state's leading research institutions as they contend with shrinking budgets and attempt to identify health policy alternatives for the estimated 1 million individuals currently uninsured in New Jersey.

Six analytic projects are currently underway as part of New Jersey's initial State Planning Grant award. A one-year no-cost extension has afforded the project teams the opportunity to continue research though June 2004.

Grant Management and Administration. Upon award of New Jersey's State Planning Grant, a Steering Committee was convened comprised of senior policymakers from the Office of the Governor as well as from the Departments of Human Services, Health and Senior Services, Banking and Insurance, and the Treasury. Matt D'Oria, representing DHS, and Joel Cantor, Principal Investigator from Rutgers Center for State Health Policy, provide ongoing committee leadership. See Appendix A for a list of Steering Committee members.

In addition to the contributions made by the members of the Steering Committee, the project team is also working with an Advisory Committee consisting of five external groups that were selected for their diversity and involvement in health policy development in the state. These groups include: The Covering Kids Coalition; The NJ FamilyCare Advisory Committee; the Individual Health Coverage Program and Small Employer Health Benefits Program Boards; and the New Jersey Family Health Survey Advisory Board. As we move forward into the second year of grant activities, we anticipate engaging these stakeholders more frequently as we broaden our outreach efforts and develop a strategy for briefings and dissemination of our research findings.

PROFILE OF NEW JERSEY'S UNINSURED

Characteristics of the Uninsured (Sections 1.1 and 1.2)

In 2001 and early 2002, Rutgers Center for State Health Policy conducted the New Jersey Family Health Survey (NJFHS) to provide timely and policy-relevant information about the health and health care utilization of New Jersey residents to policymakers. NJFHS data were collected in late 2001 through January 2002 with funding from The Robert Wood Johnson Foundation, and the project team is currently preparing the data for analysis. The NJFHS sample is designed to represent New Jersey as well as five regions of the state and includes measures of health insurance coverage, health status, utilization, access to care, employment and earnings, and demographics. A detailed description of the NJFHS design and content is included in Appendix B.

According to the NJFHS, approximately 1.08 million residents, or 15% of the non-elderly population, were uninsured in 2001-2002. The survey reveals further that lack of insurance is strongly related to household income. Although residents of households with annual income less than $20,000 are the most likely to be uninsured, the majority of the uninsured comes from households with higher annual income. Specifically, half of the state's uninsured residents live in households with incomes between $20,000 and $50,000. In part, these numbers reflect the greater eligibility for public insurance programs among the lowest income residents. Although residents from households with annual income exceeding $50,000 are the least likely to be uninsured, approximately one-fourth of the uninsured come from these households – a finding that reflects the large number of state residents who fall into this category of household income.

Lack of insurance is also related to general health status as reported by survey respondents. Twenty-five percent of those who report their health as fair or poor lack health insurance, compared to 20% of those who report good health and 11% of those who report excellent or very good health. However, since most residents of the state are not in fair or poor health (as reported in the NJFHS), poor health is not the dominant characteristic of the majority

of the uninsured. In fact, approximately one-half of the uninsured describe their health as very good or excellent.

Insurance status varies considerably by race and ethnicity. Only 10% of White non-Hispanic residents are uninsured compared to 34% of Hispanics, 17% of Blacks, and 17% who classify themselves as members of other race/ethnicity categories. Nevertheless, since White non-Hispanics make up the large majority of residents in NJ, they also account for the largest share (40%) of the uninsured population, followed very closely by Hispanics at 36% of the total.

Finally, age plays a role in the lack of health insurance. Adults ages 19-45 are the most likely to be uninsured and account for the majority (60%) of the uninsured population overall. This pattern may reflect both lower demand for insurance compared to older residents as well as less eligibility for public coverage and private dependent coverage compared to children.

Preliminary results from the NJ Family Health Survey can be found in Appendix C. In addition, a detailed Data Book on New Jersey's uninsured population will be completed in fall 2003, and will be included in our Final Report to the Secretary.

Population Groups in Particular Need of Health Insurance (Section 1.3)

Clearly, certain population groups face greater risks of being uninsured than others. Nevertheless, New Jersey's uninsured population overall exhibits considerable diversity in health and demographic characteristics. These findings underscore the difficulty involved in targeting coverage expansions to meet the dual goals of providing relief to the neediest populations while significantly reducing the total number of uninsured.

Specifically, if our goal is to help the neediest populations we would focus on those with annual household income below $20,000, those with fair or poor health status, Hispanics (and possibly other minorities), and non-elderly adults. However, if our goal is to provide the greatest number of people with health insurance, we would focus on those with annual household income between $20,000 and $50,000, very good or excellent health, white non-Hispanic, and non-elderly adults. Regardless of our specific goal, a broad category of non-elderly adults remain uninsured.

Affordable Coverage and Willingness to Pay for Coverage (Section 1.4)

In one of the SPG projects currently underway, the Center for State Health Policy team is assessing access to affordable health insurance in New Jersey. The assessment of whether health insurance is affordable for uninsured New Jersey residents recognizes that by its very nature, the concept of "affordability" is a subjective concept. Consequently, there is no objective standard upon which to assess whether coverage is affordable.

Several approaches to estimating the affordability of coverage have appeared in the literature. Researchers have used a *consumption-based definition* of affordability, which compares consumption expenditures between insured and uninsured households to determine whether health insurance is affordable (Levy and De Leire). Others have used a *behavioral approach* to define affordability (Bundorf and Pauly). The behavioral approach compares individuals in similar circumstances and deems health insurance affordable when most people

with similar characteristics are insured. Finally, researchers have looked at a *normative definition* of affordability, which selects a consumption standard representing a minimal or acceptable level of spending to meet objectives for nutrition, housing, etc. (e.g., federal poverty level or some multiple) and if income is not high enough to support this minimum standard and pay for health insurance, then health insurance is unaffordable (Bundorf and Pauly).

Our proposed approach follows the *normative definition* of affordability. In particular, we plan to apply NJ Family Care income thresholds as the minimum *consumption standard* (i.e., what a family should have left for consumption after health insurance costs). Note that this consumption standard reflects a 'political consensus' on what level of income should be available to spend on basic needs other than health insurance. We plan to provide alternative estimates differentiating between persons with/without access to employer-based health insurance. For the former, we will use data on health insurance premiums for employment-based coverage in New Jersey (derived from the Medical Expenditure Panel Survey Insurance Component or from the New Jersey Small Employer Health Benefits Program); for the latter, we will use data on individually-purchased coverage (from the New Jersey Individual Health Coverage Program) as well as premiums from New Jersey Family Care for persons deemed eligible for such coverage. The basic data on individual income, health insurance, and demographic characteristics will come from the New Jersey Family Health Survey. The results of this analysis will be included in the Final Report to the Secretary.

Analysis of Enrollment and Disenrollment in New Jersey FamilyCare (Sections 1.5 - 1.6)

As part of New Jersey's State Planning Grant activities, CSHP is conducting a supplemental survey to the NJFHS. This sample includes 650 families covered through NJ FamilyCare or Medicaid, including groups that retained coverage and others that disenrolled. In order to assess patterns of self-selection into and out of NJ FamilyCare, the project team is collecting data on health status, health care utilization, and attitudes toward health care and health insurance for enrollees, disenrollees, and eligible non-participants for NJ FamilyCare, and on disenrollees from Medicaid.

Descriptive comparisons and multivariate analyses will be conducted to discern whether systematic differences exist among NJ FamilyCare-eligible non-participants, enrollees and disenrollees in their demographic characteristics (such as family structure, the age and educational attainment of adult family members, and the race and ethnicity of family heads), residential locale, health status, and health utilization. In addition, comparisons across these groups will be made for a series of attitudinal variables to determine whether underlying differences in the value placed on health insurance and attitudes toward risk and the medical care system help to explain enrollment and retention decisions. Other factors that may affect enrollment behavior, such as the availability of free or low-cost safety-net providers, will also be considered. Finally, characteristics of Medicaid disenrollees who successfully made the transition to NJ FamilyCare will be compared to those who did not.

Survey data collection for this project will be completed by December 2003. We will report findings on the enrollment and disenrollment to NJ FamilyCare in the Final Report to the Secretary.

Non-Monetary Barriers to Purchasing Health Insurance (Section 1.10)

Upon completion of our analysis of the NJFHS statewide and supplemental surveys, we will be able to analyze the data and identify non-monetary barriers to purchasing health insurance. This information will be available for the Final Report to the Secretary.

How the Uninsured Meet Medical Needs (Section 1.11)

Data on how the uninsured are meeting their medical needs have also been collected in the NJFHS and will be available for the Final Report to the Secretary.

EMPLOYER-BASED COVERAGE
(Sections 2.1-2.4 and 2.6-2.7)

The CSHP project team is currently evaluating options to optimize New Jersey's *Premium Support Program.* Within the scope of that project, CSHP is working with RAND to create linked employer-household data. In addition, CSHP has also conducted twenty-six qualitative interviews with employers to learn more about their insurance offering decisions. Analysis of these data is underway and findings will be available in the Final Report to the Secretary.

HEALTH CARE MARKETPLACE

Prevalence of Self-Insured Firms and Impact on the Marketplace (Section 3.3)

The CSHP research team is currently compiling a profile of the uninsured in New Jersey. Using the NJ Family Health Survey linked to employer survey data as well as analyses of the Medical Expenditure Panel Survey – Insurance Component for New Jersey, the team is developing detailed population-based and employer-based information on the health insurance status of various population and employer groups. From this project, a summary of the impact of self-insured firms on the health insurance market will be included in the Final Report to the Secretary.

Looking at the Experiences of Other States in the Health Insurance Marketplace (Section 3.9)

Challenging fiscal times and shrinking state budgets make expansion of public programs very difficult at this time. Therefore, in an effort to promote public/private partnerships many states, including New Jersey, have created premium assistance programs that provide a subsidy to enable Medicaid and SCHIP eligible individuals and families to purchase employer-sponsored health insurance. As part of the scope work in one of the SPG projects currently under way (the *Premium Support Program* analysis referenced above), we looked at the experiences of other

states that had similar programs in an effort to optimize enrollment and enhance program participation in *New Jersey's Premium Support Program*. The CSHP project team conducted in-depth interviews with officials in Illinois, Iowa, Maryland, Massachusetts, Oregon, Pennsylvania, and Rhode Island to learn more about their Medicaid and SCHIP premium assistance programs. These states offered useful operational insights including best practices for determining program eligibility, collecting employer information, and determining cost effectiveness and subsidy amount.

One obstacle that the New Jersey *Premium Support Program* faces is that employers and insurance companies do not consider enrollment in the program as a qualifying event for enrollment in the employer's health insurance plan. Therefore, in many cases, this means that a family's enrollment into an employer-sponsored plan may be delayed several months until an open enrollment period. This would not be the case, however, in New Jersey's Small Employer Group Market where there is continuous enrollment.

We discovered through these interviews that many states with successful premium assistance programs require employers and insurance companies to consider eligibility for the program as a qualifying event to enrollment in their employer plan. Oregon also has an interesting approach to optimizing enrollment in their program. We learned that officials in that state contacted nearly all of the state's insurers and informally arranged for the families' enrollment in the employer-sponsored plan upon acceptance to Oregon's *Family Health Insurance Assistance Program.*

Within this project, we also looked at the experiences of other states, including Massachusetts and New York, which provide incentives for employers to offer health insurance coverage. Massachusetts' *Insurance Partnership Program* subsidizes employers for their portion of the health insurance premium for low-income individuals who qualify for MassHealth's Premium Assistance Program. Very small employers and employers with a high proportion of low-wage workers benefit greatly from this subsidy because it makes offering coverage to all their employees much more affordable. New York's *Healthy NY Program* requires that all HMOs in the state also offer a plan for small employers that have at least 30 percent of their employees earning less than $31,000 per year where Healthy NY pays 90 percent of the claims between $30,000 and $100,000. This reduces the financial risk to the insurance companies, thereby allowing them to charge lower premiums to the employer.

Information gathered from these interviews will be summarized and shared with the Steering Committee. We look forward to including this information in the Final Report to the Secretary.

OPTIONS FOR EXPANDING COVERAGE **(Sections 4.1 - 4.15)**

New Jersey has among the most expansive eligibility for adults and children under its Medicaid and NJ FamilyCare (SCHIP) programs. During the 1990s, the state also benefited from a robust employer-based health insurance market. Currently, however, state revenue shortfalls and underlying forces in private health insurance markets have begun to seriously threaten the progress New Jersey has enjoyed in providing coverage to its residents. In this context, discussions of coverage policy in the state have focused on sustaining public coverage initiatives, while shoring up private health insurance markets and preparing for a rise in the number of uninsured.

This year, New Jersey experienced an unprecedented budget shortfall, a gap of roughly $5 billion. Despite this, the Governor and Legislature sustained a high level of coverage for children (up to 350% FPL) and parents (up to 200% FPL) under NJ FamilyCare and maintained a broad scope of services under Medicaid. During the budget deliberations it appeared that nearly 60,000 adults might lose NJ FamilyCare coverage, cuts that were ultimately restored in the budget process. However, prior to the conclusion of the budget debate, and at the request of the SPG Steering Committee, CSHP prepared an analysis of the full-cost buy-in options for FamilyCare coverage. A memorandum examining experiences with an adult full-cost buy-in option in several states, including Washington and Minnesota, as well as child full-cost buy-in programs in Florida, New York, Connecticut, and North Carolina was prepared and presented at a May 2003 Steering Committee meeting. Fortunately, as noted, all FamilyCare eligibility categories were maintained in the budget passed July 1, 2003, and further analysis of full-cost buy-in options became unnecessary.

Market Regulation Considerations (Sections 4.1 - 4.3, 4.9, and 4.12)

New Jersey was among a number of states that implemented health insurance market reforms in the early 1990s to improve access to affordable health coverage. Accelerating health insurance costs and reemerging growth in the number of uninsured nationally have led many states to take stock of their health coverage policies. With a decade of experiences, research has begun to emerge analyzing the effects and sustainability of state health insurance reforms like those in New Jersey. Today, as many states reexamine their strategies, it is important that emerging studies be brought to light and carefully evaluated. The State Planning Grant afforded New Jersey that opportunity.

In April 2003, the New Jersey Departments of Human Services and Banking and Insurance and Health and Senior Services, in collaboration with Rutgers Center for State Health Policy, sponsored an Expert Panel discussion on state health insurance regulation titled, *"Toward Inclusive and Sustainable Health Insurance Markets: A Dialogue between Policymakers & Researchers."* The purpose of the Expert Panel was to stimulate a broad dialogue about the emerging body of research evidence among representatives from the policy, research, insurance carrier and consumer advocate communities. This conference was intended to provide a forum for discussion of the future of state regulations in the non-group and small-group health coverage markets and the policy changes that may be required to sustain healthy markets. While New Jersey's small-group market remains relatively stable, the enrollment in the non-group market is declining at a rate of 3% per quarter with a current membership below 80,000.

We are pleased to report that the Expert Panel was extremely well received by attendees. The audience, which numbered over one hundred, included senior officials from the Office of the Governor, the Departments of Banking and Insurance, Human Services, Health and Senior Services, the Office of Management and Budget, as well as senior representatives from health insurance carriers, community groups and The Robert Wood Johnson Foundation. A copy of the Expert Panel Agenda can be found in Appendix D.

At the suggestion of HRSA, following the Expert Panel we also convened a half-day roundtable discussion that included panelists and key senior agency officials, who also serve on the SPG Steering Committee. The purpose of this "informal" roundtable was to critically assess the current condition of the non-group and small-group markets and, based in part on the

previous day's discussion as well as the experiences of these national experts, identify both short and long term policy options to improve market performance.

Those who participated in the roundtable brought with them a broad array of perspectives. As a consequence, the group debated policy options that ranged from incremental reforms that included such things as a modified community rating structure in the non-group market and a limit on plan options (e.g., only offer HMO coverage) to more substantial reform options such as combining the non-group and small-group markets.

It is premature to comment on any immediate impact from the Expert Panel, and while no specific policy changes have been embraced, the Commissioner of the New Jersey Department of Banking and Insurance is pleased with the outcome of the Conference.

We do look forward to providing additional information about the status of the non-group and small-group coverage markets in our Final Report to the Secretary. In addition, we will be able to provide further detail about a monograph that Rutgers Center for State Health Policy is planning to publish which will include the collection of papers and presentations prepared by the Expert Panel participants.

CONSENSUS BUILDING STRATEGIES

Governance Structure (Section 5.1)

As previously discussed, the New Jersey Department of Human Services (DHS) serves as the lead agency for the New Jersey State Planning Grant, and in turn is accountable to an inter-agency Steering Committee. The Office of the Governor, and four agencies of state government – DHS, the Department of Health and Senior Services (DHSS), the Department of Banking and Insurance (DOBI) and the Office of Management and Budget (OMB) of the State Department of Treasury – are represented on the Steering Committee (see Appendix A for a list of Steering Committee members). DHS has traditionally led the development, implementation and management of state coverage initiatives, including Medicaid and SCHIP. DHSS is responsible for regulating health care institutions (including HMOs) and has traditionally played important roles in coverage policy development in the state. DOBI is the insurance regulator in the state and houses two key boards – the Individual Health Coverage Board and the Small Employer Health Benefits Board. OMB is responsible for managing the state budget and for fiscal oversight of agencies.

Throughout the past year, the Steering Committee has met every four to six weeks to discuss new project developments and approve all SPG-related products prior to their release. In addition to the scheduled meetings, Steering Committee members keep in close contact with the CSHP research team to ensure that work done is appropriate and useful to the State. This structure mirrors the workgroup that successfully developed the NJ KidCare and NJ FamilyCare initiatives.

In addition to the project activities initiated under the State Planning Grant, Governor James E. McGreevey's *Conference on Healthcare Coverage* took place on June 10, 2003, and provided an important opportunity to include a wider array of stakeholders in the policy development dialogue. Vicki Mangiaracina, Special Deputy Commissioner for Affordable and Available Health Care at the New Jersey Department of Banking and Insurance (DOBI), and member of the SPG Steering Committee, directed activities for this conference on behalf of

DOBI. She called upon the research expertise of Joel Cantor and Alan Monheit from the Center, and they worked closely with her in the planning and implementation of this conference. Drs. Cantor and Monheit served as advisors in the development of the conference agenda and the selection of panel participants. In addition, Dr. Cantor and Dr. Monheit, respectively, served as facilitator and resource person for panel discussions (see Appendix E for the Conference agenda). We hope to build upon the policy discussion that took place at the Governor's Conference with additional activities that we outlined to HRSA in our request for supplemental funding.

Soliciting Input from the Public and Key Constituents (Section 5.2)

In addition to the contributions made by the members of the Steering Committee, the project team is also working with an Advisory Committee consisting of five external groups that were selected for their diversity and involvement in health policy development in the state. These groups are:

- **Covering Kids Coalition** – This group, which is convened by the Health Research and Educational Trust of New Jersey, is a group of more than fifty agencies and organizations in New Jersey interested in improving coverage for low-income uninsured children in the state. The Coalition has agreed to convene to advise the SPG project.
- **NJ FamilyCare Advisory Committee** – This panel is convened by DHS to advise on the design and implementation of NJ FamilyCare. Its members include health care providers, social service organizations, education groups, consumer advocacy organizations, local government, and business. SPG work will be integrated into the ongoing work of this group.
- **Individual Health Coverage Program and the Small Employer Health Benefits Program Boards** – These boards are established by New Jersey statute and are responsible for implementing health insurance reforms and regulating the individual and small group coverage markets. The Board members represent insurers, HMOs, consumers, labor unions, business, physicians, and DOBI. The Boards are state agencies with rulemaking authority and are funded entirely by assessments of health insurers and HMOs. Relevant work of the SPG will be presented and discussed with the full Boards, as appropriate.
- **New Jersey Family Health Survey Advisory Board** – This group of 38 individuals representing government agencies, academia, health care providers, consumer groups and others was initially convened in 2000 by Rutgers Center for State Health Policy to assist in the design of the New Jersey Family Health Survey. The members are generally technically oriented, either on policy matters or research methodology issues.

As we move forward into the second year of grant activities, we anticipate engaging these stakeholders more frequently as we broaden our outreach efforts and develop a strategy for briefings and dissemination of our research findings.

Building Public Awareness (Section 5.3)

As we move into the next year of SPG activities, the project team will engage the Steering and Advisory Committees in a discussion to identify appropriate audiences with whom we should share SPG project related findings. Our dissemination strategy will be focused on maximizing public awareness of the key policy issues in the coverage debate.

In addition, in our supplemental funding proposal, we outlined a project to advance the health coverage policy discussion in the state by building on activities initiated at Governor McGreevey's June 2003 *Conference on Healthcare Coverage.*

Impact of the State Planning Grant on the Policy Environment and Likelihood that Coverage Expansion Proposals will be Implemented (Section 5.4)

As we have received a no-cost extension to continue the SPG projects through June 2004, it is premature to comment on the policy impact of our projects. Options to optimize coverage have been analyzed and discussed with member of the Steering Committee throughout the past year. A final analysis of the policy impact of the SPG activities, along with any relevant implementation strategies, will be provided in the Final Report to the Secretary.

LESSONS LEARNED AND RECOMMENDATIONS TO STATES

Data Collection and Usefulness (Sections 6.1-6.5)

State-specific data are critical to formulating useful policy to enhance health insurance coverage and allow isolation of variations in health insurance coverage and health related decisions apart from differences in culture, geography, industry, and the like. At this time, all proposed data collection efforts are underway and are expected to be completed by the end of our no-cost extension in June 2004.

The project team did make one noteworthy change in data collection methodology. At the outset of this project, the Center for State Health Policy planned on conducting three 2-hour employer focus groups to learn more about health insurance offering decisions among New Jersey employers *(Project 1, Optimizing the Premium Support Program*). However, the project team met with considerable resistance in recruiting employers to attend these focus groups. In addition to being constrained by time (the focus groups would have required a three-hour time commitment), employers were generally hesitant to discuss personal information about their company and their opinions about offering health insurance to their employees.

As a result of these difficulties, and after consultation with the Steering Committee, CSHP decided to conduct short telephone interviews with employers, rather than convening focus groups. The project team conducted twenty-six fifteen-minute interviews both with employers that offer health insurance and those who do not. Response to the short telephone interview has been much more positive, though most employers remain uncomfortable speaking about health insurance and decline participation.

CSHP is presently compiling the data from these interviews and will summarize the findings in a fall 2003 report to the Steering Committee. A final analysis will be included in the Report to the Secretary.

Operational, Insurance Market and Employer Community Lessons Learned (Sections 6.6-6.7)

It is premature to comment on lessons learned from SPG project activities. We look forward to incorporating this information in the Final Report to the Secretary.

Recommendations to Other States (Section 6.8)

It is premature for the State of New Jersey to make any recommendation to other states on the health coverage policy planning process. We look forward to incorporating this information in the Final Report to the Secretary.

Changes to the Political and Economic Environment in New Jersey (Section 6.9)

As previously discussed, New Jersey confronted a $5 billion deficit, which led to heated debate among the Governor and Legislature that concluded with the budget adoption on July 1, 2003. While eligibility levels for NJ FamilyCare were maintained in the FY 2004 Budget, the State will continue to operate under fiscally challenging times for the foreseeable future. As a result, opportunities to expand coverage seem unlikely, and emphasis has shifted to identifying ways to optimize current public programs and maintain affordability of private coverage in the non-group and small-group markets.

On the political front, all members of both houses of the New Jersey Legislature will be up for reelection in November 2003, while Governor McGreevey has another two years in office before the next gubernatorial election. While too early to predict the outcome and impact of these elections, the possibility for partisan turnover exists. Currently, Democrats hold the Statehouse and are the majority party in the New Jersey Assembly while the State Senate is evenly split between Democrats and Republicans.

We will be better able to assess any impact of the legislative elections in the coming months and will summarize our conclusions in the Final Report to the Secretary.

Changes to Project Goals during the Grant (Section 6.10)

As all projects are successfully underway, we look forward to completing activities outlined in our original State Planning Grant proposal by June 2004.

Next Steps (Section 6.11)

We hope to complement the research currently underway with additional project activities endorsed by the SPG Steering Committee and outlined in our request for supplemental funding.

RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

It is premature at this time to offer any recommendations to the federal government. However, as we continue our course over the coming year, we will work with the SPG Steering Committee to identify possible roles for the federal government and opportunities for successful intervention and federal/state partnership. We look forward to providing any relevant policy recommendations in our Final Report to the Secretary.

ENDNOTES

[1] Bundorf, M. Kate and Mark V. Pauly. 2002. "Is Health Insurance Affordable for the Uninsured?" Unpublished manuscript. October.

[2] Levy, Helen and Thomas DeLeire. 2002. "What Do People Buy When they Don't Buy Health Insurance?" Unpublished manuscript. May.

APPENDIX A

2002-2003 NJ State Planning Grant
Steering Committee Members

MEMBER	TITLE	DEPARTMENT
Matt D'Oria, Project Director and Committee Chair	Acting Director	Division of Medical Assistance & Health Services, NJ Department of Human Services
Deborah Bradley Kilstein	Chief of Staff	NJ Department of Human Services
Lorraine Thomas-Danzy	Special Assistant to the Deputy Commissioner	NJ Department of Human Services
Ruth Charbonneau	Director	Office of Policy & Research, NJ Department of Health & Senior Services
Marilyn M. Dahl	Senior Assistant Commissioner	NJ Department of Health & Senior Services
Dennis Doderer	Deputy Assistant Director	Division of Medical Assistance & Health Services, NJ Department of Human Services
Nashon Hornsby	Senior Policy Advisor	Office of Policy & Research, NJ Department of Health & Senior Services
Ann Clemency Kohler	Manager	Office of Management & Budget, NJ Department of the Treasury (Office of the Governor)
Vicki A. Mangiaracina	Special Deputy Commissioner for Affordable and Available Health Care	NJ Department of Banking and Insurance
Freida Phillips	Special Assistant to the Commissioner	NJ Department of Human Services
Wardell Sanders	Executive Director, New Jersey Individual Health Coverage Program and New Jersey Small Employer Health Benefits Program Boards	NJ Department of Banking and Insurance
Mary R. Sibley	Assistant Treasurer	NJ Department of the Treasury (Office of the Governor)
Michelle Walsky	Chief of Operations	Division of Medical Assistance & Health Services, NJ Department of Human Services

APPENDIX B
New Jersey Family Health Survey Content

INTRODUCTION: Screener and Family Relationships within Household

SECTION A: Health Insurance Coverage
- Current coverage; # months covered in past year; type of coverage (e.g., HMO); prescription drug coverage.
- Among uninsured, eligibility for employer coverage; ever enrolled/apply/hear of Medicaid or NJ FamilyCare.

SECTION B: Health Status
- Respondent-assessed general health and oral health status, current and compared to a year ago
- Ever had asthma or diabetes diagnoses
- Prevalence of 15 serious and morbid symptoms among adults and careseeking for up to 4 symptoms
- Activity limitation (age-specific), if mental health limitation, name of problem
- Activities of Daily Living (age appropriate) and Instrumental Activities of Daily Living (adults).

SECTION C: Utilization
- Use of inpatient, ER, well-child, preventive care, other doctor visits and telephone contacts, dental, RNs, NPs, nurse midwife, chiropractors, health aide/homemaker services past year.
- Doctor visits during uninsured periods.
- Mental health visits in past 12 months: type of MH professional, name of problem, other MH problems for which did not seek care.
- Prescription drug use, past 3 months, number of different medications.
- Family out-of-pocket costs in past 12 months for prescribed medicines and dental care
- Financial impact of out-of-pocket medical costs in past 12 months on family
- Respondent satisfaction with care, medical provider inquires about medications, medical errors

SECTION D: Access to Care
- Usual place of care and type of place
- Difficulty getting needed care
- Symptom response index

SECTION F: Attitudes about Care-Seeking, Coverage and Caregiving
- Attitudes about health insurance and risk, health worry; family financial obligations to pay for health insurance and care, acceptability of free/discounted care; private physician discount availability, medical errors/safety, efficacy of medical care, etc.

SECTION G: Caregiver Assistance and Health Planning
- Extent of caregiving to care recipients in and outside the family, relationship to care recipient, characteristics of care recipient
- Employment impact of caregiving
- Health planning (e.g., long-term care insurance, advanced directives, etc.)

SECTION H: Employment and Earnings
- Employment status past week, characteristics of current job(s)
- Family income and assets
- Own, rent, or occupy without payment (of cash rent) home or apartment

SECTION I: Demographics
- Education, Hispanic origin, Race, country of birth, US citizen status
- Primary language spoken in home, religious preference
- Migration history

APPENDIX C

Results of the New Jersey Family Health Survey

Characteristics of Uninsured				
	Children (under 19) in New Jersey, 2001		Non-Elderly Adults (19–64) in New Jersey, 2001	
	% Distribution	Population Count	% Distribution	Population Count
Overall	100	237,722	100	854,877
Household Income				
Less than $20,000	24	194,771	17	38,822
$20,000 - $49,000	50	417,131	60	138,550
$50,000 or higher	26	216,233	24	55,202
Race/Ethnicity				
Non-Hispanic White	33	77,532	43	363,970
Non-Hispanic Black	14	32,805	16	137,913
Hispanic	44	103,921	34	292,542
All Other	n/a	n/a	7	60,453
Immigration Status				
Born in U.S.	85	201,000	67	570,045
Born outside U.S.	15	36,150	n/a	n/a
Citizen	n/a	n/a	11	92,399
Non-Citizen	n/a	n/a	22	189,394
General Health				
Excellent/Very good	56	132,633	45	378,094
Good	28	65,523	34	291,208
Fair/Poor	16	38,640	21	176,972
Dental Health				
Excellent/Very good	40	92,474	25	214,907
Good	31	72,140	37	310,246
Fair/Poor	29	67,457	38	320,550
Employment Status				
Working Full Time	n/a	n/a	50	410,870
Working Part Time	n/a	n/a	12	100,849
Unemployed	n/a	n/a	18	150,419
Not in Labor Force	n/a	n/a	19	157,618
Offered and Eligible for Empl. Sponsored Cov.	n/a	n/a	11	94,646

APPENDIX C(CONT'D)

Risk of Lacking Insurance Coverage				
	Children (under 19) in New Jersey, 2001		Non-Elderly Adults (19-64) in New Jersey, 2001	
	% Uninsured	Population Count	% Uninsured	Population Count
Overall	11	2,213,487	17	4,967,826
Household Income				
Less than $20,000	13	298,297	36	541,704
$20,000 - $49,000	19	735,305	26	1,591,232
$50,000 or higher	5	1,133,984	8	2,691,119
Race/Ethnicity				
Non-Hispanic White	6	1,274,399	11	3,265,352
Non-Hispanic Black	9	368,496	22	614,475
Hispanic	24	435,690	40	726,360
All Other	17	134,902	17	361,639
Immigration Status				
Born in U.S.	9	2,119,683	14	4,121,948
Born outside U.S.	39	93,232	n/a	n/a
Citizen	n/a	n/a	21	449,774
Non-Citizen	n/a	n/a	48	393,064
General Health				
Excellent/Very good	8	1,624,693	13	2,929,427
Good	14	466,463	22	1,298,822
Fair/Poor	32	119,451	24	726,668
Dental Health				
Excellent/Very good	7	1,351,089	10	2,220,763
Good	13	549,988	19	1,651,788
Fair/Poor	29	231,623	30	1,052,181
Employment Status				
Working Full Time	n/a	n/a	14	2,892,600
Working Part Time	n/a	n/a	21	480,236
Unemployed	n/a	n/a	52	287,045
Not in Labor Force	n/a	n/a	16	1,016,337

CSHP
Rutgers Center for State Health Policy

APPENDIX D

State of New Jersey

State Health Insurance Regulation
Toward Inclusive and Sustainable Health Insurance Markets:
A Dialogue between Policymakers and Researchers
April 10, 2003

Sponsored by the New Jersey Departments of: Human Services, Banking and Insurance, Health and Senior Services and Rutgers Center for State Health Policy

Agenda

8:00–8:45A.M. **Continental Breakfast and Registration**

8:45–9:00A.M. **Remarks**

Joel C. Cantor, *Rutgers Center for State Health Policy*
Commissioner Holly Bakke, *New Jersey Department of Banking and Insurance*

9:00–10:15A.M. **Findings on Health Insurance Market Reform – Perspectives from Researchers**

Introductions and Panel Overview
Moderator: Alan C. Monheit, *University of Medicine & Dentistry of New Jersey and Rutgers Center for State Health Policy*

What Have We Learned from Research on the Small Group Market?
Presenter: Kosali Simon, *Cornell University*

What Have We Learned from Research on the Non-Group Market?
Presenter: Deborah Chollet, *Mathematica Policy Research, Inc.*

Q & A and Discussion

10:15–10:30A.M. ***Break***

10:30–11:45A.M. **Findings on Health Insurance Market Reform (Continued) – Responses to Findings on Market Reform**
Moderator: Alan C. Monheit

Panelists:

What does all this evidence say about the effects of reform?
Tom Buchmueller, *University of California, Irvine*

What should every policymaker know about the research?
Barbara Schone, *Agency for Health Care Research and Quality*

How can reform work better?
M. Susan Marquis, *RAND*

11:45A.M.–12:45P.M. ***Luncheon***

12:45–2:00P.M. **Perspectives from the Field: How Can Access to Affordable Coverage be Sustained?**

Moderator: Wardell Sanders, *Individual Health Coverage Program and Small Employer Health Benefit Program Boards*

Panelists:

Commissioner *Steven Larsen, Maryland Insurance Administration*
Mark Scherzer, *New Yorkers for Accessible Health Care*
Sanford Herman, *Guardian Life Insurance Company*
Karen Pollitz, *Georgetown University*

Q & A and Discussion

2:00–2:15P.M. ***Break***

2:15–3:15P.M. **Reforming Insurance Market Reform: What are the Possibilities? What are the Alternatives?**

Moderator: Vicki A. Mangiaracina, *NJ Department of Banking and Insurance*

Panelists:

Len M. Nichols, *Center for Studying Health Systems Change*
Kathy Swartz, *Harvard School of Public Health*

Q & A and Discussion

3:15–3:30P.M. ***Closing Remarks and Adjournment***
Joel C. Cantor

APPENDIX E

Governor James E. McGreevey's Conference on Healthcare Coverage
Agenda
June 10, 2003

AGENDA

8:45 am – 9:00 am ***Welcome and Program Overview***
Commissioner Holly C. Bakke, Esq.

9:00 am – 9:30 am ***Plenary Lecture: A Unique Perspective on Healthcare Coverage in New Jersey***
Assemblyman Herb Conaway
Deputy Speaker, New Jersey State Assembly
Introduction: Commissioner Gwendolyn Harris

9:30 am – 10:15 am ***Opening Lecture: Why Are There So Many Uninsured? Will We Ever Solve Their Problem?***
Uwe E. Reinhardt
James Madison Professor of Political Economy
Princeton University
Introduction: Dean Anne-Marie Slaughter

10:15 am – 10:30 am **Break**

10:30 AM – 10:45 AM **DEFINING THE PROBLEM: THE BEGINNING OF THE PROCESS**
Commissioner Bakke
Commissioner Clifton Lacy, M.D.

10:45 AM – 12:00 PM **THE HEALTH CARE COVERAGE CHASM**

Small Employers, Big Challenges: Understanding the Small Employer Market
Facilitator: Linda T. Bilheimer
Resource: Alan C. Monheit
Advocate: Melanie Willoughby

On Their Own: Understanding Why Individual Healthcare Coverage is Not Affordable
Facilitator: Stephen A. Somers
Resource: Deborah Chollet
Advocate: Robert E. Meehan

Beyond Affordability: Understanding Disparities in Healthcare Coverage
Facilitator: Joel C. Cantor
Resource: Cathy Shoen
Advocate: Paula Sawyer

Understanding the Uninsured
Facilitator: Wardell Sanders
Resource: David Helms
Advocate: Denise V. Rodgers, M.D.

12:00 pm – 12:30 pm ***Keynote Speaker***
Governor James E. McGreevey
Introduction: Commissioner Bakke

12:30 pm – 1:30 pm ***An Insurer's Perspective on Health Insurance and The New Jersey Regulatory Environment***

Mary Nell Lehnhard
Senior Vice President, Office of Policy and Representation
Blue Cross Blue Shield Association
Introduction: Wardell Sanders

1:45 pm – 2:45 pm ***Opportunities For Change: Perspectives On Solutions***

New State Strategies for the Small Employer Market
Facilitator: Linda T. Bilheimer
Resource: Len Nichols
Advocate: Janet Trautwein

Understanding of the Role of State Mandates on Healthcare Coverage
Facilitator: Stephen A. Somers
Resource: Alan C. Monheit
Advocate: Donald Sico

New State Strategies for the Individual Market
Facilitator: Joel C. Cantor
Resource: Karen Pollitz
Advocate: Robert E. Meehan

Designing Alternative Healthplans
Facilitator: Wardell Sanders
Resource: David Helms
Advocate: Adam Rudin

2:45 pm – 3:00 pm **Break**

3:00 pm – 3:30 pm ***Plenary Lecture***

Dr. John Lumpkin
Senior Vice President for Health Care
The Robert Wood Johnson Foundation
Introduction: Karen Jezierny

3:30 pm – 4:15 pm ***Building a Healthcare Agenda For The Future***

Breakout Sessions Report Back
Next Steps
Facilitator: Holly C. Bakke