PHILIP D. MURPHY
Governor

State of New Jersey

September 25, 2024

The Honorable Philip D. Murphy
Governor of New Jersey
Office of the Governor
PO Box 001
Trenton, NJ 08625

RE: Health Care Quality and Affordability Reports

Dear Governor Murphy,

As per signed Executive Orders (E.O. 217 and E.O. 277) that launched and required implementation of a health care spending growth benchmark program, the Governor's Office of Health Care Affordability and Transparency and the New Jersey Department of Banking and Insurance are submitting three reports that assess the quality and affordability of health care in New Jersey.

Commissioned by the New Jersey Health Care Affordability, Responsibility and Transparency (HART) Program, a joint initiative of the Governor's Office of Health Care Affordability and Transparency (OHCAT) and the Department of Banking and Insurance (DOBI), the reports represent an important milestone in advancing the State's long-term strategy to mitigate the unsustainable rate of health care cost growth.

Enclosed please find the following reports for your consideration:

- ***First Annual Cost Growth Benchmark Report: 2018-2019,*** which is based on comprehensive aggregate spending data submitted by health insurance carriers operating in New Jersey.
- ***Health Care Spending Trends for New Jersey Residents with Commercial Insurance, 2016–2021,*** which is based on detailed claims data for approximately 25% of New Jerseyans with employer-sponsored insurance, obtained through the Health Care Cost Institute.
- ***The Health Care Landscape in New Jersey: Select Indicators of Quality, Access, and Affordability,*** which summarizes New Jersey's performance on a select set of measures of quality, access, and affordability that are obtained through secondary sources.

Most significantly, these reports bring greater transparency to health care spending, providing everyone in the state with a shared understanding of how rapidly health care costs are growing and the factors contributing to high costs and cost growth.

Thank you for your consideration of these reports.

Respectfully submitted,

Shabnam Salih, Director
Office of Health Care Affordability and Transparency

Justin Zimmerman, Acting Commissioner
New Jersey Department of Banking and Insurance

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The Health Care Landscape in New Jersey: Select Indicators of Quality, Access, and Affordability

Report to the New Jersey Health Care Affordability, Responsibility, and Transparency (HART) Program

September 2024

Contents

I. Introduction

A. HART Program background

In March 2022, New Jersey Governor Phil Murphy released the blueprint for the Health Care Affordability, Responsibility, and Transparency (HART) Program, which aims to build a stronger and fairer New Jersey by helping to curb the growth of health care spending in the state. Executive Order 277, signed in December 2021, outlined the implementation of the program including the execution of a compact by relevant stakeholders around the state. The HART Program focuses on five pillars: (1) stakeholder engagement, (2) aligning health care cost growth, (3) transparency, (4) market-based solutions, and (5) iteration and learning.

B. Overview of the report

The HART Program Landscape Report was developed to present a broader picture of the health care ecosystem in New Jersey; complement other HART Program reports; and enable the HART Program to monitor key metrics of quality, access, and affordability. This report will be generated annually.

This report (1) provides an overview of the measures selected for the report; (2) presents statewide trends in quality, access, and affordability as defined by the measures; and (3) in cases with available data, highlights differences within the measures according to race and ethnicity, income, and county of residence.

Exhibit 1 lists the selected measures along with their descriptions, rationale for inclusion, and additional groupings. **Exhibit 2** summarizes the measure results. **Exhibits 3**, **4**, and **5** present the differences among groups defined by race and ethnicity, income, and county of residence. **Exhibit 6** displays the measure results in more detail, including data sources.

C. Selection and presentation of measures

In this first Landscape Report, the selected measures span the domains of quality, access, and affordability at a high level and build on past stakeholder discussions. Additional measures may be added in future reports.

The report prioritized measures that (1) represent different aspects of the health care system (such as patients' experience and hospital care); (2) capture different areas of interest, such as pediatric, behavioral health, and rural health care; (3) are widely used and readily available from reputable secondary sources; and (4) can be stratified by race and ethnicity, income, and/or region.

Subject to data availability, this report presents two comparisons for each measure: (1) a comparison between the most recently available year of data for New Jersey and the closest prior year of data and (2) a comparison between the most recently available year of data for New Jersey and the most recently available year of data for the United States as a whole. The within-state trend enables the HART Program and the health policy community to monitor progress or decline on an ongoing basis. The national comparison provides additional context for the New Jersey results.

For measures with sufficient data available, the report also shows differences among groups defined by race and ethnicity, income level, or county of residence. For race, ethnicity, and income level, the standard of comparison is the best-performing group. For counties, the standard of comparison is the statewide average. Because these data were obtained from a range of sources, the most recent year, the available stratifications, the categories used to group race and income, and terminology vary among measures.

II. New Jersey Performance on Measures of Quality, Access, and Affordability

The following section presents findings from an analysis of 20 selected measures, which are categorized into the three domains of quality, access, and affordability.

A. Quality

This report assesses 12 measures of quality, including measures related to primary care, inpatient care, and avoidable hospital utilization (**Exhibit 1a**).[1] Such quality measures offer insight into how patients interact with the health care system in New Jersey and the quality of care, and into factors that affect health outcomes and health care costs.[2]

The New Jersey trend suggests that, overall, the state has displayed consistent or improved performance on quality measures (**Exhibit 2**). Half of the measures, including both measures of preventable hospitalizations, the measure of diabetes care, two of four measures of hospital quality, and infant mortality, show improvements from the previous year. Only one measure—Emergency Department (ED) utilization—showed a decline in performance from the prior year. The remaining measures show similar performance to baseline (i.e., the prior year) or did not have sufficient prior year data to determine a performance trend.

New Jersey performed better than the national average on six of 12 quality measures, including preventable hospitalizations, cancer screening, diabetes care, and infant mortality. New Jersey performed worse than the national average on five measures, including three measures of hospital quality, childhood vaccinations, and maternal mortality. One measure of hospital quality performed similarly to the national average.

B. Access

This report assesses five measures of access, including measures that relate to the use of different types of care, cost of care, and health insurance (**Exhibit 1b**). The choice of measures recognizes that there are multiple dimensions of access, including affordability, accessibility (location of services), availability (sufficient supply), accommodation (fit with client's needs in areas such as language and culture), and acceptability (providers accepting all clients).[3]

The New Jersey trend presents mixed results for access measures. Performance on a measure of cost barriers to care shows improvement; a measure of primary care utilization demonstrates a decline; measures of adults with no personal doctor and the rate of uninsured shows similar performances; and

[1] Although this report classifies measures by domain, many measures span multiple domains. For example, a measure of avoidable hospital utilization might reflect both access to and quality of primary care.

[2] Agency for Healthcare Research and Quality. "The Challenge and Potential for Assuring Quality Health Care for the 21st Century." 2018. https://www.ahrq.gov/patient-safety/quality-measures/21st-century/index.html#:~:text=Poor%20quality%20care%20leads%20to,in%20the%20health%20care%20industry.

[3] Penchansky, R., and J.W. Thomas. "The Concept of Access: Definition and Relationship to Consumer Satisfaction." *Medical Care,* vol. 19, no. 2, 1981, pp. 127–140. https://pubmed.ncbi.nlm.nih.gov/7206846/.

one measure of unmet needs for mental health care is without sufficient data from the current year to compare to the most recent year (**Exhibit 2)**.

New Jersey outperforms the national average on all five access measures.

C. Affordability

The report includes three measures of affordability, including measures of out-of-pocket medical spending, medical cost burden, which considers out-of-pocket health care spending as a percent of annual income, and spending on health care premiums (**Exhibit 1c**). When healthcare is not affordable, families may cut back on needed care or face devastating costs.[4] A 2022 survey of 1,100 New Jersey residents found that nearly half of all respondents delayed or went without care due to costs and more than a third struggled to pay health care bills.[5]

Performance on two of three measures of affordability, out-of-pocket medical spending, and yearly health care premiums, shows a decline between the most recent year and the previous year, and an improvement in performance for a measure of medical cost burden (**Exhibit 2**). Consistent with the in-state trend, New Jersey's performance is worse than the national average on two of three measures (the same two measures) and better on the third.

[4] The Commonwealth Fund. "Paying for It: How Health Care Costs and Medical Debt Are Making Americans Sicker and Poorer." 2023. https://www.commonwealthfund.org/publications/surveys/2023/oct/paying-for-it-costs-debt-americans-sicker-poorer-2023-affordability-survey

[5] Healthcare Value Hub. "New Jersey Residents Struggle to Afford High Healthcare Costs; Worry about Affording Healthcare in the Future; Support Government Action across Party Lines." 2023. https://www.healthcarevaluehub.org/advocate-resources/publications/new-jersey-residents-struggle-afford-high-healthcare-costs-worry-about-affording-healthcare-future-support-government-action-acr

III. Differences Among Groups

The national and state experience with the COVID-19 pandemic has underscored the importance of ensuring that high-quality health care is within reach for all residents. Working toward more accessible and affordable health care for New Jerseyans is an important part of the HART Program's commitment to advancing health equity and reducing health disparities. Information from specific measures on health disparities within the state point to areas of improvement and aid in developing programs and targeting resources.

A. Groups defined by race and ethnicity

New Jersey is a diverse state with 22 percent of residents identifying as Hispanic or Latino, 11 percent as Asian, 15 percent as Black or African American, and 53 percent as White.[6,7]

Across the three domains of quality, access, and affordability, the available data show racial and ethnic disparities were present in all measures (**Exhibit 4**). These included one affordability measure, six quality measures, and two access measures. Notably, the Black, Non-Hispanic group had the worst outcomes of all groups in five of six quality measures, including measures of preventable hospitalizations, ED utilization, childhood vaccinations, and infant mortality, with substantial disparities between this group and the next best-performing group. The Hispanic or Latino group fared the worst on both measures of access which include adults with no personal doctor and the rate of uninsured, again with substantial gaps. The White group fared the worst on the affordability measure of medical cost burden.

B. Groups defined by income

New Jersey is a high-income state with a median household income of $97,126.[8] As of 2022, 21.7 percent of the population had an income between 0 and 199 percent of the federal poverty level (FPL), 23.9 percent had an income between 200 and 399 percent of the FPL, and 54.4 percent had an income above 400 percent of the FPL.[9] Measure results show disparities between income groups, with lower-income groups consistently showing worse performance than higher-income groups for three available measures, including one quality measure of cancer screening, one access measure of the rate of uninsured, and one affordability measure of medical cost burden (**Exhibit 5**).

[6] Percentages do not add up to 100 percent due to rounding.

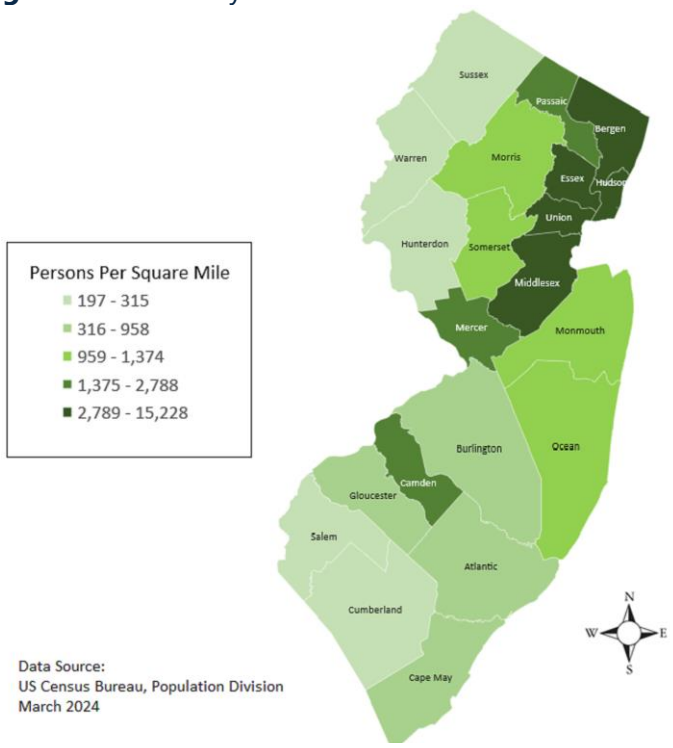
[7] U.S. Census. "Quick Facts: New Jersey." 2023. https://www.census.gov/quickfacts/fact/table/NJ/PST045223.

[8] U.S. Census. "Quick Facts: New Jersey." 2023. https://www.census.gov/quickfacts/fact/table/NJ/PST045223.

[9] U.S. Census Bureau. "Poverty Status in the Past 12 Months. American Community Survey, ACS 1-Year Estimates Subject Tables, Table S1701." 2022. https://data.census.gov/table/ACSST1Y2022.S1701?t=Income and Poverty:Poverty&g=040XX00US34.

Groups defined by counties of residence

Figure 1 New Jersey Counties



New Jersey has 21 counties with the northeastern counties densely populated and the western counties less so (**Figure 1**).

Across three measures of quality with county-level data available, which include two measures of preventable hospitalizations and one measure of ED utilization, there were systematic differences by county **Exhibit 6**). For example, Bergen, Gloucester, Middlesex, Morris, Somerset, and Sussex counties performed better than the state average across all three quality measures, and Atlantic, Camden, Cape May, Cumberland, and Mercer counties performed worse. Notably, counties that performed better than the state average were more likely to be in North or Central Jersey, while counties that performed worse were more likely to be in South Jersey.

County-level rates of uninsurance, the one access measure available at the county level, measure generally corresponded to the counties' performance on the quality measures, with the counties performing well in the quality measures also performing well in the access measure, and counties performing poorly in the quality measures also performing poorly in the access measure.

IV. Exhibits

Exhibit 1a. Quality measures

Quality measure	Description	Rationale for inclusion	Grouped by
Preventable hospitalizations—acute Preventable hospitalizations—chronic	Two measures of hospital admissions per 100,000 population, ages 18 years and older for select acute and chronic conditions.	Measuring preventable hospitalizations helps identify issues of access to quality outpatient care, including appropriate follow-up care after hospital discharge. In addition, access to high-quality outpatient care could reduce the severity of select acute and chronic conditions.	Race and ethnicity County
Emergency department (ED) utilization	The raw number of ED visits per 10,000 population	Monitoring ED visits can help the state understand the demand for emergency care and adequately monitor whether hospitals allocate resources effectively and provide appropriate, timely care. High levels of ED use often correspond to insufficient access to preventive and primary care.	Race and ethnicity County
Cancer screening	Percentage of adults ages 50 to 74 who received a sigmoidoscopy or colonoscopy in the past 10 years or a fecal occult blood test in the past two years; a mammogram in the past two years (women ages 50 to 74 only); or a Pap smear in the past three years (women ages 25 to 64 only)	Cancer screenings are an important preventative measure that can reduce the long-term complications that result from late detection or lack of screening for life-threatening illnesses.	Race and ethnicity Income
Diabetes care	Percentage of employer-insured adult patients with diabetes, ages 18 to 64, who had at least one hemoglobin A1c test during the year	Tracking whether patients receive proper diabetes care is vital for managing the disease. Engaging in regular diabetes monitoring also helps providers make treatment decisions to assist in preventing complications.	--
Hospital quality—heart attack Hospital quality—pneumonia Hospital quality—heart failure Hospital quality—stroke	Risk-adjusted rate of deaths per 100 discharges for heart attack, heart failure, pneumonia, or stroke for patients ages 18 and older	Measuring mortality rates for these conditions is an important indicator for quality of care in hospitals and how well the health care system meets the needs of the population.	--
Vaccination coverage among children	Percentage of children born in a 3-year period who received the combined (4:3:1:3:3:1:4) vaccine series by the age of 24 months	Immunizations are one of most cost-effective health prevention measures and play an essential role in reducing and eliminating disease. Vaccination coverage for children can serve as an indicator of both access to and quality of primary care for children.	Race and ethnicity
Infant mortality	Rate of death occurring under 1 year of age in a given year per 1,000 live births in the same year	Infant mortality rate is an indicator of a population's overall health and well-being. It reflects the quality of prenatal care and access to medical resources and social determinants of health such as poverty and housing, and the effectiveness of public health interventions.	Race and ethnicity
Maternal mortality	Rate of death in women while pregnant or within 42 days of termination of pregnancy[a] in a given year per 100,000 live births	Monitoring maternal mortality can help identify disparities in health care quality, reflect the quality of prenatal care, and be an indicator of proper access to medical resources or lack thereof.	--

Note: Exhibit 6 provides measure data sources.

[a] For the purposes of this report, "termination of pregnancy" means the end of a pregnancy, whether by live birth (including caesarian section), stillbirth, miscarriage, or abortion.

Exhibit 1b. Access measures

Access measure	Description	Rationale for inclusion	Grouped by
Adults with no personal doctor	Rate of adults ages 18 and older with no personal doctor (civilian, non-institutionalized population) (based on survey data)	Regular interactions with the health care system and, more specifically, with a personal doctor who knows a patient's history and background, are essential for building trust in the system and to addressing any known or acute health issues. When left unaddressed or untreated, preventable conditions can result in unnecessary and costly emergency department visits or hospitalization, as well as a lower overall quality of life.	Race and ethnicity
Primary care utilization	Percentage of individuals who had any visit with a primary care provider during the past 12 months (civilian, non-institutionalized population)	Use of preventive health care services, specifically those provided by primary care providers, is an important health-related behavior because it enables individuals to obtain information about their health status, maintain or improve their health and well-being, and respond to health problems with guidance from a health care provider. This can contribute to reducing health care costs by mitigating the impact of preventable diseases.	--
Cost barriers to care	Percentage of adults ages 18 and older who reported a time in the past 12 months when they needed to see a doctor but could not because of cost	Understanding why adults forego health care due to cost helps identify specific barriers that prevent individuals from accessing necessary medical services. It can also help to reduce health disparities that might exist and has implications for increases in long-term health care costs that can result from untreated conditions.	--
Uninsured rates	Rate of uninsurance among those ages birth to 64	Uninsured individuals might forego or delay care due to the inability to pay, which leads to poorer health and can lead to increased health care costs in the long term.	Race and ethnicity Income County
Unmet needs for mental health care	Percentage of respondents feeling a perceived need for mental health treatment or counseling that was not received	Access to effective mental health treatment can improve patients' health outcomes and mitigate unnecessary hospitalizations due to mental health crises, thereby reducing health care costs.	--

Note: Exhibit 6 provides measure data sources.

Exhibit 1c. Affordability measures

Affordability measure	Description	Rationale for inclusion	Grouped by
Out-of-pocket (OOP) medical spending	Annual median family medical OOP spending, including premiums, for individuals (civilian, non-institutionalized population)	High OOP spending can pose a significant financial burden on individuals and families and cause people to forego care. Understanding the extent of the issue for specific populations can help with developing targeted interventions to assist with mitigating that burden and to address health inequities.	--
High medical cost burden	The share of individuals who are in families in which OOP spending on health care, including premiums, accounted for more than 10 percent of annual income (civilian non-institutionalized population)	High OOP spending required by insurance plans can expose families with low and moderate incomes to unmanageable health care costs and lead to medical debt. Tracking rates of high medical care cost burden in the overall population and across different demographic groups helps in understanding trends and disparities in health care affordability.	Race and ethnicity Income
Yearly health care premiums	The average yearly cost of health insurance premiums that an employer pays for each enrolled employee's family coverage	Rising health insurance premiums have a direct effect on the financial health and stability of families. As premium contributions continue to increase for both employers and employees, the result is reduced incomes and increased financial burden for families and businesses.	--

Note: Exhibit 6 provides measure data sources.

Exhibit 2. New Jersey performance on selected measures of quality, access, and affordability

Measure number	Measure name	New Jersey's performance compared to prior year[a]	N.J. performance compared to U.S.
Quality			
Q.1	Preventable hospitalizations—acute	▲	▲
Q.2	Preventable hospitalizations—chronic	▲	▲
Q.3	ED utilization	■	▲
Q.4	Cancer screening	●	▲
Q.5	Diabetes care	▲	▲
Q.6	Hospital quality—heart attack	▲	Not available
Q.7	Hospital quality—pneumonia	●	Not available
Q.8	Hospital quality—heart failure	●	Not available
Q.9	Hospital quality—stroke	▲	Not available
Q.10	Vaccination coverage among children	●	■
Q.11	Infant mortality	▲	▲
Q.12	Maternal mortality	Not Available	■
Access			
AC.1	Adults with no personal doctor	●	▲
AC.2	Primary care utilization	■	▲
AC.3	Cost barriers to care	▲	▲
AC.4	Uninsured rates	●	▲
AC.5	Unmet needs for mental health care	Not Available	▲
Affordability			
AF.1	OOP medical spending	■	■
AF.2	High medical cost burden	▲	▲
AF.3	Yearly health care premiums	■	■

Note: Exhibit 6 provides measure values and data sources. A measure's performance is considered similar to the prior year or to the U.S. if the difference is less than 0.02 for measures represented by rates or dollar amounts, and less than 0.005 for measures represented in percentages.

[a] Prior year refers to the prior year or the most recent year of data that is available. This may include a range of years depending on the measure or may not reflect the year immediately prior due to limited data availability.

▲ = Improved or Better Performance
■ = Worsened or Worse Performance
● = Similar Performance

Exhibit 3. Differences by race

Racial disparities in quality, access, and affordability measures in New Jersey							
Measure number	**Measure**	**Units**	**Data year**	**Population**	**Rate (sorted from best to worst performance)**	**Disparity**	**Source**
Quality							
Q.1	Preventable hospitalizations—acute	Rate per 100,000	2020	Asian, Non-Hispanic	94.7	-	Prevention Quality Indicators, NJ Department of Health
				Hispanic	159.1	64.4	
				White, Non-Hispanic	182	87.3	
				Black, Non-Hispanic	197.6	102.9	
Q.2	Preventable hospitalizations—chronic	Rate per 100,000	2020	Asian, Non-Hispanic	224.1	-	Prevention Quality Indicators, NJ Department of Health
				Hispanic	546.2	322.1	
				White, Non-Hispanic	603.4	379.3	
				Black, Non-Hispanic	815	590.9	
Q.3	ED utilization	Rate per 10,000	2021	Two or More Races, Non-Hispanic	531.8	-	New Jersey State Health Assessment Data
				Asian, Non-Hispanic	777.6	245.8	
				White, Non-Hispanic	2129.6	1597.8	
				Hispanic (of any race)	3184.1	2652.3	
				Black, Non-Hispanic	5176	4644.2	
Q.4	Cancer screening	Percentage	2018–2020	Black	71.8%	-	Commonwealth Scorecard
				White	70.6%	1.2pp	
				Latinx/Hispanic	69.4%	2.4pp	
				Asian American and Native Hawaiian/Pacific Islander	61.8%	10.0pp	
Q.10	Vaccination coverage among children	Percentage	2016–2019	Other or Multiple Races, Non-Hispanic	72.7%	-	Centers for Disease Control and Prevention (National Immunization Survey)
				White, Non-Hispanic	72.7%	0.0pp	
				Hispanic	60.5%	12.2pp	
				Black, Non-Hispanic	46.1%	26.6pp	
Q.11	Infant mortality	Rate per 1,000	2021	White, Non-Hispanic	2.2	-	New Jersey State Health Assessment Data
				Hispanic (of any race)	3.7	1.5	
				Black, Non-Hispanic	7.8	5.6	

Racial disparities in quality, access, and affordability measures in New Jersey							
Measure number	**Measure**	**Units**	**Data year**	**Population**	**Rate (sorted from best to worst performance)**	**Disparity**	**Source**
Access							
AC.1	Adults with no personal doctor	Percentage	2022	White	10.1%	-	State Health Compare, State Health Access Data Assistance Center (SHADAC)
				African-American/Black	12.4%	2.3pp	
				Other/Multiple Races	13.1%	3.0pp	
				Hispanic/Latino	30.9%	20.8pp	
AC.4	Uninsured rates	Percentage	2022	White	3.5%	-	KFF State Health Facts
				Asian/Native Hawaiian and Pacific Islander	4.6%	1.1pp	
				Black	7.5%	4.0pp	
				Multiple Races	9.9%	6.4pp	
				Hispanic	18.5%	15.0pp	
Affordability							
AF.2	High medical cost burden	Percentage	2022	African-American/Black	9.0%	-	State Health Compare, SHADAC
				Hispanic/Latino	13.4%	4.5pp	
				Asian/Pacific Islander	14.1%	5.1pp	
				White	17.2%	8.3pp	

Note: pp = percentage points. Racial categories and the terminology used to describe them may differ by source. Please see text for a discussion of these findings. Measures that include data from 2020 and 2021 may be influenced by the COVID-19 pandemic, leading to deviations from typical trends.

Exhibit 4. Differences by income

Income disparities in quality, access, and affordability measures in New Jersey							
Measure number	**Measure**	**Units**	**Data year**	**Population**	**Rate (sorted from best to worst performance)**	**Disparity**	**Source**
Quality							
Q.4	Cancer screening	Percentage	2018–2020	400% FPL and above	72.9%	-	Commonwealth Scorecard
				200%–399% FPL	71.7%	1.2pp	
				0%–199% FPL	60.6%	12.3pp	
Access							
AC.4	Uninsured rates	Percentage	2022	400% or more	3.3%	-	KFF State Health Facts
				200 to 399%	11.0%	7.7pp	
				100 to 199%	16.8%	13.5pp	
				Under 100%	17.1%	13.8pp	
Affordability							
AF.2	High medical cost burden	Percentage	2022	More than 200% FPL	10.4%	-	State Health Compare, SHADAC
				0 to 200% FPL	23.6%	13.2pp	

Note: pp = percentage points. Income categories may differ by source. Please see text for a discussion of these findings. Measures that include data from 2020 and 2021 may be influenced by the COVID-19 pandemic, leading to deviations from typical trends.

Exhibit 5. Differences by county

Measure ID	Q.1		Q.2		Q.3		AC.4	
Measure name	Preventable hospitalizations—acute		Preventable hospitalizations—chronic		ED utilization		Uninsured rates	
Domain	Quality		Quality		Quality		Access	
Data year	2020		2020		2021		2021	
Source	Prevention Quality Indicators, NJ Department of Health		Prevention Quality Indicators, NJ Department of Health		New Jersey State Health Assessment Data		Small Area Health Insurance Estimates, U.S. Census Bureau	
Units	Rate per 100,000		Rate per 100,000		Rate per 10,000		Percentage	
Desired direction	Lower performance is better		Lower performance is better		Lower performance is better		Lower performance is better	
County	**Rate**	**Comparison to state average**	**Rate**	**Comparison to state average**	**Rate**	**Comparison to state average**	**Rate**	**Comparison to state average**
Statewide	**218.2**	-	**751.1**	-	**2798.2**	-	**8.3%**	-
Atlantic	307.5	■	1035.1	■	4340.3	■	9.9%	■
Bergen	127.8	▲	422.6	▲	1967.6	▲	7.3%	▲
Burlington	306.4	■	879.8	■	2525.2	▲	5.3%	▲
Camden	325.2	■	1230.1	■	3964.1	■	7.5%	▲
Cape May	241	■	795.9	■	3256.8	■	7.6%	▲
Cumberland	646.2	■	2229.7	■	6280.2	■	11.2%	■
Essex	187.5	▲	1045.6	■	3552.7	■	11.7%	■
Gloucester	169.5	▲	628.1	▲	1964.4	▲	5.4%	▲
Hudson	218	●	802.4	■	2839.7	●	11.5%	■
Hunterdon	224.6	■	457	▲	1887.8	▲	4.6%	▲
Mercer	226.8	■	902.3	■	3488.7	■	7.7%	▲
Middlesex	201.5	▲	659.2	▲	2221.7	▲	7.7%	▲
Monmouth	251.1	■	707.2	▲	2580.8	▲	6.0%	▲
Morris	144.9	▲	411.8	▲	1841.1	▲	5.6%	▲
Ocean	259.5	■	757.5	●	2794.6	●	6.4%	▲
Passaic	190.8	▲	717.1	▲	3513.5	■	12.2%	■
Salem	315	■	765.6	●	2756.8	●	6.7%	▲
Somerset	123.5	▲	406.3	▲	1459.6	▲	5.3%	▲
Sussex	207.9	▲	571.9	▲	2443.8	▲	5.7%	▲
Union	180.8	▲	656.7	▲	2774.7	●	11.7%	■
Warren	203.8	▲	731.5	▲	3009.6	■	6.9%	▲

Note: Exhibit 6 provides measure values and data sources. A measure's performance is considered similar to the prior year or to the U.S. if the difference is less than 0.02 for measures represented by rates or dollar amounts, and less than 0.005 for measures represented in percentages. Measures that include data from 2020 and 2021 may be influenced by the COVID-19 pandemic, leading to deviations from typical trends.

▲ = Improved or Better Performance
■ = Worsened or Worse Performance
● = Similar Performance

Exhibit 6. New Jersey performance on selected measures, additional detail

Measure number	Measure	Units	Desired direction	New Jersey			United States		
				Previous value	Most recent value	Performance trend	Most recent value	N.J. compared to U.S.	Source
Quality									
Q.1	Preventable hospitalizations—acute	Rate per 100,000	Lower performance is better	344.1 (2018)	218.2 (2020)	▲	235.8 (2020)	▲	NJ: Prevention Quality Indicators, NJ Department of Health US: National Healthcare Quality and Disparities Reports (NHQDR) (AHRQ)
Q.2	Preventable hospitalizations—chronic	Rate per 100,000	Lower performance is better	1123.2 (2018)	751.1 (2020)	▲	813.3 (2020)	▲	NJ: Prevention Quality Indicators, NJ Department of Health US: NHQDR (AHRQ)
Q.3	ED utilization	Rate per 10,000	Lower performance is better	2372.0 (2020)	2798.2 (2021)	■	3731.8 (2020)	▲	NJ: New Jersey State Health Assessment Data US: Healthcare Cost and Utilization Project (HCUP) Fast Stats
Q.4	Cancer screening	Percentage	Higher performance is better	69.5% (2018)	69.9% (2020)	●	68.8% (2020)	▲	Commonwealth Scorecard
Q.5	Diabetes care	Percentage	Higher performance is better	90.0% (2020)	94.6% (2021)	▲	90.1% (2021)	▲	Commonwealth Scorecard
Q.6	Hospital quality—heart attack	Deaths per 100 conditions	Lower performance is better	6.3 (2020)	6.1 (2021)	▲	4.9 (2019)	Not available[a]	NJ Department of Health (Inpatient Quality Indicators Technical Report)
Q.7	Hospital quality—pneumonia	Deaths per 100 conditions	Lower performance is better	7.3 (2020)	7.2 (2021)	●	4.3 (2019)	Not available[a]	NJ Department of Health (Inpatient Quality Indicators Technical Report)
Q.8	Hospital quality—heart failure	Deaths per 100 conditions	Lower performance is better	3.2 (2020)	3.2 (2021)	●	2.5 (2019)	Not available[a]	NJ Department of Health (Inpatient Quality Indicators Technical Report)
Q.9	Hospital quality—stroke	Deaths per 100 conditions	Lower performance is better	7.3 (2020)	6.7 (2021)	▲	6.7 (2019)	Not available[a]	NJ Department of Health (Inpatient Quality Indicators Technical Report)
Q.10	Vaccination coverage among children	Percentage	Higher performance is better	64.2% (2019)	0.642 (2020)	●	67.9% (2020)	■	Centers for Disease Control and Prevention (National Immunization Survey)
Q.11	Infant mortality	Rate per 1,000	Lower performance is better	4.1 (2020)	3.4 (2021)	▲	5.44 (2017-2021)[b]	▲	NJ: New Jersey State Health Assessment Data US: CDC WONDER database, linked birth / infant death records
Q.12	Maternal mortality	Rate per 100,000	Lower performance is better	NA	25.7 (2018-2021)	Not Available	23.5 (2018-2021)	■	KFF State Health Facts

Measure number	Measure	Units	Desired direction	New Jersey			United States		
				Previous value	Most recent value	Performance trend	Most recent value	N.J. compared to U.S.	Source
Access									
AC.1	Adults with no personal doctor	Percentage	Lower performance is better	15.3% (2021)	15.5% (2022)	●	17.9% (2022)	▲	State Health Compare, SHADAC
AC.2	Primary care Utilization	Percentage	Higher performance is better	87.1% (2019-2021)	85.7% (2020-2021)	■	85.0% (2020-2021)	▲	State Health Compare, SHADAC
AC.3	Cost barriers to care	Percentage	Lower performance is better	10.5% (2020)	9.3% (2021)	▲	10.0% (2021)	▲	Commonwealth Scorecard
AC.4	Uninsured rates	Percentage	Lower performance is better	8.4% (2021)	8.1% (2022)	●	9.6% (2022)	▲	KFF State Health Facts
AC.5	Unmet needs for mental health care	Percentage	Lower performance is better	NA	21.6% (2018-2019)	Not Available	24.7% (2018-2019)	▲	The State of Mental Health in America (SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health)
Affordability									
AF.1	OOP medical spending	Dollars	Lower performance is better	$2,000 (2021)	$2,400 (2022)	■	$1,750 (2022)	■	State Health Compare, SHADAC
AF.2	High medical cost burden	Percentage	Lower performance is better	16.0% (2021)	14.7% (2022)	▲	16.3% (2022)	▲	State Health Compare, SHADAC
AF.3	Yearly health care premiums	Dollars	Lower performance is better	$22,094 (2021)	$24,843 (2022)	■	$21,931 (2022)	■	KFF State Health Facts

Note: A measure's performance is considered similar to the prior year or to the U.S. if the difference is less than 0.02 for measures represented by rates or dollar amounts, and less than 0.005 for measures represented in percentages. Measures that include data from 2020 and 2021 may be influenced by the COVID-19 pandemic, leading to deviations from typical trends.

[a] Because the most recent available year of national data precedes the most recent available year of NJ data, a comparison is not available.

[b] The "NJ compared to U.S, assessment" uses the NJ value from CDC WONDER for the period 2017-2021; this value is 3.57.

▲ = Improved or Better Performance

■ = Worsened or Worse Performance

● = Similar Performance