State of New Jersey
DEPARTMENT OF HUMAN SERVICES
CN 700
TRENTON, NEW JERSEY 08625-0700

MEMORANDUM

TO: Brenda Bacon
Chief, Office of Management
and Budget

FROM: William Waldman
Acting Commissioner

DATE: **January 27, 1993**

SUBJECT: NGA Winter Meeting

Attached are items you requested for the Governor in preparation for the NGA Winter Meeting.

The items are:

1. Three page informational handout on the Family Development Program (FDP), New Jersey's Income Security Job-Oriented Welfare Reform program. The Governor can give this material to other Governors, the new administration, and the press. As soon as we have your approval of this piece we can have it copied, in quantity, on colored stock.

2. Talking Points for the Governor with ideas for additions and expansions he can make to other Governors. An addendum to these talking points provides underlying policy and administrative reform issues.

Please let me know if I can be of any further assistance.

c: Betty Wilson
Larry Lockhart
Marion Reitz

The Family Development Program (FDP), New Jersey's ***Income Security and Job-Oriented Welfare Reform*** *program, was signed into law in January 1992 by Governor Jim Florio. This program aims to break the cycle of poverty, by encouraging family stability while instilling a sense of individual responsibility and dignity to all participants.*

FDP replaces welfare grant dependency with job-training, education, social support and a reinforcement of the importance of the family in decision making.

New Jersey's efforts reflect some fresh thinking and new common-sense approaches to address welfare dependency. The current system increasingly traps generations of families in poverty, offering parents and their children little hope for the future.

When did the Family Development Program (FDP), New Jersey's Income Security and Job-Oriented Welfare Reform program, begin?

The Family Development Program began on October 1, 1992 for AFDC recipients in Essex, Hudson and Camden counties. The program will be phased into the remaining 18 counties over a two-year period, starting July 1, 1993.

What does FDP do?

EDUCATION AND JOB TRAINING

- requires AFDC participants with children two years of age or older to participate in training and education.
- requires a participant whose youngest child is less than two years of age to participate in counseling an vocational assessment.
- requires all participants to be involved in the development of a family plan, which includes a signed agreement, to outline each family member's educational and job goals.
- enables each family member to earn a high school diploma, or equivalency, if they are old enough, befor that person is assigned to a vocational related activity. Under certain conditions, some recipients are exempt from this requirement.
- sets up a program that will assist in providing tuition and related financial aid, as needed, to each participant or family member accepted into college or a vocational training program. This program will be provided within the limits of funds available through the New Jersey Educational Opportunity Fund, or othe scholarship or grant funds available.
- provides Individual Family Development Counseling and other social service supports.

FAMILY BASED SERVICES

- develops family plans that address the needs of the entire family in relation to that family's attainment o self-sufficiency. FDP recognizes that a two generational approach must be used to begin to break the cyc of poverty and dependency. Additional state resources of $2.5 million were provided in SFY 1993 to broaden the scope of the program in serving families, i.e. developing family resource centers, family case management and expanded educational opportunities.

EXTENDS AND EQUALIZES BENEFITS

- provides for two years of extended Medicaid benefits to qualified participants who have attained employment.

ELIMINATES MARRIAGE PENALTY

- ends the existing 30 percent penalty for some married couples. Previously, some married couples receiving AFDC were subject to a 30 percent penalty on monthly benefits. This took effect statewide October 1, 1992.

MARRIAGE AND BENEFITS

- allows benefits to a child of an AFDC participant after the participant marries a person who is not the natural parent of the child. When implemented this change will take place statewide.

WORKING AND COLLECTING BENEFITS

- allows participants who have an additional child to keep a higher percentage of their EARNED INCOME without losing benefits. On October 1, 1992, the state notified mothers on welfare that if they have children while on welfare, they will not receive additional financial benefits for that child. The family would be eligible for additional food stamps and Medicaid for any newborn child. Although a mother would be denied those additional AFDC financial benefits, she could, under the Family Development Program, work and earn up to 50 percent of her welfare grant without a loss of benefits. This change took effect statewide.

SETS PENALTIES FOR NON-COMPLIANCE WITH THE PROGRAM

- requires a reduction in AFDC benefits for not following the rules of the program. This reduction will be at least 20 percent of the current grant or ineligibility for the individual for at least 90 days.

ESTABLISHES A HOTLINE

- sets up a 24-hour hotline to provide New Jersey residents with information on job-training services, child care, health care, and other human services.

CREATES PARTNERSHIPS

- establishes a community restoration council, within the Department of Community Affairs, to advise the Governor on the priority of resource allocation with the intent of improving and expanding economic development and neighborhood revitalization. This will lead to the creation of jobs and entrepreneurial opportunities.

INTERDEPARTMENTAL COOPERATION

- emphasizes cooperation between state departments to collaboratively meet the needs of the participants and families. FDP also establishes a Community Restoration Council to advise the Governor on allocating resources to improve economic development and community restoration.

  Currently, the Department of Human Services is working closely with the Departments of Education and Labor. These departments have established agreements to match their resources with federal JOBS funds to expand services to participants. The Department of Human Services is also developing relationships with the departments of Health, Higher Education and Community Affairs to ensure that FDP participants and their families get the maximum amount of resources that are available.

  Efforts with other State Departments include maximizing resources by using the state funds of these departments as match for the federal JOBS funding.

PROVIDES INTENSIVE CASE MANAGEMENT SERVICES

- provides case management services for the entire family to ensure that family members have access to the services they need when and how they need them. Through a Family Resource Center, services are co-located to the maximum extent possible within the communities they serve. Family Resource Centers provide services with an awareness of cultural and linguistic diversities. In addition, a hotline is being established to ease the access to services needed by New Jersey's families.

FOCUS ON YOUNG FATHERS AND MOTHERS

- stresses the responsibilities of unemployed, noncustodial fathers of children receiving public assistance. Through a national project being managed by Manpower Demonstration Research Corporation(MDRC), named *Operation Fatherhood* in New Jersey, young fathers are being encouraged to provide adequate financial support for their children and to participate in the parenting process.

- Programs for adolescent mothers are also encouraged to enable them to continue their education, provide quality child care for their children, and become self sufficient.

The New Jersey Family Development Program stresses total family values, education, job development and private sector jobs for participants. The program provides counseling, vocational assessment, remedial education, English-as-a-Second Language, employment skills, on-the-job training, and support services as available.

As part of a Federal Evaluation process, control groups will be established in 10 counties.

State of New Jersey
Jim Florio, Governor

Department of Human Services
Division of Family Development

National Governors' Association
National Health Reform and Cost Containment

Suggested Talking Points

These talking points are organized along the lines of the NGA position paper on national health reform and cost containment.

1. Introduction - In New Jersey, we have achieved a great deal in health care reform and planning in the last three years - foremost among these achievements are those initiatives and programs that improve access and contain costs. Five key components in our recent reform can be useful in the national debate. The first three reform both the individual and small group insurance markets by:

   - Creating five standard insurance plans - a least one of which is a managed care plan - so that consumers can compare the price of identical plans.
   - Requiring community rating so that everyone pays the same premium regardless of age, sex, occupation, and medical history.
   - Requiring insurers to take all comers or pay a penalty.

   In addition, we created a subsidized insurance program in which the state will make-up the difference between the cost of insurance and what New Jerseyans can afford to pay. And we have set "hospital budget ceilings" as a transition from hospital rate-setting to a competitive market.

2. Basic Framework to Support Managed Competition

   <u>Information to Consumers</u>

   - New Jersey's new law establishes the Essential Health Services Commission. One responsibility of this entity will be to make information about price and quality available to purchasers.

Outcomes Research

- The Agency for Health Care Policy and Research of U.S. Department of Health and Human Services has launched us on the road to responsible research through their Patient Outcomes Research Teams (PORTs) and other research on the outcomes of health care services and procedures used to prevent, diagnose, treat and manage illness. This knowledge is crucial for responsible decision-making about how our health care dollars should be spent.

Minimum Standards for Health Insurance (see section on Primary Care for more information on insurance reform)

- Limits on premium rates - community rating will be phased in by 1995 for individual plans and 1997 for small group plans. During the phase-in, limits are set on premiums.
  - The premium rate charged by a carrier for the highest-rated individual may not be more than 150% of that of the lowest-rated individual.
  - The premium rate charged by a carrier for the highest-rated small group plan may not be more than 300% of the lowest-rated plan.

Limitations on Medical Underwriting and Guaranteed Issues

- New insurance reform has eliminated medical underwriting in the individual and small group markets. All carriers doing business in these markets will be required to "take all comers" or pay an assessment to subsidize carriers who do. Carriers will be required to establish premiums that are the same for everyone regardless of their age, sex, occupation or medical history.

Portability

- Under New Jersey's new laws, if a person leaves a job where he or she has health insurance and buys an individual plan, pre-existing conditions will be covered.

Availability and Individuals Bear Responsibility to Obtain Coverage

- With a new subsidized insurance program, New Jersey is joining Washington, Hawaii, Arizona and Minnesota in providing state subsidies for families who cannot obtain insurance through their employment or who are temporarily unemployed. Beginning in 1994, the State will share the cost of insurance premiums for families up to 300% of FPL. Subsidy will reach $200 million by 1997.

Health Insurance Purchasing Cooperatives

- We need to follow California's example and exercise our power as purchasers of health care for our government employees. We also need to "buy smart" with our Medicaid monies - need flexibility from federal government to channel beneficiaries into managed care.

Torte Reform - no comment

Claims Form

- Too much beaucracy and red tape helps run up the cost of insurance. We do not need a thousand claims forms; the closer we can get to a standardized one the better.

Core Benefits Package

- Five standard health benefits plans will reduce complexity for consumers and allow them to compare price. The standard plans must include a basic health benefits plan, a managed care plan, and three plans of enhanced benefits of proportionally increasing actuarial value. The basic health plan will include primary and preventive care. Copayments and deductibles are limited and maternity care and preventive care will have no copayments or deductibles.
  - Incentive is for managed care plans: insurers must offer either all five plans or the managed care plan alone in the individual and small group market.

Tax Treatment - no comment

Primary and Preventive Care

- A misplaced focus on hospital care, rather than on the kind of preventive and primary care that can forestall disease or mitigate its severity, has had grave consequences for health of New Jerseyans--and all Americans. Too many of us have no "medical home" to go to--an accessible physician or community-based outpatient setting where we can receive appropriate, compassionate, and less costly preventive and primary care.
- Repercussions of such a misplacement of emphasis are numerous. One of them is great disparities between the health status of our disadvantaged populations and the "rest of us." It also means unacceptably high rates of infant mortality, breast, lung, and cervical cancer, and cardiovascular disease; and epidemics of childhood infectious diseases like measles. We may have the most technologically advanced health care system in the world--but we do not have the healthiest citizens.
- A lack of accessible preventive and primary care is not only an impediment to a healthier society--it is also costing us a great deal of money--all of us. In 1989 we had 130,000 hospital admissions in New Jersey--one in every eight, costing $650 million--that might have been avoided if primary care had been sought and received.

A health care delivery system whose too-frequent entry point is a hospital emergency room is an unenlightened system: it does not promote good health and it fuels the rising cost of care.

- From beginning of this administration all of our health care planning initiatives have grown from these convictions:
  - that all New Jerseyans should have access to affordable health care;
  - that this care should whenever possible be available in a community-based "medical home"; and

- that, whenever possible, the focus should be on preventive and primary care, rather than acute hospital care.

- These convictions have driven our entire reform program: the Health Care Cost Reduction Act, the State Health Plan, and insurance reform.

- **Health Care Cost Reduction Act.** Passed in 1991, this provided for first comprehensive reform of NJ health care delivery system in over a decade. One of its chief aims was to make health care more accessible through expanded government programs--or new ones--targeted to specific groups.

  - Community Health Center Expansion Program. $10 million in '92 and again in '93. Goal: more accessible community-based "medical homes" as attractive alternatives to hospital ERs. Hours, services and staff expanded. Results immediate: 50,000 new primary care visits in '92--a 20 percent increase over '91; 20,000 visits from the uninsured, whose care was paid for from funds set aside for this purpose; and an estimated $8 million savings in ER costs.

  - Competitive Initiatives Program. Hospitals continue to have vital role to play in this more community-based delivery system. After all, from inception hospitals were community institutions. This program creates partnerships between hospitals and other community providers, in order to ensure accessible primary care through joint referrals. Consequently each institution is free to do what it does best, the full spectrum of community health care needs are better met, and many expensive and unnecessary ER visits are averted.

    As with expansion of community health centers, this initiative already bringing results. During its first full year of operation, we anticipate 12,000 referrals from hospital ERs, and

an additional 24,000 visits to our community health centers.

- **State Health Plan.** Health Care Cost Reduction Act also called for creation of a comprehensive State Health Plan. Plan to serve as blueprint for changes of NJ's health care system: it is a guide to rational and enlightened reform. Plan to be completed this spring, with chapters covering full range of health care issues from AIDS to long-term care for the elderly. But linchpin of the plan is the chapter on preventive and primary care.
- This chapter calls not only for a change in the way we organize and deliver health care in New Jersey, but for a basic change in how it is financed, through insurance reform.
- Chapter's recommendations call for support for the community health center expansion program described above; efforts to improve access to capital for non-hospital-based primary care providers; uniform preventive and primary care services in our schools; and the better coordination of primary care services among providers. Significantly, it also recommends efforts to increase the state's supply of primary care physicians and other primary care professionals, with a particular emphasis on minorities.
- Engine driving the recommendations of this chapter of State Health Plan--and indeed the entire health care planning effort--is insurance reform. Nearly a million New Jerseyans lack health insurance, and lack of insurance is single greatest barrier to the acquisition of preventive and primary health care.
- We must reduce the cost of health insurance--and in NJ we are beginning to make progress toward this objective. At end of last year, several measures signed into law which will do this. Their collective effect will be to:
  - lower cost of insurance for those who can't get it at work;
  - require insurers to "take all comers";

- establish health insurance premiums that will be same for everyone regardless of age, sex, or occupation;
- standardize insurance plans to make them user-friendly and to facilitate comparison shopping.

* Most enthusiastic, however, about a new subsidized insurance program, scheduled to be up and running the beginning of next year. Subsidy will reach $200 million by 1997.
  - This program will help working poor and temporarily unemployed to obtain health insurance at a price they can afford. Does this by subsidizing the purchase of basic health insurance packages <u>that emphasize managed preventive and primary care.</u>
  - State will contract with insurance providers of its choosing and, through subsidies, will pay the difference between the cost of the coverage and what New Jerseyans can afford to pay. Similar program in Hawaii is holding per-person health insurance costs to two-thirds those prevailing in NJ.
  - Subsidized insurance programs and other insurance reforms take state well down road to universal health care--making it a <u>right</u> for all New Jerseyas and--ultimately--all Americans.

3. Cost Containment Strategies

   * Health Care Expenditure Goals

   - Many feel that healthcare costs must be contained before universal coverage can be achieved. This argument is unacceptable. We must strive to do both, with the knowledge that, to a considerable extent, the achievement of universal health care will also help us to contain costs.
   - A battle is now raging between those who wish to control health care expenditures through regulation and those who, like Paul Elwood, Alain Enthoven and Richard Kronick, advocate achieving it through managed competition. It may in fact be

possible to have both - but that is not the present conventional wisdom. In New Jersey, the champions of managed competition appear to have won the day, and the Chapter 83 hospital rate-setting system has been scrapped. The effects of deregulation on NJ hospitals and other providers - and on New Jersey health care - remain to be seen.

Data Systems Review and Reporting Accountability:

- We can spend less money and get better health. We spend a third more per capita than any other country, but don't enjoy the good health status realized by all other industrialized nations.
- The key to successful reform is accountability - not only financial accountability, but also accountability for improving health status. HCFA has the underpinnings of financial reporting, and the CDC, with its National Center for Health Statistics, has the ability to track health status. These two kinds of data need to be integrated.

4. State and Local Management

Medicaid

- New Jersey is making inroads into managed care. In a matter on months, we've more than tripled the number of beneficiaries who have enrolled in the state-run program: from 5,000 to 16,000 people.
- We're developing a five-year plan to extend managed care to the entire Medicaid population. This includes buying coverage through private HMO contracting. States need to have the flexibility to do this without waivers from the Federal government.

ERISA Plans

- Our inability to integrate these plans was the catalyst for major reform in New Jersey. In response to a Federal district court ruling where the court found that the state's method of financing

uncompensated care (explicitly shifting the cost to other payers) was preempted by the Federal law, we were faced with the unenviable task of finding $600 million dollars to pay for care for indigents.

Access to Care

- One of the goals of the current reform effort in New Jersey is to improve the accessibility and quality of the health care delivered to minority populations in "medically underserved" inner-city and rural areas of the state. The Health Care Cost Reduction Act provided $1 million each year to pay the graduate medical education loans of primary care physicians and dentists who agree to practice in rural and urban areas. Eight doctors have been placed already.

Public Health

- Even if we are successful in providing health insurance for everyone, there is still an important role for public health. For example, New Jersey has an aging infrastructure. Many thousands of homes contain paint with toxic lead which is easily ingested by children. Such ingestion over a prolonged period can cause serious developmental disabilities. This is a problem that a visit to the doctors office or clinic cannot fix. Doctors can identify and treat the symptoms of the illness, but not the source. The solution to this problem lies in public health programs which address lead abatement measures in the home.

Long-term care

- The goal of the State Health Plan's recommendations on long-term care is to improve the quality of life for all New Jersey's elderly and disabled citizens. We are developing five alternatives to institutional care that respect individual privacy and personal preference; that keep people in their homes and communities. All of these alternatives (home care, day care, foster family care and two kinds of assisted living) can be provided at a cost lower than

nursing home care.