

## **NEW JERSEY**

**DISCLAIMER:** The views, statistical analysis, findings, and opinions expressed herein are not necessarily those of the Office of Minority Health, the Office of Public Health and Science nor the Department of Health and Human Services. The National Health Law Program, Inc. (NHeLP), under contract #282-00-0026, reviewed and analyzed existing state policies related to collecting racial and ethnic data by managed care organizations and health insurers. The information in this draft report contains the findings of NHeLP and not that of the Office of Minority Health, the OPHS, nor the U. S. Department of Health and Human Services. The study was conducted between October 2000 and May 2001. The policies and/or data per state may have changed since that time. The findings that have been updated in this draft report are the U.S. Census data (updated so that all data is from the 2000 Census) and the Center for Medicare & Medicaid Services (CMS)/HHS Medicaid data (updated from the June 30, 2000 to the December 31, 2002 reports).

## NEW JERSEY

### A. General and Health Demographics

<b>Total Population</b>	8,414,350	
Percent Black Population	13.0	
Percent American Indian and Alaskan Native Population	0.1	
Percent Asian Population	5.7	
Percent Native Hawaiian and Other Pacific Islander Population	0.0	
Percent Hispanic Population (of any race)	13.3	
Percent White Population	66.0	
Other (some other race and two or more races)	1.8	
<b>Language Use - 2000 census data</b>		
Percent Limited English Proficiency (LEP) Population	5.43	(11.11)
<b>Health Care Delivery Profile</b>		
Percent of Total Non-elderly Population Privately Insured (1997-99)	75.8	
Percent of Total Population Enrolled in HMOs	29.21	
Medicaid Enrollment (as of December 31, 2001)	759,644	(9.03%)
Medicaid Managed Care Enrollment	525,937	(69.23%)
Percent of Total Non-elderly Population Uninsured (1997-99)	17.2	

### B. Collection and Reporting of Racial and Ethnic Data by Health Insurers or Managed Care Organizations

#### 1. Statutes, Regulations, Policies and Other Written Materials

New Jersey uses the term “insurer” to encompass insurance companies, and nonprofit health, hospital, and medical service corporations.<sup>1</sup> The term managed care organizations (MCOs) refers to health maintenance organizations (HMOs) and dental plan organizations. The Department of

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<sup>1</sup> N.J. Stat. § 17B:17-19(b).

Banking and Insurance (DBI) regulates insurers and MCOs (with regard to financial and contractual issues). The Department of Health and Senior Services regulates MCOs with regard to health care access, quality of care, and medical necessity issues. This summary will use the term “insurer” as defined and the term as MCO as noted, unless there is a distinction made within the statutes or regulations regarding the issue being discussed.

New Jersey requires that all health insurance policies and any applications related to the policies receive approval from the DBI prior to their use.<sup>2</sup> The DBI has promulgated regulations that prohibit the collection of racial and ethnic data under a certain circumstances.<sup>3</sup> Pursuant to the regulation, application forms for individual health insurance “shall not include . . . questions that: pertain to race, creed, color, national origin or ancestry of the proposed insured. . . .”<sup>4</sup> In addition, New Jersey statutes prohibit the “use of any form of policy of . . . health insurance . . . which expresses, directly or indirectly, any limitation, or discrimination as to race, creed, color, national origin or ancestry. . . .”<sup>5</sup>

In order to operate in New Jersey, an HMO must obtain a certificate of authority from the Department of Health and Senior Services. As part of its application, the HMO must submit a description of the methods it will use to facilitate access to services for culturally and linguistically diverse members.<sup>6</sup> In addition, New Jersey has imposed several data collection and reporting requirements on health insurers that demonstrate that the DBI prohibition, as its language suggests, is applied only in the narrow realm of insurance application forms, and not at any other point in the process of providing coverage.

The Department of Health and Senior Services (DHSS), which also has jurisdiction over MCOs, has established a Healthcare Data Committee (HeDaC) to assist in the development of quality improvement programs and to monitor the quality of care provided to HMO members.<sup>7</sup> The HeDaC is intended in part to help DHSS develop a performance and outcome measurement system to monitor quality of care.<sup>8</sup>

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<sup>2</sup> N.J. Stat. § 17B:26-1(a) (individual health insurance policies); N.J. Stat. § 17B:27-49(a) (group health insurance policies).

<sup>3</sup> N.J.A.C. § 11:4-16.7(a)(1). This regulation applies to all individual health insurance policies, where policy means the entire contract including all policies, certificates, riders, and applications. *See* N.J.A.C. § 11:4-16.2.

<sup>4</sup> This provision is applicable to insurers and MCOs that offer individual health coverage. A person eligible for individual health insurance is “a person who is . . . not eligible to be covered under a group health benefits plan [plan for 2 or more persons], a group health plan [an employee welfare benefit plan], [or] governmental plan.” N.J. Stat. § 17B:27A-2.

<sup>5</sup> N.J. Stat. § 17B:30-12(b); N.J. Stat. § 17:29B-4(7)(d) (2000).

<sup>6</sup> N.J.A.C. § 8:38-2.3(c)13; Letter from Ruth Charbonneau, Director, Office of Policy and Research, N.J. Department of Health and Senior Services.

<sup>7</sup> N.J.A.C. § 8:38-7.4(a).

<sup>8</sup> N.J.A.C. § 8:38-7.3(a).

The performance and outcome measures must include population-based indicators of quality, access and satisfaction.<sup>9</sup> The elements of these performance measures may include, but are not limited to: (1) member satisfaction surveys; (2) encounter data; and (3) data gathered by DHSS from other statutorily-mandated collections (such as the cancer registry, vital records, and hospital records).<sup>10</sup> All HMOs licensed in New Jersey are required to submit such performance and outcome data as DHSS deems necessary. Interestingly, before DHSS makes its HMO performance findings public, it may, when appropriate, make adjustments to account for any demographic variations among HMOs.<sup>11</sup> This suggests that racial and ethnic data may indeed be incorporated into the HMOs' performance and outcome data measurements.

## 2. Discrimination

An insurer violates the unfair competition law if it “[makes] or [permits] any discrimination against any person or group of persons because of race, . . . , color, national origin or ancestry in the issuance, withholding, extension or renewal of any policy of insurance . . . .”<sup>12</sup>

New Jersey has a general anti-discrimination statute which prohibits discrimination on the basis of race or national origin with regard to access to public accommodations.<sup>13</sup> However, given the specificity and scope of the anti-discrimination provisions of the insurance statutes, it is not clear that the public accommodations statute would be deemed to cover an issue of access to health insurance, or possibly health care services offered by insurers.<sup>14</sup>

## 3. Confidentiality

An insurer, including an HMO, must not disclose any “personal or privileged” information about an individual collected or received in connection with an insurance transaction.<sup>15</sup> Disclosure is allowable if there is, among other things: (1) written consent by the individual; (2) a need by an

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<sup>9</sup> N.J.A.C. § 8:38-7.3(b)(HMOs) and N.J.A.C. § 8:38-4.16(a)(2)(other health insurers).

<sup>10</sup> N.J.A.C. § 8:38-7.3(b)(2)(5)(6).

<sup>11</sup> N.J.A.C. § 8:38-7.3(d). N.J.A.C. § 8:38-14.6(a)(4) applies this provision to health insurers, also.

<sup>12</sup> N.J. Stat. § 17:29B-4(7)(d).

<sup>13</sup> N.J. Stat. § 10:5-4.

<sup>14</sup> Although insurers may not be covered by the public accommodations statute, DHSS regulations make the New Jersey Law Against Discrimination, N.J.S.A. § 10:5-1.1 *et seq.* applicable to HMOs. *See* N.J.A.C. § 8:38-3.2(a)(6).

<sup>15</sup> N.J. Stat. § 17:23A-13. Personal information is “any individually identifiable information . . . from which judgments can be made about an individual’s character, habits, health . . . or any other personal characteristics” including name and address. Privileged information is “information that (i) relates to a claim for insurance benefits or a civil or criminal proceeding . . . , and (ii) is collected in connection with or in reasonable anticipation of a claim for insurance benefits or civil or criminal proceeding. . . .” N.J. Stat. § 17:23A-1.

insurance company in order to detect criminal activity or to perform administrative functions; (3) a need by a medical care institution for the purpose of verifying coverage or benefits; and, (4) a release to a law enforcement or government authority.<sup>16</sup>

State regulations require that DHSS ensure the confidentiality of patient specific information.<sup>17</sup> Further, all information submitted to the HeDaC through its uniform data reporting system must be held in strict confidence.<sup>18</sup>

Any information maintained by an MCO that relates to an enrollee's or applicant's diagnosis, treatment, or health status must be held in confidence.<sup>19</sup> Exceptions to this provision include releases: (1) made with the enrollee's or applicant's consent; (2) made with the enrollee's or applicant's physician's consent; (3) mandated by statute or court order; and (4) made in connection with a claim or litigation between the enrollee and MCO when the data or information is relevant to the claim.<sup>20</sup>

### **C. Collection and Reporting of Racial and Ethnic Data by Other Health Care Entities**

#### **1. Department of Human Services (DHS)**

##### **a. Statutes, Regulations, Policies and Other Written Materials**

DHS administers the New Jersey Care,<sup>21</sup> NJ FamilyCare<sup>22</sup> and NJ KidCare<sup>23</sup> Programs. There are no state statutes or regulations that require or prohibit the collection of racial and ethnic data by DHS regarding Medicaid applicants or recipients. However, New Jersey collects racial data on its application for the NJ FamilyCare program. The form provides applicants with the option to provide racial and ethnic background information about themselves and other household members. The categories from which applicants may choose are: (1) Black; (2) Hispanic; (3) White; (4) American

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<sup>16</sup> N.J. Stat. § 17:23A-13.

<sup>17</sup> N.J.A.C. § 8:38-7.3(g) (HMO's submitted data); N.J.A.C. § 8:38A-4.16(a)(8) (carrier's submitted data).

<sup>18</sup> N.J.A.C. § 8:38A-4.13(e)(2)(ii).

<sup>19</sup> N.J. Stat. § 26:2J-27 (HMOs); N.J. Stat. § 17:48D-21 (DPOs).

<sup>20</sup> *Id.*

<sup>21</sup> New Jersey Care is New Jersey's mandatory Medicaid managed care program approved by HCFA.

<sup>22</sup> NJ FamilyCare is a federal and state funded health insurance program created to help New Jersey's uninsured families, single adults, and couples without dependent children have affordable health coverage. NJ FamilyCare was created pursuant to the Family Care Health Coverage Act, P.L. 2000, c.71.

<sup>23</sup> NJ KidCare is New Jersey's SCHIP program designed to provide health insurance coverage to uninsured children ineligible for Medicaid.

Indian/Alaska Native; (5) Asian/Pacific Islander; and (6) Other.

The managed care contract between the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services and selected HMOs provides for racial and ethnic data collection and reporting only in the case of an enrollee's consent to sterilization.<sup>24</sup> However, there are several provisions within the contract that suggest that DHS is concerned with the fair and efficient delivery of health care services to New Jersey Care, NJ FamilyCare, and NJ KidCare minority beneficiaries.

First, the contract imposes a requirement that the HMO participate in DHS' Cultural and Linguistic Competency Task Force, and take any and all necessary steps to provide culturally appropriate services.<sup>25</sup> Further, the HMO must look at the correlation between culture, language, and health care outcomes.<sup>26</sup> The contract specifies several programs and policies that an HMO must implement in order to satisfy the cultural competency requirement.

Second, the HMO must provide twenty-four-hour access to interpreter services.<sup>27</sup> In addition, the HMO must provide other language-based services, including translated written materials, to enrollees if they exceed five (5) percent of the overall Medicaid enrolled population or 200 hundred enrollees, whichever is greater.<sup>28</sup>

Finally, the HMO must assess the linguistic and cultural needs of its enrollees who speak a primary language other than English.<sup>29</sup> In turn, this assessment is submitted to DHS, along with a plan designed by the HMO to deliver linguistically appropriate services.<sup>30</sup>

b. Discrimination

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<sup>24</sup> See 2001 New Jersey Managed Care Contract (New Jersey Contract), Section B, pg. 176-77. This information is voluntary on the part of the patient and is requested by the federal government.

<sup>25</sup> New Jersey Contract, § 5.14. The Contract, in Article I, defines cultural competency as “a set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance of and respect for cultural differences and similarities within, among and between groups and the sensitivity to how these differences influence relationships with enrollees. This requires a willingness and ability to draw on community-based values, traditions and customs, to devise strategies to better meet culturally diverse enrollee needs, and to work with knowledgeable persons of and from the community in developing focused interactions, communications, and other supports.”

<sup>26</sup> *Id.*

<sup>27</sup> New Jersey Contract, § 5.14(B).

<sup>28</sup> *Id.* § 5.14(D).

<sup>29</sup> *Id.* § 5.14(G).

<sup>30</sup> *Id.*

There are several regulatory and contractual provisions that prohibit discrimination against Medicaid beneficiaries based on race or national origin, in accordance with Title VI of the Civil Rights Act of 1964.

The regulations refer to Title VI to define the boundaries set for health care providers delivering services to Medicaid beneficiaries, and make compliance a condition for receiving federal funds.<sup>31</sup> In addition, the regulation mandates that all Medicaid recipients be informed of their rights under Title VI.<sup>32</sup>

The Medicaid Managed Care Contract imposes the same restrictions as the regulations with regard to discrimination against enrollees in New Jersey Care, NJ FamilyCare, and NJ KidCare. The contract further charges the HMO with the responsibility of requiring its providers and subcontractors to follow suit.<sup>33</sup> Moreover, the contract requires the HMO and its subcontractors to comply with state anti-discrimination laws (discussed below).<sup>34</sup>

In addition, the contract requires contracting HMOs to accept any individual for enrollment “without regard to race, ethnicity, . . . , color, national origin, [or] ancestry. . . .”<sup>35</sup> This mandate also is expressed in the Medicaid managed care regulations.<sup>36</sup> The contracting HMO also must provide “[equal] access, i.e., equal opportunity and consideration for needed services without exclusionary practices of providers or system design because of race, ethnicity, . . . , ancestry, [or] national origin. . . .”<sup>37</sup>

The contract requires the HMO to forward to DHS within three business days of receipt copies of all grievances alleging discrimination against an enrollee because of race, color, national origin, or ancestry.<sup>38</sup>

### c. Confidentiality

Contracting HMOs must hold in strict confidence all “records, data, and data elements collected and maintained for the operation of the [HMO] and the Department and pertaining to enrolled persons.”<sup>39</sup>

In addition, New Jersey “must provide safeguards which restrict the use or disclosure of

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<sup>31</sup> N.J.A.C. § 10:72-1.7(a); N.J.A.C. § 10:69-9.12(a).

<sup>32</sup> N.J.A.C. § 10:72-1.7(a)(2); N.J.A.C. § 10:69-9.12(a)(2).

<sup>33</sup> New Jersey Contract, § 7.8(A).

<sup>34</sup> *Id.* § 7.8(D).

<sup>35</sup> New Jersey Contract, § 5.5(A).

<sup>36</sup> N.J.A.C. § 10:74-2.1(a)(4).

<sup>37</sup> New Jersey Contract, § 7.39(B).

<sup>38</sup> *Id.* § 7.8(G).

<sup>39</sup> New Jersey Contract, § 7.40(A).

information concerning applicants and beneficiaries to purposes directly connected with the administration of [Medicaid].”<sup>40</sup> However, “any statistical data or other information not including any names or personal information may be released.”<sup>41</sup>

1. The New Jersey Department of Health and Senior Services (DHSS)

a. Statutes, Regulations, Policies and Other Written Materials

The DHSS is responsible for the licensure and monitoring of various health care facilities including hospitals, home health agencies, nursing homes, cardiac facilities and ambulatory care facilities. In addition, DHSS monitors the health status of New Jersey citizens and ensures access to quality services.

The DHSS collects racial and ethnic data for a variety of conditions and diseases. Some of the racial and ethnic data collection and reporting provisions include: (1) HIV infection and AIDS diagnoses;<sup>42</sup> (2) encounter data for regional cardiac surgery centers;<sup>43</sup> (3) performance reports concerning organ transplantation;<sup>44</sup> (4) home health agencies medical/health records;<sup>45</sup> and, (5) communicable diseases (tuberculosis, tetanus, hepatitis C, etc.) reporting by hospitals.<sup>46</sup> In addition, New Jersey collects and reports race and Hispanic origin information with regard to births and deaths.<sup>47</sup>

b. Discrimination

Every person admitted to a hospital has the right to receive treatment without discrimination because of race or national origin.<sup>48</sup> In addition, nursing home residents must be treated without discrimination on the basis of race or national origin.<sup>49</sup>

c. Confidentiality

Information and data maintained by the DHSS “pertaining to the health of any named person, procured in connection with research studies . . . shall be kept in the confidence of the [DHSS] and

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<sup>40</sup> N.J.A.C. § 10:71-8.7.

<sup>41</sup> N.J.A.C. § 10:69-7.10.

<sup>42</sup> N.J.A.C. § 8:57-2.2(a); N.J.A.C. § 8:57-2.4(a).

<sup>43</sup> N.J.A.C. § 8:33E-2.10(a)(3)

<sup>44</sup> N.J.A.C. § 8:33Q-1.9(b)(1).

<sup>45</sup> N.J.A.C. § 8:42-11.2(c)(1).

<sup>46</sup> N.J.A.C. § 8:57-1.5(a).

<sup>47</sup> Although not statutorily required, DHSS collects racial information from the birth mother.

See for birth and death reports <http://www.state.nj.us/health/chs/munilevel.htm>.

<sup>48</sup> N.J. Stat. § 26:2H-12.8.

<sup>49</sup> N.J. Stat. § 30:13-3.

shall not be revealed or disclosed in any manner. . .”<sup>50</sup>

#### **D. Observations**

New Jersey is one of the few states that has an express prohibition against the collection of race or ethnic data on an insurance application. Another statute prohibits the “use of *any* form of policy of . . . health insurance . . . which expresses, directly or indirectly, any limitation, or discrimination as to race, creed, color, national origin or ancestry. . .”<sup>51</sup> (Emphasis added.)

Notably, HMOs participating in Medicaid managed care must examine the correlation between culture, language and health outcomes.<sup>52</sup>

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<sup>50</sup> N.J. Stat. § 26-1A-37.2.

<sup>51</sup> N.J. Stat. § 17B:30-12(b); N.J. Stat. § 17:29B-4(7)(d).

<sup>52</sup> New Jersey Contract, § 5.14.