30:4J-1 to 30:4J-6

LEGISLATIVE HISTORY CHECKLIST

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LAWS OF: 2000 **CHAPTER:** 71

NJSA: 30:4J-1 ("FamilyCare Health Coverage Act")

BILL NO: A49 (Substituted for S1467)

SPONSOR(S): Vandervalk and Thompson

DATE INTRODUCED: May 11, 2000

COMMITTEE: **ASSEMBLY:** Health; Appropriations

SENATE: Budget and Appropriations

AMENDED DURING PASSAGE: Yes

DATE OF PASSAGE: **ASSEMBLY:** June 15, 2000

SENATE: June 29,2000

DATE OF APPROVAL: July 13, 2000

FOLLOWING ARE ATTACHED IF AVAILABLE:

FINAL TEXT OF BILL (Second Reprint)
(Amendments during passage denoted by superscript numbers)

A49

SPONSORS STATEMENT: (Begins on page 13 of original bill) Yes

COMMITTEE STATEMENT: **ASSEMBLY**: Yes 6-1-2000 (Health)
6-8-2000 (Approp.)

SENATE: Yes

FLOOR AMENDMENT STATEMENTS: No

LEGISLATIVE FISCAL ESTIMATE: No

S1467

SPONSORS STATEMENT: (Begins on page 13 of original bill) Yes
Bill and Sponsors Statement identical to A49

COMMITTEE STATEMENT: **ASSEMBLY**: No

SENATE: Yes
Identical to Senate Statement for A49

FLOOR AMENDMENT STATEMENTS: No

LEGISLATIVE FISCAL ESTIMATE: No

VETO MESSAGE: No

GOVERNOR'S PRESS RELEASE ON SIGNING: Yes

FOLLOWING WERE PRINTED:

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REPORTS: No

HEARINGS: No

NEWSPAPER ARTICLES: Yes

"Whitman signs law giving insurance to working poor," 7-14-2000 Trenton Times, p.A9

ASSEMBLY, No. 49

STATE OF NEW JERSEY

209th LEGISLATURE

INTRODUCED MAY 11, 2000

Sponsored by:
Assemblywoman CHARLOTTE VANDERVALK
District 39 (Bergen)
Assemblyman SAMUEL D. THOMPSON
District 13 (Middlesex and Monmouth)

SYNOPSIS

"FamilyCare Health Coverage Act."

CURRENT VERSION OF TEXT

As introduced.

1 **AN ACT** establishing the FamilyCare Health Coverage Program,
2 supplementing Title 30 of the Revised Statutes and amending
3 P.L.1968, c.413 and P.L.1997, c.13.
4
5 **BE IT ENACTED** *by the Senate and General Assembly of the State*
6 *of New Jersey:*
7
8 1. (New section) This act shall be known and may be cited as the
9 "FamilyCare Health Coverage Act."
10
11 2. (New section) The Legislature finds and declares that:
12 a. The most serious health problem facing over one million New
13 Jersey residents is their lack of access to affordable health care
14 coverage, and this lack of coverage forces too many families to go
15 without needed preventive and other care until serious illness requires
16 expensive hospital care;
17 b. Research has shown that affordable and accessible health care
18 coverage for parents has a positive impact upon children, since, by
19 having a connection to ongoing health coverage, these parents are
20 more likely to ensure that their children get necessary immunizations
21 and regular checkups from their primary care physicians;
22 c. Providing health care coverage for uninsured adults encourages
23 continued work efforts, reduces dependence on welfare and other
24 State-subsidized programs, and alleviates reliance on hospital charity
25 care funding;
26 d. The FamilyCare Health Coverage Program established pursuant
27 to this act builds on New Jersey's long-standing commitment to assure
28 access to quality health care provided in an efficient and effective
29 manner and at reasonable cost; and
30 e. It is appropriate that the FamilyCare Health Coverage Program
31 utilize resources from the funds that the State receives under the
32 Master Settlement Agreement between the State and tobacco product
33 manufacturers, and other State resources, to establish the foundation
34 for assuring health care coverage for low and moderate-income,
35 uninsured adults.
36
37 3. (New section) As used in this act:
38 "Commissioner" means the Commissioner of Human Services.
39 "Poverty level" means the official poverty level based on family size
40 established and adjusted under Section 673(2) of Subtitle B, the
41 "Community Services Block Grant Act," of Pub.L.97-35 (42 U.S.C.
42 s.9902(2)).
43 "Program" means the FamilyCare Health Coverage Program

EXPLANATION - Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined thus is new matter.

1 established pursuant to this act.
2 "Qualified applicant" means a person who: is a resident of this
3 State; is a citizen of the United States, or an eligible alien as defined
4 in section 3 of P.L.1968, c.413 (C.30:4D-3); has no health insurance
5 coverage; and is ineligible for the Medicaid program established
6 pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.).
7
8 4. (New section) a. The FamilyCare Health Coverage Program is
9 established in the Department of Human Services. The purpose of the
10 program shall be to provide subsidized private health insurance
11 coverage, and other health care benefits as determined by the
12 commissioner, within the limits of funds appropriated or otherwise
13 made available for the program, to any qualified applicant who is: a
14 parent or caretaker relative of a child whose gross family income does
15 not exceed 200% of the poverty level, or a single adult or couple
16 without dependent children whose gross family income does not
17 exceed 100% of the poverty level.
18 b. For the purposes of this program, the commissioner:
19 (1) shall require that a qualified applicant purchase coverage that
20 is available to the qualified applicant through an employer-sponsored
21 health insurance plan which is determined to be cost-effective and is
22 approved by the commissioner, and shall provide assistance to the
23 qualified applicant to purchase that coverage;
24 (2) shall by regulation establish standards for determining eligibility
25 and other requirements for the program, including, but not limited to,
26 restrictions on voluntary disenrollments from existing health insurance
27 coverage;
28 (3) may by regulation establish plans of coverage or benefits to be
29 covered under the program, except that the provisions of this act shall
30 not apply to coverage for medications that are used exclusively to treat
31 AIDS or HIV infection;
32 (4) may contract with one or more appropriate entities to assist in
33 administering the program;
34 (5) may require premium contributions and copayments from
35 qualified applicants as determined by the commissioner; and
36 (6) shall take, or cause to be taken, any action necessary to secure
37 for the State the maximum amount of federal financial participation
38 available with respect to the program, subject to the constraints of
39 fiscal responsibility and within the limits of available funding in any
40 fiscal year.
41 c. The provisions of this section shall not be construed to require
42 an employer to provide health insurance coverage for any employee or
43 any employee's spouse or dependent child.
44 d. A qualified applicant who is a single adult or couple without
45 dependent children shall be ineligible to receive health care services
46 that are covered by the program from any other State-funded program
47 for which the qualified applicant is eligible.

1 5. (New section) a. In order to provide persons in need of health
2 care services with an efficient transition into the program, the
3 commissioner, in consultation with the Commissioner of Health and
4 Senior Services, may establish, for such period of time as the
5 commissioner determines necessary, a process to provide for
6 presumptive eligibility for the program in accordance with the
7 provisions of this section:
8 (1) A person without health insurance coverage who presents for
9 treatment at an acute care hospital or a federally qualified health center
10 shall be deemed presumptively eligible for the program if a preliminary
11 determination by hospital or health center staff indicates that the
12 person meets the eligibility requirements of this act and the program
13 eligibility standards established by regulation of the commissioner;
14 (2) During the period in which the person is presumptively eligible
15 for the program, coverage shall be limited to inpatient and outpatient
16 hospital and federally qualified health center services and prescription
17 drug benefits designated by the commissioner;
18 (3) A person shall be limited to a single period of presumptive
19 eligibility for the program. The presumptive eligibility period shall
20 begin with the month in which presumptive eligibility is determined
21 and expire at the end of the following month; except that an extension
22 of the presumptive eligibility period may be authorized until the
23 person's application for the program is approved or denied, subject to
24 the person's cooperation with the application process during the
25 presumptive eligibility period. The person's failure to provide such
26 cooperation within a period of time determined by the commissioner
27 shall result in a denial of the application; and
28 (4) A person without health insurance coverage who presents for
29 treatment at an acute care hospital and is determined to not qualify for
30 presumptive eligibility or for the program shall be evaluated for
31 eligibility for charity care pursuant to P.L.1992, c.160 (C.26:2H-18.51
32 et al.).
33 b. Notwithstanding the provisions of this act, or any rule or
34 regulation adopted pursuant thereto, to the contrary, the commissioner
35 may:
36 (1) within the limits of funds appropriated or otherwise made
37 available for the program, reallocate such funds in order to increase
38 the amount available for covered health care services received by
39 persons who are presumptively eligible for the program, for which
40 purpose the commissioner shall cause a notice of such reallocation of
41 funds to be published in the New Jersey Register; and
42 (2) terminate the presumptive eligibility process, upon the
43 commissioner's finding that all monies appropriated for the program
44 will be expended for covered health care services received by persons
45 enrolled in the program, for which purpose the commissioner shall
46 cause a notice of termination of the presumptive eligibility process to
47 be published in the New Jersey Register.

1 6. (New section) The commissioner shall adopt rules and
2 regulations pursuant to the "Administrative Procedure Act," P.L.1968,
3 c.410 (C.52:14B-1 et seq.) to effectuate the purposes of this act;
4 except that, notwithstanding any provision of P.L.1968, c.410 to the
5 contrary, the commissioner may adopt, immediately upon filing with
6 the Office of Administrative Law, such regulations as the
7 commissioner deems necessary to implement the provisions of this act,
8 which shall be effective for a period not to exceed six months and may
9 thereafter be amended, adopted or readopted by the commissioner in
10 accordance with the requirements of P.L.1968, c.410.
11
12 7. Section 3 of P.L.1968, c.413 (C.30:4D-3) is amended to read as
13 follows:
14 3. Definitions. As used in this act, and unless the context
15 otherwise requires:
16 a. "Applicant" means any person who has made application for
17 purposes of becoming a "qualified applicant."
18 b. "Commissioner" means the Commissioner of Human Services.
19 c. "Department" means the Department of Human Services, which
20 is herein designated as the single State agency to administer the
21 provisions of this act.
22 d. "Director" means the Director of the Division of Medical
23 Assistance and Health Services.
24 e. "Division" means the Division of Medical Assistance and Health
25 Services.
26 f. "Medicaid" means the New Jersey Medical Assistance and Health
27 Services Program.
28 g. "Medical assistance" means payments on behalf of recipients to
29 providers for medical care and services authorized under this act.
30 h. "Provider" means any person, public or private institution,
31 agency or business concern approved by the division lawfully
32 providing medical care, services, goods and supplies authorized under
33 this act, holding, where applicable, a current valid license to provide
34 such services or to dispense such goods or supplies.
35 i. "Qualified applicant" means a person who is a resident of this
36 State, and either a citizen of the United States or an eligible alien, and
37 is determined to need medical care and services as provided under this
38 act, and who:
39 (1) Is a dependent child or parent or caretaker relative of a
40 dependent child [and a recipient of benefits under the Work First New
41 Jersey program established pursuant to P.L.1997, c.38 (C.44:10-55 et
42 seq.)] who would be, except for resources, eligible for the aid to
43 families with dependent children program under the State Plan for
44 Title IV-A of the federal Social Security Act as of July 16, 1996;
45 (2) Is a recipient of Supplemental Security Income for the Aged,
46 Blind and Disabled under Title XVI of the Social Security Act;

(3) Is an "ineligible spouse" of a recipient of Supplemental Security Income for the Aged, Blind and Disabled under Title XVI of the Social Security Act, as defined by the federal Social Security Administration;

(4) Would be eligible to receive Supplemental Security Income under Title XVI of the federal Social Security Act or, [using the resource standards of the Work First New Jersey program] without regard to resources, would be eligible for the aid to families with dependent children program under the State Plan for Title IV-A of the federal Social Security Act as of July 16, 1996, except for failure to meet an eligibility condition or requirement imposed under such State program which is prohibited under Title XIX of the federal Social Security Act such as a durational residency requirement, relative responsibility, consent to imposition of a lien;

(5) [Is a child between 18 and 21 years of age who, using the resource standards of the Work First New Jersey program, would be eligible for the aid to families with dependent children program under the State Plan for Title IV-A of the federal Social Security Act as of July 16, 1996, living in the family group except for lack of school attendance or pursuit of formalized vocational or technical training] (Deleted by amendment, P.L. , c.)(pending before the Legislature as this bill);

(6) Is an individual under 21 years of age who, [using the resource standards of the Work First New Jersey program] without regard to resources, would be, except for dependent child requirements, eligible for the aid to families with dependent children program under the State Plan for Title IV-A of the federal Social Security Act as of July 16, 1996, or groups of such individuals, including but not limited to, children in foster placement under supervision of the Division of Youth and Family Services whose maintenance is being paid in whole or in part from public funds, children placed in a foster home or institution by a private adoption agency in New Jersey or children in intermediate care facilities, including developmental centers for the developmentally disabled, or in psychiatric hospitals;

(7) [Using the resource standards of the Work First New Jersey program, would] Would be eligible for the [aid to families with dependent children program under the State Plan for Title IV-A of the federal Social Security Act in effect as of July 16, 1996 or the] Supplemental Security Income program, but is not receiving such assistance and applies for medical assistance only;

(8) Is determined to be medically needy and meets all the eligibility requirements described below:

(a) The following individuals are eligible for services, if they are determined to be medically needy:

(i) Pregnant women;

(ii) Dependent children under the age of 21;

1 (iii) Individuals who are 65 years of age and older; and
2 (iv) Individuals who are blind or disabled pursuant to either
3 42 C.F.R.435.530 et seq. or 42 C.F.R.435.540 et seq., respectively.
4 (b) The following income standard shall be used to determine
5 medically needy eligibility:
6 (i) For one person and two person households, the income standard
7 shall be the maximum allowable under federal law, but shall not exceed
8 133 1/3% of the State's payment level to two person households under
9 the aid to families with dependent children program under the State
10 Plan for Title IV-A of the federal Social Security Act in effect as of
11 July 16, 1996; and
12 (ii) For households of three or more persons, the income standard
13 shall be set at 133 1/3% of the State's payment level to similar size
14 households under the aid to families with dependent children program
15 under the State Plan for Title IV-A of the federal Social Security Act
16 in effect as of July 16, 1996.
17 (c) The following resource standard shall be used to determine
18 medically needy eligibility:
19 (i) For one person households, the resource standard shall be 200%
20 of the resource standard for recipients of Supplemental Security
21 Income pursuant to 42 U.S.C.s.1382(1)(B);
22 (ii) For two person households, the resource standard shall be
23 200% of the resource standard for recipients of Supplemental Security
24 Income pursuant to 42 U.S.C.s.1382(2)(B);
25 (iii) For households of three or more persons, the resource
26 standard in subparagraph (c)(ii) above shall be increased by $100.00
27 for each additional person; and
28 (iv) The resource standards established in (i), (ii), and (iii) are
29 subject to federal approval and the resource standard may be lower if
30 required by the federal Department of Health and Human Services.
31 (d) Individuals whose income exceeds those established in
32 subparagraph (b) of paragraph (8) of this subsection may become
33 medically needy by incurring medical expenses as defined in 42
34 C.F.R.435.831(c) which will reduce their income to the applicable
35 medically needy income established in subparagraph (b) of paragraph
36 (8) of this subsection.
37 (e) A six-month period shall be used to determine whether an
38 individual is medically needy.
39 (f) Eligibility determinations for the medically needy program shall
40 be administered as follows:
41 (i) County welfare agencies and other entities designated by the
42 commissioner are responsible for determining and certifying the
43 eligibility of pregnant women and dependent children. The division
44 shall reimburse county welfare agencies for 100% of the reasonable
45 costs of administration which are not reimbursed by the federal
46 government for the first 12 months of this program's operation.

Thereafter, 75% of the administrative costs incurred by county welfare agencies which are not reimbursed by the federal government shall be reimbursed by the division;

(ii) The division is responsible for certifying the eligibility of individuals who are 65 years of age and older and individuals who are blind or disabled. The division may enter into contracts with county welfare agencies to determine certain aspects of eligibility. In such instances the division shall provide county welfare agencies with all information the division may have available on the individual.

The division shall notify all eligible recipients of the Pharmaceutical Assistance to the Aged and Disabled program, P.L.1975, c.194 (C.30:4D-20 et seq.) on an annual basis of the medically needy program and the program's general requirements. The division shall take all reasonable administrative actions to ensure that Pharmaceutical Assistance to the Aged and Disabled recipients, who notify the division that they may be eligible for the program, have their applications processed expeditiously, at times and locations convenient to the recipients; and

(iii) The division is responsible for certifying incurred medical expenses for all eligible persons who attempt to qualify for the program pursuant to subparagraph (d) of paragraph (8) of this subsection;

(9) (a) Is a child who is at least one year of age and under 19 years of age <u>and, if older than six years of age but under 19 years of age, is uninsured</u>; and

(b) Is a member of a family whose income does not exceed 133% of the poverty level and who meets the federal Medicaid eligibility requirements set forth in section 9401 of Pub.L.99-509 (42 U.S.C. s.1396a);

(10) Is a pregnant woman who is determined by a provider to be presumptively eligible for medical assistance based on criteria established by the commissioner, pursuant to section 9407 of Pub.L.99-509 (42 U.S.C. s.1396a(a));

(11) Is an individual 65 years of age and older, or an individual who is blind or disabled pursuant to section 301 of Pub.L.92-603 (42 U.S.C. s.1382c), whose income does not exceed 100% of the poverty level, adjusted for family size, and whose resources do not exceed 100% of the resource standard used to determine medically needy eligibility pursuant to paragraph (8) of this subsection;

(12) Is a qualified disabled and working individual pursuant to section 6408 of Pub.L.101-239 (42 U.S.C. s.1396d) whose income does not exceed 200% of the poverty level and whose resources do not exceed 200% of the resource standard used to determine eligibility under the Supplemental Security Income Program, P.L.1973, c.256 (C.44:7-85 et seq.);

(13) Is a pregnant woman or is a child who is under one year of

1 age and is a member of a family whose income does not exceed 185%
2 of the poverty level and who meets the federal Medicaid eligibility
3 requirements set forth in section 9401 of Pub.L.99-509 (42 U.S.C.
4 s.1396a), except that a pregnant woman who is determined to be a
5 qualified applicant shall, notwithstanding any change in the income of
6 the family of which she is a member, continue to be deemed a qualified
7 applicant until the end of the 60-day period beginning on the last day
8 of her pregnancy; **[**or**]**
9 (14) (Deleted by amendment, P.L.1997, c.272).
10 (15) (a) Is a specified low-income Medicare beneficiary pursuant
11 to 42 U.S.C. s.1396a(a)10(E)iii whose resources beginning January 1,
12 1993 do not exceed 200% of the resource standard used to determine
13 eligibility under the Supplemental Security Income program, P.L.1973,
14 c.256 (C.44:7-85 et seq.) and whose income beginning January 1,
15 1993 does not exceed 110% of the poverty level, and beginning
16 January 1, 1995 does not exceed 120% of the poverty level;
17 (16) Subject to federal approval under Title XIX of the federal
18 Social Security Act, is a dependent child, parent or specified caretaker
19 relative of a child who is a qualified applicant, who would be eligible,
20 without regard to resources, for the aid to families with dependent
21 children program under the State Plan for Title IV-A of the federal
22 Social Security Act as of July 16, 1996, except for the income
23 eligibility requirements of that program, and whose family earned
24 income does not exceed 133% of the poverty level plus such earned
25 income disregards as shall be determined according to a methodology
26 to be established by regulation of the commissioner; or
27 (17) Is an individual from 18 through 20 years of age who is not
28 a dependent child and would be eligible for medical assistance
29 pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.), without regard to
30 income or resources, who, on the individual's 18th birthday was in
31 foster care under the care and custody of the Division of Youth and
32 Family Services and whose maintenance was being paid in whole or in
33 part from public funds.
34 (b) An individual who has, within 36 months, or within 60 months
35 in the case of funds transferred into a trust, of applying to be a
36 qualified applicant for Medicaid services in a nursing facility or a
37 medical institution, or for home or community-based services under
38 section 1915(c) of the federal Social Security Act (42 U.S.C.
39 s.1396n(c)), disposed of resources or income for less than fair market
40 value shall be ineligible for assistance for nursing facility services, an
41 equivalent level of services in a medical institution, or home or
42 community-based services under section 1915(c) of the federal Social
43 Security Act (42 U.S.C. s.1396n(c)). The period of the ineligibility
44 shall be the number of months resulting from dividing the
45 uncompensated value of the transferred resources or income by the
46 average monthly private payment rate for nursing facility services in

1 the State as determined annually by the commissioner. In the case of
2 multiple resource or income transfers, the resulting penalty periods
3 shall be imposed sequentially. Application of this requirement shall be
4 governed by 42 U.S.C. s.1396p(c). In accordance with federal law,
5 this provision is effective for all transfers of resources or income made
6 on or after August 11, 1993. Notwithstanding the provisions of this
7 subsection to the contrary, the State eligibility requirements
8 concerning resource or income transfers shall not be more restrictive
9 than those enacted pursuant to 42 U.S.C. s.1396p(c).
10 (c) An individual seeking nursing facility services or home or
11 community-based services and who has a community spouse shall be
12 required to expend those resources which are not protected for the
13 needs of the community spouse in accordance with section 1924(c) of
14 the federal Social Security Act (42 U.S.C. s.1396r-5(c)) on the costs
15 of long-term care, burial arrangements, and any other expense deemed
16 appropriate and authorized by the commissioner. An individual shall
17 be ineligible for Medicaid services in a nursing facility or for home or
18 community-based services under section 1915(c) of the federal Social
19 Security Act (42 U.S.C. s.1396n(c)) if the individual expends funds in
20 violation of this subparagraph. The period of ineligibility shall be the
21 number of months resulting from dividing the uncompensated value of
22 transferred resources and income by the average monthly private
23 payment rate for nursing facility services in the State as determined by
24 the commissioner. The period of ineligibility shall begin with the
25 month that the individual would otherwise be eligible for Medicaid
26 coverage for nursing facility services or home or community-based
27 services.
28 This subparagraph shall be operative only if all necessary approvals
29 are received from the federal government including, but not limited to,
30 approval of necessary State plan amendments and approval of any
31 waivers.
32 j. "Recipient" means any qualified applicant receiving benefits
33 under this act.
34 k. "Resident" means a person who is living in the State voluntarily
35 with the intention of making his home here and not for a temporary
36 purpose. Temporary absences from the State, with subsequent returns
37 to the State or intent to return when the purposes of the absences have
38 been accomplished, do not interrupt continuity of residence.
39 l. "State Medicaid Commission" means the Governor, the
40 Commissioner of Human Services, the President of the Senate and the
41 Speaker of the General Assembly, hereby constituted a commission to
42 approve and direct the means and method for the payment of claims
43 pursuant to this act.
44 m. "Third party" means any person, institution, corporation,
45 insurance company, group health plan as defined in section 607(1) of
46 the federal "Employee Retirement and Income Security Act of 1974,"

1 29 U.S.C. s.1167(1), service benefit plan, health maintenance
2 organization, or other prepaid health plan, or public, private or
3 governmental entity who is or may be liable in contract, tort, or
4 otherwise by law or equity to pay all or part of the medical cost of
5 injury, disease or disability of an applicant for or recipient of medical
6 assistance payable under this act.
7 n. "Governmental peer grouping system" means a separate class of
8 skilled nursing and intermediate care facilities administered by the
9 State or county governments, established for the purpose of screening
10 their reported costs and setting reimbursement rates under the
11 Medicaid program that are reasonable and adequate to meet the costs
12 that must be incurred by efficiently and economically operated State
13 or county skilled nursing and intermediate care facilities.
14 o. "Comprehensive maternity or pediatric care provider" means any
15 person or public or private health care facility that is a provider and
16 that is approved by the commissioner to provide comprehensive
17 maternity care or comprehensive pediatric care as defined in
18 subsection b. (18) and (19) of section 6 of P.L.1968, c.413
19 (C.30:4D-6).
20 p. "Poverty level" means the official poverty level based on family
21 size established and adjusted under Section 673(2) of Subtitle B, the
22 "Community Services Block Grant Act," of Pub.L.97-35 (42 U.S.C.
23 s.9902(2)).
24 q. "Eligible alien" means one of the following:
25 (1) an alien present in the United States prior to August 22, 1996,
26 who is:
27 (a) a lawful permanent resident;
28 (b) a refugee pursuant to section 207 of the federal "Immigration
29 and Nationality Act" (8 U.S.C. s.1157);
30 (c) an asylee pursuant to section 208 of the federal "Immigration
31 and Nationality Act" (8 U.S.C. s.1158);
32 (d) an alien who has had deportation withheld pursuant to section
33 243(h) of the federal "Immigration and Nationality Act" (8 U.S.C.
34 s.1253 (h));
35 (e) an alien who has been granted parole for less than one year by
36 the federal Immigration and Naturalization Service pursuant to section
37 212(d)(5) of the federal "Immigration and Nationality Act" (8 U.S.C.
38 s.1182(d)(5));
39 (f) an alien granted conditional entry pursuant to section 203(a)(7)
40 of the federal "Immigration and Nationality Act" (8 U.S.C.
41 s.1153(a)(7)) in effect prior to April 1, 1980; or
42 (g) an alien who is honorably discharged from or on active duty in
43 the United States armed forces and the alien's spouse and unmarried
44 dependent child.
45 (2) An alien who entered the United States on or after August 22,
46 1996, who is:

(a) an alien as described in paragraph (1)(b), (c), (d) or (g) of this subsection; or

(b) an alien as described in paragraph (1)(a), (e) or (f) of this subsection who entered the United States at least five years ago.

(3) A legal alien who is a victim of domestic violence in accordance with criteria specified for eligibility for public benefits as provided in Title V of the federal "Illegal Immigration Reform and Immigrant Responsibility Act of 1996" (8 U.S.C. s.1641).

(cf: P.L.1997, c.352, s.1)

8. Section 7 of P.L.1997, c.13 (C.44:10-40) is amended to read as follows:

7. a. Single adults and couples without dependent children shall not be eligible for medical assistance for inpatient or outpatient hospital care or long-term care under the program, except that medical assistance shall be provided for the following, in accordance with regulations adopted by the commissioner:

(1) inpatient hospitalization costs for a recipient of general public assistance pursuant to P.L.1947, c.156 (C.44:8-107 et seq.) who is admitted to a special hospital licensed by the Department of Health and Senior Services which is not eligible to receive a charity care subsidy from the Health Care Subsidy Fund established pursuant to P.L.1992, c.160 (C.26:2H-18.51 et al.) and to which payments were made prior to July 1, 1991 on behalf of patients receiving general public assistance;

(2) nursing home costs for a person residing in a non-Medicaid certified nursing facility prior to July 1, 1995, whose income is above the Medicaid institutional cap and who does not otherwise qualify for State-funded nursing home care as a medically needy person pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.), to be paid for out of a separate account from the Medicaid program; which assistance shall continue until the person is no longer eligible for long-term care; and

(3) nursing home costs for an alien residing in a Medicaid certified nursing facility prior to the effective date of this act who is not Medicaid-eligible under Pub.L.104-193; which assistance shall continue until the person is no longer eligible for long-term care.

b. The provisions of this section shall not affect the eligibility of a single adult or a couple without dependent children for the New Jersey FamilyCare Health Coverage Program established pursuant to section 4 of P.L. , c. (C.)(pending before the Legislature as this bill).

(cf: P.L.1997, c.13, s.7)

9. This act shall take effect immediately.

1 STATEMENT
2
3 This bill, which is designated the "FamilyCare Health Coverage
4 Act," establishes the FamilyCare Health Coverage Program in the
5 Department of Human Services.
6 This program will provide health care coverage to approximately
7 125,000 low and moderate-income residents of New Jersey and, by
8 doing so, encourage these individuals to work, reinforce welfare
9 reform efforts, and emphasize personal responsibility and self-
10 sufficiency. Persons with health care coverage are more likely to
11 address their health problems and ensure that their children obtain
12 necessary care, including immunizations and well-child visits with a
13 primary care physician. This program will also reduce reliance on the
14 hospital charity care program among low and moderate-income
15 residents of the State and place these individuals into a regular system
16 of primary and preventive care.
17 Specifically, the FamilyCare Health Coverage Program will provide
18 subsidized private health insurance coverage, and other health care
19 benefits as determined by the Commissioner of Human Services, within
20 the limits of funds appropriated or otherwise made available for the
21 program, to parents or caretaker relatives of children who are eligible
22 for, or already enrolled in, the NJ KidCare program, with gross family
23 incomes of up to 200% of the poverty level, and single adults and
24 couples without dependent children with gross family incomes of up
25 to 100% of the poverty level.
26 The bill provides that, for the purposes of this program, the
27 commissioner:
28 C shall require that eligible persons purchase available employer-
29 sponsored health insurance coverage that is determined to be cost-
30 effective and is approved by the commissioner, and shall provide
31 assistance in the purchase of that coverage;
32 C shall by regulation establish standards for determining eligibility and
33 other requirements for the program, including, but not limited to,
34 restrictions on voluntary disenrollments from existing health
35 insurance coverage;
36 C may by regulation establish plans of coverage or benefits to be
37 covered under the program, except that the provisions of the bill
38 shall not apply to coverage for medications that are used
39 exclusively to treat AIDS or HIV infection through the AIDS drug
40 distribution program;
41 C may contract with one or more appropriate entities to assist in
42 administering the program;
43 C may require premium contributions and copayments from qualified
44 applicants as determined by the commissioner; and
45 C shall take, or cause to be taken, any action necessary to secure for
46 the State the maximum amount of federal financial participation

1 available with respect to the program, subject to the constraints of
2 fiscal responsibility and within the limits of available funding in any
3 fiscal year.
4 The bill stipulates that its provisions shall not be construed to
5 require an employer to provide health insurance coverage for any
6 employee or any employee's spouse or dependent child.
7 In addition, consistent with the NJ KidCare program and the
8 proposed FamilyCare Health Coverage Program, this bill would
9 eliminate the assets test for lower-income families to qualify for
10 Medicaid.
11 The bill also extends Medicaid coverage to any independent
12 adolescent from 18 through 20 years of age who would be eligible for
13 Medicaid, without regard to income or resources, and on that
14 individual's 18th birthday was in foster care under the care and custody
15 of the Division of Youth and Family Services and maintained in whole
16 or in part from public funds.
17 Finally, the bill requires the Commissioner of Human Services, in
18 consultation with the Commissioner of Health and Senior Services, to
19 establish a process to provide for presumptive eligibility for the
20 program whereby a person without health insurance coverage who
21 presents for treatment at an acute care hospital or a federally qualified
22 health center shall be deemed presumptively eligible for the program
23 if a preliminary determination by hospital or health center staff
24 indicates that the person meets the eligibility requirements of this bill
25 and the program eligibility standards established by regulation of the
26 commissioner. The commissioner may: reallocate funds appropriated
27 or otherwise made available for the program in order to increase the
28 amount available for covered health care services received by persons
29 who are presumptively eligible for the program; and terminate the
30 presumptive eligibility process, upon the commissioner's finding that
31 all monies appropriated for the program will be expended for covered
32 health care services received by persons enrolled in the program.

[First Reprint]

ASSEMBLY, No. 49

STATE OF NEW JERSEY

209th LEGISLATURE

INTRODUCED MAY 11, 2000

Sponsored by:
Assemblywoman CHARLOTTE VANDERVALK
District 39 (Bergen)
Assemblyman SAMUEL D. THOMPSON
District 13 (Middlesex and Monmouth)

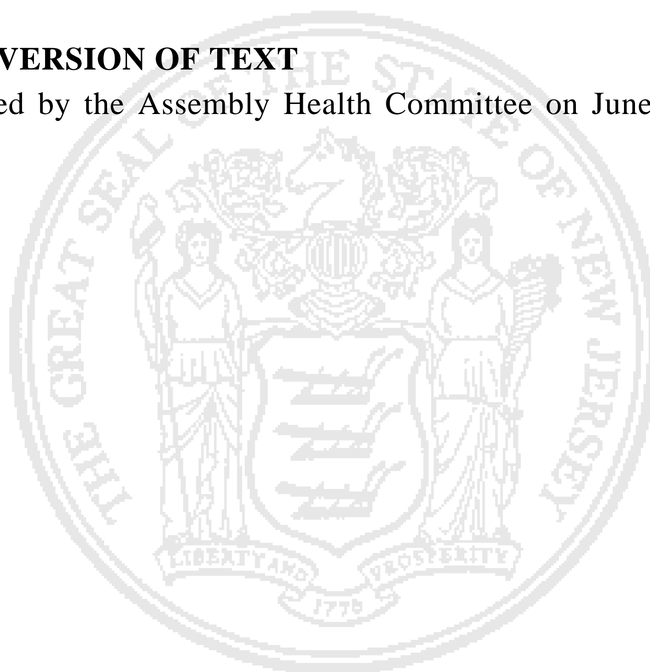
Co-Sponsored by:
Assemblywomen Quigley and Weinberg

SYNOPSIS

"FamilyCare Health Coverage Act."

CURRENT VERSION OF TEXT

As reported by the Assembly Health Committee on June 1, 2000, with amendments.



(Sponsorship Updated As Of: 6/6/2000)

AN ACT establishing the FamilyCare Health Coverage Program, supplementing Title 30 of the Revised Statutes and amending P.L.1968, c.413 and P.L.1997, c.13.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. (New section) This act shall be known and may be cited as the "FamilyCare Health Coverage Act."

2. (New section) The Legislature finds and declares that:

a. The most serious health problem facing over one million New Jersey residents is their lack of access to affordable health care coverage, and this lack of coverage forces too many families to go without needed preventive and other care until serious illness requires expensive hospital care;

b. Research has shown that affordable and accessible health care coverage for parents has a positive impact upon children, since, by having a connection to ongoing health coverage, these parents are more likely to ensure that their children get necessary immunizations and regular checkups from their primary care physicians;

c. Providing health care coverage for uninsured adults encourages continued work efforts, reduces dependence on welfare and other State-subsidized programs, and alleviates reliance on hospital charity care funding;

d. The FamilyCare Health Coverage Program established pursuant to this act builds on New Jersey's long-standing commitment to assure access to quality health care provided in an efficient and effective manner and at reasonable cost; and

e. It is appropriate that the FamilyCare Health Coverage Program utilize resources from the funds that the State receives under the Master Settlement Agreement between the State and tobacco product manufacturers, and other State resources, to establish the foundation for assuring health care coverage for low and moderate-income, uninsured adults.

3. (New section) As used in this act:

"Commissioner" means the Commissioner of Human Services.

"Poverty level" means the official poverty level based on family size established and adjusted under Section 673(2) of Subtitle B, the "Community Services Block Grant Act," of Pub.L.97-35 (42 U.S.C. s.9902(2)).

EXPLANATION - Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined <u>thus</u> is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
[1] Assembly AHL committee amendments adopted June 1, 2000.

1 "Program" means the FamilyCare Health Coverage Program
2 established pursuant to this act.
3 "Qualified applicant" means a person who: is a resident of this
4 State; is a citizen of the United States, or [1][an eligible alien as defined
5 in section 3 of P.L.1968, c.413 (C.30:4D-3)] has been lawfully
6 admitted into and remains lawfully present in the United States[1]; has
7 no health insurance coverage; and is ineligible for the Medicaid
8 program established pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.)
9 [1]and the Children's Health Care Coverage Program established
10 pursuant to P.L.1997, c.272 (C.30:4I-1 et seq.)[1].
11
12 4. (New section) a. The FamilyCare Health Coverage Program is
13 established in the Department of Human Services. The purpose of the
14 program shall be to provide subsidized private health insurance
15 coverage, and other health care benefits as determined by the
16 commissioner, within the limits of funds appropriated or otherwise
17 made available for the program, to any qualified applicant who is: a
18 parent or caretaker relative of a child whose gross family income does
19 not exceed 200% of the poverty level, [1]a child whose gross family
20 income does not exceed 350% of the poverty level,[1] or a single adult
21 or couple without dependent children whose gross family income does
22 not exceed 100% of the poverty level.
23 b. For the purposes of this program, the commissioner:
24 (1) shall require that a qualified applicant purchase coverage [1][that
25 is] , if[1] available to the qualified applicant[1],[1] through an employer-
26 sponsored health insurance plan which is determined to be cost-
27 effective and is approved by the commissioner, and shall provide
28 assistance to the qualified applicant to purchase that coverage;
29 (2) shall by regulation establish standards for determining eligibility
30 and other requirements for the program, including, but not limited to,
31 restrictions on voluntary disenrollments from existing health insurance
32 coverage;
33 (3) may by regulation establish plans of coverage or benefits to be
34 covered under the program, except that the provisions of this act shall
35 not apply to coverage for medications that are used exclusively to treat
36 AIDS or HIV infection;
37 (4) may contract with one or more appropriate entities to assist in
38 administering the program;
39 (5) may require premium contributions and copayments from
40 qualified applicants as determined by the commissioner; and
41 (6) shall take, or cause to be taken, any action necessary to secure
42 for the State the maximum amount of federal financial participation
43 available with respect to the program, subject to the constraints of
44 fiscal responsibility and within the limits of available funding in any
45 fiscal year.
46 c. The provisions of this section shall not be construed to require
47 an employer to provide health insurance coverage for any employee or

1 any employee's spouse or dependent child.
2 d. A qualified applicant who is a single adult or couple without
3 dependent children shall be ineligible to receive health care services
4 that are covered by the program from any other State-funded program
5 for which the qualified applicant is eligible.
6
7 5. (New section) a. In order to provide persons in need of health
8 care services with an efficient transition into the program, the
9 commissioner, in consultation with the Commissioner of Health and
10 Senior Services, may establish, for such period of time as the
11 commissioner determines necessary, a process to provide for
12 presumptive eligibility for the program in accordance with the
13 provisions of this section:
14 (1) A person without health insurance coverage who presents for
15 treatment at an acute care hospital or a federally qualified health center
16 shall be deemed presumptively eligible for the program if a preliminary
17 determination by hospital or health center staff indicates that the
18 person meets the eligibility requirements of this act and the program
19 eligibility standards established by regulation of the commissioner;
20 (2) During the period in which the person is presumptively eligible
21 for the program, coverage shall be limited to inpatient and outpatient
22 hospital and federally qualified health center services and prescription
23 drug benefits designated by the commissioner;
24 (3) A person shall be limited to a single period of presumptive
25 eligibility for the program. The presumptive eligibility period shall
26 begin with the month in which presumptive eligibility is determined
27 and expire at the end of the following month; except that an extension
28 of the presumptive eligibility period may be authorized until the
29 person's application for the program is approved or denied, subject to
30 the person's cooperation with the application process during the
31 presumptive eligibility period. The person's failure to provide such
32 cooperation within a period of time determined by the commissioner
33 shall result in a denial of the application; and
34 (4) A person without health insurance coverage who presents for
35 treatment at an acute care hospital and is determined to not qualify for
36 presumptive eligibility or for the program shall be evaluated for
37 eligibility for charity care pursuant to P.L.1992, c.160 (C.26:2H-18.51
38 et al.).
39 b. Notwithstanding the provisions of this act, or any rule or
40 regulation adopted pursuant thereto, to the contrary, the commissioner
41 may:
42 (1) within the limits of funds appropriated or otherwise made
43 available for the program, reallocate such funds in order to increase
44 the amount available for covered health care services received by
45 persons who are presumptively eligible for the program, for which
46 purpose the commissioner shall cause a notice of such reallocation of
47 funds to be published in the New Jersey Register; and

1 (2) terminate the presumptive eligibility process, upon the
2 commissioner's finding that all monies appropriated for the program
3 will be expended for covered health care services received by persons
4 enrolled in the program, for which purpose the commissioner shall
5 cause a notice of termination of the presumptive eligibility process to
6 be published in the New Jersey Register.
7
8 6. (New section) The commissioner shall adopt rules and
9 regulations pursuant to the "Administrative Procedure Act," P.L.1968,
10 c.410 (C.52:14B-1 et seq.) to effectuate the purposes of this act;
11 except that, notwithstanding any provision of P.L.1968, c.410 to the
12 contrary, the commissioner may adopt, immediately upon filing with
13 the Office of Administrative Law, such regulations as the
14 commissioner deems necessary to implement the provisions of this act,
15 which shall be effective for a period not to exceed six months and may
16 thereafter be amended, adopted or readopted by the commissioner in
17 accordance with the requirements of P.L.1968, c.410.
18
19 7. Section 3 of P.L.1968, c.413 (C.30:4D-3) is amended to read as
20 follows:
21 3. Definitions. As used in this act, and unless the context
22 otherwise requires:
23 a. "Applicant" means any person who has made application for
24 purposes of becoming a "qualified applicant."
25 b. "Commissioner" means the Commissioner of Human Services.
26 c. "Department" means the Department of Human Services, which
27 is herein designated as the single State agency to administer the
28 provisions of this act.
29 d. "Director" means the Director of the Division of Medical
30 Assistance and Health Services.
31 e. "Division" means the Division of Medical Assistance and Health
32 Services.
33 f. "Medicaid" means the New Jersey Medical Assistance and Health
34 Services Program.
35 g. "Medical assistance" means payments on behalf of recipients to
36 providers for medical care and services authorized under this act.
37 h. "Provider" means any person, public or private institution,
38 agency or business concern approved by the division lawfully
39 providing medical care, services, goods and supplies authorized under
40 this act, holding, where applicable, a current valid license to provide
41 such services or to dispense such goods or supplies.
42 i. "Qualified applicant" means a person who is a resident of this
43 State, and either a citizen of the United States or an eligible alien, and
44 is determined to need medical care and services as provided under this
45 act, and who:
46 (1) Is a dependent child or parent or caretaker relative of a

1 dependent child [and a recipient of benefits under the Work First New
2 Jersey program established pursuant to P.L.1997, c.38 (C.44:10-55 et
3 seq.)] who would be, except for resources, eligible for the aid to
4 families with dependent children program under the State Plan for
5 Title IV-A of the federal Social Security Act as of July 16, 1996;
6 (2) Is a recipient of Supplemental Security Income for the Aged,
7 Blind and Disabled under Title XVI of the Social Security Act;
8 (3) Is an "ineligible spouse" of a recipient of Supplemental Security
9 Income for the Aged, Blind and Disabled under Title XVI of the Social
10 Security Act, as defined by the federal Social Security Administration;
11 (4) Would be eligible to receive Supplemental Security Income
12 under Title XVI of the federal Social Security Act or, [using the
13 resource standards of the Work First New Jersey program] <u>without</u>
14 <u>regard to resources</u>, would be eligible for the aid to families with
15 dependent children program under the State Plan for Title IV-A of the
16 federal Social Security Act as of July 16, 1996, except for failure to
17 meet an eligibility condition or requirement imposed under such State
18 program which is prohibited under Title XIX of the federal Social
19 Security Act such as a durational residency requirement, relative
20 responsibility, consent to imposition of a lien;
21 (5) [Is a child between 18 and 21 years of age who, using the
22 resource standards of the Work First New Jersey program, would be
23 eligible for the aid to families with dependent children program under
24 the State Plan for Title IV-A of the federal Social Security Act as of
25 July 16, 1996, living in the family group except for lack of school
26 attendance or pursuit of formalized vocational or technical training]
27 <u>(Deleted by amendment, P.L. , c.)(pending before the Legislature</u>
28 <u>as this bill)</u>;
29 (6) Is an individual under 21 years of age who, [using the resource
30 standards of the Work First New Jersey program] <u>without regard to</u>
31 <u>resources</u>, would be, except for dependent child requirements, eligible
32 for the aid to families with dependent children program under the State
33 Plan for Title IV-A of the federal Social Security Act as of July 16,
34 1996, or groups of such individuals, including but not limited to,
35 children in foster placement under supervision of the Division of
36 Youth and Family Services whose maintenance is being paid in whole
37 or in part from public funds, children placed in a foster home or
38 institution by a private adoption agency in New Jersey or children in
39 intermediate care facilities, including developmental centers for the
40 developmentally disabled, or in psychiatric hospitals;
41 (7) [Using the resource standards of the Work First New Jersey
42 program, would] <u>Would</u> be eligible for the [aid to families with
43 dependent children program under the State Plan for Title IV-A of the
44 federal Social Security Act in effect as of July 16, 1996 or the]
45 Supplemental Security Income program, but is not receiving such

1 assistance and applies for medical assistance only;
2 (8) Is determined to be medically needy and meets all the eligibility
3 requirements described below:
4 (a) The following individuals are eligible for services, if they are
5 determined to be medically needy:
6 (i) Pregnant women;
7 (ii) Dependent children under the age of 21;
8 (iii) Individuals who are 65 years of age and older; and
9 (iv) Individuals who are blind or disabled pursuant to either
10 42 C.F.R.435.530 et seq. or 42 C.F.R.435.540 et seq., respectively.
11 (b) The following income standard shall be used to determine
12 medically needy eligibility:
13 (i) For one person and two person households, the income standard
14 shall be the maximum allowable under federal law, but shall not exceed
15 133 1/3% of the State's payment level to two person households under
16 the aid to families with dependent children program under the State
17 Plan for Title IV-A of the federal Social Security Act in effect as of
18 July 16, 1996; and
19 (ii) For households of three or more persons, the income standard
20 shall be set at 133 1/3% of the State's payment level to similar size
21 households under the aid to families with dependent children program
22 under the State Plan for Title IV-A of the federal Social Security Act
23 in effect as of July 16, 1996.
24 (c) The following resource standard shall be used to determine
25 medically needy eligibility:
26 (i) For one person households, the resource standard shall be 200%
27 of the resource standard for recipients of Supplemental Security
28 Income pursuant to 42 U.S.C.s.1382(1)(B);
29 (ii) For two person households, the resource standard shall be
30 200% of the resource standard for recipients of Supplemental Security
31 Income pursuant to 42 U.S.C.s.1382(2)(B);
32 (iii) For households of three or more persons, the resource
33 standard in subparagraph (c)(ii) above shall be increased by $100.00
34 for each additional person; and
35 (iv) The resource standards established in (i), (ii), and (iii) are
36 subject to federal approval and the resource standard may be lower if
37 required by the federal Department of Health and Human Services.
38 (d) Individuals whose income exceeds those established in
39 subparagraph (b) of paragraph (8) of this subsection may become
40 medically needy by incurring medical expenses as defined in 42
41 C.F.R.435.831(c) which will reduce their income to the applicable
42 medically needy income established in subparagraph (b) of paragraph
43 (8) of this subsection.
44 (e) A six-month period shall be used to determine whether an
45 individual is medically needy.
46 (f) Eligibility determinations for the medically needy program shall

1 be administered as follows:
2 (i) County welfare agencies and other entities designated by the
3 commissioner are responsible for determining and certifying the
4 eligibility of pregnant women and dependent children. The division
5 shall reimburse county welfare agencies for 100% of the reasonable
6 costs of administration which are not reimbursed by the federal
7 government for the first 12 months of this program's operation.
8 Thereafter, 75% of the administrative costs incurred by county welfare
9 agencies which are not reimbursed by the federal government shall be
10 reimbursed by the division;
11 (ii) The division is responsible for certifying the eligibility of
12 individuals who are 65 years of age and older and individuals who are
13 blind or disabled. The division may enter into contracts with county
14 welfare agencies to determine certain aspects of eligibility. In such
15 instances the division shall provide county welfare agencies with all
16 information the division may have available on the individual.
17 The division shall notify all eligible recipients of the Pharmaceutical
18 Assistance to the Aged and Disabled program, P.L.1975, c.194
19 (C.30:4D-20 et seq.) on an annual basis of the medically needy
20 program and the program's general requirements. The division shall
21 take all reasonable administrative actions to ensure that
22 Pharmaceutical Assistance to the Aged and Disabled recipients, who
23 notify the division that they may be eligible for the program, have their
24 applications processed expeditiously, at times and locations convenient
25 to the recipients; and
26 (iii) The division is responsible for certifying incurred medical
27 expenses for all eligible persons who attempt to qualify for the
28 program pursuant to subparagraph (d) of paragraph (8) of this
29 subsection;
30 (9) (a) Is a child who is at least one year of age and under 19 years
31 of age <u>and, if older than six years of age but under 19 years of age, is</u>
32 <u>uninsured</u>; and
33 (b) Is a member of a family whose income does not exceed 133%
34 of the poverty level and who meets the federal Medicaid eligibility
35 requirements set forth in section 9401 of Pub.L.99-509 (42 U.S.C.
36 s.1396a);
37 (10) Is a pregnant woman who is determined by a provider to be
38 presumptively eligible for medical assistance based on criteria
39 established by the commissioner, pursuant to section 9407 of
40 Pub.L.99-509 (42 U.S.C. s.1396a(a));
41 (11) Is an individual 65 years of age and older, or an individual
42 who is blind or disabled pursuant to section 301 of Pub.L.92-603 (42
43 U.S.C. s.1382c), whose income does not exceed 100% of the poverty
44 level, adjusted for family size, and whose resources do not exceed
45 100% of the resource standard used to determine medically needy
46 eligibility pursuant to paragraph (8) of this subsection;

(12) Is a qualified disabled and working individual pursuant to section 6408 of Pub.L.101-239 (42 U.S.C. s.1396d) whose income does not exceed 200% of the poverty level and whose resources do not exceed 200% of the resource standard used to determine eligibility under the Supplemental Security Income Program, P.L.1973, c.256 (C.44:7-85 et seq.);

(13) Is a pregnant woman or is a child who is under one year of age and is a member of a family whose income does not exceed 185% of the poverty level and who meets the federal Medicaid eligibility requirements set forth in section 9401 of Pub.L.99-509 (42 U.S.C. s.1396a), except that a pregnant woman who is determined to be a qualified applicant shall, notwithstanding any change in the income of the family of which she is a member, continue to be deemed a qualified applicant until the end of the 60-day period beginning on the last day of her pregnancy; [or]

(14) (Deleted by amendment, P.L.1997, c.272).

(15) (a) Is a specified low-income Medicare beneficiary pursuant to 42 U.S.C. s.1396a(a)10(E)iii whose resources beginning January 1, 1993 do not exceed 200% of the resource standard used to determine eligibility under the Supplemental Security Income program, P.L.1973, c.256 (C.44:7-85 et seq.) and whose income beginning January 1, 1993 does not exceed 110% of the poverty level, and beginning January 1, 1995 does not exceed 120% of the poverty level[1][;

(16) Subject to federal approval under Title XIX of the federal Social Security Act, is a dependent child, parent or specified caretaker relative of a child who is a qualified applicant, who would be eligible, without regard to resources, for the aid to families with dependent children program under the State Plan for Title IV-A of the federal Social Security Act as of July 16, 1996, except for the income eligibility requirements of that program, and whose family earned income does not exceed 133% of the poverty level plus such earned income disregards as shall be determined according to a methodology to be established by regulation of the commissioner; or

(17) Is an individual from 18 through 20 years of age who is not a dependent child and would be eligible for medical assistance pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.), without regard to income or resources, who, on the individual's 18th birthday was in foster care under the care and custody of the Division of Youth and Family Services and whose maintenance was being paid in whole or in part from public funds][1].

(b) An individual who has, within 36 months, or within 60 months in the case of funds transferred into a trust, of applying to be a qualified applicant for Medicaid services in a nursing facility or a medical institution, or for home or community-based services under section 1915(c) of the federal Social Security Act (42 U.S.C. s.1396n(c)), disposed of resources or income for less than fair market

1 value shall be ineligible for assistance for nursing facility services, an
2 equivalent level of services in a medical institution, or home or
3 community-based services under section 1915(c) of the federal Social
4 Security Act (42 U.S.C. s.1396n(c)). The period of the ineligibility
5 shall be the number of months resulting from dividing the
6 uncompensated value of the transferred resources or income by the
7 average monthly private payment rate for nursing facility services in
8 the State as determined annually by the commissioner. In the case of
9 multiple resource or income transfers, the resulting penalty periods
10 shall be imposed sequentially. Application of this requirement shall be
11 governed by 42 U.S.C. s.1396p(c). In accordance with federal law,
12 this provision is effective for all transfers of resources or income made
13 on or after August 11, 1993. Notwithstanding the provisions of this
14 subsection to the contrary, the State eligibility requirements
15 concerning resource or income transfers shall not be more restrictive
16 than those enacted pursuant to 42 U.S.C. s.1396p(c).
17 (c) An individual seeking nursing facility services or home or
18 community-based services and who has a community spouse shall be
19 required to expend those resources which are not protected for the
20 needs of the community spouse in accordance with section 1924(c) of
21 the federal Social Security Act (42 U.S.C. s.1396r-5(c)) on the costs
22 of long-term care, burial arrangements, and any other expense deemed
23 appropriate and authorized by the commissioner. An individual shall
24 be ineligible for Medicaid services in a nursing facility or for home or
25 community-based services under section 1915(c) of the federal Social
26 Security Act (42 U.S.C. s.1396n(c)) if the individual expends funds in
27 violation of this subparagraph. The period of ineligibility shall be the
28 number of months resulting from dividing the uncompensated value of
29 transferred resources and income by the average monthly private
30 payment rate for nursing facility services in the State as determined by
31 the commissioner. The period of ineligibility shall begin with the
32 month that the individual would otherwise be eligible for Medicaid
33 coverage for nursing facility services or home or community-based
34 services.
35 This subparagraph shall be operative only if all necessary approvals
36 are received from the federal government including, but not limited to,
37 approval of necessary State plan amendments and approval of any
38 waivers.
39 [1](16) Subject to federal approval under Title XIX of the federal
40 Social Security Act, is a dependent child, parent or specified caretaker
41 relative of a child who is a qualified applicant, who would be eligible,
42 without regard to resources, for the aid to families with dependent
43 children program under the State Plan for Title IV-A of the federal
44 Social Security Act as of July 16, 1996, except for the income
45 eligibility requirements of that program, and whose family earned
46 income does not exceed 133% of the poverty level plus such earned

income disregards as shall be determined according to a methodology to be established by regulation of the commissioner; or

(17) Is an individual from 18 through 20 years of age who is not a dependent child and would be eligible for medical assistance pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.), without regard to income or resources, who, on the individual's 18th birthday was in foster care under the care and custody of the Division of Youth and Family Services and whose maintenance was being paid in whole or in part from public funds.[1]

j. "Recipient" means any qualified applicant receiving benefits under this act.

k. "Resident" means a person who is living in the State voluntarily with the intention of making his home here and not for a temporary purpose. Temporary absences from the State, with subsequent returns to the State or intent to return when the purposes of the absences have been accomplished, do not interrupt continuity of residence.

l. "State Medicaid Commission" means the Governor, the Commissioner of Human Services, the President of the Senate and the Speaker of the General Assembly, hereby constituted a commission to approve and direct the means and method for the payment of claims pursuant to this act.

m. "Third party" means any person, institution, corporation, insurance company, group health plan as defined in section 607(1) of the federal "Employee Retirement and Income Security Act of 1974," 29 U.S.C. s.1167(1), service benefit plan, health maintenance organization, or other prepaid health plan, or public, private or governmental entity who is or may be liable in contract, tort, or otherwise by law or equity to pay all or part of the medical cost of injury, disease or disability of an applicant for or recipient of medical assistance payable under this act.

n. "Governmental peer grouping system" means a separate class of skilled nursing and intermediate care facilities administered by the State or county governments, established for the purpose of screening their reported costs and setting reimbursement rates under the Medicaid program that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated State or county skilled nursing and intermediate care facilities.

o. "Comprehensive maternity or pediatric care provider" means any person or public or private health care facility that is a provider and that is approved by the commissioner to provide comprehensive maternity care or comprehensive pediatric care as defined in subsection b. (18) and (19) of section 6 of P.L.1968, c.413 (C.30:4D-6).

p. "Poverty level" means the official poverty level based on family size established and adjusted under Section 673(2) of Subtitle B, the "Community Services Block Grant Act," of Pub.L.97-35 (42 U.S.C.

1 s.9902(2)).
2 q. "Eligible alien" means one of the following:
3 (1) an alien present in the United States prior to August 22, 1996,
4 who is:
5 (a) a lawful permanent resident;
6 (b) a refugee pursuant to section 207 of the federal "Immigration
7 and Nationality Act" (8 U.S.C. s.1157);
8 (c) an asylee pursuant to section 208 of the federal "Immigration
9 and Nationality Act" (8 U.S.C. s.1158);
10 (d) an alien who has had deportation withheld pursuant to section
11 243(h) of the federal "Immigration and Nationality Act" (8 U.S.C.
12 s.1253 (h));
13 (e) an alien who has been granted parole for less than one year by
14 the federal Immigration and Naturalization Service pursuant to section
15 212(d)(5) of the federal "Immigration and Nationality Act" (8 U.S.C.
16 s.1182(d)(5));
17 (f) an alien granted conditional entry pursuant to section 203(a)(7)
18 of the federal "Immigration and Nationality Act" (8 U.S.C.
19 s.1153(a)(7)) in effect prior to April 1, 1980; or
20 (g) an alien who is honorably discharged from or on active duty in
21 the United States armed forces and the alien's spouse and unmarried
22 dependent child.
23 (2) An alien who entered the United States on or after August 22,
24 1996, who is:
25 (a) an alien as described in paragraph (1)(b), (c), (d) or (g) of this
26 subsection; or
27 (b) an alien as described in paragraph (1)(a), (e) or (f) of this
28 subsection who entered the United States at least five years ago.
29 (3) A legal alien who is a victim of domestic violence in
30 accordance with criteria specified for eligibility for public benefits as
31 provided in Title V of the federal "Illegal Immigration Reform and
32 Immigrant Responsibility Act of 1996" (8 U.S.C. s.1641).
33 (cf: P.L.1997, c.352, s.1)
34
35 8. Section 7 of P.L.1997, c.13 (C.44:10-40) is amended to read as
36 follows:
37 7. <u>a.</u> Single adults and couples without dependent children shall
38 not be eligible for medical assistance for inpatient or outpatient
39 hospital care or long-term care under the program, except that medical
40 assistance shall be provided for the following, in accordance with
41 regulations adopted by the commissioner:
42 (1) inpatient hospitalization costs for a recipient of general public
43 assistance pursuant to P.L.1947, c.156 (C.44:8-107 et seq.) who is
44 admitted to a special hospital licensed by the Department of Health
45 and Senior Services which is not eligible to receive a charity care
46 subsidy from the Health Care Subsidy Fund established pursuant to

1 P.L.1992, c.160 (C.26:2H-18.51 et al.) and to which payments were
2 made prior to July 1, 1991 on behalf of patients receiving general
3 public assistance;
4 (2) nursing home costs for a person residing in a non-Medicaid
5 certified nursing facility prior to July 1, 1995, whose income is above
6 the Medicaid institutional cap and who does not otherwise qualify for
7 State-funded nursing home care as a medically needy person pursuant
8 to P.L.1968, c.413 (C.30:4D-1 et seq.), to be paid for out of a
9 separate account from the Medicaid program; which assistance shall
10 continue until the person is no longer eligible for long-term care; and
11 (3) nursing home costs for an alien residing in a Medicaid certified
12 nursing facility prior to the effective date of this act who is not
13 Medicaid-eligible under Pub.L.104-193; which assistance shall
14 continue until the person is no longer eligible for long-term care.
15 b. The provisions of this section shall not affect the eligibility of a
16 single adult or a couple without dependent children for the New Jersey
17 FamilyCare Health Coverage Program established pursuant to section
18 4 of P.L. , c. (C.)(pending before the Legislature as this bill).
19 (cf: P.L.1997, c.13, s.7)
20
21 9. This act shall take effect immediately.

ASSEMBLY HEALTH COMMITTEE

STATEMENT TO

ASSEMBLY, No. 49

with committee amendments

STATE OF NEW JERSEY

DATED: JUNE 1, 2000

The Assembly Health Committee reports favorably and with committee amendments Assembly Bill No. 49.

As amended by the committee, this bill, which is designated the "FamilyCare Health Coverage Act," establishes the FamilyCare Health Coverage Program in the Department of Human Services.

This program will provide health care coverage to approximately 125,000 low and moderate-income residents of New Jersey and, by doing so, encourage these individuals to work, reinforce welfare reform efforts, and emphasize personal responsibility and self-sufficiency. Persons with health care coverage are more likely to address their health problems and ensure that their children obtain necessary care, including immunizations and well-child visits with a primary care physician. This program will also reduce reliance on the hospital charity care program among low and moderate-income residents of the State and place these individuals into a regular system of primary and preventive care.

Specifically, the FamilyCare Health Coverage Program will provide subsidized private health insurance coverage, and other health care benefits as determined by the Commissioner of Human Services, within the limits of funds appropriated or otherwise made available for the program, to parents or caretaker relatives of children who are eligible for, or already enrolled in, the NJ KidCare program, with gross family incomes of up to 200% of the poverty level, children with gross family incomes up to 350% of the poverty level, and single adults and couples without dependent children with gross family incomes of up to 100% of the poverty level.

The bill provides that, for the purposes of this program, the commissioner:

- shall require that eligible persons purchase available employer-sponsored health insurance coverage that is determined to be cost-effective and is approved by the commissioner, and shall provide assistance in the purchase of that coverage;
- shall by regulation establish standards for determining eligibility and other requirements for the program, including, but not limited to, restrictions on voluntary disenrollments from existing health

insurance coverage;

- C may by regulation establish plans of coverage or benefits to be covered under the program, except that the provisions of the bill shall not apply to coverage for medications that are used exclusively to treat AIDS or HIV infection through the AIDS drug distribution program;
- C may contract with one or more appropriate entities to assist in administering the program;
- C may require premium contributions and copayments from qualified applicants as determined by the commissioner; and
- C shall take, or cause to be taken, any action necessary to secure for the State the maximum amount of federal financial participation available with respect to the program, subject to the constraints of fiscal responsibility and within the limits of available funding in any fiscal year.

The bill stipulates that its provisions shall not be construed to require an employer to provide health insurance coverage for any employee or any employee's spouse or dependent child.

In addition, consistent with the NJ KidCare program and the proposed FamilyCare Health Coverage Program, this bill would eliminate the assets test for lower-income families to qualify for Medicaid.

The bill also extends Medicaid coverage to any independent adolescent from 18 through 20 years of age who would be eligible for Medicaid, without regard to income or resources, and on that individual's 18th birthday was in foster care under the care and custody of the Division of Youth and Family Services and maintained in whole or in part from public funds.

Finally, the bill requires the Commissioner of Human Services, in consultation with the Commissioner of Health and Senior Services, to establish a process to provide for presumptive eligibility for the program whereby a person without health insurance coverage who presents for treatment at an acute care hospital or a federally qualified health center shall be deemed presumptively eligible for the program if a preliminary determination by hospital or health center staff indicates that the person meets the eligibility requirements of this bill and the program eligibility standards established by regulation of the commissioner. The commissioner may: reallocate funds appropriated or otherwise made available for the program in order to increase the amount available for covered health care services received by persons who are presumptively eligible for the program; and terminate the presumptive eligibility process, upon the commissioner's finding that all monies appropriated for the program will be expended for covered health care services received by persons enrolled in the program.

The committee amendments:

-- clarify the definition of "qualified applicant" as a person who: is a resident of this State; is a citizen of the United States, or has been

lawfully admitted into and remains lawfully present in the United States (rather than an eligible alien as defined in N.J.S.A.30:4D-3, as provided in the original bill); has no health insurance coverage; and is ineligible for both Medicaid and NJ KidCare (rather than only Medicaid, as provided in the original bill);

-- expand the eligible population for this program to include children whose gross family income does not exceed 350% of the poverty level;

-- clarify the language in paragraph (1) of subsection b. of section 4 regarding the purchase of employer-sponsored coverage by a qualified applicant under the program to provide that the commissioner shall require a qualified applicant to purchase coverage, if available to that person, through an employer-sponsored plan that meets the requirements of that paragraph; and

-- correct the placement of the amendatory language in N.J.S.A.30:4D-3 (section 7 of the bill) concerning the elimination of the assets test for lower-income families to qualify for Medicaid and the extension of Medicaid coverage to certain independent adolescents from 18 through 20 years of age.

ASSEMBLY APPROPRIATIONS COMMITTEE

STATEMENT TO

[First Reprint]

ASSEMBLY, No. 49

with Assembly committee amendments

STATE OF NEW JERSEY

DATED: JUNE 8, 2000

The Assembly Appropriations Committee reports favorably Assembly Bill No. 49 (1R), with committee amendments.

Assembly Bill No. 49 (1R), as amended, the "FamilyCare Health Coverage Act," establishes the FamilyCare Health Coverage Program in the Department of Human Services.

The FamilyCare Health Coverage Program will provide subsidized private health insurance coverage, and other health care benefits as determined by the Commissioner of Human Services, within the limits of funds appropriated or otherwise made available for the program, to parents or caretaker relatives of children who are eligible for, or already enrolled in, the NJ KidCare program, with gross family incomes of up to 200% of the poverty level, and single adults and couples without dependent children with gross family incomes of up to 100% of the poverty level.

The bill provides that, for the purposes of this program, the commissioner:

- shall require that eligible persons purchase available employer-sponsored health insurance coverage that is determined to be cost-effective and is approved by the commissioner, and shall provide assistance in the purchase of that coverage;
- shall by regulation establish standards for determining eligibility and other requirements for the program, including, but not limited to, restrictions on voluntary disenrollments from existing health insurance coverage;
- may by regulation establish plans of coverage or benefits to be covered under the program, except that the provisions of the bill shall not apply to coverage for medications that are used exclusively to treat AIDS or HIV infection through the AIDS drug distribution program;
- may contract with one or more appropriate entities to assist in administering the program;
- may require premium contributions and copayments from qualified applicants as determined by the commissioner; and

- shall take, or cause to be taken, any action necessary to secure for the State the maximum amount of federal financial participation available with respect to the program, subject to the constraints of fiscal responsibility and within the limits of available funding in any fiscal year.

The bill stipulates that its provisions shall not be construed to require an employer to provide health insurance coverage for any employee or any employee's spouse or dependent child.

Consistent with the NJ KidCare program and the proposed FamilyCare Health Coverage Program, this bill eliminates the assets test for lower-income families to qualify for Medicaid.

The bill extends Medicaid coverage to any independent adolescent from 18 through 20 years of age who would be eligible for Medicaid, without regard to income or resources, and who on that individual's 18th birthday was in foster care under the care and custody of the Division of Youth and Family Services and was maintained in whole or in part from public funds.

Finally, the bill requires the Commissioner of Human Services, in consultation with the Commissioner of Health and Senior Services, to establish a process to provide for presumptive eligibility for the program whereby a person without health insurance coverage who presents for treatment at an acute care hospital or a federally qualified health center shall be deemed presumptively eligible for the program if a preliminary determination by hospital or health center staff indicates that the person meets the eligibility requirements of this bill and the program eligibility standards established by regulation of the commissioner.

The commissioner may reallocate funds appropriated or otherwise made available for the program, to increase the amount available for covered health care services received by persons who are presumptively eligible for the program, and may terminate the presumptive eligibility process, upon the commissioner's finding that all monies appropriated for the program will be expended for covered health care services received by persons enrolled in the program.

FISCAL IMPACT:

Information supplied by the Executive Branch delineates the multiple sources of the FamilyCare Health Coverage Program. The program will use State commitment of tobacco settlement funds to attract other funds: matching federal funds to New Jersey for expanding Medicaid for low-income working families, other State funds redirected from related programs, employer funds and employee contributions. These funding sources are detailed the following chart.

FUNDING SOURCES	First Year	Second Year	Third Year
Tobacco Settlement	$70.0	$94.0	$100.0
Federal (Medicaid)	$46.0	$47.0	$48.0
Employee Funds	$2.8	$4.3	$5.0
Employer Funds	$13.3	$20.7	$24.0
State Program Redirection	$21.0	$25.0	$29.0
Total	$153.3	$191.0	$206.0

COMMITTEE AMENDMENTS:

The amendments clarify that qualified applicants for the purposes of the program include those only those noncitizens of the United States who are lawfully admitted into permanent residence in the United States.

SENATE BUDGET AND APPROPRIATIONS COMMITTEE

STATEMENT TO

[Second Reprint]
ASSEMBLY, No. 49

STATE OF NEW JERSEY

DATED: JUNE 26, 2000

The Senate Budget and Appropriations Committee reports favorably Assembly Bill No. 49 (2R).

This bill, the "FamilyCare Health Coverage Act," establishes the FamilyCare Health Coverage Program in the Department of Human Services.

The FamilyCare Health Coverage Program will, within the limits of funds appropriated or otherwise made available for it, provide subsidized private health insurance coverage and other health care benefits as determined by the Commissioner of Human Services to (1) parents or caretaker relatives of children who are eligible for, or already enrolled in, the NJ KidCare program, with gross family incomes of up to 200% of the poverty level, (2) children with gross family incomes of up to 350% of the poverty level, and (3) single adults and couples without dependent children with gross family incomes of up to 100% of the poverty level.

The bill provides that, for the purposes of this program, the commissioner:

C shall require that eligible persons purchase available employer-sponsored health insurance coverage that is determined to be cost-effective and is approved by the commissioner, and shall provide assistance in the purchase of that coverage;

C shall by regulation establish standards for determining eligibility and other requirements for the program, including, but not limited to, restrictions on voluntary disenrollments from existing health insurance coverage;

C may by regulation establish plans of coverage or benefits to be covered under the program, except that the provisions of the bill shall not apply to coverage for medications that are used exclusively to treat AIDS or HIV infection through the AIDS drug distribution program;

C may contract with one or more appropriate entities to assist in administering the program;

C may require premium contributions and copayments from qualified applicants as determined by the commissioner; and

- shall take, or cause to be taken, any action necessary to secure for the State the maximum amount of federal financial participation available with respect to the program, subject to the constraints of fiscal responsibility and within the limits of available funding in any fiscal year.

The bill stipulates that its provisions shall not be construed to require an employer to provide health insurance coverage for any employee or any employee's spouse or dependent child.

Consistent with the NJ KidCare program and the proposed FamilyCare Health Coverage Program, this bill eliminates the assets test for lower-income families to qualify for Medicaid.

The bill extends Medicaid coverage to any independent adolescent from 18 through 20 years of age who would be eligible for Medicaid, without regard to income or resources, and who on that individual's 18th birthday was in foster care under the care and custody of the Division of Youth and Family Services and was maintained in whole or in part from public funds.

Finally, the bill requires the Commissioner of Human Services, in consultation with the Commissioner of Health and Senior Services, to establish a process to provide for presumptive eligibility for the program whereby people without health insurance coverage who present themselves for treatment at an acute care hospital or a federally qualified health center shall be deemed presumptively eligible for the program if a preliminary determination by hospital or health center staff indicates that they meet the eligibility requirements of this bill and the program eligibility standards established by regulation of the commissioner. During the period of presumptive eligibility, coverage would be limited to inpatient and outpatient hospital and federally qualified health center services and prescription drug benefits designated by the commissioner.

The commissioner may reallocate funds appropriated or otherwise made available for the program, to increase the amount available for covered health care services received by persons who are presumptively eligible for the program, and may terminate the presumptive eligibility process upon finding that all moneys appropriated for the program will be expended for covered health care services received by persons enrolled in the program.

It is the intent of the committee that the benefits provided under this bill be extended to cover as many persons, eligible therefor under the terms of the legislation, as is practicable.

The provisions of the bill are identical to those of Senate Bill No. 1467, which the committee also reports this day.

<u>FISCAL IMPACT</u>:

Information supplied by the Executive Branch delineates the multiple sources of the FamilyCare Health Coverage Program. The program will use State commitment of tobacco settlement funds to

attract other funds: matching federal funds to New Jersey for expanding Medicaid for low-income working families, other State funds redirected from related programs, employer funds and employee contributions. These funding sources are detailed the following chart:

Funding Sources	First Year	Second Year	Third Year
Tobacco Settlement	$70.0	$94.0	$100.0
Federal (Medicaid)	$46.0	$47.0	$48.0
Employee Funds	$2.8	$4.3	$5.0
Employer Funds	$13.3	$20.7	$24.0
State Program Redirection	$21.0	$25.0	$29.0
Total	$153.3	$191.0	$206.0

[Second Reprint]

ASSEMBLY, No. 49

STATE OF NEW JERSEY

209th LEGISLATURE

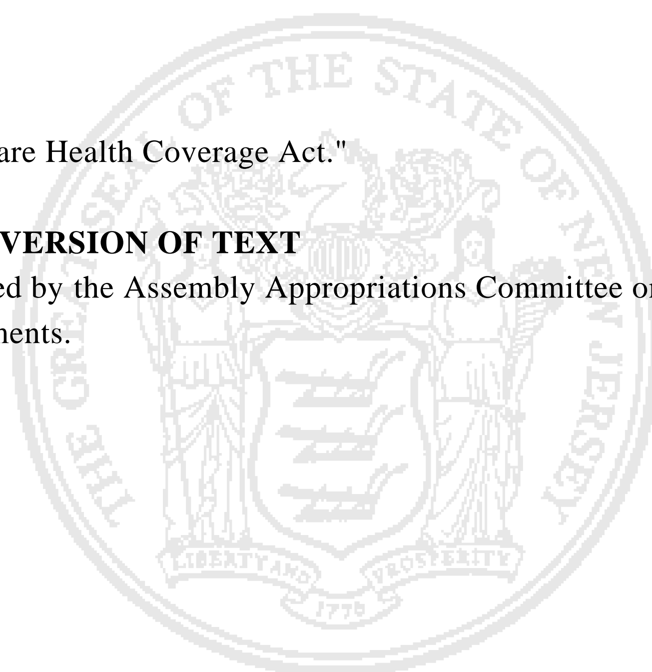
INTRODUCED MAY 11, 2000

Sponsored by:
Assemblywoman CHARLOTTE VANDERVALK
District 39 (Bergen)
Assemblyman SAMUEL D. THOMPSON
District 13 (Middlesex and Monmouth)

Co-Sponsored by:
Assemblywomen Quigley, Weinberg, Assemblyman Augustine, Assemblywoman Pou, Assemblymen Geist, Corodemus, Blee, Biondi, Felice, Assemblywoman Cruz-Perez, Assemblyman Conners, Assemblywoman Previte, Assemblymen Jones, Gusciora, Assemblywoman Watson Coleman, Assemblyman Zecker, Senators Inverso, Vitale, Singer, Robertson, Matheussen, Allen, Kosco and Bucco

SYNOPSIS
"FamilyCare Health Coverage Act."

CURRENT VERSION OF TEXT
As reported by the Assembly Appropriations Committee on June 8, 2000, with amendments.



(Sponsorship Updated As Of: 6/30/2000)

1 **AN ACT** establishing the FamilyCare Health Coverage Program,
2 supplementing Title 30 of the Revised Statutes and amending
3 P.L.1968, c.413 and P.L.1997, c.13.
4
5 **BE IT ENACTED** *by the Senate and General Assembly of the State*
6 *of New Jersey:*
7
8 1. (New section) This act shall be known and may be cited as the
9 "FamilyCare Health Coverage Act."
10
11 2. (New section) The Legislature finds and declares that:
12 a. The most serious health problem facing over one million New
13 Jersey residents is their lack of access to affordable health care
14 coverage, and this lack of coverage forces too many families to go
15 without needed preventive and other care until serious illness requires
16 expensive hospital care;
17 b. Research has shown that affordable and accessible health care
18 coverage for parents has a positive impact upon children, since, by
19 having a connection to ongoing health coverage, these parents are
20 more likely to ensure that their children get necessary immunizations
21 and regular checkups from their primary care physicians;
22 c. Providing health care coverage for uninsured adults encourages
23 continued work efforts, reduces dependence on welfare and other
24 State-subsidized programs, and alleviates reliance on hospital charity
25 care funding;
26 d. The FamilyCare Health Coverage Program established pursuant
27 to this act builds on New Jersey's long-standing commitment to assure
28 access to quality health care provided in an efficient and effective
29 manner and at reasonable cost; and
30 e. It is appropriate that the FamilyCare Health Coverage Program
31 utilize resources from the funds that the State receives under the
32 Master Settlement Agreement between the State and tobacco product
33 manufacturers, and other State resources, to establish the foundation
34 for assuring health care coverage for low and moderate-income,
35 uninsured adults.
36
37 3. (New section) As used in this act:
38 "Commissioner" means the Commissioner of Human Services.
39 "Poverty level" means the official poverty level based on family size
40 established and adjusted under Section 673(2) of Subtitle B, the
41 "Community Services Block Grant Act," of Pub.L.97-35 (42 U.S.C.

EXPLANATION - Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined <u>thus</u> is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
[1] Assembly AHL committee amendments adopted June 1, 2000.
[2] Assembly AAP committee amendments adopted June 8, 2000.

s.9902(2)).

"Program" means the FamilyCare Health Coverage Program established pursuant to this act.

"Qualified applicant" means a person who: is a resident of this State; is a citizen of the United States, or [1]**[**an eligible alien as defined in section 3 of P.L.1968, c.413 (C.30:4D-3)**]** has been lawfully admitted [2]for permanent residence[2] into and remains lawfully present in the United States[1]; has no health insurance coverage; and is ineligible for the Medicaid program established pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.) [1]and the Children's Health Care Coverage Program established pursuant to P.L.1997, c.272 (C.30:4I-1 et seq.)[1].

4. (New section) a. The FamilyCare Health Coverage Program is established in the Department of Human Services. The purpose of the program shall be to provide subsidized private health insurance coverage, and other health care benefits as determined by the commissioner, within the limits of funds appropriated or otherwise made available for the program, to any qualified applicant who is: a parent or caretaker relative of a child whose gross family income does not exceed 200% of the poverty level, [1]a child whose gross family income does not exceed 350% of the poverty level,[1] or a single adult or couple without dependent children whose gross family income does not exceed 100% of the poverty level.

b. For the purposes of this program, the commissioner:

(1) shall require that a qualified applicant purchase coverage [1]**[**that is**]** , if[1] available to the qualified applicant[1],[1] through an employer-sponsored health insurance plan which is determined to be cost-effective and is approved by the commissioner, and shall provide assistance to the qualified applicant to purchase that coverage;

(2) shall by regulation establish standards for determining eligibility and other requirements for the program, including, but not limited to, restrictions on voluntary disenrollments from existing health insurance coverage;

(3) may by regulation establish plans of coverage or benefits to be covered under the program, except that the provisions of this act shall not apply to coverage for medications that are used exclusively to treat AIDS or HIV infection;

(4) may contract with one or more appropriate entities to assist in administering the program;

(5) may require premium contributions and copayments from qualified applicants as determined by the commissioner; and

(6) shall take, or cause to be taken, any action necessary to secure for the State the maximum amount of federal financial participation available with respect to the program, subject to the constraints of fiscal responsibility and within the limits of available funding in any fiscal year.

c. The provisions of this section shall not be construed to require

1 an employer to provide health insurance coverage for any employee or
2 any employee's spouse or dependent child.
3 d. A qualified applicant who is a single adult or couple without
4 dependent children shall be ineligible to receive health care services
5 that are covered by the program from any other State-funded program
6 for which the qualified applicant is eligible.
7
8 5. (New section) a. In order to provide persons in need of health
9 care services with an efficient transition into the program, the
10 commissioner, in consultation with the Commissioner of Health and
11 Senior Services, may establish, for such period of time as the
12 commissioner determines necessary, a process to provide for
13 presumptive eligibility for the program in accordance with the
14 provisions of this section:
15 (1) A person without health insurance coverage who presents for
16 treatment at an acute care hospital or a federally qualified health center
17 shall be deemed presumptively eligible for the program if a preliminary
18 determination by hospital or health center staff indicates that the
19 person meets the eligibility requirements of this act and the program
20 eligibility standards established by regulation of the commissioner;
21 (2) During the period in which the person is presumptively eligible
22 for the program, coverage shall be limited to inpatient and outpatient
23 hospital and federally qualified health center services and prescription
24 drug benefits designated by the commissioner;
25 (3) A person shall be limited to a single period of presumptive
26 eligibility for the program. The presumptive eligibility period shall
27 begin with the month in which presumptive eligibility is determined
28 and expire at the end of the following month; except that an extension
29 of the presumptive eligibility period may be authorized until the
30 person's application for the program is approved or denied, subject to
31 the person's cooperation with the application process during the
32 presumptive eligibility period. The person's failure to provide such
33 cooperation within a period of time determined by the commissioner
34 shall result in a denial of the application; and
35 (4) A person without health insurance coverage who presents for
36 treatment at an acute care hospital and is determined to not qualify for
37 presumptive eligibility or for the program shall be evaluated for
38 eligibility for charity care pursuant to P.L.1992, c.160 (C.26:2H-18.51
39 et al.).
40 b. Notwithstanding the provisions of this act, or any rule or
41 regulation adopted pursuant thereto, to the contrary, the commissioner
42 may:
43 (1) within the limits of funds appropriated or otherwise made
44 available for the program, reallocate such funds in order to increase
45 the amount available for covered health care services received by
46 persons who are presumptively eligible for the program, for which
47 purpose the commissioner shall cause a notice of such reallocation of

1 funds to be published in the New Jersey Register; and
2 (2) terminate the presumptive eligibility process, upon the
3 commissioner's finding that all monies appropriated for the program
4 will be expended for covered health care services received by persons
5 enrolled in the program, for which purpose the commissioner shall
6 cause a notice of termination of the presumptive eligibility process to
7 be published in the New Jersey Register.
8
9 6. (New section) The commissioner shall adopt rules and
10 regulations pursuant to the "Administrative Procedure Act," P.L.1968,
11 c.410 (C.52:14B-1 et seq.) to effectuate the purposes of this act;
12 except that, notwithstanding any provision of P.L.1968, c.410 to the
13 contrary, the commissioner may adopt, immediately upon filing with
14 the Office of Administrative Law, such regulations as the
15 commissioner deems necessary to implement the provisions of this act,
16 which shall be effective for a period not to exceed six months and may
17 thereafter be amended, adopted or readopted by the commissioner in
18 accordance with the requirements of P.L.1968, c.410.
19
20 7. Section 3 of P.L.1968, c.413 (C.30:4D-3) is amended to read as
21 follows:
22 3. Definitions. As used in this act, and unless the context
23 otherwise requires:
24 a. "Applicant" means any person who has made application for
25 purposes of becoming a "qualified applicant."
26 b. "Commissioner" means the Commissioner of Human Services.
27 c. "Department" means the Department of Human Services, which
28 is herein designated as the single State agency to administer the
29 provisions of this act.
30 d. "Director" means the Director of the Division of Medical
31 Assistance and Health Services.
32 e. "Division" means the Division of Medical Assistance and Health
33 Services.
34 f. "Medicaid" means the New Jersey Medical Assistance and Health
35 Services Program.
36 g. "Medical assistance" means payments on behalf of recipients to
37 providers for medical care and services authorized under this act.
38 h. "Provider" means any person, public or private institution,
39 agency or business concern approved by the division lawfully
40 providing medical care, services, goods and supplies authorized under
41 this act, holding, where applicable, a current valid license to provide
42 such services or to dispense such goods or supplies.
43 i. "Qualified applicant" means a person who is a resident of this
44 State, and either a citizen of the United States or an eligible alien, and
45 is determined to need medical care and services as provided under this
46 act, and who:

1 (1) Is a dependent child or parent or caretaker relative of a
2 dependent child [and a recipient of benefits under the Work First New
3 Jersey program established pursuant to P.L.1997, c.38 (C.44:10-55 et
4 seq.)] who would be, except for resources, eligible for the aid to
5 families with dependent children program under the State Plan for
6 Title IV-A of the federal Social Security Act as of July 16, 1996;
7 (2) Is a recipient of Supplemental Security Income for the Aged,
8 Blind and Disabled under Title XVI of the Social Security Act;
9 (3) Is an "ineligible spouse" of a recipient of Supplemental Security
10 Income for the Aged, Blind and Disabled under Title XVI of the Social
11 Security Act, as defined by the federal Social Security Administration;
12 (4) Would be eligible to receive Supplemental Security Income
13 under Title XVI of the federal Social Security Act or, [using the
14 resource standards of the Work First New Jersey program] without
15 regard to resources, would be eligible for the aid to families with
16 dependent children program under the State Plan for Title IV-A of the
17 federal Social Security Act as of July 16, 1996, except for failure to
18 meet an eligibility condition or requirement imposed under such State
19 program which is prohibited under Title XIX of the federal Social
20 Security Act such as a durational residency requirement, relative
21 responsibility, consent to imposition of a lien;
22 (5) [Is a child between 18 and 21 years of age who, using the
23 resource standards of the Work First New Jersey program, would be
24 eligible for the aid to families with dependent children program under
25 the State Plan for Title IV-A of the federal Social Security Act as of
26 July 16, 1996, living in the family group except for lack of school
27 attendance or pursuit of formalized vocational or technical training]
28 (Deleted by amendment, P.L. , c.)(pending before the Legislature
29 as this bill);
30 (6) Is an individual under 21 years of age who, [using the resource
31 standards of the Work First New Jersey program] without regard to
32 resources, would be, except for dependent child requirements, eligible
33 for the aid to families with dependent children program under the State
34 Plan for Title IV-A of the federal Social Security Act as of July 16,
35 1996, or groups of such individuals, including but not limited to,
36 children in foster placement under supervision of the Division of
37 Youth and Family Services whose maintenance is being paid in whole
38 or in part from public funds, children placed in a foster home or
39 institution by a private adoption agency in New Jersey or children in
40 intermediate care facilities, including developmental centers for the
41 developmentally disabled, or in psychiatric hospitals;
42 (7) [Using the resource standards of the Work First New Jersey
43 program, would] Would be eligible for the [aid to families with
44 dependent children program under the State Plan for Title IV-A of the
45 federal Social Security Act in effect as of July 16, 1996 or the]

1 Supplemental Security Income program, but is not receiving such
2 assistance and applies for medical assistance only;
3 (8) Is determined to be medically needy and meets all the eligibility
4 requirements described below:
5 (a) The following individuals are eligible for services, if they are
6 determined to be medically needy:
7 (i) Pregnant women;
8 (ii) Dependent children under the age of 21;
9 (iii) Individuals who are 65 years of age and older; and
10 (iv) Individuals who are blind or disabled pursuant to either
11 42 C.F.R.435.530 et seq. or 42 C.F.R.435.540 et seq., respectively.
12 (b) The following income standard shall be used to determine
13 medically needy eligibility:
14 (i) For one person and two person households, the income standard
15 shall be the maximum allowable under federal law, but shall not exceed
16 133 1/3% of the State's payment level to two person households under
17 the aid to families with dependent children program under the State
18 Plan for Title IV-A of the federal Social Security Act in effect as of
19 July 16, 1996; and
20 (ii) For households of three or more persons, the income standard
21 shall be set at 133 1/3% of the State's payment level to similar size
22 households under the aid to families with dependent children program
23 under the State Plan for Title IV-A of the federal Social Security Act
24 in effect as of July 16, 1996.
25 (c) The following resource standard shall be used to determine
26 medically needy eligibility:
27 (i) For one person households, the resource standard shall be 200%
28 of the resource standard for recipients of Supplemental Security
29 Income pursuant to 42 U.S.C.s.1382(1)(B);
30 (ii) For two person households, the resource standard shall be
31 200% of the resource standard for recipients of Supplemental Security
32 Income pursuant to 42 U.S.C.s.1382(2)(B);
33 (iii) For households of three or more persons, the resource
34 standard in subparagraph (c)(ii) above shall be increased by $100.00
35 for each additional person; and
36 (iv) The resource standards established in (i), (ii), and (iii) are
37 subject to federal approval and the resource standard may be lower if
38 required by the federal Department of Health and Human Services.
39 (d) Individuals whose income exceeds those established in
40 subparagraph (b) of paragraph (8) of this subsection may become
41 medically needy by incurring medical expenses as defined in 42
42 C.F.R.435.831(c) which will reduce their income to the applicable
43 medically needy income established in subparagraph (b) of paragraph
44 (8) of this subsection.
45 (e) A six-month period shall be used to determine whether an
46 individual is medically needy.

1 (f) Eligibility determinations for the medically needy program shall
2 be administered as follows:
3 (i) County welfare agencies and other entities designated by the
4 commissioner are responsible for determining and certifying the
5 eligibility of pregnant women and dependent children. The division
6 shall reimburse county welfare agencies for 100% of the reasonable
7 costs of administration which are not reimbursed by the federal
8 government for the first 12 months of this program's operation.
9 Thereafter, 75% of the administrative costs incurred by county welfare
10 agencies which are not reimbursed by the federal government shall be
11 reimbursed by the division;
12 (ii) The division is responsible for certifying the eligibility of
13 individuals who are 65 years of age and older and individuals who are
14 blind or disabled. The division may enter into contracts with county
15 welfare agencies to determine certain aspects of eligibility. In such
16 instances the division shall provide county welfare agencies with all
17 information the division may have available on the individual.
18 The division shall notify all eligible recipients of the Pharmaceutical
19 Assistance to the Aged and Disabled program, P.L.1975, c.194
20 (C.30:4D-20 et seq.) on an annual basis of the medically needy
21 program and the program's general requirements. The division shall
22 take all reasonable administrative actions to ensure that
23 Pharmaceutical Assistance to the Aged and Disabled recipients, who
24 notify the division that they may be eligible for the program, have their
25 applications processed expeditiously, at times and locations convenient
26 to the recipients; and
27 (iii) The division is responsible for certifying incurred medical
28 expenses for all eligible persons who attempt to qualify for the
29 program pursuant to subparagraph (d) of paragraph (8) of this
30 subsection;
31 (9) (a) Is a child who is at least one year of age and under 19 years
32 of age <u>and, if older than six years of age but under 19 years of age, is
33 uninsured</u>; and
34 (b) Is a member of a family whose income does not exceed 133%
35 of the poverty level and who meets the federal Medicaid eligibility
36 requirements set forth in section 9401 of Pub.L.99-509 (42 U.S.C.
37 s.1396a);
38 (10) Is a pregnant woman who is determined by a provider to be
39 presumptively eligible for medical assistance based on criteria
40 established by the commissioner, pursuant to section 9407 of
41 Pub.L.99-509 (42 U.S.C. s.1396a(a));
42 (11) Is an individual 65 years of age and older, or an individual
43 who is blind or disabled pursuant to section 301 of Pub.L.92-603 (42
44 U.S.C. s.1382c), whose income does not exceed 100% of the poverty
45 level, adjusted for family size, and whose resources do not exceed
46 100% of the resource standard used to determine medically needy

1 eligibility pursuant to paragraph (8) of this subsection;
2 (12) Is a qualified disabled and working individual pursuant to
3 section 6408 of Pub.L.101-239 (42 U.S.C. s.1396d) whose income
4 does not exceed 200% of the poverty level and whose resources do
5 not exceed 200% of the resource standard used to determine eligibility
6 under the Supplemental Security Income Program, P.L.1973, c.256
7 (C.44:7-85 et seq.);
8 (13) Is a pregnant woman or is a child who is under one year of
9 age and is a member of a family whose income does not exceed 185%
10 of the poverty level and who meets the federal Medicaid eligibility
11 requirements set forth in section 9401 of Pub.L.99-509 (42 U.S.C.
12 s.1396a), except that a pregnant woman who is determined to be a
13 qualified applicant shall, notwithstanding any change in the income of
14 the family of which she is a member, continue to be deemed a qualified
15 applicant until the end of the 60-day period beginning on the last day
16 of her pregnancy; [or]
17 (14) (Deleted by amendment, P.L.1997, c.272).
18 (15) (a) Is a specified low-income Medicare beneficiary pursuant
19 to 42 U.S.C. s.1396a(a)10(E)iii whose resources beginning January 1,
20 1993 do not exceed 200% of the resource standard used to determine
21 eligibility under the Supplemental Security Income program, P.L.1973,
22 c.256 (C.44:7-85 et seq.) and whose income beginning January 1,
23 1993 does not exceed 110% of the poverty level, and beginning
24 January 1, 1995 does not exceed 120% of the poverty level[1] [;
25 (16) Subject to federal approval under Title XIX of the federal
26 Social Security Act, is a dependent child, parent or specified caretaker
27 relative of a child who is a qualified applicant, who would be eligible,
28 without regard to resources, for the aid to families with dependent
29 children program under the State Plan for Title IV-A of the federal
30 Social Security Act as of July 16, 1996, except for the income
31 eligibility requirements of that program, and whose family earned
32 income does not exceed 133% of the poverty level plus such earned
33 income disregards as shall be determined according to a methodology
34 to be established by regulation of the commissioner; or
35 (17) Is an individual from 18 through 20 years of age who is not
36 a dependent child and would be eligible for medical assistance
37 pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.), without regard to
38 income or resources, who, on the individual's 18th birthday was in
39 foster care under the care and custody of the Division of Youth and
40 Family Services and whose maintenance was being paid in whole or in
41 part from public funds][1].
42 (b) An individual who has, within 36 months, or within 60 months
43 in the case of funds transferred into a trust, of applying to be a
44 qualified applicant for Medicaid services in a nursing facility or a
45 medical institution, or for home or community-based services under
46 section 1915(c) of the federal Social Security Act (42 U.S.C.

1 s.1396n(c)), disposed of resources or income for less than fair market
2 value shall be ineligible for assistance for nursing facility services, an
3 equivalent level of services in a medical institution, or home or
4 community-based services under section 1915(c) of the federal Social
5 Security Act (42 U.S.C. s.1396n(c)). The period of the ineligibility
6 shall be the number of months resulting from dividing the
7 uncompensated value of the transferred resources or income by the
8 average monthly private payment rate for nursing facility services in
9 the State as determined annually by the commissioner. In the case of
10 multiple resource or income transfers, the resulting penalty periods
11 shall be imposed sequentially. Application of this requirement shall be
12 governed by 42 U.S.C. s.1396p(c). In accordance with federal law,
13 this provision is effective for all transfers of resources or income made
14 on or after August 11, 1993. Notwithstanding the provisions of this
15 subsection to the contrary, the State eligibility requirements
16 concerning resource or income transfers shall not be more restrictive
17 than those enacted pursuant to 42 U.S.C. s.1396p(c).
18 (c) An individual seeking nursing facility services or home or
19 community-based services and who has a community spouse shall be
20 required to expend those resources which are not protected for the
21 needs of the community spouse in accordance with section 1924(c) of
22 the federal Social Security Act (42 U.S.C. s.1396r-5(c)) on the costs
23 of long-term care, burial arrangements, and any other expense deemed
24 appropriate and authorized by the commissioner. An individual shall
25 be ineligible for Medicaid services in a nursing facility or for home or
26 community-based services under section 1915(c) of the federal Social
27 Security Act (42 U.S.C. s.1396n(c)) if the individual expends funds in
28 violation of this subparagraph. The period of ineligibility shall be the
29 number of months resulting from dividing the uncompensated value of
30 transferred resources and income by the average monthly private
31 payment rate for nursing facility services in the State as determined by
32 the commissioner. The period of ineligibility shall begin with the
33 month that the individual would otherwise be eligible for Medicaid
34 coverage for nursing facility services or home or community-based
35 services.
36 This subparagraph shall be operative only if all necessary approvals
37 are received from the federal government including, but not limited to,
38 approval of necessary State plan amendments and approval of any
39 waivers.
40 [1]<u>(16) Subject to federal approval under Title XIX of the federal</u>
41 <u>Social Security Act, is a dependent child, parent or specified caretaker</u>
42 <u>relative of a child who is a qualified applicant, who would be eligible,</u>
43 <u>without regard to resources, for the aid to families with dependent</u>
44 <u>children program under the State Plan for Title IV-A of the federal</u>
45 <u>Social Security Act as of July 16, 1996, except for the income</u>
46 <u>eligibility requirements of that program, and whose family earned</u>

1 income does not exceed 133% of the poverty level plus such earned
2 income disregards as shall be determined according to a methodology
3 to be established by regulation of the commissioner; or
4 (17) Is an individual from 18 through 20 years of age who is not
5 a dependent child and would be eligible for medical assistance
6 pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.), without regard to
7 income or resources, who, on the individual's 18th birthday was in
8 foster care under the care and custody of the Division of Youth and
9 Family Services and whose maintenance was being paid in whole or in
10 part from public funds.[1]
11 j. "Recipient" means any qualified applicant receiving benefits
12 under this act.
13 k. "Resident" means a person who is living in the State voluntarily
14 with the intention of making his home here and not for a temporary
15 purpose. Temporary absences from the State, with subsequent returns
16 to the State or intent to return when the purposes of the absences have
17 been accomplished, do not interrupt continuity of residence.
18 l. "State Medicaid Commission" means the Governor, the
19 Commissioner of Human Services, the President of the Senate and the
20 Speaker of the General Assembly, hereby constituted a commission to
21 approve and direct the means and method for the payment of claims
22 pursuant to this act.
23 m. "Third party" means any person, institution, corporation,
24 insurance company, group health plan as defined in section 607(1) of
25 the federal "Employee Retirement and Income Security Act of 1974,"
26 29 U.S.C. s.1167(1), service benefit plan, health maintenance
27 organization, or other prepaid health plan, or public, private or
28 governmental entity who is or may be liable in contract, tort, or
29 otherwise by law or equity to pay all or part of the medical cost of
30 injury, disease or disability of an applicant for or recipient of medical
31 assistance payable under this act.
32 n. "Governmental peer grouping system" means a separate class of
33 skilled nursing and intermediate care facilities administered by the
34 State or county governments, established for the purpose of screening
35 their reported costs and setting reimbursement rates under the
36 Medicaid program that are reasonable and adequate to meet the costs
37 that must be incurred by efficiently and economically operated State
38 or county skilled nursing and intermediate care facilities.
39 o. "Comprehensive maternity or pediatric care provider" means any
40 person or public or private health care facility that is a provider and
41 that is approved by the commissioner to provide comprehensive
42 maternity care or comprehensive pediatric care as defined in
43 subsection b. (18) and (19) of section 6 of P.L.1968, c.413
44 (C.30:4D-6).
45 p. "Poverty level" means the official poverty level based on family
46 size established and adjusted under Section 673(2) of Subtitle B, the

1 "Community Services Block Grant Act," of Pub.L.97-35 (42 U.S.C.
2 s.9902(2)).
3 q. "Eligible alien" means one of the following:
4 (1) an alien present in the United States prior to August 22, 1996,
5 who is:
6 (a) a lawful permanent resident;
7 (b) a refugee pursuant to section 207 of the federal "Immigration
8 and Nationality Act" (8 U.S.C. s.1157);
9 (c) an asylee pursuant to section 208 of the federal "Immigration
10 and Nationality Act" (8 U.S.C. s.1158);
11 (d) an alien who has had deportation withheld pursuant to section
12 243(h) of the federal "Immigration and Nationality Act" (8 U.S.C.
13 s.1253 (h));
14 (e) an alien who has been granted parole for less than one year by
15 the federal Immigration and Naturalization Service pursuant to section
16 212(d)(5) of the federal "Immigration and Nationality Act" (8 U.S.C.
17 s.1182(d)(5));
18 (f) an alien granted conditional entry pursuant to section 203(a)(7)
19 of the federal "Immigration and Nationality Act" (8 U.S.C.
20 s.1153(a)(7)) in effect prior to April 1, 1980; or
21 (g) an alien who is honorably discharged from or on active duty in
22 the United States armed forces and the alien's spouse and unmarried
23 dependent child.
24 (2) An alien who entered the United States on or after August 22,
25 1996, who is:
26 (a) an alien as described in paragraph (1)(b), (c), (d) or (g) of this
27 subsection; or
28 (b) an alien as described in paragraph (1)(a), (e) or (f) of this
29 subsection who entered the United States at least five years ago.
30 (3) A legal alien who is a victim of domestic violence in
31 accordance with criteria specified for eligibility for public benefits as
32 provided in Title V of the federal "Illegal Immigration Reform and
33 Immigrant Responsibility Act of 1996" (8 U.S.C. s.1641).
34 (cf: P.L.1997, c.352, s.1)
35
36 8. Section 7 of P.L.1997, c.13 (C.44:10-40) is amended to read as
37 follows:
38 7. <u>a.</u> Single adults and couples without dependent children shall
39 not be eligible for medical assistance for inpatient or outpatient
40 hospital care or long-term care under the program, except that medical
41 assistance shall be provided for the following, in accordance with
42 regulations adopted by the commissioner:
43 (1) inpatient hospitalization costs for a recipient of general public
44 assistance pursuant to P.L.1947, c.156 (C.44:8-107 et seq.) who is
45 admitted to a special hospital licensed by the Department of Health
46 and Senior Services which is not eligible to receive a charity care

1 subsidy from the Health Care Subsidy Fund established pursuant to
2 P.L.1992, c.160 (C.26:2H-18.51 et al.) and to which payments were
3 made prior to July 1, 1991 on behalf of patients receiving general
4 public assistance;
5 (2) nursing home costs for a person residing in a non-Medicaid
6 certified nursing facility prior to July 1, 1995, whose income is above
7 the Medicaid institutional cap and who does not otherwise qualify for
8 State-funded nursing home care as a medically needy person pursuant
9 to P.L.1968, c.413 (C.30:4D-1 et seq.), to be paid for out of a
10 separate account from the Medicaid program; which assistance shall
11 continue until the person is no longer eligible for long-term care; and
12 (3) nursing home costs for an alien residing in a Medicaid certified
13 nursing facility prior to the effective date of this act who is not
14 Medicaid-eligible under Pub.L.104-193; which assistance shall
15 continue until the person is no longer eligible for long-term care.
16 b. The provisions of this section shall not affect the eligibility of a
17 single adult or a couple without dependent children for the New Jersey
18 FamilyCare Health Coverage Program established pursuant to section
19 4 of P.L. , c. (C.)(pending before the Legislature as this bill).
20 (cf: P.L.1997, c.13, s.7)
21
22 9. This act shall take effect immediately.

Title 30.
Chapter 4J. (New)
Family Care Health Coverage
§§1-6
C.30:4J-1 to 30:4J-6

P.L. 2000, CHAPTER 71, ***approved July 13, 2000***
Assembly, No. 49 ***(Second Reprint)***

1 **AN ACT** establishing the FamilyCare Health Coverage Program,
2 supplementing Title 30 of the Revised Statutes and amending
3 P.L.1968, c.413 and P.L.1997, c.13.
4
5 **BE IT ENACTED** *by the Senate and General Assembly of the State*
6 *of New Jersey:*
7
8 1. (New section) This act shall be known and may be cited as the
9 "FamilyCare Health Coverage Act."
10
11 2. (New section) The Legislature finds and declares that:
12 a. The most serious health problem facing over one million New
13 Jersey residents is their lack of access to affordable health care
14 coverage, and this lack of coverage forces too many families to go
15 without needed preventive and other care until serious illness requires
16 expensive hospital care;
17 b. Research has shown that affordable and accessible health care
18 coverage for parents has a positive impact upon children, since, by
19 having a connection to ongoing health coverage, these parents are
20 more likely to ensure that their children get necessary immunizations
21 and regular checkups from their primary care physicians;
22 c. Providing health care coverage for uninsured adults encourages
23 continued work efforts, reduces dependence on welfare and other
24 State-subsidized programs, and alleviates reliance on hospital charity
25 care funding;
26 d. The FamilyCare Health Coverage Program established pursuant
27 to this act builds on New Jersey's long-standing commitment to assure
28 access to quality health care provided in an efficient and effective
29 manner and at reasonable cost; and
30 e. It is appropriate that the FamilyCare Health Coverage Program
31 utilize resources from the funds that the State receives under the
32 Master Settlement Agreement between the State and tobacco product
33 manufacturers, and other State resources, to establish the foundation
34 for assuring health care coverage for low and moderate-income,

EXPLANATION - Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined thus is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
[1] Assembly AHL committee amendments adopted June 1, 2000.
[2] Assembly AAP committee amendments adopted June 8, 2000.

uninsured adults.

3. (New section) As used in this act:

"Commissioner" means the Commissioner of Human Services.

"Poverty level" means the official poverty level based on family size established and adjusted under Section 673(2) of Subtitle B, the "Community Services Block Grant Act," of Pub.L.97-35 (42 U.S.C. s.9902(2)).

"Program" means the FamilyCare Health Coverage Program established pursuant to this act.

"Qualified applicant" means a person who: is a resident of this State; is a citizen of the United States, or [1] [an eligible alien as defined in section 3 of P.L.1968, c.413 (C.30:4D-3)] has been lawfully admitted [2] for permanent residence[2] into and remains lawfully present in the United States[1]; has no health insurance coverage; and is ineligible for the Medicaid program established pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.) [1] and the Children's Health Care Coverage Program established pursuant to P.L.1997, c.272 (C.30:4I-1 et seq.)[1].

4. (New section) a. The FamilyCare Health Coverage Program is established in the Department of Human Services. The purpose of the program shall be to provide subsidized private health insurance coverage, and other health care benefits as determined by the commissioner, within the limits of funds appropriated or otherwise made available for the program, to any qualified applicant who is: a parent or caretaker relative of a child whose gross family income does not exceed 200% of the poverty level, [1] a child whose gross family income does not exceed 350% of the poverty level,[1] or a single adult or couple without dependent children whose gross family income does not exceed 100% of the poverty level.

b. For the purposes of this program, the commissioner:

(1) shall require that a qualified applicant purchase coverage [1] [that is] , if[1] available to the qualified applicant[1] ,[1] through an employer-sponsored health insurance plan which is determined to be cost-effective and is approved by the commissioner, and shall provide assistance to the qualified applicant to purchase that coverage;

(2) shall by regulation establish standards for determining eligibility and other requirements for the program, including, but not limited to, restrictions on voluntary disenrollments from existing health insurance coverage;

(3) may by regulation establish plans of coverage or benefits to be covered under the program, except that the provisions of this act shall not apply to coverage for medications that are used exclusively to treat AIDS or HIV infection;

(4) may contract with one or more appropriate entities to assist in administering the program;

(5) may require premium contributions and copayments from

qualified applicants as determined by the commissioner; and

(6) shall take, or cause to be taken, any action necessary to secure for the State the maximum amount of federal financial participation available with respect to the program, subject to the constraints of fiscal responsibility and within the limits of available funding in any fiscal year.

c. The provisions of this section shall not be construed to require an employer to provide health insurance coverage for any employee or any employee's spouse or dependent child.

d. A qualified applicant who is a single adult or couple without dependent children shall be ineligible to receive health care services that are covered by the program from any other State-funded program for which the qualified applicant is eligible.

5. (New section) a. In order to provide persons in need of health care services with an efficient transition into the program, the commissioner, in consultation with the Commissioner of Health and Senior Services, may establish, for such period of time as the commissioner determines necessary, a process to provide for presumptive eligibility for the program in accordance with the provisions of this section:

(1) A person without health insurance coverage who presents for treatment at an acute care hospital or a federally qualified health center shall be deemed presumptively eligible for the program if a preliminary determination by hospital or health center staff indicates that the person meets the eligibility requirements of this act and the program eligibility standards established by regulation of the commissioner;

(2) During the period in which the person is presumptively eligible for the program, coverage shall be limited to inpatient and outpatient hospital and federally qualified health center services and prescription drug benefits designated by the commissioner;

(3) A person shall be limited to a single period of presumptive eligibility for the program. The presumptive eligibility period shall begin with the month in which presumptive eligibility is determined and expire at the end of the following month; except that an extension of the presumptive eligibility period may be authorized until the person's application for the program is approved or denied, subject to the person's cooperation with the application process during the presumptive eligibility period. The person's failure to provide such cooperation within a period of time determined by the commissioner shall result in a denial of the application; and

(4) A person without health insurance coverage who presents for treatment at an acute care hospital and is determined to not qualify for presumptive eligibility or for the program shall be evaluated for eligibility for charity care pursuant to P.L.1992, c.160 (C.26:2H-18.51 et al.).

b. Notwithstanding the provisions of this act, or any rule or

1 regulation adopted pursuant thereto, to the contrary, the commissioner
2 may:
3 (1) within the limits of funds appropriated or otherwise made
4 available for the program, reallocate such funds in order to increase
5 the amount available for covered health care services received by
6 persons who are presumptively eligible for the program, for which
7 purpose the commissioner shall cause a notice of such reallocation of
8 funds to be published in the New Jersey Register; and
9 (2) terminate the presumptive eligibility process, upon the
10 commissioner's finding that all monies appropriated for the program
11 will be expended for covered health care services received by persons
12 enrolled in the program, for which purpose the commissioner shall
13 cause a notice of termination of the presumptive eligibility process to
14 be published in the New Jersey Register.
15
16 6. (New section) The commissioner shall adopt rules and
17 regulations pursuant to the "Administrative Procedure Act," P.L.1968,
18 c.410 (C.52:14B-1 et seq.) to effectuate the purposes of this act;
19 except that, notwithstanding any provision of P.L.1968, c.410 to the
20 contrary, the commissioner may adopt, immediately upon filing with
21 the Office of Administrative Law, such regulations as the
22 commissioner deems necessary to implement the provisions of this act,
23 which shall be effective for a period not to exceed six months and may
24 thereafter be amended, adopted or readopted by the commissioner in
25 accordance with the requirements of P.L.1968, c.410.
26
27 7. Section 3 of P.L.1968, c.413 (C.30:4D-3) is amended to read as
28 follows:
29 3. Definitions. As used in this act, and unless the context
30 otherwise requires:
31 a. "Applicant" means any person who has made application for
32 purposes of becoming a "qualified applicant."
33 b. "Commissioner" means the Commissioner of Human Services.
34 c. "Department" means the Department of Human Services, which
35 is herein designated as the single State agency to administer the
36 provisions of this act.
37 d. "Director" means the Director of the Division of Medical
38 Assistance and Health Services.
39 e. "Division" means the Division of Medical Assistance and Health
40 Services.
41 f. "Medicaid" means the New Jersey Medical Assistance and Health
42 Services Program.
43 g. "Medical assistance" means payments on behalf of recipients to
44 providers for medical care and services authorized under this act.
45 h. "Provider" means any person, public or private institution,
46 agency or business concern approved by the division lawfully

providing medical care, services, goods and supplies authorized under this act, holding, where applicable, a current valid license to provide such services or to dispense such goods or supplies.

i. "Qualified applicant" means a person who is a resident of this State, and either a citizen of the United States or an eligible alien, and is determined to need medical care and services as provided under this act, and who:

(1) Is a dependent child or parent or caretaker relative of a dependent child [and a recipient of benefits under the Work First New Jersey program established pursuant to P.L.1997, c.38 (C.44:10-55 et seq.)] who would be, except for resources, eligible for the aid to families with dependent children program under the State Plan for Title IV-A of the federal Social Security Act as of July 16, 1996;

(2) Is a recipient of Supplemental Security Income for the Aged, Blind and Disabled under Title XVI of the Social Security Act;

(3) Is an "ineligible spouse" of a recipient of Supplemental Security Income for the Aged, Blind and Disabled under Title XVI of the Social Security Act, as defined by the federal Social Security Administration;

(4) Would be eligible to receive Supplemental Security Income under Title XVI of the federal Social Security Act or, [using the resource standards of the Work First New Jersey program] without regard to resources, would be eligible for the aid to families with dependent children program under the State Plan for Title IV-A of the federal Social Security Act as of July 16, 1996, except for failure to meet an eligibility condition or requirement imposed under such State program which is prohibited under Title XIX of the federal Social Security Act such as a durational residency requirement, relative responsibility, consent to imposition of a lien;

(5) [Is a child between 18 and 21 years of age who, using the resource standards of the Work First New Jersey program, would be eligible for the aid to families with dependent children program under the State Plan for Title IV-A of the federal Social Security Act as of July 16, 1996, living in the family group except for lack of school attendance or pursuit of formalized vocational or technical training] (Deleted by amendment, P.L. , c.)(pending before the Legislature as this bill);

(6) Is an individual under 21 years of age who, [using the resource standards of the Work First New Jersey program] without regard to resources, would be, except for dependent child requirements, eligible for the aid to families with dependent children program under the State Plan for Title IV-A of the federal Social Security Act as of July 16, 1996, or groups of such individuals, including but not limited to, children in foster placement under supervision of the Division of Youth and Family Services whose maintenance is being paid in whole or in part from public funds, children placed in a foster home or institution by a private adoption agency in New Jersey or children in

1 intermediate care facilities, including developmental centers for the
2 developmentally disabled, or in psychiatric hospitals;
3 (7) [Using the resource standards of the Work First New Jersey
4 program, would] Would be eligible for the [aid to families with
5 dependent children program under the State Plan for Title IV-A of the
6 federal Social Security Act in effect as of July 16, 1996 or the]
7 Supplemental Security Income program, but is not receiving such
8 assistance and applies for medical assistance only;
9 (8) Is determined to be medically needy and meets all the eligibility
10 requirements described below:
11 (a) The following individuals are eligible for services, if they are
12 determined to be medically needy:
13 (i) Pregnant women;
14 (ii) Dependent children under the age of 21;
15 (iii) Individuals who are 65 years of age and older; and
16 (iv) Individuals who are blind or disabled pursuant to either
17 42 C.F.R.435.530 et seq. or 42 C.F.R.435.540 et seq., respectively.
18 (b) The following income standard shall be used to determine
19 medically needy eligibility:
20 (i) For one person and two person households, the income standard
21 shall be the maximum allowable under federal law, but shall not exceed
22 133 1/3% of the State's payment level to two person households under
23 the aid to families with dependent children program under the State
24 Plan for Title IV-A of the federal Social Security Act in effect as of
25 July 16, 1996; and
26 (ii) For households of three or more persons, the income standard
27 shall be set at 133 1/3% of the State's payment level to similar size
28 households under the aid to families with dependent children program
29 under the State Plan for Title IV-A of the federal Social Security Act
30 in effect as of July 16, 1996.
31 (c) The following resource standard shall be used to determine
32 medically needy eligibility:
33 (i) For one person households, the resource standard shall be 200%
34 of the resource standard for recipients of Supplemental Security
35 Income pursuant to 42 U.S.C.s.1382(1)(B);
36 (ii) For two person households, the resource standard shall be
37 200% of the resource standard for recipients of Supplemental Security
38 Income pursuant to 42 U.S.C.s.1382(2)(B);
39 (iii) For households of three or more persons, the resource
40 standard in subparagraph (c)(ii) above shall be increased by $100.00
41 for each additional person; and
42 (iv) The resource standards established in (i), (ii), and (iii) are
43 subject to federal approval and the resource standard may be lower if
44 required by the federal Department of Health and Human Services.
45 (d) Individuals whose income exceeds those established in
46 subparagraph (b) of paragraph (8) of this subsection may become

medically needy by incurring medical expenses as defined in 42 C.F.R.435.831(c) which will reduce their income to the applicable medically needy income established in subparagraph (b) of paragraph (8) of this subsection.

(e) A six-month period shall be used to determine whether an individual is medically needy.

(f) Eligibility determinations for the medically needy program shall be administered as follows:

(i) County welfare agencies and other entities designated by the commissioner are responsible for determining and certifying the eligibility of pregnant women and dependent children. The division shall reimburse county welfare agencies for 100% of the reasonable costs of administration which are not reimbursed by the federal government for the first 12 months of this program's operation. Thereafter, 75% of the administrative costs incurred by county welfare agencies which are not reimbursed by the federal government shall be reimbursed by the division;

(ii) The division is responsible for certifying the eligibility of individuals who are 65 years of age and older and individuals who are blind or disabled. The division may enter into contracts with county welfare agencies to determine certain aspects of eligibility. In such instances the division shall provide county welfare agencies with all information the division may have available on the individual.

The division shall notify all eligible recipients of the Pharmaceutical Assistance to the Aged and Disabled program, P.L.1975, c.194 (C.30:4D-20 et seq.) on an annual basis of the medically needy program and the program's general requirements. The division shall take all reasonable administrative actions to ensure that Pharmaceutical Assistance to the Aged and Disabled recipients, who notify the division that they may be eligible for the program, have their applications processed expeditiously, at times and locations convenient to the recipients; and

(iii) The division is responsible for certifying incurred medical expenses for all eligible persons who attempt to qualify for the program pursuant to subparagraph (d) of paragraph (8) of this subsection;

(9) (a) Is a child who is at least one year of age and under 19 years of age and, if older than six years of age but under 19 years of age, is uninsured; and

(b) Is a member of a family whose income does not exceed 133% of the poverty level and who meets the federal Medicaid eligibility requirements set forth in section 9401 of Pub.L.99-509 (42 U.S.C. s.1396a);

(10) Is a pregnant woman who is determined by a provider to be presumptively eligible for medical assistance based on criteria established by the commissioner, pursuant to section 9407 of

Pub.L.99-509 (42 U.S.C. s.1396a(a));

(11) Is an individual 65 years of age and older, or an individual who is blind or disabled pursuant to section 301 of Pub.L.92-603 (42 U.S.C. s.1382c), whose income does not exceed 100% of the poverty level, adjusted for family size, and whose resources do not exceed 100% of the resource standard used to determine medically needy eligibility pursuant to paragraph (8) of this subsection;

(12) Is a qualified disabled and working individual pursuant to section 6408 of Pub.L.101-239 (42 U.S.C. s.1396d) whose income does not exceed 200% of the poverty level and whose resources do not exceed 200% of the resource standard used to determine eligibility under the Supplemental Security Income Program, P.L.1973, c.256 (C.44:7-85 et seq.);

(13) Is a pregnant woman or is a child who is under one year of age and is a member of a family whose income does not exceed 185% of the poverty level and who meets the federal Medicaid eligibility requirements set forth in section 9401 of Pub.L.99-509 (42 U.S.C. s.1396a), except that a pregnant woman who is determined to be a qualified applicant shall, notwithstanding any change in the income of the family of which she is a member, continue to be deemed a qualified applicant until the end of the 60-day period beginning on the last day of her pregnancy; **[**or**]**

(14) (Deleted by amendment, P.L.1997, c.272).

(15) (a) Is a specified low-income Medicare beneficiary pursuant to 42 U.S.C. s.1396a(a)10(E)iii whose resources beginning January 1, 1993 do not exceed 200% of the resource standard used to determine eligibility under the Supplemental Security Income program, P.L.1973, c.256 (C.44:7-85 et seq.) and whose income beginning January 1, 1993 does not exceed 110% of the poverty level, and beginning January 1, 1995 does not exceed 120% of the poverty level[1] **[**;

(16) Subject to federal approval under Title XIX of the federal Social Security Act, is a dependent child, parent or specified caretaker relative of a child who is a qualified applicant, who would be eligible, without regard to resources, for the aid to families with dependent children program under the State Plan for Title IV-A of the federal Social Security Act as of July 16, 1996, except for the income eligibility requirements of that program, and whose family earned income does not exceed 133% of the poverty level plus such earned income disregards as shall be determined according to a methodology to be established by regulation of the commissioner; or

(17) Is an individual from 18 through 20 years of age who is not a dependent child and would be eligible for medical assistance pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.), without regard to income or resources, who, on the individual's 18th birthday was in foster care under the care and custody of the Division of Youth and Family Services and whose maintenance was being paid in whole or in

1 part from public funds]¹.
2 (b) An individual who has, within 36 months, or within 60 months
3 in the case of funds transferred into a trust, of applying to be a
4 qualified applicant for Medicaid services in a nursing facility or a
5 medical institution, or for home or community-based services under
6 section 1915(c) of the federal Social Security Act (42 U.S.C.
7 s.1396n(c)), disposed of resources or income for less than fair market
8 value shall be ineligible for assistance for nursing facility services, an
9 equivalent level of services in a medical institution, or home or
10 community-based services under section 1915(c) of the federal Social
11 Security Act (42 U.S.C. s.1396n(c)). The period of the ineligibility
12 shall be the number of months resulting from dividing the
13 uncompensated value of the transferred resources or income by the
14 average monthly private payment rate for nursing facility services in
15 the State as determined annually by the commissioner. In the case of
16 multiple resource or income transfers, the resulting penalty periods
17 shall be imposed sequentially. Application of this requirement shall be
18 governed by 42 U.S.C. s.1396p(c). In accordance with federal law,
19 this provision is effective for all transfers of resources or income made
20 on or after August 11, 1993. Notwithstanding the provisions of this
21 subsection to the contrary, the State eligibility requirements
22 concerning resource or income transfers shall not be more restrictive
23 than those enacted pursuant to 42 U.S.C. s.1396p(c).
24 (c) An individual seeking nursing facility services or home or
25 community-based services and who has a community spouse shall be
26 required to expend those resources which are not protected for the
27 needs of the community spouse in accordance with section 1924(c) of
28 the federal Social Security Act (42 U.S.C. s.1396r-5(c)) on the costs
29 of long-term care, burial arrangements, and any other expense deemed
30 appropriate and authorized by the commissioner. An individual shall
31 be ineligible for Medicaid services in a nursing facility or for home or
32 community-based services under section 1915(c) of the federal Social
33 Security Act (42 U.S.C. s.1396n(c)) if the individual expends funds in
34 violation of this subparagraph. The period of ineligibility shall be the
35 number of months resulting from dividing the uncompensated value of
36 transferred resources and income by the average monthly private
37 payment rate for nursing facility services in the State as determined by
38 the commissioner. The period of ineligibility shall begin with the
39 month that the individual would otherwise be eligible for Medicaid
40 coverage for nursing facility services or home or community-based
41 services.
42 This subparagraph shall be operative only if all necessary approvals
43 are received from the federal government including, but not limited to,
44 approval of necessary State plan amendments and approval of any
45 waivers.
46 ¹(16) Subject to federal approval under Title XIX of the federal

1 Social Security Act, is a dependent child, parent or specified caretaker
2 relative of a child who is a qualified applicant, who would be eligible,
3 without regard to resources, for the aid to families with dependent
4 children program under the State Plan for Title IV-A of the federal
5 Social Security Act as of July 16, 1996, except for the income
6 eligibility requirements of that program, and whose family earned
7 income does not exceed 133% of the poverty level plus such earned
8 income disregards as shall be determined according to a methodology
9 to be established by regulation of the commissioner; or
10 (17) Is an individual from 18 through 20 years of age who is not
11 a dependent child and would be eligible for medical assistance
12 pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.), without regard to
13 income or resources, who, on the individual's 18th birthday was in
14 foster care under the care and custody of the Division of Youth and
15 Family Services and whose maintenance was being paid in whole or in
16 part from public funds.[1]
17 j. "Recipient" means any qualified applicant receiving benefits
18 under this act.
19 k. "Resident" means a person who is living in the State voluntarily
20 with the intention of making his home here and not for a temporary
21 purpose. Temporary absences from the State, with subsequent returns
22 to the State or intent to return when the purposes of the absences have
23 been accomplished, do not interrupt continuity of residence.
24 l. "State Medicaid Commission" means the Governor, the
25 Commissioner of Human Services, the President of the Senate and the
26 Speaker of the General Assembly, hereby constituted a commission to
27 approve and direct the means and method for the payment of claims
28 pursuant to this act.
29 m. "Third party" means any person, institution, corporation,
30 insurance company, group health plan as defined in section 607(1) of
31 the federal "Employee Retirement and Income Security Act of 1974,"
32 29 U.S.C. s.1167(1), service benefit plan, health maintenance
33 organization, or other prepaid health plan, or public, private or
34 governmental entity who is or may be liable in contract, tort, or
35 otherwise by law or equity to pay all or part of the medical cost of
36 injury, disease or disability of an applicant for or recipient of medical
37 assistance payable under this act.
38 n. "Governmental peer grouping system" means a separate class of
39 skilled nursing and intermediate care facilities administered by the
40 State or county governments, established for the purpose of screening
41 their reported costs and setting reimbursement rates under the
42 Medicaid program that are reasonable and adequate to meet the costs
43 that must be incurred by efficiently and economically operated State
44 or county skilled nursing and intermediate care facilities.
45 o. "Comprehensive maternity or pediatric care provider" means any
46 person or public or private health care facility that is a provider and

1 that is approved by the commissioner to provide comprehensive
2 maternity care or comprehensive pediatric care as defined in
3 subsection b. (18) and (19) of section 6 of P.L.1968, c.413
4 (C.30:4D-6).
5 p. "Poverty level" means the official poverty level based on family
6 size established and adjusted under Section 673(2) of Subtitle B, the
7 "Community Services Block Grant Act," of Pub.L.97-35 (42 U.S.C.
8 s.9902(2)).
9 q. "Eligible alien" means one of the following:
10 (1) an alien present in the United States prior to August 22, 1996,
11 who is:
12 (a) a lawful permanent resident;
13 (b) a refugee pursuant to section 207 of the federal "Immigration
14 and Nationality Act" (8 U.S.C. s.1157);
15 (c) an asylee pursuant to section 208 of the federal "Immigration
16 and Nationality Act" (8 U.S.C. s.1158);
17 (d) an alien who has had deportation withheld pursuant to section
18 243(h) of the federal "Immigration and Nationality Act" (8 U.S.C.
19 s.1253 (h));
20 (e) an alien who has been granted parole for less than one year by
21 the federal Immigration and Naturalization Service pursuant to section
22 212(d)(5) of the federal "Immigration and Nationality Act" (8 U.S.C.
23 s.1182(d)(5));
24 (f) an alien granted conditional entry pursuant to section 203(a)(7)
25 of the federal "Immigration and Nationality Act" (8 U.S.C.
26 s.1153(a)(7)) in effect prior to April 1, 1980; or
27 (g) an alien who is honorably discharged from or on active duty in
28 the United States armed forces and the alien's spouse and unmarried
29 dependent child.
30 (2) An alien who entered the United States on or after August 22,
31 1996, who is:
32 (a) an alien as described in paragraph (1)(b), (c), (d) or (g) of this
33 subsection; or
34 (b) an alien as described in paragraph (1)(a), (e) or (f) of this
35 subsection who entered the United States at least five years ago.
36 (3) A legal alien who is a victim of domestic violence in
37 accordance with criteria specified for eligibility for public benefits as
38 provided in Title V of the federal "Illegal Immigration Reform and
39 Immigrant Responsibility Act of 1996" (8 U.S.C. s.1641).
40 (cf: P.L.1997, c.352, s.1)
41
42 8. Section 7 of P.L.1997, c.13 (C.44:10-40) is amended to read as
43 follows:
44 7. <u>a.</u> Single adults and couples without dependent children shall
45 not be eligible for medical assistance for inpatient or outpatient
46 hospital care or long-term care under the program, except that medical

1 assistance shall be provided for the following, in accordance with
2 regulations adopted by the commissioner:
3 (1) inpatient hospitalization costs for a recipient of general public
4 assistance pursuant to P.L.1947, c.156 (C.44:8-107 et seq.) who is
5 admitted to a special hospital licensed by the Department of Health
6 and Senior Services which is not eligible to receive a charity care
7 subsidy from the Health Care Subsidy Fund established pursuant to
8 P.L.1992, c.160 (C.26:2H-18.51 et al.) and to which payments were
9 made prior to July 1, 1991 on behalf of patients receiving general
10 public assistance;
11 (2) nursing home costs for a person residing in a non-Medicaid
12 certified nursing facility prior to July 1, 1995, whose income is above
13 the Medicaid institutional cap and who does not otherwise qualify for
14 State-funded nursing home care as a medically needy person pursuant
15 to P.L.1968, c.413 (C.30:4D-1 et seq.), to be paid for out of a
16 separate account from the Medicaid program; which assistance shall
17 continue until the person is no longer eligible for long-term care; and
18 (3) nursing home costs for an alien residing in a Medicaid certified
19 nursing facility prior to the effective date of this act who is not
20 Medicaid-eligible under Pub.L.104-193; which assistance shall
21 continue until the person is no longer eligible for long-term care.
22 b. The provisions of this section shall not affect the eligibility of a
23 single adult or a couple without dependent children for the New Jersey
24 FamilyCare Health Coverage Program established pursuant to section
25 4 of P.L. , c. (C.)(pending before the Legislature as this bill).
26 (cf: P.L.1997, c.13, s.7)
27
28 9. This act shall take effect immediately.
29
30
31 ---
32
33 "FamilyCare Health Coverage Act."

CHAPTER 71

AN ACT establishing the FamilyCare Health Coverage Program, supplementing Title 30 of the Revised Statutes and amending P.L.1968, c.413 and P.L.1997, c.13.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

C.30:4J-1 Short title.

1. This act shall be known and may be cited as the "FamilyCare Health Coverage Act."

C.30:4J-2 Findings, declarations regarding FamilyCare Health Coverage Program.

2. The Legislature finds and declares that:

a. The most serious health problem facing over one million New Jersey residents is their lack of access to affordable health care coverage, and this lack of coverage forces too many families to go without needed preventive and other care until serious illness requires expensive hospital care;

b. Research has shown that affordable and accessible health care coverage for parents has a positive impact upon children, since, by having a connection to ongoing health coverage, these parents are more likely to ensure that their children get necessary immunizations and regular checkups from their primary care physicians;

c. Providing health care coverage for uninsured adults encourages continued work efforts, reduces dependence on welfare and other State-subsidized programs, and alleviates reliance on hospital charity care funding;

d. The FamilyCare Health Coverage Program established pursuant to this act builds on New Jersey's long-standing commitment to assure access to quality health care provided in an efficient and effective manner and at reasonable cost; and

e. It is appropriate that the FamilyCare Health Coverage Program utilize resources from the funds that the State receives under the Master Settlement Agreement between the State and tobacco product manufacturers, and other State resources, to establish the foundation for assuring health care coverage for low and moderate-income, uninsured adults.

C.30:4J-3 Definitions regarding the FamilyCare Health Coverage Program.

3. As used in this act:

"Commissioner" means the Commissioner of Human Services.

"Poverty level" means the official poverty level based on family size established and adjusted under Section 673(2) of Subtitle B, the "Community Services Block Grant Act," of Pub.L.97-35 (42 U.S.C. s.9902(2)).

"Program" means the FamilyCare Health Coverage Program established pursuant to this act.

"Qualified applicant" means a person who: is a resident of this State; is a citizen of the United States, or has been lawfully admitted for permanent residence into and remains lawfully present in the United States; has no health insurance coverage; and is ineligible for the Medicaid program established pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.) and the Children's Health Care Coverage Program established pursuant to P.L.1997, c.272 (C.30:4I-1 et seq.).

C.30:4J-4 The FamilyCare Health Coverage Program.

4. a. The FamilyCare Health Coverage Program is established in the Department of Human Services. The purpose of the program shall be to provide subsidized private health insurance coverage, and other health care benefits as determined by the commissioner, within the limits of funds appropriated or otherwise made available for the program, to any qualified applicant who is: a parent or caretaker relative of a child whose gross family income does not exceed 200% of the poverty level, a child whose gross family income does not exceed 350% of the poverty level,or a single adult or couple without dependent children whose gross family income does not exceed 100% of the poverty level.

b. For the purposes of this program, the commissioner:

(1) shall require that a qualified applicant purchase coverage , if available to the qualified applicant,through an employer-sponsored health insurance plan which is determined to be cost-effective and is approved by the commissioner, and shall provide assistance to the qualified applicant to purchase that coverage;

(2) shall by regulation establish standards for determining eligibility and other requirements

for the program, including, but not limited to, restrictions on voluntary disenrollments from existing health insurance coverage;

(3) may by regulation establish plans of coverage or benefits to be covered under the program, except that the provisions of this act shall not apply to coverage for medications that are used exclusively to treat AIDS or HIV infection;

(4) may contract with one or more appropriate entities to assist in administering the program;

(5) may require premium contributions and copayments from qualified applicants as determined by the commissioner; and

(6) shall take, or cause to be taken, any action necessary to secure for the State the maximum amount of federal financial participation available with respect to the program, subject to the constraints of fiscal responsibility and within the limits of available funding in any fiscal year.

c. The provisions of this section shall not be construed to require an employer to provide health insurance coverage for any employee or any employee's spouse or dependent child.

d. A qualified applicant who is a single adult or couple without dependent children shall be ineligible to receive health care services that are covered by the program from any other State-funded program for which the qualified applicant is eligible.

C.30:4J-5 Process to provide presumptive eligibility.

5. a. In order to provide persons in need of health care services with an efficient transition into the program, the commissioner, in consultation with the Commissioner of Health and Senior Services, may establish, for such period of time as the commissioner determines necessary, a process to provide for presumptive eligibility for the program in accordance with the provisions of this section:

(1) A person without health insurance coverage who presents for treatment at an acute care hospital or a federally qualified health center shall be deemed presumptively eligible for the program if a preliminary determination by hospital or health center staff indicates that the person meets the eligibility requirements of this act and the program eligibility standards established by regulation of the commissioner;

(2) During the period in which the person is presumptively eligible for the program, coverage shall be limited to inpatient and outpatient hospital and federally qualified health center services and prescription drug benefits designated by the commissioner;

(3) A person shall be limited to a single period of presumptive eligibility for the program. The presumptive eligibility period shall begin with the month in which presumptive eligibility is determined and expire at the end of the following month; except that an extension of the presumptive eligibility period may be authorized until the person's application for the program is approved or denied, subject to the person's cooperation with the application process during the presumptive eligibility period. The person's failure to provide such cooperation within a period of time determined by the commissioner shall result in a denial of the application; and

(4) A person without health insurance coverage who presents for treatment at an acute care hospital and is determined to not qualify for presumptive eligibility or for the program shall be evaluated for eligibility for charity care pursuant to P.L.1992, c.160 (C.26:2H-18.51 et al.).

b. Notwithstanding the provisions of this act, or any rule or regulation adopted pursuant thereto, to the contrary, the commissioner may:

(1) within the limits of funds appropriated or otherwise made available for the program, reallocate such funds in order to increase the amount available for covered health care services received by persons who are presumptively eligible for the program, for which purpose the commissioner shall cause a notice of such reallocation of funds to be published in the New Jersey Register; and

(2) terminate the presumptive eligibility process, upon the commissioner's finding that all monies appropriated for the program will be expended for covered health care services received by persons enrolled in the program, for which purpose the commissioner shall cause a notice of termination of the presumptive eligibility process to be published in the New Jersey Register.

C.30:4J-6 Rules, regulations.

6. The commissioner shall adopt rules and regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) to effectuate the purposes of this act;

except that, notwithstanding any provision of P.L.1968, c.410 to the contrary, the commissioner may adopt, immediately upon filing with the Office of Administrative Law, such regulations as the commissioner deems necessary to implement the provisions of this act, which shall be effective for a period not to exceed six months and may thereafter be amended, adopted or readopted by the commissioner in accordance with the requirements of P.L.1968, c.410.

7. Section 3 of P.L.1968, c.413 (C.30:4D-3) is amended to read as follows:

C.30:4D-3 Definitions.

3. Definitions. As used in this act, and unless the context otherwise requires:

a. "Applicant" means any person who has made application for purposes of becoming a "qualified applicant."

b. "Commissioner" means the Commissioner of Human Services.

c. "Department" means the Department of Human Services, which is herein designated as the single State agency to administer the provisions of this act.

d. "Director" means the Director of the Division of Medical Assistance and Health Services.

e. "Division" means the Division of Medical Assistance and Health Services.

f. "Medicaid" means the New Jersey Medical Assistance and Health Services Program.

g. "Medical assistance" means payments on behalf of recipients to providers for medical care and services authorized under this act.

h. "Provider" means any person, public or private institution, agency or business concern approved by the division lawfully providing medical care, services, goods and supplies authorized under this act, holding, where applicable, a current valid license to provide such services or to dispense such goods or supplies.

i. "Qualified applicant" means a person who is a resident of this State, and either a citizen of the United States or an eligible alien, and is determined to need medical care and services as provided under this act, and who:

(1) Is a dependent child or parent or caretaker relative of a dependent child who would be, except for resources, eligible for the aid to families with dependent children program under the State Plan for Title IV-A of the federal Social Security Act as of July 16, 1996;

(2) Is a recipient of Supplemental Security Income for the Aged, Blind and Disabled under Title XVI of the Social Security Act;

(3) Is an "ineligible spouse" of a recipient of Supplemental Security Income for the Aged, Blind and Disabled under Title XVI of the Social Security Act, as defined by the federal Social Security Administration;

(4) Would be eligible to receive Supplemental Security Income under Title XVI of the federal Social Security Act or, without regard to resources, would be eligible for the aid to families with dependent children program under the State Plan for Title IV-A of the federal Social Security Act as of July 16, 1996, except for failure to meet an eligibility condition or requirement imposed under such State program which is prohibited under Title XIX of the federal Social Security Act such as a durational residency requirement, relative responsibility, consent to imposition of a lien;

(5) (Deleted by amendment, P.L.2000, c.71);

(6) Is an individual under 21 years of age who, without regard to resources, would be, except for dependent child requirements, eligible for the aid to families with dependent children program under the State Plan for Title IV-A of the federal Social Security Act as of July 16, 1996, or groups of such individuals, including but not limited to, children in foster placement under supervision of the Division of Youth and Family Services whose maintenance is being paid in whole or in part from public funds, children placed in a foster home or institution by a private adoption agency in New Jersey or children in intermediate care facilities, including developmental centers for the developmentally disabled, or in psychiatric hospitals;

(7) Would be eligible for the Supplemental Security Income program, but is not receiving such assistance and applies for medical assistance only;

(8) Is determined to be medically needy and meets all the eligibility requirements described below:

(a) The following individuals are eligible for services, if they are determined to be medically

needy:

(i) Pregnant women;

(ii) Dependent children under the age of 21;

(iii) Individuals who are 65 years of age and older; and

(iv) Individuals who are blind or disabled pursuant to either 42 C.F.R.435.530 et seq. or 42 C.F.R.435.540 et seq., respectively.

(b) The following income standard shall be used to determine medically needy eligibility:

(i) For one person and two person households, the income standard shall be the maximum allowable under federal law, but shall not exceed 133 1/3% of the State's payment level to two person households under the aid to families with dependent children program under the State Plan for Title IV-A of the federal Social Security Act in effect as of July 16, 1996; and

(ii) For households of three or more persons, the income standard shall be set at 133 1/3% of the State's payment level to similar size households under the aid to families with dependent children program under the State Plan for Title IV-A of the federal Social Security Act in effect as of July 16, 1996.

(c) The following resource standard shall be used to determine medically needy eligibility:

(i) For one person households, the resource standard shall be 200% of the resource standard for recipients of Supplemental Security Income pursuant to 42 U.S.C.s.1382(1)(B);

(ii) For two person households, the resource standard shall be 200% of the resource standard for recipients of Supplemental Security Income pursuant to 42 U.S.C.s.1382(2)(B);

(iii) For households of three or more persons, the resource standard in subparagraph (c)(ii) above shall be increased by $100.00 for each additional person; and

(iv) The resource standards established in (i), (ii), and (iii) are subject to federal approval and the resource standard may be lower if required by the federal Department of Health and Human Services.

(d) Individuals whose income exceeds those established in subparagraph (b) of paragraph (8) of this subsection may become medically needy by incurring medical expenses as defined in 42 C.F.R.435.831(c) which will reduce their income to the applicable medically needy income established in subparagraph (b) of paragraph (8) of this subsection.

(e) A six-month period shall be used to determine whether an individual is medically needy.

(f) Eligibility determinations for the medically needy program shall be administered as follows:

(i) County welfare agencies and other entities designated by the commissioner are responsible for determining and certifying the eligibility of pregnant women and dependent children. The division shall reimburse county welfare agencies for 100% of the reasonable costs of administration which are not reimbursed by the federal government for the first 12 months of this program's operation. Thereafter, 75% of the administrative costs incurred by county welfare agencies which are not reimbursed by the federal government shall be reimbursed by the division;

(ii) The division is responsible for certifying the eligibility of individuals who are 65 years of age and older and individuals who are blind or disabled. The division may enter into contracts with county welfare agencies to determine certain aspects of eligibility. In such instances the division shall provide county welfare agencies with all information the division may have available on the individual.

The division shall notify all eligible recipients of the Pharmaceutical Assistance to the Aged and Disabled program, P.L.1975, c.194 (C.30:4D-20 et seq.) on an annual basis of the medically needy program and the program's general requirements. The division shall take all reasonable administrative actions to ensure that Pharmaceutical Assistance to the Aged and Disabled recipients, who notify the division that they may be eligible for the program, have their applications processed expeditiously, at times and locations convenient to the recipients; and

(iii) The division is responsible for certifying incurred medical expenses for all eligible persons who attempt to qualify for the program pursuant to subparagraph (d) of paragraph (8) of this subsection;

(9) (a) Is a child who is at least one year of age and under 19 years of age and, if older than six years of age but under 19 years of age, is uninsured; and

(b) Is a member of a family whose income does not exceed 133% of the poverty level and

who meets the federal Medicaid eligibility requirements set forth in section 9401 of Pub.L.99-509 (42 U.S.C. s.1396a);

(10) Is a pregnant woman who is determined by a provider to be presumptively eligible for medical assistance based on criteria established by the commissioner, pursuant to section 9407 of Pub.L.99-509 (42 U.S.C. s.1396a(a));

(11) Is an individual 65 years of age and older, or an individual who is blind or disabled pursuant to section 301 of Pub.L.92-603 (42 U.S.C. s.1382c), whose income does not exceed 100% of the poverty level, adjusted for family size, and whose resources do not exceed 100% of the resource standard used to determine medically needy eligibility pursuant to paragraph (8) of this subsection;

(12) Is a qualified disabled and working individual pursuant to section 6408 of Pub.L.101-239 (42 U.S.C. s.1396d) whose income does not exceed 200% of the poverty level and whose resources do not exceed 200% of the resource standard used to determine eligibility under the Supplemental Security Income Program, P.L.1973, c.256 (C.44:7-85 et seq.);

(13) Is a pregnant woman or is a child who is under one year of age and is a member of a family whose income does not exceed 185% of the poverty level and who meets the federal Medicaid eligibility requirements set forth in section 9401 of Pub.L.99-509 (42 U.S.C. s.1396a), except that a pregnant woman who is determined to be a qualified applicant shall, notwithstanding any change in the income of the family of which she is a member, continue to be deemed a qualified applicant until the end of the 60-day period beginning on the last day of her pregnancy;

(14) (Deleted by amendment, P.L.1997, c.272).

(15) (a) Is a specified low-income Medicare beneficiary pursuant to 42 U.S.C. s.1396a(a)10(E)iii whose resources beginning January 1, 1993 do not exceed 200% of the resource standard used to determine eligibility under the Supplemental Security Income program, P.L.1973, c.256 (C.44:7-85 et seq.) and whose income beginning January 1, 1993 does not exceed 110% of the poverty level, and beginning January 1, 1995 does not exceed 120% of the poverty level.

(b) An individual who has, within 36 months, or within 60 months in the case of funds transferred into a trust, of applying to be a qualified applicant for Medicaid services in a nursing facility or a medical institution, or for home or community-based services under section 1915(c) of the federal Social Security Act (42 U.S.C. s.1396n(c)), disposed of resources or income for less than fair market value shall be ineligible for assistance for nursing facility services, an equivalent level of services in a medical institution, or home or community-based services under section 1915(c) of the federal Social Security Act (42 U.S.C. s.1396n(c)). The period of the ineligibility shall be the number of months resulting from dividing the uncompensated value of the transferred resources or income by the average monthly private payment rate for nursing facility services in the State as determined annually by the commissioner. In the case of multiple resource or income transfers, the resulting penalty periods shall be imposed sequentially. Application of this requirement shall be governed by 42 U.S.C. s.1396p(c). In accordance with federal law, this provision is effective for all transfers of resources or income made on or after August 11, 1993. Notwithstanding the provisions of this subsection to the contrary, the State eligibility requirements concerning resource or income transfers shall not be more restrictive than those enacted pursuant to 42 U.S.C. s.1396p(c).

(c) An individual seeking nursing facility services or home or community-based services and who has a community spouse shall be required to expend those resources which are not protected for the needs of the community spouse in accordance with section 1924(c) of the federal Social Security Act (42 U.S.C. s.1396r-5(c)) on the costs of long-term care, burial arrangements, and any other expense deemed appropriate and authorized by the commissioner. An individual shall be ineligible for Medicaid services in a nursing facility or for home or community-based services under section 1915(c) of the federal Social Security Act (42 U.S.C. s.1396n(c)) if the individual expends funds in violation of this subparagraph. The period of ineligibility shall be the number of months resulting from dividing the uncompensated value of transferred resources and income by the average monthly private payment rate for nursing facility services in the State as determined by the commissioner. The period of ineligibility shall begin

with the month that the individual would otherwise be eligible for Medicaid coverage for nursing facility services or home or community-based services.

This subparagraph shall be operative only if all necessary approvals are received from the federal government including, but not limited to, approval of necessary State plan amendments and approval of any waivers.

(16) Subject to federal approval under Title XIX of the federal Social Security Act, is a dependent child, parent or specified caretaker relative of a child who is a qualified applicant, who would be eligible, without regard to resources, for the aid to families with dependent children program under the State Plan for Title IV-A of the federal Social Security Act as of July 16, 1996, except for the income eligibility requirements of that program, and whose family earned income does not exceed 133% of the poverty level plus such earned income disregards as shall be determined according to a methodology to be established by regulation of the commissioner; or

(17) Is an individual from 18 through 20 years of age who is not a dependent child and would be eligible for medical assistance pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.), without regard to income or resources, who, on the individual's 18th birthday was in foster care under the care and custody of the Division of Youth and Family Services and whose maintenance was being paid in whole or in part from public funds. j. "Recipient" means any qualified applicant receiving benefits under this act.

k. "Resident" means a person who is living in the State voluntarily with the intention of making his home here and not for a temporary purpose. Temporary absences from the State, with subsequent returns to the State or intent to return when the purposes of the absences have been accomplished, do not interrupt continuity of residence.

l. "State Medicaid Commission" means the Governor, the Commissioner of Human Services, the President of the Senate and the Speaker of the General Assembly, hereby constituted a commission to approve and direct the means and method for the payment of claims pursuant to this act.

m. "Third party" means any person, institution, corporation, insurance company, group health plan as defined in section 607(1) of the federal "Employee Retirement and Income Security Act of 1974," 29 U.S.C. s.1167(1), service benefit plan, health maintenance organization, or other prepaid health plan, or public, private or governmental entity who is or may be liable in contract, tort, or otherwise by law or equity to pay all or part of the medical cost of injury, disease or disability of an applicant for or recipient of medical assistance payable under this act.

n. "Governmental peer grouping system" means a separate class of skilled nursing and intermediate care facilities administered by the State or county governments, established for the purpose of screening their reported costs and setting reimbursement rates under the Medicaid program that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated State or county skilled nursing and intermediate care facilities.

o. "Comprehensive maternity or pediatric care provider" means any person or public or private health care facility that is a provider and that is approved by the commissioner to provide comprehensive maternity care or comprehensive pediatric care as defined in subsection b. (18) and (19) of section 6 of P.L.1968, c.413 (C.30:4D-6).

p. "Poverty level" means the official poverty level based on family size established and adjusted under Section 673(2) of Subtitle B, the "Community Services Block Grant Act," of Pub.L.97-35 (42 U.S.C. s.9902(2)).

q. "Eligible alien" means one of the following:

(1) an alien present in the United States prior to August 22, 1996, who is:

(a) a lawful permanent resident;

(b) a refugee pursuant to section 207 of the federal "Immigration and Nationality Act" (8 U.S.C. s.1157);

(c) an asylee pursuant to section 208 of the federal "Immigration and Nationality Act" (8 U.S.C. s.1158);

(d) an alien who has had deportation withheld pursuant to section 243(h) of the federal "Immigration and Nationality Act" (8 U.S.C. s.1253 (h));

(e) an alien who has been granted parole for less than one year by the federal Immigration and Naturalization Service pursuant to section 212(d)(5) of the federal "Immigration and Nationality Act" (8 U.S.C. s.1182(d)(5));

(f) an alien granted conditional entry pursuant to section 203(a)(7) of the federal "Immigration and Nationality Act" (8 U.S.C. s.1153(a)(7)) in effect prior to April 1, 1980; or

(g) an alien who is honorably discharged from or on active duty in the United States armed forces and the alien's spouse and unmarried dependent child.

(2) An alien who entered the United States on or after August 22, 1996, who is:

(a) an alien as described in paragraph (1)(b), (c), (d) or (g) of this subsection; or

(b) an alien as described in paragraph (1)(a), (e) or (f) of this subsection who entered the United States at least five years ago.

(3) A legal alien who is a victim of domestic violence in accordance with criteria specified for eligibility for public benefits as provided in Title V of the federal "Illegal Immigration Reform and Immigrant Responsibility Act of 1996" (8 U.S.C. s.1641).

8. Section 7 of P.L.1997, c.13 (C.44:10-40) is amended to read as follows:

C.44:10-40 Medical assistance allowed, certain.

7. a. Single adults and couples without dependent children shall not be eligible for medical assistance for inpatient or outpatient hospital care or long-term care under the program, except that medical assistance shall be provided for the following, in accordance with regulations adopted by the commissioner:

(1) inpatient hospitalization costs for a recipient of general public assistance pursuant to P.L.1947, c.156 (C.44:8-107 et seq.) who is admitted to a special hospital licensed by the Department of Health and Senior Services which is not eligible to receive a charity care subsidy from the Health Care Subsidy Fund established pursuant to P.L.1992, c.160 (C.26:2H-18.51 et al.) and to which payments were made prior to July 1, 1991 on behalf of patients receiving general public assistance;

(2) nursing home costs for a person residing in a non-Medicaid certified nursing facility prior to July 1, 1995, whose income is above the Medicaid institutional cap and who does not otherwise qualify for State-funded nursing home care as a medically needy person pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.), to be paid for out of a separate account from the Medicaid program; which assistance shall continue until the person is no longer eligible for long-term care; and

(3) nursing home costs for an alien residing in a Medicaid certified nursing facility prior to the effective date of this act who is not Medicaid-eligible under Pub.L.104-193; which assistance shall continue until the person is no longer eligible for long-term care.

b. The provisions of this section shall not affect the eligibility of a single adult or a couple without dependent children for the New Jersey FamilyCare Health Coverage Program established pursuant to section 4 of P.L.2000, c.71 (C.30:4J-4).

9. This act shall take effect immediately.

Approved July 13, 2000.

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NEWS RELEASE

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Governor Signs FamilyCare Health Coverage Act Expanding Options for Low and Moderate Income Residents

Gov. Christie Whitman today signed the New Jersey FamilyCare Health Coverage Act at the Hamilton Area YMCA in Hamilton to increase access to affordable health care coverage to an estimated 125,000 New Jersey residents with low and moderate-income.

"It's called NJ FamilyCare, but I call it peace of mind," said Gov. Whitman who singled out the initiative as one of the most important items on her policy agenda and was highlighted in this year's budget address. "New Jerseyans will now be able to get annual checkups, preventive care, and routine primary care that most of us take for granted."

"Nobody should have to choose between health care or paying rent," continued the Governor. "Yet right now, too many New Jersey residents face that choice and forego health insurance. That means they don't get checkups or preventive care, such as annual cancer screenings or flu shots. It also means that when they're sick, they don't go to the doctor for fear of what it will cost."

NJ FamilyCare, explained Gov. Whitman, will enable previously uninsured adults to live healthier lives and receive medical services before serious health problems develop.

The bill, A-49, was sponsored by Assembly Members Charlotte Vandervalk (R-Bergen) and Samuel D. Thompson (R-Middlesex/ Monmouth) and Senators Peter A. Inverso (R-Mercer/Middlesex) and Joseph F. Vitale (D-Middlesex), who the Governor thanked for their leadership on this important measure.

The State will invest $160 million in the NJ FamilyCare program from tobacco settlement funds in the next two years, which will attract federal money and also help state hospitals and clinics by reducing their dependence on charity care. When fully implemented in the third year, the NJ FamilyCare Program is expected to cost $206 million per year, with $100 million coming from tobacco settlement monies, and the remainder from a combination of federal aid, General Assistance funds, and employer and employee contributions.

"New Jersey has a subsidized children's health insurance program called NJ KidCare, which now connects nearly 70,000 kids in low- and moderate-income households to the health care they need," said the Governor. "Today, with the signing of this legislation, we are offering a similar program of free or low-cost insurance for working adults."

Residents can apply for this program by completing a three-page application at one of 450 designated sites in New Jersey, such as the Hamilton YMCA in Mercer County where the Governor signed the bill, or by calling a toll-free number, 1-800-701-0710, and requesting an application from the Department of Human Services. The Department will review all NJ FamilyCare Health Coverage Program applications.

The eligible populations under the NJ FamilyCare Program are as follows:

- Working parents with household incomes up to 133 percent of the federal poverty level will be eligible for Medicaid coverage. Currently, Medicaid eligibility for this population is limited to an average of 60 percent of the federal poverty level.
- Working parents with household incomes from 133-200 percent of the federal poverty level will be eligible for a typical managed care benefit used widely in the private sector in New Jersey. Those with incomes above 150 percent in this category will be required to contribute a $25 monthly premium per adult.
- Childless individuals and couples with household incomes up to 50 percent of the federal poverty level will be eligible for medical benefits similar to the Medicaid program. Currently, Medicaid eligibility for this population is limited to less than 30 percent of the federal poverty level.
- Childless individuals and couples with household incomes between 50-100 percent of the federal poverty level will be eligible for typical managed care benefits used widely in the private sector.

Like the NJ KidCare Program, the bill will allow hospitals and federally-qualified health care centers to immediately enroll adults who need care.

The Governor concluded by saying, "With the signing of this bill, working families now have peace of mind. FamilyCare is one more way we are making New Jersey the best place in which to live, work and raise a family."