30:4J-8

LEGISLATIVE HISTORY CHECKLIST

Compiled by the NJ State Law Library

LAWS OF: 2005 **CHAPTER:** 156

NJSA: 30:4J-8 ("Family Health Care Coverage Act")

BILL NO: S2236 (Substituted forA3724)

SPONSOR(S): Vitale and others

DATE INTRODUCED: January 24, 2005

COMMITTEE: **ASSEMBLY:** Budget
SENATE: Health Human Services and Senior Citizens; Budget and Appropriations

AMENDED DURING PASSAGE: Yes

DATE OF PASSAGE: **ASSEMBLY:** June 30, 2005

SENATE: June 23, 2005

DATE OF APPROVAL: July 13, 2005

FOLLOWING ARE ATTACHED IF AVAILABLE:

FINAL TEXT OF BILL (Senate Committee Substitute for S2236 enacted)

S2236

SPONSOR'S STATEMENT: (Begins on page 18 of original bill) Yes

COMMITTEE STATEMENT: **ASSEMBLY**: Yes

SENATE: Yes 1-24-2005 (H,HS & SC)
6-23-2005 (Bud & App.)

FLOOR AMENDMENT STATEMENT: No

LEGISLATIVE FISCAL ESTIMATE: No

A3724

SPONSOR'S STATEMENT: (Begins on page 18 of original bill) Yes

COMMITTEE STATEMENT: **ASSEMBLY**: Yes 2-7-2005 (H &HS)
6-27-2005 (Budget)

SENATE: No

FLOOR AMENDMENT STATEMENT: No

LEGISLATIVE FISCAL ESTIMATE: No

VETO MESSAGE: No

GOVERNOR'S PRESS RELEASE ON SIGNING: Yes

FOLLOWING WERE PRINTED:

To check for circulating copies, contact New Jersey State Government Publications at the State Library (609) 278-2640 ext. 103 or mailto:refdesk@njstatelib.org

REPORTS: No

HEARINGS: No

NEWSPAPER ARTICLES: Yes

"Codey OKs plan adding parents to FamilyCare," 7-14-2005 Asbury Park Press, p.A8
"More care for more children," 7-14-2005 The Times, p.A5
"Codey OKs bill to expand health insurance coverage," 7-14-2005 Courier Post, p.2A
"Trenton expands health care plan for parents, kids," 7-14-2005 Star Ledger, p.13
"Codey signs law restoring Family Care,"7-14-2005 The Press, p.C1

IS 8/10/07

§§1-6,11,15,16 -
C.30:4J-8 to
30:4J-16
§9 - C.30:4D-3b
§§10,12,13 - T&E &
Note to §1
§14 - C.44:8-159
§17 - Repealer
§18 - Note to §§1-17

P.L. 2005, CHAPTER 156, ***approved July 13, 2005***
Senate Committee Substitute for
Senate, No. 2236

1 **AN ACT** concerning health care coverage for children and their parents
2 and revising parts of the statutory law.
3
4 **BE IT ENACTED** *by the Senate and General Assembly of the State*
5 *of New Jersey:*
6
7 1. (New section) This act shall be known and may be cited as the
8 "Family Health Care Coverage Act."
9
10 2. (New section) The Legislature finds and declares that:
11 a. The most serious health problem facing approximately 1.2
12 million New Jersey residents, including approximately 264,000
13 children, is lack of access to affordable health care coverage, which
14 forces too many New Jersey families to go without needed preventive
15 and other nonemergency care until serious illness requires expensive
16 hospital care.
17 b. Research has shown that affordable and accessible health care
18 coverage for parents can benefit their children, since parents who have
19 a connection to ongoing health care coverage are more likely to ensure
20 that their children get necessary immunizations and regular checkups
21 from a primary care provider. Adults and children who lack insurance
22 coverage forgo care until medical conditions, which were either
23 preventable or treatable at the outset, require more extensive and
24 expensive intervention or treatment.
25 c. Children with health care coverage have a significantly greater
26 opportunity to be healthier, realize their full educational and
27 developmental potential and become productive citizens. Providing
28 health care coverage for uninsured adults increases worker
29 productivity and can reduce dependence on public assistance and other
30 State-subsidized programs including hospital charity care.
31 d. The federal State Children's Health Insurance Program
32 (SCHIP), established in 1997 as Title XXI of the federal Social
33 Security Act, allows a state to establish a health insurance program for
34 low-income children. In response to the enactment of SCHIP, New

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 Jersey established the NJ KidCare program in 1997 and the NJ
2 FamilyCare program in 2000 to provide subsidized private health
3 insurance coverage to children whose family income does not exceed
4 350% of the federal poverty level (FPL) and to their parents if their
5 income does not exceed 200% of the FPL. NJ FamilyCare also
6 provided coverage for adults without children whose income did not
7 exceed 100% of the FPL.
8 Upon the establishment of NJ FamilyCare, the two programs were
9 combined and administered as NJ FamilyCare. Within a short time,
10 enrollment of adults far exceeded expectations and available funding,
11 and various changes were made to the program to contain costs, such
12 as scaling back benefits, limiting eligibility to parents and other adults
13 who were already enrolled in, or had applied for, the program as of
14 June 14, 2002, and no longer accepting any new applications from
15 parents or other adults.
16 e. Initially, NJ FamilyCare appreciably reduced the costs of charity
17 care provided by hospitals, but when NJ FamilyCare coverage for
18 parents and other adults was curtailed, charity care costs again
19 increased.
20 f. In order to (1) ensure that the original purpose of NJ
21 FamilyCare is realized, that is, low income parents as well as their
22 children are given access to health insurance coverage, (2) increase
23 enrollment of children, and (3) maximize federal financial participation
24 under both the State Medicaid and NJ FamilyCare programs, it is
25 necessary and appropriate to restore coverage for parents of children
26 who qualify for Medicaid or NJ FamilyCare, by increasing income
27 eligibility levels, over a three-year period, for parents under the
28 Medicaid program to 133% of the FPL. Further, to provide for a more
29 comprehensive health care system, it is also necessary and appropriate
30 to restore coverage through the Medicaid program, over a three-year
31 period, for adults without dependent children whose income is up to
32 100% of the FPL, subject to the availability of federal Medicaid funds.
33 g. Since 2002, the number of parents enrolled in NJ FamilyCare
34 has steadily declined and the growth in coverage of children has
35 slowed. Current application and renewal procedures create
36 unnecessary barriers for applicants and enrollees, and have contributed
37 to a decline in the enrollment of additional children and in the retention
38 of enrollees. Experience in other states suggests that adopting certain
39 enrollment simplification reforms in both the NJ FamilyCare and
40 Medicaid programs can significantly increase enrollment and retention
41 of eligible children and their parents.
42 h. The expanded health care coverage provided by this act builds
43 on New Jersey's longstanding commitment to assure access to quality
44 health care that is provided in an efficient and effective manner and at
45 a reasonable cost.

3. (New section) The NJ FamilyCare Program is established in the Department of Human Services.

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

"Commissioner" means the Commissioner of Human Services.

"Department" means the Department of Human Services.

"Medicaid" means the New Jersey Medical Assistance and Health Services Program established pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.).

"NJ FamilyCare" or "program" means the NJ FamilyCare Program established pursuant to sections 3 through 5 of P.L. , c. (C.) (pending before the Legislature as this bill).

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

"Qualified applicant" means:

a. a child under 19 years of age: (1) whose family gross income does not exceed 350% of the poverty level; (2) who has no health insurance, as determined by the commissioner, and is ineligible for Medicaid; (3) who is a resident of this State; and (4) who is a citizen of the United States, or has been lawfully admitted for permanent residence into and remains lawfully present in the United States;

b. a parent or caretaker: (1) whose gross family income does not exceed 200% of the poverty level; (2) who is enrolled in NJ FamilyCare on the effective date of P.L. , c. (C.)(pending before the Legislature as this bill); (3) who has no health insurance, as determined by the commissioner, and is ineligible for Medicaid; (4) who is a resident of this State; and (5) who is a citizen of the United States, or has been lawfully admitted for permanent residence into and remains lawfully present in the United States; and

c. a single adult or couple without dependent children: (1) whose family gross income does not exceed 100% of the poverty level; (2) who is enrolled in NJ FamilyCare on the effective date of P.L. , c. (C.)(pending before the Legislature as this bill) and is ineligible for Medicaid; (3) who is a resident of this State; and (4) who is a citizen of the United States, or has been lawfully admitted for permanent residence into and remains lawfully present in the United States.

5. (New section) a. The purpose of the program shall be to provide subsidized health insurance coverage, and other health care benefits as determined by the commissioner, to children under 19 years of age and their parents or caretakers and to adults without dependent children, within the limits of funds appropriated or otherwise made available for the program.

The program shall require families to pay copayments and make premium contributions, based upon a sliding income scale. The program shall include the provision of well-child and other preventive services, hospitalization, physician care, laboratory and x-ray services, prescription drugs, mental health services, and other services as determined by the commissioner.

b. The commissioner shall take such actions as are necessary to implement and operate the program in accordance with the State Children's Health Insurance Program established pursuant to 42 U.S.C.s.1397aa et seq.

c. The commissioner:

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

(2) shall require that a parent or caretaker who is a qualified applicant purchase coverage, if available, 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, except that the provisions of this paragraph shall not be construed to require an employer to provide health insurance coverage for any employee or employee's spouse or dependent child;

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

(4) shall establish, by regulation, other requirements for the program, including, but not limited to, premium payments and copayments, and may contract with one or more appropriate entities, including managed care organizations, to assist in administering the program. The period for which eligibility for the program is determined shall be the maximum period permitted under federal law.

d. The commissioner shall establish procedures for determining eligibility, which shall include, at a minimum, the following enrollment simplification practices:

(1) A streamlined application form as established pursuant to subsection k. of this section;

(2) Require new applicants to submit no more than one recent pay stub from the applicant's employer, or, if the applicant has more than one employer, no more than one from each of the applicant's employers, to verify income. In the event the applicant cannot provide a recent pay stub, the applicant may submit another form of income verification as deemed appropriate by the commissioner. If an applicant does not submit income verification in a timely manner, before determining the applicant ineligible for the program, the

1 commissioner shall seek to verify the applicant's income by reviewing
2 available Department of the Treasury or Department of Labor records
3 concerning the applicant, or such other records as the commissioner
4 determines appropriate.
5 The commissioner may establish such retrospective auditing or
6 income verification procedures as he deems appropriate, such as
7 sample auditing and matching reported income with records of the
8 Department of the Treasury or the Department of Labor or such other
9 records as the commissioner determines appropriate.
10 If the commissioner elects to match reported income with
11 confidential records of the Department of the Treasury, the
12 commissioner shall require an applicant to provide written
13 authorization for the Division of Taxation in the Department of the
14 Treasury to release applicable tax information to the commissioner for
15 the purposes of establishing income eligibility for the program. The
16 authorization, which shall be included on the program application
17 form, shall be developed by the commissioner, in consultation with the
18 State Treasurer;
19 (3) Online enrollment and renewal, in addition to enrollment and
20 renewal by mail. The online enrollment and renewal forms shall
21 include electronic links to other State and federal health and social
22 services programs;
23 (4) Continuous enrollment;
24 (5) Simplified renewal by sending an enrollee a preprinted renewal
25 form and requiring the enrollee to sign and return the form, with any
26 applicable changes in the information provided in the form, no later
27 than 30 days after the date the enrollee's annual eligibility expires. The
28 commissioner may establish such auditing or income verification
29 procedures as he deems appropriate, as provided in paragraph (1) of
30 this subsection; and
31 (6) Provision of program eligibility-identification cards that are
32 issued no more frequently than once a year.
33 e. The commissioner shall take, or cause to be taken, any action
34 necessary to secure for the State the maximum amount of federal
35 financial participation available with respect to the program, subject
36 to the constraints of fiscal responsibility and within the limits of
37 available funding in any fiscal year. In this regard, notwithstanding the
38 definition of "qualified applicant," the commissioner may enroll in the
39 program such children or their parents or caretakers who may
40 otherwise be eligible for the Medicaid program in order to maximize
41 use of federal funds that may be available pursuant to 42 U.S.C.
42 s.1397aa et seq.
43 f. Subject to federal approval, a child shall be determined
44 ineligible for the program if the child was voluntarily disenrolled from
45 employer-sponsored group insurance coverage within six months prior
46 to application to the program.

1 g. The commissioner shall provide, by regulation, for presumptive
2 eligibility for the program in accordance with the following provisions:
3 (1) A child who presents himself for treatment at a general
4 hospital, federally qualified or community health center, local health
5 department that provides primary care, or other State licensed
6 community-based primary care provider shall be deemed presumptively
7 eligible for the program if a preliminary determination by hospital,
8 health center, local health department or licensed health care provider
9 staff indicates that the child meets program eligibility standards and is
10 a member of a household with an income that does not exceed 350%
11 of the poverty level;
12 (2) The provisions of paragraph (1) of this subsection shall also
13 apply to a child who is deemed presumptively eligible for Medicaid
14 coverage pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.);
15 (3) The parent or caretaker of a child deemed presumptively
16 eligible pursuant to this subsection shall be required to submit a
17 completed application for the program no later than the end of the
18 month following the month in which presumptive eligibility is
19 determined;
20 (4) A child shall be eligible to receive all services covered by the
21 program during the period in which the child is presumptively eligible;
22 and
23 (5) The commissioner may, by regulation, establish a limit on the
24 number of times a child may be deemed presumptively eligible for NJ
25 FamilyCare.
26 h. The commissioner, in consultation with the Commissioner of
27 Education, shall administer an ongoing enrollment initiative to provide
28 outreach to children throughout the State who may be eligible for the
29 program.
30 (1) With respect to school-age children, the commissioner, in
31 consultation with the Commissioner of Education and the Secretary of
32 Agriculture, shall develop a form that provides information about the
33 NJ FamilyCare and Medicaid programs and provides an opportunity
34 for the parent or guardian who signs the school lunch application form
35 to give consent for information to be shared with the Department of
36 Human Services for the purpose of determining eligibility for the
37 programs. The form shall be attached to, included with, or
38 incorporated into, the school lunch application form.
39 The commissioner, in consultation with the Commissioner of
40 Education, shall establish procedures for schools to transmit
41 information attached to, included with, or provided on the school
42 lunch application form regarding the NJ FamilyCare and Medicaid
43 programs to the Department of Human Services, in order to enable the
44 department to determine eligibility for the programs.
45 (2) The commissioner or the Commissioner of Education, as
46 applicable, shall:

1 (a) make available to each elementary and secondary school,
2 licensed child care center, registered family day care home, unified
3 child care agency, local health department that provides primary care,
4 and community-based primary care provider, informational materials
5 about the program, including instructions for applying online or by
6 mail, as well as copies of the program application form.
7 The entity shall make the informational and application materials
8 available, upon request, to persons interested in the program; and
9 (b) request each entity to distribute a notice at least annually, as
10 developed by the commissioner, to households of children attending
11 or receiving its services or care, informing them about the program
12 and the availability of informational and application materials. In the
13 case of elementary and secondary schools, the information attached to,
14 included with, or incorporated into, the school lunch application form
15 for school-age children pursuant to this subparagraph shall be deemed
16 to meet the requirements of this paragraph.
17 i. Subject to federal approval, the commissioner shall, by
18 regulation, establish that in determining income eligibility for a child,
19 any gross family income above 200% of the poverty level, up to a
20 maximum of 350% of the poverty level, shall be disregarded.
21 j. The commissioner shall establish a NJ FamilyCare coverage
22 buy-in program through which a parent or caretaker whose family
23 income exceeds 350% of the poverty level may purchase coverage
24 under NJ FamilyCare for a child under the age of 19, who is uninsured
25 and was not voluntarily disenrolled from employer-sponsored group
26 insurance coverage within six months prior to application to the
27 program.
28 The commissioner shall establish the premium and cost sharing
29 amounts required to purchase coverage, except that the premium shall
30 not exceed the amount the program pays per month to a managed care
31 organization under NJ FamilyCare for a child of comparable age
32 whose family income is between 200% and 350% of the poverty level,
33 plus a reasonable processing fee.
34 k. The commissioner, in consultation with the Rutgers Center for
35 State Health Policy, shall develop a streamlined application form for
36 the NJ FamilyCare and Medicaid programs.
37
38 6. (New section) Whenever the terms "Children's Health Care
39 Coverage Program," "NJ KidCare," "FamilyCare Health Coverage
40 Program" or "NJ FamilyCare" occur or any reference is made thereto
41 in any law, contract or document, the same shall be deemed to mean
42 or refer to the NJ FamilyCare Program established pursuant to
43 P.L. , c. (C.)(pending before the Legislature as this bill).
44
45 7. Section 3 of P.L.1999, c.171 (C.18A:40-34) is amended to read
46 as follows:

1 3. The Commissioner of Education, in consultation with the
2 Commissioner of Human Services and pursuant to the "Administrative
3 Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt
4 regulations to:
5 a. provide for the implementation by the board of education in
6 each school district of such procedures by each public elementary and
7 secondary school in the district as the commissioner deems necessary
8 to effectuate the purposes of subsection [f. of section 4 of P.L.1997,
9 c.272 (C.30:4I-4)] <u>h. of section 5 of P.L. , c. (C.)(pending</u>
10 <u>before the Legislature as this bill)</u>; and
11 b. facilitate and provide for the participation of nonpublic
12 elementary and secondary schools in the [partnership] <u>enrollment</u>
13 initiative created pursuant to subsection [f. of section 4 of P.L.1997,
14 c.272 (C.30:4I-4), including the provision of in-kind awards to
15 participating nonpublic schools, in the form of educational resource
16 materials that would be the property of the public schools, for each
17 household enrolled in the Children's Health Care Coverage Program
18 established pursuant to P.L.1997, c.272 (C.30:4I-1 et seq.) which was
19 referred by the nonpublic school] <u>h. of section 5 of P.L. , c.</u>
20 <u>(C.)(pending before the Legislature as this bill)</u>.
21 (cf: P.L.1999, c.171, s.3)
22
23 8. Section 3 of P.L.1968, c.413 (C.30:4D-3) is amended to read
24 as follows:
25 30:4D-3 Definitions.
26 3. Definitions. As used in this act, and unless the context
27 otherwise requires:
28 a. "Applicant" means any person who has made application for
29 purposes of becoming a "qualified applicant."
30 b. "Commissioner" means the Commissioner of Human Services.
31 c. "Department" means the Department of Human Services, which
32 is herein designated as the single State agency to administer the
33 provisions of this act.
34 d. "Director" means the Director of the Division of Medical
35 Assistance and Health Services.
36 e. "Division" means the Division of Medical Assistance and
37 Health Services.
38 f. "Medicaid" means the New Jersey Medical Assistance and
39 Health Services Program.
40 g. "Medical assistance" means payments on behalf of recipients to
41 providers for medical care and services authorized under this act.
42 h. "Provider" means any person, public or private institution,
43 agency or business concern approved by the division lawfully
44 providing medical care, services, goods and supplies authorized under
45 this act, holding, where applicable, a current valid license to provide
46 such services or to dispense such goods or supplies.

1 i. "Qualified applicant" means a person who is a resident of this
2 State, and either a citizen of the United States or an eligible alien, and
3 is determined to need medical care and services as provided under this
4 act, with respect to whom the period for which eligibility to be a
5 recipient is determined shall be the maximum period permitted under
6 federal law, and who:
7 (1) Is a dependent child or parent or caretaker relative of a
8 dependent child who would be, except for resources, eligible for the
9 temporary assistance for needy families program under the State Plan
10 for Title IV-A of the federal Social Security Act as of July 16, 1996;
11 (2) Is a recipient of Supplemental Security Income for the Aged,
12 Blind and Disabled under Title XVI of the Social Security Act;
13 (3) Is an "ineligible spouse" of a recipient of Supplemental Security
14 Income for the Aged, Blind and Disabled under Title XVI of the Social
15 Security Act, as defined by the federal Social Security Administration;
16 (4) Would be eligible to receive Supplemental Security Income
17 under Title XVI of the federal Social Security Act or, without regard
18 to resources, would be eligible for the temporary assistance for needy
19 families program under the State Plan for Title IV-A of the federal
20 Social Security Act as of July 16, 1996, except for failure to meet an
21 eligibility condition or requirement imposed under such State program
22 which is prohibited under Title XIX of the federal Social Security Act
23 such as a durational residency requirement, relative responsibility,
24 consent to imposition of a lien;
25 (5) (Deleted by amendment, P.L.2000, c.71).
26 (6) Is an individual under 21 years of age who, without regard to
27 resources, would be, except for dependent child requirements, eligible
28 for the temporary assistance for needy families program under the
29 State Plan for Title IV-A of the federal Social Security Act as of July
30 16, 1996, or groups of such individuals, including but not limited to,
31 children in resource family placement under supervision of the Division
32 of Youth and Family Services whose maintenance is being paid in
33 whole or in part from public funds, children placed in a resource family
34 home or institution by a private adoption agency in New Jersey or
35 children in intermediate care facilities, including developmental centers
36 for the developmentally disabled, or in psychiatric hospitals;
37 (7) Would be eligible for the Supplemental Security Income
38 program, but is not receiving such assistance and applies for medical
39 assistance only;
40 (8) Is determined to be medically needy and meets all the
41 eligibility requirements described below:
42 (a) The following individuals are eligible for services, if they are
43 determined to be medically needy:
44 (i) Pregnant women;
45 (ii) Dependent children under the age of 21;
46 (iii) Individuals who are 65 years of age and older; and

1 (iv) Individuals who are blind or disabled pursuant to either 42
2 C.F.R.435.530 et seq. or 42 C.F.R.435.540 et seq., respectively.
3 (b) The following income standard shall be used to determine
4 medically needy eligibility:
5 (i) For one person and two person households, the income
6 standard shall be the maximum allowable under federal law, but shall
7 not exceed 133 1/3% of the State's payment level to two person
8 households under the temporary assistance for needy families program
9 under the State Plan for Title IV-A of the federal Social Security Act
10 in effect as of July 16, 1996; and
11 (ii) For households of three or more persons, the income standard
12 shall be set at 133 1/3% of the State's payment level to similar size
13 households under the temporary assistance for needy families program
14 under the State Plan for Title IV-A of the federal Social Security Act
15 in effect as of July 16, 1996.
16 (c) The following resource standard shall be used to determine
17 medically needy eligibility:
18 (i) For one person households, the resource standard shall be
19 200% of the resource standard for recipients of Supplemental Security
20 Income pursuant to 42 U.S.C. s.1382(1)(B);
21 (ii) For two person households, the resource standard shall be
22 200% of the resource standard for recipients of Supplemental Security
23 Income pursuant to 42 U.S.C. s.1382(2)(B);
24 (iii) For households of three or more persons, the resource
25 standard in subparagraph (c)(ii) above shall be increased by $100.00
26 for each additional person; and
27 (iv) The resource standards established in (i), (ii), and (iii) are
28 subject to federal approval and the resource standard may be lower if
29 required by the federal Department of Health and Human Services.
30 (d) Individuals whose income exceeds those established in
31 subparagraph (b) of paragraph (8) of this subsection may become
32 medically needy by incurring medical expenses as defined in 42
33 C.F.R.435.831(c) which will reduce their income to the applicable
34 medically needy income established in subparagraph (b) of paragraph
35 (8) of this subsection.
36 (e) A six-month period shall be used to determine whether an
37 individual is medically needy.
38 (f) Eligibility determinations for the medically needy program shall
39 be administered as follows:
40 (i) County welfare agencies and other entities designated by the
41 commissioner are responsible for determining and certifying the
42 eligibility of pregnant women and dependent children. The division
43 shall reimburse county welfare agencies for 100% of the reasonable
44 costs of administration which are not reimbursed by the federal
45 government for the first 12 months of this program's operation.
46 Thereafter, 75% of the administrative costs incurred by county welfare

1 agencies which are not reimbursed by the federal government shall be
2 reimbursed by the division;
3 (ii) The division is responsible for certifying the eligibility of
4 individuals who are 65 years of age and older and individuals who are
5 blind or disabled. The division may enter into contracts with county
6 welfare agencies to determine certain aspects of eligibility. In such
7 instances the division shall provide county welfare agencies with all
8 information the division may have available on the individual.
9 The division shall notify all eligible recipients of the Pharmaceutical
10 Assistance to the Aged and Disabled program, P.L.1975, c.194
11 (C.30:4D-20 et seq.) on an annual basis of the medically needy
12 program and the program's general requirements. The division shall
13 take all reasonable administrative actions to ensure that
14 Pharmaceutical Assistance to the Aged and Disabled recipients, who
15 notify the division that they may be eligible for the program, have their
16 applications processed expeditiously, at times and locations convenient
17 to the recipients; and
18 (iii) The division is responsible for certifying incurred medical
19 expenses for all eligible persons who attempt to qualify for the
20 program pursuant to subparagraph (d) of paragraph (8) of this
21 subsection;
22 (9) (a) Is a child who is at least one year of age and under 19
23 years of age and, if older than six years of age but under 19 years of
24 age, is uninsured; and
25 (b) Is a member of a family whose income does not exceed 133%
26 of the poverty level and who meets the federal Medicaid eligibility
27 requirements set forth in section 9401 of Pub.L.99-509 (42 U.S.C.
28 s.1396a);
29 (10) Is a pregnant woman who is determined by a provider to be
30 presumptively eligible for medical assistance based on criteria
31 established by the commissioner, pursuant to section 9407 of
32 Pub.L.99-509 (42 U.S.C. s.1396a(a));
33 (11) Is an individual 65 years of age and older, or an individual
34 who is blind or disabled pursuant to section 301 of Pub.L.92-603 (42
35 U.S.C. s.1382c), whose income does not exceed 100% of the poverty
36 level, adjusted for family size, and whose resources do not exceed
37 100% of the resource standard used to determine medically needy
38 eligibility pursuant to paragraph (8) of this subsection;
39 (12) Is a qualified disabled and working individual pursuant to
40 section 6408 of Pub.L.101-239 (42 U.S.C. s.1396d) whose income
41 does not exceed 200% of the poverty level and whose resources do
42 not exceed 200% of the resource standard used to determine eligibility
43 under the Supplemental Security Income Program, P.L.1973, c.256
44 (C.44:7-85 et seq.);
45 (13) Is a pregnant woman or is a child who is under one year of
46 age and is a member of a family whose income does not exceed 185%

1 of the poverty level and who meets the federal Medicaid eligibility
2 requirements set forth in section 9401 of Pub.L.99-509 (42 U.S.C.
3 s.1396a), except that a pregnant woman who is determined to be a
4 qualified applicant shall, notwithstanding any change in the income of
5 the family of which she is a member, continue to be deemed a qualified
6 applicant until the end of the 60-day period beginning on the last day
7 of her pregnancy;
8 (14) (Deleted by amendment, P.L.1997, c.272).
9 (15) (a) Is a specified low-income Medicare beneficiary pursuant
10 to 42 U.S.C. s.1396a(a)10(E)iii whose resources beginning January 1,
11 1993 do not exceed 200% of the resource standard used to determine
12 eligibility under the Supplemental Security Income program, P.L.1973,
13 c.256 (C.44:7-85 et seq.) and whose income beginning January 1,
14 1993 does not exceed 110% of the poverty level, and beginning
15 January 1, 1995 does not exceed 120% of the poverty level.
16 (b) An individual who has, within 36 months, or within 60 months
17 in the case of funds transferred into a trust, of applying to be a
18 qualified applicant for Medicaid services in a nursing facility or a
19 medical institution, or for home or community-based services under
20 section 1915(c) of the federal Social Security Act (42 U.S.C.
21 s.1396n(c)), disposed of resources or income for less than fair market
22 value shall be ineligible for assistance for nursing facility services, an
23 equivalent level of services in a medical institution, or home or
24 community-based services under section 1915(c) of the federal Social
25 Security Act (42 U.S.C. s.1396n(c)). The period of the ineligibility
26 shall be the number of months resulting from dividing the
27 uncompensated value of the transferred resources or income by the
28 average monthly private payment rate for nursing facility services in
29 the State as determined annually by the commissioner. In the case of
30 multiple resource or income transfers, the resulting penalty periods
31 shall be imposed sequentially. Application of this requirement shall be
32 governed by 42 U.S.C. s.1396p(c). In accordance with federal law,
33 this provision is effective for all transfers of resources or income made
34 on or after August 11, 1993. Notwithstanding the provisions of this
35 subsection to the contrary, the State eligibility requirements
36 concerning resource or income transfers shall not be more restrictive
37 than those enacted pursuant to 42 U.S.C. s.1396p(c).
38 (c) An individual seeking nursing facility services or home or
39 community-based services and who has a community spouse shall be
40 required to expend those resources which are not protected for the
41 needs of the community spouse in accordance with section 1924(c) of
42 the federal Social Security Act (42 U.S.C. s.1396r-5(c)) on the costs
43 of long-term care, burial arrangements, and any other expense deemed
44 appropriate and authorized by the commissioner. An individual shall
45 be ineligible for Medicaid services in a nursing facility or for home or
46 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 temporary assistance for needy families 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,

(a) if a dependent child, does not exceed 133% of the poverty level, and

(b) if a parent or specified caretaker relative, beginning September 1, 2005 does not exceed 100% of the poverty level, beginning September 1, 2006 does not exceed 115% of the poverty level and beginning September 1, 2007 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.

The commissioner may increase the income eligibility limits for children and parents and specified caretaker relatives, as funding permits;

(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 resource family 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;

(18) Is a person between the ages of 16 and 65 who is permanently disabled and working, and:

(a) whose income is at or below 250% of the poverty level, plus other established disregards;

(b) who pays the premium contribution and other cost sharing as established by the commissioner, subject to the limits and conditions

of federal law; and

(c) whose assets, resources and unearned income do not exceed limitations as established by the commissioner; [or]

(19) Is an uninsured individual under 65 years of age who:

(a) has been screened for breast or cervical cancer under the federal Centers for Disease Control and Prevention breast and cervical cancer early detection program;

(b) requires treatment for breast or cervical cancer based upon criteria established by the commissioner;

(c) has an income that does not exceed the income standard established by the commissioner pursuant to federal guidelines;

(d) meets all other Medicaid eligibility requirements; and

(e) in accordance with Pub.L.106-354, is determined by a qualified entity to be presumptively eligible for medical assistance pursuant to 42 U.S.C. s.1396a(aa), based upon criteria established by the commissioner pursuant to section 1920B of the federal Social Security Act (42 U.S.C. s.1396r-1b); or

(20) Subject to federal approval under Title XIX of the federal Social Security Act, is a single adult or couple, without dependent children, whose income in 2006 does not exceed 50% of the poverty level, in 2007 does not exceed 75% of the poverty level and in 2008 and each year thereafter does not exceed 100% of the poverty level; except that a person who is a recipient of Work First New Jersey general public assistance, pursuant to P.L.1947, c.156 (C.44:8-107 et seq.), shall not be a qualified applicant.

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.

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

1 provided in Title V of the federal "Illegal Immigration Reform and
2 Immigrant Responsibility Act of 1996" (8 U.S.C. s.1641).
3 (cf: P.L.2004, c.130, s.93)
4
5 9. (New section) No later than January 1, 2006, the
6 Commissioner of Human Services shall, at a minimum, establish the
7 following enrollment simplification practices for dependent children
8 and their parents or specified caretaker relatives who are applicants for
9 or recipients of the Medicaid program:
10 a. A streamlined application form as established pursuant to
11 subsection k. of section 5 of P.L. , c. (C.)(pending before the
12 Legislature as this bill);
13 b. Require new applicants to submit no more than one recent pay
14 stub from the applicant's employer, or, if the applicant has more than
15 one employer, no more than one from each of the applicant's
16 employers, to verify income. In the event the applicant cannot provide
17 a recent pay stub, the applicant may submit another form of income
18 verification as deemed appropriate by the commissioner. If an
19 applicant does not submit income verification in a timely manner,
20 before determining the applicant ineligible for the program, the
21 commissioner shall seek to verify the applicant's income by reviewing
22 available Department of the Treasury or Department of Labor records
23 concerning the applicant or such other records as the commissioner
24 determines appropriate.
25 The commissioner may establish such retrospective auditing or
26 income verification procedures as he deems appropriate, such as
27 sample auditing and matching reported income with records of the
28 Department of the Treasury or the Department of Labor or such other
29 records as the commissioner determines appropriate.
30 If the commissioner elects to match reported income with
31 confidential records of the Department of the Treasury, the
32 commissioner shall require an applicant to provide written
33 authorization for the Division of Taxation in the Department of the
34 Treasury to release applicable tax information to the commissioner for
35 the purposes of establishing income eligibility for the program. The
36 authorization, which shall be included on the program application
37 form, shall be developed by the commissioner, in consultation with the
38 State Treasurer;
39 c. Online enrollment and renewal, in addition to enrollment and
40 renewal by mail. The online enrollment and renewal forms shall
41 include electronic links to other State and federal health and social
42 services programs;
43 d. Continuous enrollment;
44 e. Simplified renewal by sending a recipient a preprinted renewal
45 form and requiring the recipient to sign and return the form, with any
46 applicable changes in the information provided in the form, no later

1 than 30 days after the date the recipient's annual eligibility expires.
2 The commissioner may establish such auditing or income verification
3 procedures as he deems appropriate, as provided in subsection a. of
4 this section; and
5 f. Provision of program eligibility-identification cards that are
6 issued no more frequently than once a year.
7
8 10. (New section) The commissioner shall apply for such State
9 plan amendments or waivers as may be necessary to implement the
10 provisions of this act and to secure federal financial participation for
11 State Medicaid expenditures under the federal Medicaid program and
12 for NJ FamilyCare expenditures under the State Children's Health
13 Insurance Program pursuant to 42 U.S.C.s.1397aa et seq.
14
15 11. (New section) The Commissioner of Human Services shall
16 report to the Chairman of the Senate Health, Human Services and
17 Senior Citizens Committee and the Chairmen of the Assembly Health
18 and Human Services and Assembly Family, Women and Children's
19 Issues committees on the implementation of this act.
20 The commissioner shall issue an interim report six months after the
21 effective date of this act and shall issue an annual report six months
22 later and once each year thereafter.
23 The report shall include the number of persons who are enrolled in
24 the Medicaid and NJ FamilyCare programs pursuant to the provisions
25 of this act, the cost of providing coverage for these persons, the status
26 of any Medicaid plan amendments or waivers necessary for
27 implementation of this act, the status of implementing the enrollment
28 simplification practices for both the NJ FamilyCare and Medicaid
29 programs, and such other information as the commissioner deems
30 appropriate. The commissioner may also include any recommendations
31 for legislation he deems necessary to further the purposes of this act.
32
33 12. (New section) Within 60 days of the date of enactment of this
34 act, the Commissioner of Human Services shall report to the Chairman
35 of the Senate Health, Human Services and Senior Citizens Committee
36 and the Chairmen of the Assembly Health and Human Services and
37 Assembly Family, Women and Children's Issues committees regarding
38 the department's plan to implement the NJ FamilyCare buy-in for
39 children whose income is greater than 350% of the poverty level, as
40 provided in subsection j. of section 5 of P.L. , c. (C.)(pending
41 before the Legislature as this bill).
42 13. (New section) a. Within one year of the effective date of this
43 act, the Commissioner of Human Services shall:
44 (1) establish a plan to develop and implement a universal
45 identification card that can be issued to and used by recipients of
46 Medicaid, Work First New Jersey, NJ FamilyCare, food stamps and

1 other public social service and health programs; and
2 (2) prepare a request for proposal to develop an online, interactive
3 database that can be used by health care facilities for enrolling, or
4 determining the status of an application for, children and their parents
5 or caretakers and adults without dependent children who present
6 themselves at the health care facility for services and who may be
7 eligible for NJ FamilyCare or Medicaid. The database shall enable the
8 health care facility to notify a county welfare agency or the appropriate
9 office in the Department of Human Services about a program applicant
10 so that the agency or office can follow-up on the application and
11 complete the eligibility determination process.
12 b. The commissioner shall include in his reports to the Legislature
13 required pursuant to section 11 of P.L. , c. (C.)(pending before
14 the Legislature as this bill) the status of the commissioner's plan for a
15 universal identification card and the request for proposals for an
16 interactive database.
17
18 14. (New section) a. The Commissioner of Human Services shall
19 contract with manufacturers of pharmaceutical products to provide
20 rebates for pharmaceutical products covered under the Work First
21 New Jersey General Public Assistance program (WFNJ-GA),
22 established pursuant to P.L.1947, c.156 (C.44:8-107 et seq.) on the
23 same basis as is required under the "Pharmaceutical Assistance to the
24 Aged and Disabled" program established pursuant to P.L.1975, c.194
25 (C.30:4D-20 et seq.) and "Senior Gold Prescription Discount
26 Program" established pursuant to P.L.2001, c.96 (C.30:4D-43 et seq.)
27 and in section 1927(a) through (c) of the federal Social Security Act,
28 42 U.S.C. s.1396r-8(a)-(c).
29 b. The contracts entered into pursuant to this section shall take
30 effect on the date of enactment of P.L. , c. (C.)(pending before the
31 Legislature as this bill).
32 (1) A manufacturer who is participating in the WFNJ-GA program
33 on the date of enactment of P.L. , c. (pending before the Legislature
34 as this bill) shall enter into a contract, as a condition of continued
35 19participation in the program.
36 (2) A manufacturer who was not participating in the WFNJ-GA
37 program on the date of enactment of P.L. , c. (pending before the
38 Legislature as this bill) may enter into a contract with the
39 commissioner and become a participating manufacturer.
40 (3) A manufacturer who participates in the WFNJ-GA program
41 pursuant to this section shall provide to the commissioner such
42 information as the commissioner may request to carry out the purposes
43 of this section.
44
45 15. (New section) a. Funding to carry out the expansion of
46 eligibility in the Medicaid program as provided in this act shall include

1 monies made available to the State from pharmaceutical manufacturers
2 who agree to provide rebates to the State in the Work First New
3 Jersey General Assistance program pursuant to section 14 of P.L. , c.
4 (C.)(pending before the Legislature as this bill). Amounts received
5 as rebates under rebate agreements entered into pursuant to that
6 section are appropriated to the Department of Human Services for the
7 support of the Medicaid expansion.
8 b. Any unexpended balances for the NJ FamilyCare Program shall
9 be appropriated to carry out the purposes of this act. Any transfer of
10 NJ FamilyCare appropriations to other accounts shall be subject to the
11 approval of the Joint Budget Oversight Committee.
12
13 16. (New section) The commissioner, pursuant to the
14 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
15 seq.), shall adopt rules and regulations to effectuate the purposes of
16 this act. The rules and regulations shall provide for a transition from
17 enrollment in the NJ FamilyCare program to the Medicaid program of
18 parents or caretaker relatives who become eligible for Medicaid in
19 2006 as a result of the changes in the Medicaid income eligibility levels
20 provided for in this act.
21
22 17. P.L.1997, c.272 (C.30:4I-1 et seq.) and P.L.2000, c.71
23 (C.30:4J-1 et seq.) are repealed.
24
25 18. This act shall take effect on the 180th day after enactment,
26 except that section 8 shall take effect on September 1, 2005, sections
27 10, 14 and 15 shall take effect immediately, and the commissioner shall
28 take such anticipatory administrative action in advance as may be
29 necessary to carry out the purposes of this act.
30
31
32 ________________
33
34 "Family Health Care Coverage Act"; reestablishes NJ FamilyCare
35 Program, expands eligibility for Medicaid program for parents and
36 adults without dependent children and provides for pharmaceutical
37 manufacturer rebates for GA program.

SENATE, No. 2236

STATE OF NEW JERSEY

211th LEGISLATURE

INTRODUCED JANUARY 24, 2005

Sponsored by:
Senator JOSEPH F. VITALE
District 19 (Middlesex)
Senator BARBARA BUONO
District 18 (Middlesex)

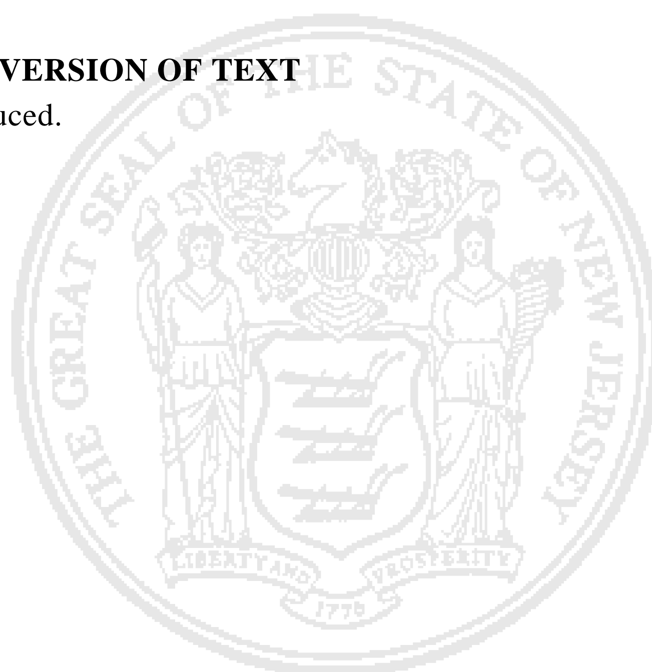
Co-Sponsored by:
Senators T.Kean, Madden, Rice and Singer

SYNOPSIS

"Family Health Care Coverage Act"; reestablishes NJ FamilyCare Program and expands eligibility for Medicaid program for parents and adults without dependent children.

CURRENT VERSION OF TEXT

As introduced.



(Sponsorship Updated As Of: 1/25/2005)

AN ACT concerning health care coverage for children and their parents and revising parts of the statutory law.

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 "Family Health Care Coverage Act."

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

a. The most serious health problem facing approximately 1.2 million New Jersey residents, including approximately 264,000 children, is lack of access to affordable health care coverage, which forces too many New Jersey families to go without needed preventive and other nonemergency care until serious illness requires expensive hospital care.

b. Research has shown that affordable and accessible health care coverage for parents can benefit their children, since parents who have a connection to ongoing health care coverage are more likely to ensure that their children get necessary immunizations and regular checkups from a primary care provider. Adults and children who lack insurance coverage forgo care until medical conditions, which were either preventable or treatable at the outset, require more extensive and expensive intervention or treatment.

c. Children with health care coverage have a significantly greater opportunity to be healthier, realize their full educational and developmental potential and become productive citizens. Providing health care coverage for uninsured adults increases worker productivity and can reduce dependence on public assistance and other State-subsidized programs including hospital charity care.

d. The federal State Children's Health Insurance Program (SCHIP), established in 1997 as Title XXI of the federal Social Security Act, allows a state to establish a health insurance program for low-income children. In response to the enactment of SCHIP, New Jersey established the NJ KidCare program in 1997 and the NJ FamilyCare program in 2000 to provide subsidized private health insurance coverage to children whose family income does not exceed 350% of the federal poverty level (FPL) and to their parents if their income does not exceed 200% of the FPL. NJ FamilyCare also provided coverage for adults without children whose income did not exceed 100% of the FPL.

Upon the establishment of NJ FamilyCare, the two programs were combined and administered as NJ FamilyCare. Within a short time,

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.

1 enrollment of adults far exceeded expectations and available funding,
2 and various changes were made to the program to contain costs, such
3 as scaling back benefits, limiting eligibility to parents and other adults
4 who were already enrolled in, or had applied for, the program as of
5 June 14, 2002, and no longer accepting any new applications from
6 parents or other adults.
7 e. Initially, NJ FamilyCare appreciably reduced the costs of charity
8 care provided by hospitals, but when NJ FamilyCare coverage for
9 parents and other adults was curtailed, charity care costs again
10 increased.
11 f. In order to (1) ensure that the original purpose of NJ FamilyCare
12 is realized, that is, low income parents as well as their children are
13 given access to health insurance coverage, (2) increase enrollment of
14 children, and (3) maximize federal financial participation under both
15 the State Medicaid and NJ FamilyCare programs, it is necessary and
16 appropriate to restore coverage for parents of children who qualify for
17 Medicaid or NJ FamilyCare, by increasing income eligibility levels,
18 over a three-year period, for parents under the Medicaid program to
19 200% of the FPL. Further, to provide for a more comprehensive health
20 care system, it is also necessary and appropriate to restore coverage
21 through the Medicaid program, over a three-year period, for adults
22 without dependent children whose income is up to 100% of the FPL,
23 subject to the availability of federal Medicaid funds.
24 g. Since 2002, the number of parents enrolled in NJ FamilyCare has
25 steadily declined and the growth in coverage of children has slowed.
26 Current application and renewal procedures create unnecessary
27 barriers for applicants and enrollees, and have contributed to a decline
28 in the enrollment of additional children and in the retention of
29 enrollees. Experience in other states suggests that adopting certain
30 enrollment simplification reforms in both the NJ FamilyCare and
31 Medicaid programs can significantly increase enrollment and retention
32 of eligible children and their parents.
33 h. The expanded health care coverage provided by this act builds
34 on New Jersey's longstanding commitment to assure access to quality
35 health care that is provided in an efficient and effective manner and at
36 a reasonable cost.
37
38 3. (New section) The NJ FamilyCare Program is established in the
39 Department of Human Services.
40
41 4. (New section) As used in this act:
42 "Commissioner" means the Commissioner of Human Services.
43 "Department" means the Department of Human Services.
44 "Medicaid" means the New Jersey Medical Assistance and Health
45 Services Program established pursuant to P.L.1968, c.413 (C.30:4D-1
46 et seq.).

1 "NJ FamilyCare" or "program" means the NJ FamilyCare Program
2 established pursuant to sections 3 through 5 of P.L. , c.
3 (C.)(pending before the Legislature as this bill).
4 "Poverty level" means the official federal poverty level based on
5 family size, established and adjusted under Section 673(2) of Subtitle
6 B, the "Community Services Block Grant Act," Pub.L.97-35 (42
7 U.S.C. s.9902(2)).
8 "Qualified applicant" means:
9 a. a child under 19 years of age: (1) whose family gross income
10 does not exceed 350% of the poverty level; (2) who has no health
11 insurance, as determined by the commissioner, and is ineligible for
12 Medicaid; (3) who is a resident of this State; and (4) who is a citizen
13 of the United States, or has been lawfully admitted for permanent
14 residence into and remains lawfully present in the United States;
15 b. a parent or caretaker: (1) whose gross family income does not
16 exceed 200% of the poverty level; (2) who is enrolled in NJ
17 FamilyCare on the effective date of P.L. , c. (C.)(pending before
18 the Legislature as this bill); (3) who has no health insurance, as
19 determined by the commissioner, and is ineligible for Medicaid; (4)
20 who is a resident of this State; and (5) who is a citizen of the United
21 States, or has been lawfully admitted for permanent residence into and
22 remains lawfully present in the United States; and
23 c. a single adult or couple without dependent children: (1) whose
24 family gross income does not exceed 100% of the poverty level; (2)
25 who is enrolled in NJ FamilyCare on the effective date of P.L. ,
26 c. (C.)(pending before the Legislature as this bill) and is
27 ineligible for Medicaid; (3) who is a resident of this State; and (4) who
28 is a citizen of the United States, or has been lawfully admitted for
29 permanent residence into and remains lawfully present in the United
30 States.
31
32 5. (New section) a. The purpose of the program shall be to
33 provide subsidized health insurance coverage, and other health care
34 benefits as determined by the commissioner, to children under 19 years
35 of age and their parents or caretakers and to adults without dependent
36 children, within the limits of funds appropriated or otherwise made
37 available for the program.
38 The program shall require families to pay copayments and make
39 premium contributions, based upon a sliding income scale. The
40 program shall include the provision of well-child and other preventive
41 services, hospitalization, physician care, laboratory and x-ray services,
42 prescription drugs, mental health services, and other services as
43 determined by the commissioner.
44 b. The commissioner shall take such actions as are necessary to
45 implement and operate the program in accordance with the State

1 Children's Health Insurance Program established pursuant to 42
2 U.S.C.s.1397aa et seq.
3 c. The commissioner:
4 (1) shall, by regulation, establish standards for determining
5 eligibility and other program requirements, including, but not limited
6 to, restrictions on voluntary disenrollments from existing health
7 insurance coverage;
8 (2) shall require that a parent or caretaker who is a qualified
9 applicant purchase coverage, if available, through an
10 employer-sponsored health insurance plan which is determined to be
11 cost-effective and is approved by the commissioner, and shall provide
12 assistance to the qualified applicant to purchase that coverage, except
13 that the provisions of this paragraph shall not be construed to require
14 an employer to provide health insurance coverage for any employee or
15 employee's spouse or dependent child;
16 (3) may, by regulation, establish plans of coverage and benefits to
17 be covered under the program, except that the provisions of this
18 section shall not apply to coverage for medications used exclusively to
19 treat AIDS or HIV infection; and
20 (4) shall establish, by regulation, other requirements for the
21 program, including, but not limited to, premium payments and
22 copayments, and may contract with one or more appropriate entities,
23 including managed care organizations, to assist in administering the
24 program. The period for which eligibility for the program is
25 determined shall be the maximum period permitted under federal law.
26 d. The commissioner shall establish procedures for determining
27 eligibility, which shall include, at a minimum, the following enrollment
28 simplification practices:
29 (1) A streamlined application form as established pursuant to
30 subsection k. of this section;
31 (2) Self declaration of income for new applicants. The
32 commissioner may establish such retrospective auditing or income
33 verification procedures as he deems appropriate, such as sample
34 auditing and matching reported income with records of the
35 Department of the Treasury or the Department of Labor. If the
36 commissioner elects to match reported income with confidential
37 records of the Department of the Treasury, the commissioner shall
38 require an applicant to provide written authorization for the Division
39 of Taxation in the Department of the Treasury to release applicable tax
40 information to the commissioner for the purposes of establishing
41 income eligibility for the program. The authorization, which shall be
42 included on the program application form, shall be developed by the
43 commissioner, in consultation with the State Treasurer;
44 (3) Online enrollment and renewal, in addition to enrollment and
45 renewal by mail. The online enrollment and renewal forms shall
46 include electronic links to other State and federal health and social

services programs;
(4) Continuous enrollment;
(5) Automatic, passive renewal if an enrollee does not indicate any change in circumstances or if the enrollee has established eligibility for another income-tested State or federal program, such as Food Stamps or the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), whose income eligibility limits are equal to or less than that of NJ FamilyCare. The commissioner may establish such auditing or income verification procedures as he deems appropriate, as provided in paragraph (1) of this subsection; and
(6) Provision of program eligibility-identification cards that are issued no more frequently than once a year.
e. The commissioner 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. In this regard, notwithstanding the definition of "qualified applicant," the commissioner may enroll in the program such children or their parents or caretakers who may otherwise be eligible for the Medicaid program in order to maximize use of federal funds that may be available pursuant to 42 U.S.C. s.1397aa et seq.
f. Subject to federal approval, a child shall be determined ineligible for the program if the child was voluntarily disenrolled from employer-sponsored group insurance coverage within six months prior to application to the program.
g. The commissioner shall provide, by regulation, for presumptive eligibility for the program in accordance with the following provisions:
(1) A child who presents himself for treatment at a general hospital, federally qualified or community health center, local health department that provides primary care, or other State licensed health care provider that provides primary care shall be deemed presumptively eligible for the program if a preliminary determination by hospital, health center, local health department or licensed health care provider staff indicates that the child meets program eligibility standards and is a member of a household with an income that does not exceed 350% of the poverty level;
(2) The provisions of paragraph (1) of this subsection shall also apply to a child who is deemed presumptively eligible for Medicaid coverage pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.);
(3) The parent or caretaker of a child deemed presumptively eligible pursuant to this subsection shall be required to submit a completed application for the program no later than the end of the month following the month in which presumptive eligibility is determined;
(4) A child shall be eligible to receive all services covered by the

program during the period in which the child is presumptively eligible; and

(5) The commissioner may, by regulation, establish a limit on the number of times a child may be deemed presumptively eligible for NJ FamilyCare.

h. The commissioner, in consultation with the Commissioner of Education, shall administer an ongoing enrollment initiative to provide outreach to children throughout the State who may be eligible for the program.

(1) With respect to school-age children, the commissioner, in consultation with the Commissioner of Education and the Secretary of Agriculture, shall develop a form that provides information about the NJ FamilyCare and Medicaid programs and provides an opportunity for the parent or guardian who signs the school lunch application form to give consent for information to be shared with the Department of Human Services for the purpose of determining eligibility for the programs. The form shall be attached to, included with, or incorporated into, the school lunch application form.

The commissioner, in consultation with the Commissioner of Education, shall establish procedures for schools to transmit information attached to, included with, or provided on the school lunch application form regarding the NJ FamilyCare and Medicaid programs to the Department of Human Services, in order to enable the department to determine eligibility for the programs.

(2) The commissioner or the Commissioner of Education, as applicable, shall:

(a) make available to each elementary and secondary school, licensed child care center, registered family day care home, unified child care agency, local health department that provides primary care, and community-based primary care provider, informational materials about the program, including instructions for applying online or by mail, as well as copies of the program application form.

The entity shall make the informational and application materials available, upon request, to persons interested in the program; and

(b) request each entity to distribute a notice at least annually, as developed by the commissioner, to households of children attending or receiving its services or care, informing them about the program and the availability of informational and application materials. In the case of elementary and secondary schools, the information attached to, included with, or incorporated into, the school lunch application form for school-age children pursuant to this subparagraph shall be deemed to meet the requirements of this paragraph.

i. Subject to federal approval, the commissioner shall, by regulation, establish that in determining income eligibility for a child, any gross family income above 200% of the poverty level, up to a maximum of 350% of the poverty level, shall be disregarded.

1 j. The commissioner shall establish a NJ FamilyCare coverage buy-
2 in program through which a parent or caretaker whose family income
3 exceeds 350% of the poverty level may purchase coverage under NJ
4 FamilyCare for a child under the age of 19, who is uninsured and was
5 not voluntarily disenrolled from employer-sponsored group insurance
6 coverage within six months prior to application to the program.
7 The commissioner shall establish the premium and cost sharing
8 amounts required to purchase coverage, except that the premium shall
9 not exceed the amount the program pays per month to a managed care
10 organization under NJ FamilyCare for a child of comparable age
11 whose family income is between 200% and 350% of the poverty level,
12 plus a reasonable processing fee.
13 k. The commissioner, in consultation with the Rutgers Center for
14 State Health Policy, shall develop a streamlined application form for
15 the NJ FamilyCare and Medicaid programs.
16
17 6. (New section) Whenever the terms "Children's Health Care
18 Coverage Program," "NJ KidCare," "FamilyCare Health Coverage
19 Program" or "NJ FamilyCare" occur or any reference is made thereto
20 in any law, contract or document, the same shall be deemed to mean
21 or refer to the NJ FamilyCare Program established pursuant to
22 P.L. , c. (C.)(pending before the Legislature as this bill).
23
24 7. Section 3 of P.L.1999, c.171 (C.18A:40-34) is amended to read
25 as follows:
26 3. The Commissioner of Education, in consultation with the
27 Commissioner of Human Services and pursuant to the "Administrative
28 Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt
29 regulations to:
30 a. provide for the implementation by the board of education in each
31 school district of such procedures by each public elementary and
32 secondary school in the district as the commissioner deems necessary
33 to effectuate the purposes of subsection [f. of section 4 of P.L.1997,
34 c.272 (C.30:4I-4)] h. of section 5 of P.L. , c. (C.)(pending before
35 the Legislature as this bill); and
36 b. facilitate and provide for the participation of nonpublic
37 elementary and secondary schools in the [partnership] enrollment
38 initiative created pursuant to subsection [f. of section 4 of P.L.1997,
39 c.272 (C.30:4I-4), including the provision of in-kind awards to
40 participating nonpublic schools, in the form of educational resource
41 materials that would be the property of the public schools, for each
42 household enrolled in the Children's Health Care Coverage Program
43 established pursuant to P.L.1997, c.272 (C.30:4I-1 et seq.) which was
44 referred by the nonpublic school] h. of section 5 of P.L. , c.
45 (C.)(pending before the Legislature as this bill).
46 (cf: P.L.1999, c.171, s.3)

1 8. Section 3 of P.L.1968, c.413 (C.30:4D-3) is amended to read as
2 follows:
3 30:4D-3 Definitions.
4 3. Definitions. As used in this act, and unless the context
5 otherwise requires:
6 a. "Applicant" means any person who has made application for
7 purposes of becoming a "qualified applicant."
8 b. "Commissioner" means the Commissioner of Human Services.
9 c. "Department" means the Department of Human Services, which
10 is herein designated as the single State agency to administer the
11 provisions of this act.
12 d. "Director" means the Director of the Division of Medical
13 Assistance and Health Services.
14 e. "Division" means the Division of Medical Assistance and Health
15 Services.
16 f. "Medicaid" means the New Jersey Medical Assistance and Health
17 Services Program.
18 g. "Medical assistance" means payments on behalf of recipients to
19 providers for medical care and services authorized under this act.
20 h. "Provider" means any person, public or private institution,
21 agency or business concern approved by the division lawfully
22 providing medical care, services, goods and supplies authorized under
23 this act, holding, where applicable, a current valid license to provide
24 such services or to dispense such goods or supplies.
25 i. "Qualified applicant" means a person who is a resident of this
26 State, and either a citizen of the United States or an eligible alien, and
27 is determined to need medical care and services as provided under this
28 act, with respect to whom the period for which eligibility to be a
29 recipient is determined shall be the maximum period permitted under
30 federal law, and who:
31 (1) Is a dependent child or parent or caretaker relative of a
32 dependent child who would be, except for resources, eligible for the
33 temporary assistance for needy families program under the State Plan
34 for Title IV-A of the federal Social Security Act as of July 16, 1996;
35 (2) Is a recipient of Supplemental Security Income for the Aged,
36 Blind and Disabled under Title XVI of the Social Security Act;
37 (3) Is an "ineligible spouse" of a recipient of Supplemental Security
38 Income for the Aged, Blind and Disabled under Title XVI of the Social
39 Security Act, as defined by the federal Social Security Administration;
40 (4) Would be eligible to receive Supplemental Security Income
41 under Title XVI of the federal Social Security Act or, without regard
42 to resources, would be eligible for the temporary assistance for needy
43 families program under the State Plan for Title IV-A of the federal
44 Social Security Act as of July 16, 1996, except for failure to meet an
45 eligibility condition or requirement imposed under such State program
46 which is prohibited under Title XIX of the federal Social Security Act

1 such as a durational residency requirement, relative responsibility,
2 consent to imposition of a lien;
3 (5) (Deleted by amendment, P.L.2000, c.71).
4 (6) Is an individual under 21 years of age who, without regard to
5 resources, would be, except for dependent child requirements, eligible
6 for the temporary assistance for needy families program under the
7 State Plan for Title IV-A of the federal Social Security Act as of July
8 16, 1996, or groups of such individuals, including but not limited to,
9 children in resource family placement under supervision of the Division
10 of Youth and Family Services whose maintenance is being paid in
11 whole or in part from public funds, children placed in a resource family
12 home or institution by a private adoption agency in New Jersey or
13 children in intermediate care facilities, including developmental centers
14 for the developmentally disabled, or in psychiatric hospitals;
15 (7) Would be eligible for the Supplemental Security Income
16 program, but is not receiving such assistance and applies for medical
17 assistance only;
18 (8) Is determined to be medically needy and meets all the eligibility
19 requirements described below:
20 (a) The following individuals are eligible for services, if they are
21 determined to be medically needy:
22 (i) Pregnant women;
23 (ii) Dependent children under the age of 21;
24 (iii) Individuals who are 65 years of age and older; and
25 (iv) Individuals who are blind or disabled pursuant to either 42
26 C.F.R.435.530 et seq. or 42 C.F.R.435.540 et seq., respectively.
27 (b) The following income standard shall be used to determine
28 medically needy eligibility:
29 (i) For one person and two person households, the income standard
30 shall be the maximum allowable under federal law, but shall not exceed
31 133 1/3% of the State's payment level to two person households under
32 the temporary assistance for needy families program under the State
33 Plan for Title IV-A of the federal Social Security Act in effect as of
34 July 16, 1996; and
35 (ii) For households of three or more persons, the income standard
36 shall be set at 133 1/3% of the State's payment level to similar size
37 households under the temporary assistance for needy families program
38 under the State Plan for Title IV-A of the federal Social Security Act
39 in effect as of July 16, 1996.
40 (c) The following resource standard shall be used to determine
41 medically needy eligibility:
42 (i) For one person households, the resource standard shall be 200%
43 of the resource standard for recipients of Supplemental Security
44 Income pursuant to 42 U.S.C. s.1382(1)(B);
45 (ii) For two person households, the resource standard shall be
46 200% of the resource standard for recipients of Supplemental Security

1 Income pursuant to 42 U.S.C. s.1382(2)(B);
2 (iii) For households of three or more persons, the resource
3 standard in subparagraph (c)(ii) above shall be increased by $100.00
4 for each additional person; and
5 (iv) The resource standards established in (i), (ii), and (iii) are
6 subject to federal approval and the resource standard may be lower if
7 required by the federal Department of Health and Human Services.
8 (d) Individuals whose income exceeds those established in
9 subparagraph (b) of paragraph (8) of this subsection may become
10 medically needy by incurring medical expenses as defined in 42
11 C.F.R.435.831(c) which will reduce their income to the applicable
12 medically needy income established in subparagraph (b) of paragraph
13 (8) of this subsection.
14 (e) A six-month period shall be used to determine whether an
15 individual is medically needy.
16 (f) Eligibility determinations for the medically needy program shall
17 be administered as follows:
18 (i) County welfare agencies and other entities designated by the
19 commissioner are responsible for determining and certifying the
20 eligibility of pregnant women and dependent children. The division
21 shall reimburse county welfare agencies for 100% of the reasonable
22 costs of administration which are not reimbursed by the federal
23 government for the first 12 months of this program's operation.
24 Thereafter, 75% of the administrative costs incurred by county welfare
25 agencies which are not reimbursed by the federal government shall be
26 reimbursed by the division;
27 (ii) The division is responsible for certifying the eligibility of
28 individuals who are 65 years of age and older and individuals who are
29 blind or disabled. The division may enter into contracts with county
30 welfare agencies to determine certain aspects of eligibility. In such
31 instances the division shall provide county welfare agencies with all
32 information the division may have available on the individual.
33 The division shall notify all eligible recipients of the Pharmaceutical
34 Assistance to the Aged and Disabled program, P.L.1975, c.194
35 (C.30:4D-20 et seq.) on an annual basis of the medically needy
36 program and the program's general requirements. The division shall
37 take all reasonable administrative actions to ensure that
38 Pharmaceutical Assistance to the Aged and Disabled recipients, who
39 notify the division that they may be eligible for the program, have their
40 applications processed expeditiously, at times and locations convenient
41 to the recipients; and
42 (iii) The division is responsible for certifying incurred medical
43 expenses for all eligible persons who attempt to qualify for the
44 program pursuant to subparagraph (d) of paragraph (8) of this
45 subsection;
46 (9) (a) Is a child who is at least one year of age and under 19 years

1 of age and, if older than six years of age but under 19 years of age, is
2 uninsured; and
3 (b) Is a member of a family whose income does not exceed 133%
4 of the poverty level and who meets the federal Medicaid eligibility
5 requirements set forth in section 9401 of Pub.L.99-509 (42 U.S.C.
6 s.1396a);
7 (10) Is a pregnant woman who is determined by a provider to be
8 presumptively eligible for medical assistance based on criteria
9 established by the commissioner, pursuant to section 9407 of
10 Pub.L.99-509 (42 U.S.C. s.1396a(a));
11 (11) Is an individual 65 years of age and older, or an individual
12 who is blind or disabled pursuant to section 301 of Pub.L.92-603 (42
13 U.S.C. s.1382c), whose income does not exceed 100% of the poverty
14 level, adjusted for family size, and whose resources do not exceed
15 100% of the resource standard used to determine medically needy
16 eligibility pursuant to paragraph (8) of this subsection;
17 (12) Is a qualified disabled and working individual pursuant to
18 section 6408 of Pub.L.101-239 (42 U.S.C. s.1396d) whose income
19 does not exceed 200% of the poverty level and whose resources do
20 not exceed 200% of the resource standard used to determine eligibility
21 under the Supplemental Security Income Program, P.L.1973, c.256
22 (C.44:7-85 et seq.);
23 (13) Is a pregnant woman or is a child who is under one year of
24 age and is a member of a family whose income does not exceed 185%
25 of the poverty level and who meets the federal Medicaid eligibility
26 requirements set forth in section 9401 of Pub.L.99-509 (42 U.S.C.
27 s.1396a), except that a pregnant woman who is determined to be a
28 qualified applicant shall, notwithstanding any change in the income of
29 the family of which she is a member, continue to be deemed a qualified
30 applicant until the end of the 60-day period beginning on the last day
31 of her pregnancy;
32 (14) (Deleted by amendment, P.L.1997, c.272).
33 (15) (a) Is a specified low-income Medicare beneficiary pursuant
34 to 42 U.S.C. s.1396a(a)10(E)iii whose resources beginning January 1,
35 1993 do not exceed 200% of the resource standard used to determine
36 eligibility under the Supplemental Security Income program, P.L.1973,
37 c.256 (C.44:7-85 et seq.) and whose income beginning January 1,
38 1993 does not exceed 110% of the poverty level, and beginning
39 January 1, 1995 does not exceed 120% of the poverty level.
40 (b) An individual who has, within 36 months, or within 60 months
41 in the case of funds transferred into a trust, of applying to be a
42 qualified applicant for Medicaid services in a nursing facility or a
43 medical institution, or for home or community-based services under
44 section 1915(c) of the federal Social Security Act (42 U.S.C.
45 s.1396n(c)), disposed of resources or income for less than fair market
46 value shall be ineligible for assistance for nursing facility services, an

1 equivalent level of services in a medical institution, or home or
2 community-based services under section 1915(c) of the federal Social
3 Security Act (42 U.S.C. s.1396n(c)). The period of the ineligibility
4 shall be the number of months resulting from dividing the
5 uncompensated value of the transferred resources or income by the
6 average monthly private payment rate for nursing facility services in
7 the State as determined annually by the commissioner. In the case of
8 multiple resource or income transfers, the resulting penalty periods
9 shall be imposed sequentially. Application of this requirement shall be
10 governed by 42 U.S.C. s.1396p(c). In accordance with federal law,
11 this provision is effective for all transfers of resources or income made
12 on or after August 11, 1993. Notwithstanding the provisions of this
13 subsection to the contrary, the State eligibility requirements
14 concerning resource or income transfers shall not be more restrictive
15 than those enacted pursuant to 42 U.S.C. s.1396p(c).
16 (c) An individual seeking nursing facility services or home or
17 community-based services and who has a community spouse shall be
18 required to expend those resources which are not protected for the
19 needs of the community spouse in accordance with section 1924(c) of
20 the federal Social Security Act (42 U.S.C. s.1396r-5(c)) on the costs
21 of long-term care, burial arrangements, and any other expense deemed
22 appropriate and authorized by the commissioner. An individual shall
23 be ineligible for Medicaid services in a nursing facility or for home or
24 community-based services under section 1915(c) of the federal Social
25 Security Act (42 U.S.C. s.1396n(c)) if the individual expends funds in
26 violation of this subparagraph. The period of ineligibility shall be the
27 number of months resulting from dividing the uncompensated value of
28 transferred resources and income by the average monthly private
29 payment rate for nursing facility services in the State as determined by
30 the commissioner. The period of ineligibility shall begin with the
31 month that the individual would otherwise be eligible for Medicaid
32 coverage for nursing facility services or home or community-based
33 services.
34 This subparagraph shall be operative only if all necessary approvals
35 are received from the federal government including, but not limited to,
36 approval of necessary State plan amendments and approval of any
37 waivers;
38 (16) Subject to federal approval under Title XIX of the federal
39 Social Security Act, is a dependent child, parent or specified caretaker
40 relative of a child who is a qualified applicant, who would be eligible,
41 without regard to resources, for the temporary assistance for needy
42 families program under the State Plan for Title IV-A of the federal
43 Social Security Act as of July 16, 1996, except for the income
44 eligibility requirements of that program, and whose family earned
45 income beginning January 1, 2006 does not exceed 133% of the
46 poverty level, beginning January 1, 2007 does not exceed 150% of the

1 poverty level and beginning January 1, 2008 does not exceed 200% of
2 the poverty level, plus such earned income disregards as shall be
3 determined according to a methodology to be established by regulation
4 of the commissioner. In the case of dependent children and parents or
5 specified caretaker relatives whose family earned income is at least
6 150% and does not exceed 200% of the poverty level, the
7 commissioner shall seek a federal waiver to permit the department to
8 require copayments and premium contributions based on a sliding
9 income scale;
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 resource family care under the care and custody of the Division of
15 Youth and Family Services and whose maintenance was being paid in
16 whole or in part from public funds;
17 (18) Is a person between the ages of 16 and 65 who is permanently
18 disabled and working, and:
19 (a) whose income is at or below 250% of the poverty level, plus
20 other established disregards;
21 (b) who pays the premium contribution and other cost sharing as
22 established by the commissioner, subject to the limits and conditions
23 of federal law; and
24 (c) whose assets, resources and unearned income do not exceed
25 limitations as established by the commissioner; **[**or**]**
26 (19) Is an uninsured individual under 65 years of age who:
27 (a) has been screened for breast or cervical cancer under the
28 federal Centers for Disease Control and Prevention breast and cervical
29 cancer early detection program;
30 (b) requires treatment for breast or cervical cancer based upon
31 criteria established by the commissioner;
32 (c) has an income that does not exceed the income standard
33 established by the commissioner pursuant to federal guidelines;
34 (d) meets all other Medicaid eligibility requirements; and
35 (e) in accordance with Pub.L.106-354, is determined by a qualified
36 entity to be presumptively eligible for medical assistance pursuant to
37 42 U.S.C. s.1396a(aa), based upon criteria established by the
38 commissioner pursuant to section 1920B of the federal Social Security
39 Act (42 U.S.C. s.1396r-1b); or
40 (20) Subject to federal approval under Title XIX of the federal
41 Social Security Act, is a single adult or couple, without dependent
42 children, whose income in 2006 does not exceed 50% of the poverty
43 level, in 2007 does not exceed 75% of the poverty level and in 2008
44 and each year thereafter does not exceed 100% of the poverty level;
45 except that a person who is a recipient of Work First New Jersey
46 general public assistance, pursuant to P.L.1947, c.156 (C.44:8-107 et

1 <u>seq.), shall not be a qualified applicant</u>.
2 j. "Recipient" means any qualified applicant receiving benefits
3 under this act.
4 k. "Resident" means a person who is living in the State voluntarily
5 with the intention of making his home here and not for a temporary
6 purpose. Temporary absences from the State, with subsequent returns
7 to the State or intent to return when the purposes of the absences have
8 been accomplished, do not interrupt continuity of residence.
9 l. "State Medicaid Commission" means the Governor, the
10 Commissioner of Human Services, the President of the Senate and the
11 Speaker of the General Assembly, hereby constituted a commission to
12 approve and direct the means and method for the payment of claims
13 pursuant to this act.
14 m. "Third party" means any person, institution, corporation,
15 insurance company, group health plan as defined in section 607(1) of
16 the federal "Employee Retirement and Income Security Act of 1974,"
17 29 U.S.C. s.1167(1), service benefit plan, health maintenance
18 organization, or other prepaid health plan, or public, private or
19 governmental entity who is or may be liable in contract, tort, or
20 otherwise by law or equity to pay all or part of the medical cost of
21 injury, disease or disability of an applicant for or recipient of medical
22 assistance payable under this act.
23 n. "Governmental peer grouping system" means a separate class of
24 skilled nursing and intermediate care facilities administered by the
25 State or county governments, established for the purpose of screening
26 their reported costs and setting reimbursement rates under the
27 Medicaid program that are reasonable and adequate to meet the costs
28 that must be incurred by efficiently and economically operated State
29 or county skilled nursing and intermediate care facilities.
30 o. "Comprehensive maternity or pediatric care provider" means any
31 person or public or private health care facility that is a provider and
32 that is approved by the commissioner to provide comprehensive
33 maternity care or comprehensive pediatric care as defined in
34 subsection b. (18) and (19) of section 6 of P.L.1968, c.413
35 (C.30:4D-6).
36 p. "Poverty level" means the official poverty level based on family
37 size established and adjusted under Section 673(2) of Subtitle B, the
38 "Community Services Block Grant Act," of Pub.L.97-35 (42 U.S.C.
39 s.9902(2)).
40 q. "Eligible alien" means one of the following:
41 (1) an alien present in the United States prior to August 22, 1996,
42 who is:
43 (a) a lawful permanent resident;
44 (b) a refugee pursuant to section 207 of the federal "Immigration
45 and Nationality Act" (8 U.S.C. s.1157);
46 (c) an asylee pursuant to section 208 of the federal "Immigration

1 and Nationality Act" (8 U.S.C. s.1158);
2 (d) an alien who has had deportation withheld pursuant to section
3 243(h) of the federal "Immigration and Nationality Act" (8 U.S.C.
4 s.1253 (h));
5 (e) an alien who has been granted parole for less than one year by
6 the U.S. Citizenship and Immigration Services pursuant to section
7 212(d)(5) of the federal "Immigration and Nationality Act" (8 U.S.C.
8 s.1182(d)(5));
9 (f) an alien granted conditional entry pursuant to section 203(a)(7)
10 of the federal "Immigration and Nationality Act" (8 U.S.C.
11 s.1153(a)(7)) in effect prior to April 1, 1980; or
12 (g) an alien who is honorably discharged from or on active duty in
13 the United States armed forces and the alien's spouse and unmarried
14 dependent child.
15 (2) An alien who entered the United States on or after August 22,
16 1996, who is:
17 (a) an alien as described in paragraph (1)(b), (c), (d) or (g) of this
18 subsection; or
19 (b) an alien as described in paragraph (1)(a), (e) or (f) of this
20 subsection who entered the United States at least five years ago.
21 (3) A legal alien who is a victim of domestic violence in
22 accordance with criteria specified for eligibility for public benefits as
23 provided in Title V of the federal "Illegal Immigration Reform and
24 Immigrant Responsibility Act of 1996" (8 U.S.C. s.1641).
25 (cf: P.L.2004, c.130, s.93)
26
27 9. (New section) No later than January 1, 2006, the Commissioner
28 of Human Services shall, at a minimum, establish the following
29 enrollment simplification practices for dependent children and their
30 parents or specified caretaker relatives who are applicants for or
31 recipients of the Medicaid program:
32 a. A streamlined application form as established pursuant to
33 subsection k. of section 5 of P.L. , c. (C.)(pending before the
34 Legislature as this bill);
35 b. Self declaration of income for new applicants. The commissioner
36 may establish such retrospective auditing or income verification
37 procedures as he deems appropriate, such as sample auditing and
38 matching reported income with records of the Department of the
39 Treasury or the Department of Labor. If the commissioner elects to
40 match reported income with confidential records of the Department of
41 the Treasury, the commissioner shall require an applicant to provide
42 written authorization for the Division of Taxation in the Department
43 of the Treasury to release applicable tax information to the
44 commissioner for the purposes of establishing income eligibility for the
45 program. The authorization, which shall be included on the program
46 application form, shall be developed by the commissioner, in

consultation with the State Treasurer;

c. Online enrollment and renewal, in addition to enrollment and renewal by mail. The online enrollment and renewal forms shall include electronic links to other State and federal health and social services programs;

d. Continuous enrollment;

e. Automatic, passive renewal if a recipient does not indicate any change in circumstances or if the recipient has established eligibility for another income-tested State or federal program, such as Food Stamps or the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), whose income eligibility limits are equal to or less than that of the Medicaid program. The commissioner may establish such auditing or income verification procedures as he deems appropriate, as provided in subsection a. of this section; and

f. Provision of program eligibility-identification cards that are issued no more frequently than once a year.

10. (New section) The commissioner shall apply for such State plan amendments or waivers as may be necessary to implement the provisions of this act and to secure federal financial participation for State Medicaid expenditures under the federal Medicaid program and for NJ FamilyCare expenditures under the State Children's Health Insurance Program pursuant to 42 U.S.C.s.1397aa et seq.

11. (New section) The Commissioner of Human Services shall report to the Chairman of the Senate Health, Human Services and Senior Citizens Committee and the Chairmen of the Assembly Health and Human Services and Assembly Family, Women and Children's Issues committees on the implementation of this act.

The commissioner shall issue an interim report six months after the effective date of this act and shall issue an annual report six months later and once each year thereafter.

The report shall include the number of persons who are enrolled in the Medicaid and NJ FamilyCare programs pursuant to the provisions of this act, the cost of providing coverage for these persons, the status of any Medicaid plan amendments or waivers necessary for implementation of this act, the status of implementing the enrollment simplification practices for both the NJ FamilyCare and Medicaid programs, and such other information as the commissioner deems appropriate. The commissioner may also include any recommendations for legislation he deems necessary to further the purposes of this act.

12. (New section) a. Within one year of the effective date of this act, the Commissioner of Human Services shall:

(1) establish a plan to develop and implement a universal

1 identification card that can be issued to and used by recipients of
2 Medicaid, Work First New Jersey, NJ FamilyCare, food stamps and
3 other public social service and health programs; and
4 (2) prepare a request for proposal to develop an online, interactive
5 database that can be used by health care facilities for enrolling, or
6 determining the status of an application for, children and their parents
7 or caretakers and adults without dependent children who present
8 themselves at the health care facility for services and who may be
9 eligible for NJ FamilyCare or Medicaid. The database shall enable the
10 health care facility to notify a county welfare agency or the appropriate
11 office in the Department of Human Services about a program applicant
12 so that the agency or office can follow-up on the application and
13 complete the eligibility determination process.
14 b. The commissioner shall include in his reports to the Legislature
15 required pursuant to section 11 of P.L. , c. (C.)(pending before the
16 Legislature as this bill) the status of the commissioner's plan for a
17 universal identification card and the request for proposals for an
18 interactive database.
19
20 13. (New section) The commissioner, pursuant to the
21 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
22 seq.), shall adopt rules and regulations to effectuate the purposes of
23 this act. The rules and regulations shall provide for a transition from
24 enrollment in the NJ FamilyCare program to the Medicaid program of
25 children and their parents or caretakers who become eligible for
26 Medicaid in 2006 as a result of the changes in the Medicaid income
27 eligibility levels provided for in this act.
28
29 14. P.L.1997, c.272 (C.30:4I-1 et seq.) and P.L.2000, c.71
30 (C.30:4J-1 et seq.) are repealed.
31
32 15. This act shall take effect on the 180th day after enactment.
33
34
35 STATEMENT
36
37 This bill, the "Family Health Care Coverage Act," reforms the NJ
38 FamilyCare Program and provides for an expansion of NJ FamilyCare
39 and Medicaid eligibility for parents and adults without dependent
40 children, in order to fulfill the original promise of the NJ FamilyCare
41 program to provide health care coverage for low income children, their
42 parents and adults without dependent children.
43 The bill also consolidates the State's NJ KidCare and NJ
44 FamilyCare programs into the NJ FamilyCare Program, and requires
45 the Commissioner of Human Services to adopt various enrollment
46 simplification practices in both the NJ FamilyCare and Medicaid

programs, in order to eliminate unnecessary barriers to enrollment for new applicants and renewal of enrollment for persons who are already participating in the program. The bill takes effect 180 days after its enactment.

Expansion of Eligibility for Health Care Coverage:

- Children up to age 19 whose family gross income is up to 350% of the federal poverty level (FPL) will continue to be eligible for either Medicaid or NJ FamilyCare, based on their family's income.
- Effective January 1, 2006, parents of eligible children whose family earned income does not exceed 133% of the FPL will be eligible for Medicaid (under current law, eligibility for parents is limited to persons whose income does not exceed approximately 34% of the FPL).
- Effective January 1, 2007 parents of eligible children whose family earned income does not exceed 150% of the FPL will be eligible for Medicaid.
- Effective January 1, 2008 parents of eligible children whose family earned income does not exceed 200% of the FPL will be eligible for Medicaid.
- Effective 180 days after the date of enactment, the commissioner shall establish a NJ FamilyCare coverage "buy-in" program through which a parent or caretaker whose family gross income exceeds 350% of the poverty level may purchase coverage under NJ FamilyCare for a child under the age of 19, who is uninsured and was not voluntarily disenrolled from employer-sponsored group insurance coverage within six months prior to application to the program. The premium for coverage shall not exceed the amount the program pays per month to a managed care organization under NJ FamilyCare for a child of comparable age whose family income is between 200% and 350% of the FPL, plus a reasonable processing fee.
- Pending approval from the federal government, adults without dependent children whose income does not exceed 100% of the FPL will be eligible for Medicaid. The income eligibility limit will be phased in over a three-year period.

NJ FamilyCare Program:

The bill reestablishes the NJ FamilyCare program in the Department of Human Services to provide subsidized health insurance coverage for children under 19 years of age and their parents and other adults without dependent children who were enrolled in the program on the effective date of this bill and do not qualify for Medicaid.

Program Requirements:

- Families would be required to pay copayments and premium contributions, based upon a sliding income scale.

- Services covered by the program will include: well-child and other preventive services, hospitalization, physician care, laboratory and x-ray services, prescription drugs, mental health services, and other services as determined by the commissioner.
- A parent or caretaker who is a qualified applicant must purchase coverage, if available, through an employer-sponsored health insurance plan which is determined to be cost-effective and is approved by the commissioner.
- Subject to federal approval, a child shall be determined ineligible for the program if the child was voluntarily disenrolled from employer-sponsored group insurance coverage within six months prior to application to the program.
- Presumptive eligibility is authorized for children who present themselves for treatment at a general hospital, federally qualified or community health center, local health department that provides primary care or other State licensed health care provider if a preliminary determination by hospital, health center, local health department or health care provider staff indicates that the child meets program eligibility standards. The child's parent or caretaker would be required to submit a completed application for the program no later than the end of the month following the month in which presumptive eligibility is determined in order to maintain the child's eligibility for the program.
- The Commissioner of Human Services may contract with one or more appropriate entities, including managed care organizations, to assist in administering the NJ FamilyCare Program.
- The Commissioner of Human Services, in consultation with the Commissioner of Education, shall administer an ongoing enrollment initiative to provide outreach to children throughout the State who may be eligible for the program.

    --The initiative shall include a school lunch "express enrollment" program whereby a parent or guardian who signs the school lunch application form can give consent for information to be shared with the Department of Human Services for the purpose of determining eligibility for the NJ FamilyCare and Medicaid programs. The bill also requires the commissioners to establish procedures for schools to transmit enrollment information to the Department of Human Services, in order to enable the department to determine eligibility for the programs.

    --The Commissioner of Human Services or the Commissioner of Education, as applicable, also shall make available to each elementary and secondary school, licensed child care center, registered family day care home, unified child care agency, local health department that provides primary care, and community-based primary care provider, informational materials about the program, including instructions for applying online or by mail, as well as

copies of the program application form. The entity would be required to make the informational and application materials available, upon request, to persons interested in the program and to distribute a notice at least annually to households of children attending or receiving its services or care, informing them about the program and the availability of informational and application materials.

NJ FamilyCare and Medicaid Enrollment Reforms:

The Commissioner of Human Services will be required to implement certain enrollment simplification practices for the NJ FamilyCare and Medicaid programs. Implementation of these reforms in the NJ FamilyCare Program will begin 180 days after enactment of the bill, and in the Medicaid program no later than January 1, 2006. The enrollment simplification practices include:

- A streamlined application form that will be developed by the commissioner, in consultation with the Rutgers Center for State Health Policy;
- Self declaration of income for new applicants. In order to verify the income of applicants, the commissioner may establish such retrospective auditing or income verification procedures as he deems appropriate, such as sample auditing and matching reported income with records of the Department of the Treasury or the Department of Labor;
- Online enrollment and renewal, in addition to enrollment and renewal by mail. The online enrollment and renewal forms shall include electronic links to other State and federal health and social services programs;
- Continuous enrollment;
- Automatic, passive renewal if an enrollee does not indicate any change in circumstances or if the enrollee has established eligibility for another income-tested State or federal program, such as Food Stamps or the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), whose income eligibility limits are equal to or less than that of NJ FamilyCare. In order to verify the income of enrollees, the commissioner may establish such auditing or income verification procedures as he deems appropriate, as specified above; and
- Provision of program eligibility-identification cards that are issued no more frequently than once a year.

Implementation:

In order to implement the expansion of eligibility and administrative reforms provided in this bill, and to monitor the implementation, the bill directs the Commissioner of Human Services to:

- Apply for such State plan amendments or waivers as may be

necessary to implement the provisions of the bill and to secure federal financial participation for State Medicaid expenditures under the federal Medicaid program and for NJ FamilyCare expenditures under the State Children's Health Insurance Program.

C Within one year of the effective date of the bill, establish a plan to develop and implement a universal identification card that can be issued to and used by recipients of Medicaid, Work First New Jersey, NJ FamilyCare, food stamps and other public social service and health programs.

C Within one year of the effective date of the bill, prepare a request for proposal to develop an online, interactive database that can be used by health care facilities for enrolling, or determining the status of an application for, children and their parents or caretakers and adults without dependent children who present themselves at the health care facility for services and who may be eligible for NJ FamilyCare or Medicaid. The database shall enable the health care facility to notify a county welfare agency or the appropriate office in the Department of Human Services about a program applicant so that the agency or office can follow-up on the application and complete the eligibility determination process.

C Report to the Chairman of the Senate Health, Human Services and Senior Citizens Committee and the Chairmen of the Assembly Health and Human Services and Assembly Family, Women and Children's Issues committees on the implementation of this bill. The commissioner shall issue an interim report six months after the effective date and shall issue an annual report six months later and once each year thereafter.

Finally, the bill repeals N.J.S.A.30:4I-1 et seq. and 30:4J-1 et seq., which established the NJ KidCare and NJ FamilyCare programs, since these programs are consolidated and reestablished under the provisions of this bill.

ASSEMBLY BUDGET COMMITTEE

STATEMENT TO

SENATE COMMITTEE SUBSTITUTE FOR

SENATE, No. 2236

STATE OF NEW JERSEY

DATED: JUNE 27, 2005

The Assembly Budget Committee reports favorably Senate Bill No. 2236 (SCS).

Senate Bill No. 2336 (SCS), the "Family Health Care Coverage Act," reforms the NJ FamilyCare Program and provides for an expansion of NJ FamilyCare and Medicaid eligibility for parents and adults without dependent children, in order to fulfill the original promise of the NJ FamilyCare program to provide health care coverage for low income children and their parents, and adults without dependent children.

The substitute also consolidates the State's NJ KidCare and NJ FamilyCare programs into the NJ FamilyCare Program, and requires the Commissioner of Human Services to adopt various enrollment simplification practices in both the NJ FamilyCare and Medicaid programs, in order to eliminate unnecessary barriers to enrollment for new applicants and renewal of enrollment for persons who are already participating in the program.

As reported, this bill is identical to Assembly Bill No. 3724 (1R), as also reported by the committee.

Expansion of Eligibility for Health Care Coverage:

C Children up to age 19 whose family gross income is up to 350% of the federal poverty level (FPL) will continue to be eligible for either Medicaid or NJ FamilyCare, based on their family's income.

C Effective September 1, 2005, parents of eligible children whose family earned income does not exceed 100% of the FPL will be eligible for Medicaid (under current law, eligibility for parents is limited to persons whose income does not exceed approximately 34% of the FPL).

C Effective September 1, 2006, parents of eligible children whose family earned income does not exceed 115% of the FPL will be eligible for Medicaid.

C Effective September 1, 2007, parents of eligible children whose family earned income does not exceed 133% of the FPL will be eligible for Medicaid.

C Effective 180 days after the date of enactment, the commissioner

shall establish a NJ FamilyCare coverage "buy-in" program through which a parent or caretaker whose family gross income exceeds 350% of the poverty level may purchase coverage under NJ FamilyCare for a child under the age of 19, who is uninsured and was not voluntarily disenrolled from employer-sponsored group insurance coverage within six months prior to application to the program. The premium for coverage shall not exceed the amount the program pays per month to a managed care organization under NJ FamilyCare for a child of comparable age whose family income is between 200% and 350% of the FPL, plus a reasonable processing fee.

C Pending approval from the federal government, adults without dependent children whose income does not exceed 100% of the FPL will be eligible for Medicaid. The income eligibility limit will be phased in over a three-year period.

NJ FamilyCare Program:

The substitute reestablishes the NJ FamilyCare program in the Department of Human Services to provide subsidized health insurance coverage for children under 19 years of age and their parents and other adults without dependent children who were enrolled in the program on the effective date of this substitute and do not qualify for Medicaid.

Program Requirements:

C Families would be required to pay copayments and premium contributions, based upon a sliding income scale.

C Services covered by the program will include: well-child and other preventive services, hospitalization, physician care, laboratory and x-ray services, prescription drugs, mental health services, and other services as determined by the commissioner.

C A parent or caretaker who is a qualified applicant must purchase coverage, if available, through an employer-sponsored health insurance plan which is determined to be cost-effective and is approved by the commissioner.

C Subject to federal approval, a child shall be determined ineligible for the program if the child was voluntarily disenrolled from employer-sponsored group insurance coverage within six months prior to application to the program.

C Presumptive eligibility is authorized for children who present themselves for treatment at a general hospital, federally qualified or community health center, local health department that provides primary care or other State licensed community-based primary care provider if a preliminary determination by hospital, health center, local health department or health care provider staff indicates that the child meets program eligibility standards. The child's parent or caretaker would be required to submit a completed application for the program no later than the end of the month following the month in which presumptive eligibility is determined in order to maintain the child's eligibility for the program.

- The Commissioner of Human Services may contract with one or more appropriate entities, including managed care organizations, to assist in administering the NJ FamilyCare Program.
- The Commissioner of Human Services, in consultation with the Commissioner of Education, shall administer an ongoing enrollment initiative to provide outreach to children throughout the State who may be eligible for the program.

  --The initiative shall include a school lunch "express enrollment" program whereby a parent or guardian who signs the school lunch application form can give consent for information to be shared with the Department of Human Services for the purpose of determining eligibility for the NJ FamilyCare and Medicaid programs. The substitute also requires the commissioners to establish procedures for schools to transmit enrollment information to the Department of Human Services, in order to enable the department to determine eligibility for the programs.

  -- The Commissioner of Human Services or the Commissioner of Education, as applicable, also shall make available to each elementary and secondary school, licensed child care center, registered family day care home, unified child care agency, local health department that provides primary care, and community-based primary care provider, informational materials about the program, including instructions for applying online or by mail, as well as copies of the program application form. The entity would be required to make the informational and application materials available, upon request, to persons interested in the program and to distribute a notice at least annually to households of children attending or receiving its services or care, informing them about the program and the availability of informational and application materials.

NJ FamilyCare and Medicaid Enrollment Reforms:

The Commissioner of Human Services will be required to implement certain enrollment simplification practices for the NJ FamilyCare and Medicaid programs. Implementation of these reforms in the NJ FamilyCare Program will begin 180 days after enactment of the substitute, and in the Medicaid program no later than January 1, 2006. The enrollment simplification practices include:

- A streamlined application form that will be developed by the commissioner, in consultation with the Rutgers Center for State Health Policy;
- Require new applicants to submit no more than one recent pay stub from the applicant's employer or, if the applicant has more than one employer, no more than one from each of the applicant's employers, to verify income. In the event the applicant cannot provide a recent pay stub, the applicant may submit another form of income verification as deemed appropriate by the commissioner. If an applicant does not submit income verification in a timely

manner, before determining the applicant ineligible for the program, the commissioner shall seek to verify the applicant's income by reviewing available Department of the Treasury or Department of Labor records concerning the applicant, or such other records as the commissioner determines appropriate.

In order to further verify the income of applicants, the commissioner may establish such retrospective auditing or income verification procedures as he deems appropriate, such as sample auditing and matching reported income with records of the Department of the Treasury or the Department of Labor or such other records as the commissioner deems appropriate;

C Online enrollment and renewal, in addition to enrollment and renewal by mail. The online enrollment and renewal forms shall include electronic links to other State and federal health and social services programs;

C Continuous enrollment;

C Simplified renewal by sending an enrollee a preprinted renewal form and requiring the enrollee to sign and return the form, with any applicable changes in the information provided in the form, no later than 30 days after the date the enrollee's annual eligibility expires. In order to verify the income of enrollees, the commissioner may establish such auditing or income verification procedures as he deems appropriate, as specified above; and

C Provision of program eligibility-identification cards that are issued no more frequently than once a year.

Implementation:

In order to implement the expansion of eligibility and administrative reforms provided in this substitute, and to monitor the implementation, the substitute directs the Commissioner of Human Services to:

C Apply for such State plan amendments or waivers as may be necessary to implement the provisions of the substitute and to secure federal financial participation for State Medicaid expenditures under the federal Medicaid program and for NJ FamilyCare expenditures under the State Children's Health Insurance Program.

C Within 60 days of the date of enactment of the substitute, report to the chairmen of the Senate Health, Human Services and Senior Citizens, Assembly Health and Human Services and Assembly Family, Women and Children's Issues committees regarding the department's plans for implementation of the NJ FamilyCare buy-in for children whose income is greater than 350% of the poverty level.

C Within one year of the effective date of the substitute, establish a plan to develop and implement a universal identification card that can be issued to and used by recipients of Medicaid, Work First New Jersey, NJ FamilyCare, food stamps and other public social

service and health programs.

- C Within one year of the effective date of the substitute, prepare a request for proposal to develop an online, interactive database that can be used by health care facilities for enrolling, or determining the status of an application for, children and their parents or caretakers and adults without dependent children who present themselves at the health care facility for services and who may be eligible for NJ FamilyCare or Medicaid. The database shall enable the health care facility to notify a county welfare agency or the appropriate office in the Department of Human Services about a program applicant so that the agency or office can follow-up on the application and complete the eligibility determination process.
- C Report to the chairmen of the Senate Health, Human Services and Senior Citizens, Assembly Health and Human Services and Assembly Family, Women and Children's Issues committees on the implementation of this substitute. The commissioner shall issue an interim report six months after the effective date and an annual report six months later and once each year thereafter.

Pharmaceutical Rebates for General Public Assistance Program, Program Funding:

- C The Commissioner of Human Services is directed to contract with manufacturers of pharmaceutical products to provide rebates for pharmaceutical products covered under the Work First New Jersey General Public Assistance program (WFNJ-GA), established pursuant to N.J.S.A.44:8-107 et seq. on the same basis as is required under the PAAD, Senior Gold and Medicaid programs. A manufacturer would be required to contract with the State as a condition of continued participation in the WFNJ-GA program. These rebates are not intended to establish a new federal "best price," as that term is used in the federal Medicaid law.
- C The monies from the rebates would be used to fund, in part, the expansion of eligibility in the Medicaid program provided in this substitute.
- C The substitute provides that any unexpended balances for the NJ FamilyCare Program shall be appropriated to carry out the purposes of the substitute. Any transfer of NJ FamilyCare appropriations to other accounts shall be subject to the approval of the Joint Budget Oversight Committee.

Repealer and Effective Date of Substitute:

- C The substitute repeals N.J.S.A.30:4I-1 et seq. and 30:4J-1 et seq., which established the NJ KidCare and NJ FamilyCare programs, since these programs are consolidated and reestablished under the provisions of this substitute.
- C The substitute takes effect 180 days after enactment, except that: the Medicaid expansion for parents and caretaker relatives to 100% of the poverty level takes effect on September 1, 2006; the

directive that the commissioner apply for such Medicaid State plan amendments and waivers as are necessary to implement the substitute takes effect immediately; and the WFNJ-GA pharmaceutical rebates and related funding language takes effect immediately.

- The commissioner is directed to take such anticipatory administrative action in advance of the effective date as may be necessary to carry out the purposes of the substitute.

As reported by the committee, this bill is identical to the Assembly Committee Substitute for Assembly Bill No. 3724 (1R) as substituted and reported by the committee.

FISCAL IMPACT:

The Office of Legislative Services (OLS) is unable to estimate the cost of the legislation because State costs will depend on the number of children and adults who apply for and qualify for the NJ FamilyCare and Medicaid programs, respectively, and whether the federal government approves the various State Medicaid Plan amendments or waivers that may be necessary to implement the legislation.

The OLS, however, notes the following:

- In the NJ FamilyCare program, the State spends approximately: $113 per month for each child; $200 per month for each parent; and $390 per month on each adult without dependent children enrolled in the program.
- For every 10,000 additional children determined eligible for NJ FamilyCare, annual gross costs would be about $13.6 million, or between $4.8 - $6.8 million State share, depending on the federal matching rate. The Rutgers Center for State Health Policy (CSHP) provided estimates that indicates, based on data from the 2004 Current Population Survey (CPS) conducted by the US Census Bureau and the 2001-02 New Jersey Family Health Survey, an additional 101,000 children may be eligible for Medicaid or NJ FamilyCare than are currently enrolled in the programs.
- For every 10,000 additional parents determined eligible for Medicaid, annual gross costs would be around $24.0 million, or $12.0 million State share, based on a 50% federal matching rate.
- If a federal Medicaid waiver to cover adults without dependent children is obtained, the annual gross cost of covering 10,000 such adults who are not on General Assistance would be approximately $47.0 million, or $23.5 million State share; however, it is uncertain whether the federal government will approve the waiver, as federal Medicaid law does not recognize this population as being categorically eligible for the program. (NOTE: coverage of these adults will not go into effect unless the waiver is obtained.)

Additionally:

- C The substitute requires pharmaceutical manufacturers to pay rebates for drugs provided under the WFNJ-GA program and appropriates the revenues from the rebates to the Medicaid expansion established in the substitute. The rebates could produce approximately $12 million annually in revenue.
- C Federal revenue (S-CHIP funds), including the recent award of $172 million in redistribution funds, should be sufficient to cover the enrollment of additional children at least for the next year.
- C Costs associated with the legislation should also be offset by reduced State appropriations for Charity Care in future years, as hospitals should experience a reduction in the number of uninsured persons who currently use their facilities to access health care. Other cost offsets may result from administrative simplification procedures in the NJ FamilyCare and Medicaid programs that are established in the bill.

SENATE HEALTH, HUMAN SERVICES AND SENIOR CITIZENS COMMITTEE

STATEMENT TO

SENATE, No. 2236

with committee amendments

STATE OF NEW JERSEY

DATED: JANUARY 24, 2005

The Senate Health, Human Services and Senior Citizens Committee reports favorably and with committee amendments Senate Bill No. 2236.

As amended by committee, this bill, the "Family Health Care Coverage Act," reforms the NJ FamilyCare Program and provides for an expansion of NJ FamilyCare and Medicaid eligibility for parents and adults without dependent children, in order to fulfill the original promise of the NJ FamilyCare program to provide health care coverage for low income children and their parents, and adults without dependent children.

The bill also consolidates the State's NJ KidCare and NJ FamilyCare programs into the NJ FamilyCare Program, and requires the Commissioner of Human Services to adopt various enrollment simplification practices in both the NJ FamilyCare and Medicaid programs, in order to eliminate unnecessary barriers to enrollment for new applicants and renewal of enrollment for persons who are already participating in the program. The bill takes effect 180 days after its enactment.

Expansion of Eligibility for Health Care Coverage:

C Children up to age 19 whose family gross income is up to 350% of the federal poverty level (FPL) will continue to be eligible for either Medicaid or NJ FamilyCare, based on their family's income.

C Effective January 1, 2006, parents of eligible children whose family earned income does not exceed 133% of the FPL will be eligible for Medicaid (under current law, eligibility for parents is limited to persons whose income does not exceed approximately 34% of the FPL).

C Effective January 1, 2007 parents of eligible children whose family earned income does not exceed 150% of the FPL will be eligible for Medicaid.

C Effective January 1, 2008 parents of eligible children whose family earned income does not exceed 200% of the FPL will be eligible

for Medicaid.

- Effective 180 days after the date of enactment, the commissioner shall establish a NJ FamilyCare coverage "buy-in" program through which a parent or caretaker whose family gross income exceeds 350% of the poverty level may purchase coverage under NJ FamilyCare for a child under the age of 19, who is uninsured and was not voluntarily disenrolled from employer-sponsored group insurance coverage within six months prior to application to the program. The premium for coverage shall not exceed the amount the program pays per month to a managed care organization under NJ FamilyCare for a child of comparable age whose family income is between 200% and 350% of the FPL, plus a reasonable processing fee.
- Pending approval from the federal government, adults without dependent children whose income does not exceed 100% of the FPL will be eligible for Medicaid. The income eligibility limit will be phased in over a three-year period.

NJ FamilyCare Program:

The bill reestablishes the NJ FamilyCare program in the Department of Human Services to provide subsidized health insurance coverage for children under 19 years of age and their parents and other adults without dependent children who were enrolled in the program on the effective date of this bill and do not qualify for Medicaid.

Program Requirements:

- Families would be required to pay copayments and premium contributions, based upon a sliding income scale.
- Services covered by the program will include: well-child and other preventive services, hospitalization, physician care, laboratory and x-ray services, prescription drugs, mental health services, and other services as determined by the commissioner.
- A parent or caretaker who is a qualified applicant must purchase coverage, if available, through an employer-sponsored health insurance plan which is determined to be cost-effective and is approved by the commissioner.
- Subject to federal approval, a child shall be determined ineligible for the program if the child was voluntarily disenrolled from employer-sponsored group insurance coverage within six months prior to application to the program.
- Presumptive eligibility is authorized for children who present themselves for treatment at a general hospital, federally qualified or community health center, local health department that provides primary care or other State licensed community-based primary care provider if a preliminary determination by hospital, health center, local health department or health care provider staff indicates that the child meets program eligibility standards. The child's parent or caretaker would be required to submit a completed application for the program no later than the end of the month following the

month in which presumptive eligibility is determined in order to maintain the child's eligibility for the program.

C The Commissioner of Human Services may contract with one or more appropriate entities, including managed care organizations, to assist in administering the NJ FamilyCare Program.

C The Commissioner of Human Services, in consultation with the Commissioner of Education, shall administer an ongoing enrollment initiative to provide outreach to children throughout the State who may be eligible for the program.

--The initiative shall include a school lunch "express enrollment" program whereby a parent or guardian who signs the school lunch application form can give consent for information to be shared with the Department of Human Services for the purpose of determining eligibility for the NJ FamilyCare and Medicaid programs. The bill also requires the commissioners to establish procedures for schools to transmit enrollment information to the Department of Human Services, in order to enable the department to determine eligibility for the programs.

-- The Commissioner of Human Services or the Commissioner of Education, as applicable, also shall make available to each elementary and secondary school, licensed child care center, registered family day care home, unified child care agency, local health department that provides primary care, and community-based primary care provider, informational materials about the program, including instructions for applying online or by mail, as well as copies of the program application form. The entity would be required to make the informational and application materials available, upon request, to persons interested in the program and to distribute a notice at least annually to households of children attending or receiving its services or care, informing them about the program and the availability of informational and application materials.

NJ FamilyCare and Medicaid Enrollment Reforms:

The Commissioner of Human Services will be required to implement certain enrollment simplification practices for the NJ FamilyCare and Medicaid programs. Implementation of these reforms in the NJ FamilyCare Program will begin 180 days after enactment of the bill, and in the Medicaid program no later than January 1, 2006. The enrollment simplification practices include:

C A streamlined application form that will be developed by the commissioner, in consultation with the Rutgers Center for State Health Policy;

C Self declaration of income for new applicants. In order to verify the income of applicants, the commissioner may establish such retrospective auditing or income verification procedures as he deems appropriate, such as sample auditing and matching reported income with records of the Department of the Treasury or the

Department of Labor;

- Online enrollment and renewal, in addition to enrollment and renewal by mail. The online enrollment and renewal forms shall include electronic links to other State and federal health and social services programs;
- Continuous enrollment;
- Automatic, passive renewal if an enrollee does not indicate any change in circumstances or if the enrollee has established eligibility for another income-tested State or federal program, such as Food Stamps or the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), whose income eligibility limits are equal to or less than that of NJ FamilyCare or Medicaid, as applicable. In order to verify the income of enrollees, the commissioner may establish such auditing or income verification procedures as he deems appropriate, as specified above; and
- Provision of program eligibility-identification cards that are issued no more frequently than once a year.

Implementation:

In order to implement the expansion of eligibility and administrative reforms provided in this bill, and to monitor the implementation, the bill directs the Commissioner of Human Services to:

- Apply for such State plan amendments or waivers as may be necessary to implement the provisions of the bill and to secure federal financial participation for State Medicaid expenditures under the federal Medicaid program and for NJ FamilyCare expenditures under the State Children's Health Insurance Program.
- Within one year of the effective date of the bill, establish a plan to develop and implement a universal identification card that can be issued to and used by recipients of Medicaid, Work First New Jersey, NJ FamilyCare, food stamps and other public social service and health programs.
- Within one year of the effective date of the bill, prepare a request for proposal to develop an online, interactive database that can be used by health care facilities for enrolling, or determining the status of an application for, children and their parents or caretakers and adults without dependent children who present themselves at the health care facility for services and who may be eligible for NJ FamilyCare or Medicaid. The database shall enable the health care facility to notify a county welfare agency or the appropriate office in the Department of Human Services about a program applicant so that the agency or office can follow-up on the application and complete the eligibility determination process.
- Report to the Chairman of the Senate Health, Human Services and Senior Citizens Committee and the Chairmen of the Assembly Health and Human Services and Assembly Family, Women and Children's Issues committees on the implementation of this bill.

The commissioner shall issue an interim report six months after the effective date and an annual report six months later and once each year thereafter.

Finally, the bill repeals N.J.S.A.30:4I-1 et seq. and 30:4J-1 et seq., which established the NJ KidCare and NJ FamilyCare programs, since these programs are consolidated and reestablished under the provisions of this bill.

Committee Amendments:

The committee amended the bill to:

- specify that children who present themselves at State-licensed community-based primary care providers, as well as general hospitals, federally qualified or community health centers and local health departments that provide primary care can be determined presumptively eligible for NJ FamilyCare; and

- specify that in addition to directing the Commissioner of Human Services to seek a federal Medicaid waiver to permit the department to require copayments and premium contributions for parents and children with income between 150% and 200% of the poverty level who will be phased-in the Medicaid expansion in 2007 and 2008 (as is currently required in the FamilyCare program), the commissioner shall seek a waiver to provide a benefit package that is comparable to that provided to parents and children under the current FamilyCare program.

SENATE BUDGET AND APPROPRIATIONS COMMITTEE

STATEMENT TO

SENATE COMMITTEE SUBSTITUTE FOR
SENATE, No. 2236

STATE OF NEW JERSEY

DATED: JUNE 23, 2005

The Senate Budget and Appropriations Committee reports favorably a Senate Committee Substitute for Senate Bill No. 2236 .

This committee substitute, the "Family Health Care Coverage Act," reforms the NJ FamilyCare Program and provides for an expansion of NJ FamilyCare and Medicaid eligibility for parents and adults without dependent children, in order to fulfill the original promise of the NJ FamilyCare program to provide health care coverage for low income children and their parents, and adults without dependent children.

The substitute also consolidates the State's NJ KidCare and NJ FamilyCare programs into the NJ FamilyCare Program, and requires the Commissioner of Human Services to adopt various enrollment simplification practices in both the NJ FamilyCare and Medicaid programs, in order to eliminate unnecessary barriers to enrollment for new applicants and renewal of enrollment for persons who are already participating in the program.

Expansion of Eligibility for Health Care Coverage:

C Children up to age 19 whose family gross income is up to 350% of the federal poverty level (FPL) will continue to be eligible for either Medicaid or NJ FamilyCare, based on their family's income.

C Effective September 1, 2005, parents of eligible children whose family earned income does not exceed 100% of the FPL will be eligible for Medicaid (under current law, eligibility for parents is limited to persons whose income does not exceed approximately 34% of the FPL).

C Effective September 1, 2006, parents of eligible children whose family earned income does not exceed 115% of the FPL will be eligible for Medicaid.

C Effective September 1, 2007, parents of eligible children whose family earned income does not exceed 133% of the FPL will be eligible for Medicaid.

C Effective 180 days after the date of enactment, the commissioner shall establish a NJ FamilyCare coverage "buy-in" program through which a parent or caretaker whose family gross income exceeds 350% of the poverty level may purchase coverage under NJ

FamilyCare for a child under the age of 19, who is uninsured and was not voluntarily disenrolled from employer-sponsored group insurance coverage within six months prior to application to the program. The premium for coverage shall not exceed the amount the program pays per month to a managed care organization under NJ FamilyCare for a child of comparable age whose family income is between 200% and 350% of the FPL, plus a reasonable processing fee.

C Pending approval from the federal government, adults without dependent children whose income does not exceed 100% of the FPL will be eligible for Medicaid. The income eligibility limit will be phased in over a three-year period.

NJ FamilyCare Program:

The substitute reestablishes the NJ FamilyCare program in the Department of Human Services to provide subsidized health insurance coverage for children under 19 years of age and their parents and other adults without dependent children who were enrolled in the program on the effective date of this substitute and do not qualify for Medicaid.

Program Requirements:

C Families would be required to pay copayments and premium contributions, based upon a sliding income scale.

C Services covered by the program will include: well-child and other preventive services, hospitalization, physician care, laboratory and x-ray services, prescription drugs, mental health services, and other services as determined by the commissioner.

C A parent or caretaker who is a qualified applicant must purchase coverage, if available, through an employer-sponsored health insurance plan which is determined to be cost-effective and is approved by the commissioner.

C Subject to federal approval, a child shall be determined ineligible for the program if the child was voluntarily disenrolled from employer-sponsored group insurance coverage within six months prior to application to the program.

C Presumptive eligibility is authorized for children who present themselves for treatment at a general hospital, federally qualified or community health center, local health department that provides primary care or other State licensed community-based primary care provider if a preliminary determination by hospital, health center, local health department or health care provider staff indicates that the child meets program eligibility standards. The child's parent or caretaker would be required to submit a completed application for the program no later than the end of the month following the month in which presumptive eligibility is determined in order to maintain the child's eligibility for the program.

C The Commissioner of Human Services may contract with one or more appropriate entities, including managed care organizations, to assist in administering the NJ FamilyCare Program.

- The Commissioner of Human Services, in consultation with the Commissioner of Education, shall administer an ongoing enrollment initiative to provide outreach to children throughout the State who may be eligible for the program.

  --The initiative shall include a school lunch "express enrollment" program whereby a parent or guardian who signs the school lunch application form can give consent for information to be shared with the Department of Human Services for the purpose of determining eligibility for the NJ FamilyCare and Medicaid programs. The substitute also requires the commissioners to establish procedures for schools to transmit enrollment information to the Department of Human Services, in order to enable the department to determine eligibility for the programs.

  -- The Commissioner of Human Services or the Commissioner of Education, as applicable, also shall make available to each elementary and secondary school, licensed child care center, registered family day care home, unified child care agency, local health department that provides primary care, and community-based primary care provider, informational materials about the program, including instructions for applying online or by mail, as well as copies of the program application form. The entity would be required to make the informational and application materials available, upon request, to persons interested in the program and to distribute a notice at least annually to households of children attending or receiving its services or care, informing them about the program and the availability of informational and application materials.

NJ FamilyCare and Medicaid Enrollment Reforms:

The Commissioner of Human Services will be required to implement certain enrollment simplification practices for the NJ FamilyCare and Medicaid programs. Implementation of these reforms in the NJ FamilyCare Program will begin 180 days after enactment of the substitute, and in the Medicaid program no later than January 1, 2006. The enrollment simplification practices include:

- A streamlined application form that will be developed by the commissioner, in consultation with the Rutgers Center for State Health Policy;
- Require new applicants to submit no more than one recent pay stub from the applicant's employer or, if the applicant has more than one employer, no more than one from each of the applicant's employers, to verify income. In the event the applicant cannot provide a recent pay stub, the applicant may submit another form of income verification as deemed appropriate by the commissioner. If an applicant does not submit income verification in a timely manner, before determining the applicant ineligible for the program, the commissioner shall seek to verify the applicant's income by reviewing available Department of the Treasury or

Department of Labor records concerning the applicant, or such other records as the commissioner determines appropriate.

In order to further verify the income of applicants, the commissioner may establish such retrospective auditing or income verification procedures as he deems appropriate, such as sample auditing and matching reported income with records of the Department of the Treasury or the Department of Labor or such other records as the commissioner deems appropriate;

C Online enrollment and renewal, in addition to enrollment and renewal by mail. The online enrollment and renewal forms shall include electronic links to other State and federal health and social services programs;

C Continuous enrollment;

C Simplified renewal by sending an enrollee a preprinted renewal form and requiring the enrollee to sign and return the form, with any applicable changes in the information provided in the form, no later than 30 days after the date the enrollee's annual eligibility expires. In order to verify the income of enrollees, the commissioner may establish such auditing or income verification procedures as he deems appropriate, as specified above; and

C Provision of program eligibility-identification cards that are issued no more frequently than once a year.

Implementation:

In order to implement the expansion of eligibility and administrative reforms provided in this substitute, and to monitor the implementation, the substitute directs the Commissioner of Human Services to:

C Apply for such State plan amendments or waivers as may be necessary to implement the provisions of the substitute and to secure federal financial participation for State Medicaid expenditures under the federal Medicaid program and for NJ FamilyCare expenditures under the State Children's Health Insurance Program.

C Within 60 days of the date of enactment of the substitute, report to the chairmen of the Senate Health, Human Services and Senior Citizens, Assembly Health and Human Services and Assembly Family, Women and Children's Issues committees regarding the department's plans for implementation of the NJ FamilyCare buy-in for children whose income is greater than 350% of the poverty level.

C Within one year of the effective date of the substitute, establish a plan to develop and implement a universal identification card that can be issued to and used by recipients of Medicaid, Work First New Jersey, NJ FamilyCare, food stamps and other public social service and health programs.

C Within one year of the effective date of the substitute, prepare a request for proposal to develop an online, interactive database that

can be used by health care facilities for enrolling, or determining the status of an application for, children and their parents or caretakers and adults without dependent children who present themselves at the health care facility for services and who may be eligible for NJ FamilyCare or Medicaid. The database shall enable the health care facility to notify a county welfare agency or the appropriate office in the Department of Human Services about a program applicant so that the agency or office can follow-up on the application and complete the eligibility determination process.

- Report to the chairmen of the Senate Health, Human Services and Senior Citizens, Assembly Health and Human Services and Assembly Family, Women and Children's Issues committees on the implementation of this substitute. The commissioner shall issue an interim report six months after the effective date and an annual report six months later and once each year thereafter.

Pharmaceutical Rebates for General Public Assistance Program, Program Funding:

- The Commissioner of Human Services is directed to contract with manufacturers of pharmaceutical products to provide rebates for pharmaceutical products covered under the Work First New Jersey General Public Assistance program (WFNJ-GA), established pursuant to N.J.S.A.44:8-107 et seq. on the same basis as is required under the PAAD, Senior Gold and Medicaid programs. A manufacturer would be required to contract with the State as a condition of continued participation in the WFNJ-GA program. These rebates are not intended to establish a new federal "best price," as that term is used in the federal Medicaid law.
- The monies from the rebates would be used to fund, in part, the expansion of eligibility in the Medicaid program provided in this substitute.
- The substitute provides that any unexpended balances for the NJ FamilyCare Program shall be appropriated to carry out the purposes of the substitute. Any transfer of NJ FamilyCare appropriations to other accounts shall be subject to the approval of the Joint Budget Oversight Committee.

Repealer and Effective Date of Substitute:

- The substitute repeals N.J.S.A.30:4I-1 et seq. and 30:4J-1 et seq., which established the NJ KidCare and NJ FamilyCare programs, since these programs are consolidated and reestablished under the provisions of this substitute.
- The substitute takes effect 180 days after enactment, except that: the Medicaid expansion for parents and caretaker relatives to 100% of the poverty level takes effect on September 1, 2006; the directive that the commissioner apply for such Medicaid State plan amendments and waivers as are necessary to implement the substitute takes effect immediately; and the WFNJ-GA

pharmaceutical rebates and related funding language takes effect immediately.

- The commissioner is directed to take such anticipatory administrative action in advance of the effective date as may be necessary to carry out the purposes of the substitute.

FISCAL IMPACT:

The Office of Legislative Services (OLS) is unable to estimate the cost of the legislation because State costs will depend on the number of children and adults who apply for and qualify for the NJ FamilyCare and Medicaid programs, respectively, and whether the federal government approves the various State Medicaid Plan amendments or waivers that may be necessary to implement the legislation.

The OLS, however, notes the following:

- In the NJ FamilyCare program, the State spends approximately: $113 per month for each child; $200 per month for each parent; and $390 per month on each adult without dependent children enrolled in the program.
- For every 10,000 additional children determined eligible for NJ FamilyCare, annual gross costs would be about $13.6 million, or between $4.8 - $6.8 million State share, depending on the federal matching rate. The Rutgers Center for State Health Policy (CSHP) provided estimates that indicates, based on data from the 2004 Current Population Survey (CPS) conducted by the US Census Bureau and the 2001-02 New Jersey Family Health Survey, an additional 101,000 children may be eligible for Medicaid or NJ FamilyCare than are currently enrolled in the programs.
- For every 10,000 additional parents determined eligible for Medicaid, annual gross costs would be around $24.0 million, or $12.0 million State share, based on a 50% federal matching rate.
- If a federal Medicaid waiver to cover adults without dependent children is obtained, the annual gross cost of covering 10,000 such adults who are not on General Assistance would be approximately $47.0 million, or $23.5 million State share; however, it is uncertain whether the federal government will approve the waiver, as federal Medicaid law does not recognize this population as being categorically eligible for the program. (NOTE: coverage of these adults will not go into effect unless the waiver is obtained.)

Additionally:

- The substitute requires pharmaceutical manufacturers to pay rebates for drugs provided under the WFNJ-GA program and appropriates the revenues from the rebates to the Medicaid expansion established in the substitute. The rebates could produce approximately $12 million annually in revenue.
- Federal revenue (S-CHIP funds), including the recent award of $172 million in redistribution funds, should be sufficient to cover

the enrollment of additional children at least for the next year.

- Costs associated with the legislation should also be offset by reduced State appropriations for Charity Care in future years, as hospitals should experience a reduction in the number of uninsured persons who currently use their facilities to access health care. Other cost offsets may result from administrative simplification procedures in the NJ FamilyCare and Medicaid programs that are established in the bill.

ASSEMBLY, No. 3724

STATE OF NEW JERSEY

211th LEGISLATURE

INTRODUCED JANUARY 13, 2005

Sponsored by:
Assemblyman ROBERT MORGAN
District 12 (Mercer and Monmouth)
Assemblywoman LORETTA WEINBERG
District 37 (Bergen)
Assemblyman ROBERT GORDON
District 38 (Bergen)
Assemblyman JOHN S. WISNIEWSKI
District 19 (Middlesex)
Assemblywoman JOAN VOSS
District 38 (Bergen)
Assemblywoman MARY T. PREVITE
District 6 (Camden)

Co-Sponsored by:
Assemblymen Barnes, Conners, Chiappone, Hackett, Assemblywomen Greenstein, Oliver, Vandervalk, Assemblymen Stanley, Roberts, Assemblywoman Quigley, Assemblymen Gusciora, Chivukula, Panter, Diegnan, Prieto, Fisher, Assemblywoman Cruz-Perez, Assemblymen Wolfe, Scalera, Assemblywoman Stender, Assemblymen Vas, Manzo and Stack

SYNOPSIS
"Family Health Care Coverage Act"; reestablishes NJ FamilyCare Program and expands eligibility for Medicaid program for parents and adults without dependent children.

CURRENT VERSION OF TEXT
As introduced.

(Sponsorship Updated As Of: 2/8/2005)

AN ACT concerning health care coverage for children and their parents and revising parts of the statutory law.

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 "Family Health Care Coverage Act."

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

a. The most serious health problem facing approximately 1.2 million New Jersey residents, including approximately 264,000 children, is lack of access to affordable health care coverage, which forces too many New Jersey families to go without needed preventive and other nonemergency care until serious illness requires expensive hospital care.

b. Research has shown that affordable and accessible health care coverage for parents can benefit their children, since parents who have a connection to ongoing health care coverage are more likely to ensure that their children get necessary immunizations and regular checkups from a primary care provider. Adults and children who lack insurance coverage forgo care until medical conditions, which were either preventable or treatable at the outset, require more extensive and expensive intervention or treatment.

c. Children with health care coverage have a significantly greater opportunity to be healthier, realize their full educational and developmental potential and become productive citizens. Providing health care coverage for uninsured adults increases worker productivity and can reduce dependence on public assistance and other State-subsidized programs including hospital charity care.

d. The federal State Children's Health Insurance Program (SCHIP), established in 1997 as Title XXI of the federal Social Security Act, allows a state to establish a health insurance program for low-income children. In response to the enactment of SCHIP, New Jersey established the NJ KidCare program in 1997 and the NJ FamilyCare program in 2000 to provide subsidized private health insurance coverage to children whose family income does not exceed 350% of the federal poverty level (FPL) and to their parents if their income does not exceed 200% of the FPL. NJ FamilyCare also provided coverage for adults without children whose income did not exceed 100% of the FPL.

Upon the establishment of NJ FamilyCare, the two programs were combined and administered as NJ FamilyCare. Within a short time,

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.

enrollment of adults far exceeded expectations and available funding, and various changes were made to the program to contain costs, such as scaling back benefits, limiting eligibility to parents and other adults who were already enrolled in, or had applied for, the program as of June 14, 2002, and no longer accepting any new applications from parents or other adults.

e. Initially, NJ FamilyCare appreciably reduced the costs of charity care provided by hospitals, but when NJ FamilyCare coverage for parents and other adults was curtailed, charity care costs again increased.

f. In order to (1) ensure that the original purpose of NJ FamilyCare is realized, that is, low income parents as well as their children are given access to health insurance coverage, (2) increase enrollment of children, and (3) maximize federal financial participation under both the State Medicaid and NJ FamilyCare programs, it is necessary and appropriate to restore coverage for parents of children who qualify for Medicaid or NJ FamilyCare, by increasing income eligibility levels, over a three-year period, for parents under the Medicaid program to 200% of the FPL. Further, to provide for a more comprehensive health care system, it is also necessary and appropriate to restore coverage through the Medicaid program, over a three-year period, for adults without dependent children whose income is up to 100% of the FPL, subject to the availability of federal Medicaid funds.

g. Since 2002, the number of parents enrolled in NJ FamilyCare has steadily declined and the growth in coverage of children has slowed. Current application and renewal procedures create unnecessary barriers for applicants and enrollees, and have contributed to a decline in the enrollment of additional children and in the retention of enrollees. Experience in other states suggests that adopting certain enrollment simplification reforms in both the NJ FamilyCare and Medicaid programs can significantly increase enrollment and retention of eligible children and their parents.

h. The expanded health care coverage provided by this act builds on New Jersey's longstanding commitment to assure access to quality health care that is provided in an efficient and effective manner and at a reasonable cost.

3. (New section) The NJ FamilyCare Program is established in the Department of Human Services.

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

"Commissioner" means the Commissioner of Human Services.

"Department" means the Department of Human Services.

"Medicaid" means the New Jersey Medical Assistance and Health Services Program established pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.).

1 "NJ FamilyCare" or "program" means the NJ FamilyCare Program
2 established pursuant to sections 3 through 5 of P.L. , c. (C.)(pending
3 before the Legislature as this bill).
4 "Poverty level" means the official federal poverty level based on
5 family size, established and adjusted under Section 673(2) of Subtitle
6 B, the "Community Services Block Grant Act," Pub.L.97-35 (42
7 U.S.C. s.9902(2)).
8 "Qualified applicant" means:
9 a. a child under 19 years of age: (1) whose family gross income
10 does not exceed 350% of the poverty level; (2) who has no health
11 insurance, as determined by the commissioner, and is ineligible for
12 Medicaid; (3) who is a resident of this State; and (4) who is a citizen
13 of the United States, or has been lawfully admitted for permanent
14 residence into and remains lawfully present in the United States;
15 b. a parent or caretaker: (1) whose gross family income does not
16 exceed 200% of the poverty level; (2) who is enrolled in NJ
17 FamilyCare on the effective date of P.L. , c. (C.)(pending before
18 the Legislature as this bill); (3) who has no health insurance, as
19 determined by the commissioner, and is ineligible for Medicaid; (4)
20 who is a resident of this State; and (5) who is a citizen of the United
21 States, or has been lawfully admitted for permanent residence into and
22 remains lawfully present in the United States; and
23 c. a single adult or couple without dependent children: (1) whose
24 family gross income does not exceed 100% of the poverty level; (2)
25 who is enrolled in NJ FamilyCare on the effective date of P.L. , c.
26 (C.)(pending before the Legislature as this bill) and is ineligible for
27 Medicaid; (3) who is a resident of this State; and (4) who is a citizen
28 of the United States, or has been lawfully admitted for permanent
29 residence into and remains lawfully present in the United States.
30
31 5. (New section) a. The purpose of the program shall be to
32 provide subsidized health insurance coverage, and other health care
33 benefits as determined by the commissioner, to children under 19 years
34 of age and their parents or caretakers and to adults without dependent
35 children, within the limits of funds appropriated or otherwise made
36 available for the program.
37 The program shall require families to pay copayments and make
38 premium contributions, based upon a sliding income scale. The
39 program shall include the provision of well-child and other preventive
40 services, hospitalization, physician care, laboratory and x-ray services,
41 prescription drugs, mental health services, and other services as
42 determined by the commissioner.
43 b. The commissioner shall take such actions as are necessary to
44 implement and operate the program in accordance with the State
45 Children's Health Insurance Program established pursuant to 42
46 U.S.C.s.1397aa et seq.

c. The commissioner:

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

(2) shall require that a parent or caretaker who is a qualified applicant purchase coverage, if available, 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, except that the provisions of this paragraph shall not be construed to require an employer to provide health insurance coverage for any employee or employee's spouse or dependent child;

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

(4) shall establish, by regulation, other requirements for the program, including, but not limited to, premium payments and copayments, and may contract with one or more appropriate entities, including managed care organizations, to assist in administering the program. The period for which eligibility for the program is determined shall be the maximum period permitted under federal law.

d. The commissioner shall establish procedures for determining eligibility, which shall include, at a minimum, the following enrollment simplification practices:

(1) A streamlined application form as established pursuant to subsection k. of this section;

(2) Self declaration of income for new applicants. The commissioner may establish such retrospective auditing or income verification procedures as he deems appropriate, such as sample auditing and matching reported income with records of the Department of the Treasury or the Department of Labor. If the commissioner elects to match reported income with confidential records of the Department of the Treasury, the commissioner shall require an applicant to provide written authorization for the Division of Taxation in the Department of the Treasury to release applicable tax information to the commissioner for the purposes of establishing income eligibility for the program. The authorization, which shall be included on the program application form, shall be developed by the commissioner, in consultation with the State Treasurer;

(3) Online enrollment and renewal, in addition to enrollment and renewal by mail. The online enrollment and renewal forms shall include electronic links to other State and federal health and social services programs;

(4) Continuous enrollment;

1 (5) Automatic, passive renewal if an enrollee does not indicate any
2 change in circumstances or if the enrollee has established eligibility for
3 another income-tested State or federal program, such as Food Stamps
4 or the Special Supplemental Nutrition Program for Women, Infants
5 and Children (WIC), whose income eligibility limits are equal to or less
6 than that of NJ FamilyCare. The commissioner may establish such
7 auditing or income verification procedures as he deems appropriate,
8 as provided in paragraph (1) of this subsection; and
9 (6) Provision of program eligibility-identification cards that are
10 issued no more frequently than once a year.
11 e. The commissioner shall take, or cause to be taken, any action
12 necessary to secure for the State the maximum amount of federal
13 financial participation available with respect to the program, subject
14 to the constraints of fiscal responsibility and within the limits of
15 available funding in any fiscal year. In this regard, notwithstanding the
16 definition of "qualified applicant," the commissioner may enroll in the
17 program such children or their parents or caretakers who may
18 otherwise be eligible for the Medicaid program in order to maximize
19 use of federal funds that may be available pursuant to 42 U.S.C.
20 s.1397aa et seq.
21 f. Subject to federal approval, a child shall be determined ineligible
22 for the program if the child was voluntarily disenrolled from
23 employer-sponsored group insurance coverage within six months prior
24 to application to the program.
25 g. The commissioner shall provide, by regulation, for presumptive
26 eligibility for the program in accordance with the following provisions:
27 (1) A child who presents himself for treatment at a general hospital,
28 federally qualified or community health center, local health department
29 that provides primary care, or other State licensed health care provider
30 that provides primary care shall be deemed presumptively eligible for
31 the program if a preliminary determination by hospital, health center,
32 local health department or licensed health care provider staff indicates
33 that the child meets program eligibility standards and is a member of
34 a household with an income that does not exceed 350% of the poverty
35 level;
36 (2) The provisions of paragraph (1) of this subsection shall also
37 apply to a child who is deemed presumptively eligible for Medicaid
38 coverage pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.);
39 (3) The parent or caretaker of a child deemed presumptively eligible
40 pursuant to this subsection shall be required to submit a completed
41 application for the program no later than the end of the month
42 following the month in which presumptive eligibility is determined;
43 (4) A child shall be eligible to receive all services covered by the
44 program during the period in which the child is presumptively eligible;
45 and
46 (5) The commissioner may, by regulation, establish a limit on the

1 number of times a child may be deemed presumptively eligible for NJ
2 FamilyCare.
3 h. The commissioner, in consultation with the Commissioner of
4 Education, shall administer an ongoing enrollment initiative to provide
5 outreach to children throughout the State who may be eligible for the
6 program.
7 (1) With respect to school-age children, the commissioner, in
8 consultation with the Commissioner of Education and the Secretary of
9 Agriculture, shall develop a form that provides information about the
10 NJ FamilyCare and Medicaid programs and provides an opportunity
11 for the parent or guardian who signs the school lunch application form
12 to give consent for information to be shared with the Department of
13 Human Services for the purpose of determining eligibility for the
14 programs. The form shall be attached to, included with, or
15 incorporated into, the school lunch application form.
16 The commissioner, in consultation with the Commissioner of
17 Education, shall establish procedures for schools to transmit
18 information attached to, included with, or provided on the school
19 lunch application form regarding the NJ FamilyCare and Medicaid
20 programs to the Department of Human Services, in order to enable the
21 department to determine eligibility for the programs.
22 (2) The commissioner or the Commissioner of Education, as
23 applicable, shall:
24 (a) make available to each elementary and secondary school,
25 licensed child care center, registered family day care home, unified
26 child care agency, local health department that provides primary care,
27 and community-based primary care provider, informational materials
28 about the program, including instructions for applying online or by
29 mail, as well as copies of the program application form.
30 The entity shall make the informational and application materials
31 available, upon request, to persons interested in the program; and
32 (b) request each entity to distribute a notice at least annually, as
33 developed by the commissioner, to households of children attending
34 or receiving its services or care, informing them about the program
35 and the availability of informational and application materials. In the
36 case of elementary and secondary schools, the information attached to,
37 included with, or incorporated into, the school lunch application form
38 for school-age children pursuant to this subparagraph shall be deemed
39 to meet the requirements of this paragraph.
40 i. Subject to federal approval, the commissioner shall, by
41 regulation, establish that in determining income eligibility for a child,
42 any gross family income above 200% of the poverty level, up to a
43 maximum of 350% of the poverty level, shall be disregarded.
44 j. The commissioner shall establish a NJ FamilyCare coverage buy-
45 in program through which a parent or caretaker whose family income
46 exceeds 350% of the poverty level may purchase coverage under NJ

FamilyCare for a child under the age of 19, who is uninsured and was not voluntarily disenrolled from employer-sponsored group insurance coverage within six months prior to application to the program.

The commissioner shall establish the premium and cost sharing amounts required to purchase coverage, except that the premium shall not exceed the amount the program pays per month to a managed care organization under NJ FamilyCare for a child of comparable age whose family income is between 200% and 350% of the poverty level, plus a reasonable processing fee.

k. The commissioner, in consultation with the Rutgers Center for State Health Policy, shall develop a streamlined application form for the NJ FamilyCare and Medicaid programs.

6. (New section) Whenever the terms "Children's Health Care Coverage Program," "NJ KidCare," "FamilyCare Health Coverage Program" or "NJ FamilyCare" occur or any reference is made thereto in any law, contract or document, the same shall be deemed to mean or refer to the NJ FamilyCare Program established pursuant to P.L. , c. (C.)(pending before the Legislature as this bill).

7. Section 3 of P.L.1999, c.171 (C.18A:40-34) is amended to read as follows:

3. The Commissioner of Education, in consultation with the Commissioner of Human Services and pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt regulations to:

a. provide for the implementation by the board of education in each school district of such procedures by each public elementary and secondary school in the district as the commissioner deems necessary to effectuate the purposes of subsection [f. of section 4 of P.L.1997, c.272 (C.30:4I-4)] h. of section 5 of P.L. , c. (C.)(pending before the Legislature as this bill); and

b. facilitate and provide for the participation of nonpublic elementary and secondary schools in the [partnership] enrollment initiative created pursuant to subsection [f. of section 4 of P.L.1997, c.272 (C.30:4I-4), including the provision of in-kind awards to participating nonpublic schools, in the form of educational resource materials that would be the property of the public schools, for each household enrolled in the Children's Health Care Coverage Program established pursuant to P.L.1997, c.272 (C.30:4I-1 et seq.) which was referred by the nonpublic school] h. of section 5 of P.L. , c. (C.)(pending before the Legislature as this bill).

(cf: P.L.1999, c.171, s.3)

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

1 30:4D-3 Definitions.
2 3. Definitions. As used in this act, and unless the context
3 otherwise requires:
4 a. "Applicant" means any person who has made application for
5 purposes of becoming a "qualified applicant."
6 b. "Commissioner" means the Commissioner of Human Services.
7 c. "Department" means the Department of Human Services, which
8 is herein designated as the single State agency to administer the
9 provisions of this act.
10 d. "Director" means the Director of the Division of Medical
11 Assistance and Health Services.
12 e. "Division" means the Division of Medical Assistance and Health
13 Services.
14 f. "Medicaid" means the New Jersey Medical Assistance and Health
15 Services Program.
16 g. "Medical assistance" means payments on behalf of recipients to
17 providers for medical care and services authorized under this act.
18 h. "Provider" means any person, public or private institution,
19 agency or business concern approved by the division lawfully
20 providing medical care, services, goods and supplies authorized under
21 this act, holding, where applicable, a current valid license to provide
22 such services or to dispense such goods or supplies.
23 i. "Qualified applicant" means a person who is a resident of this
24 State, and either a citizen of the United States or an eligible alien, and
25 is determined to need medical care and services as provided under this
26 act, with respect to whom the period for which eligibility to be a
27 recipient is determined shall be the maximum period permitted under
28 federal law, and who:
29 (1) Is a dependent child or parent or caretaker relative of a
30 dependent child who would be, except for resources, eligible for the
31 temporary assistance for needy families program under the State Plan
32 for Title IV-A of the federal Social Security Act as of July 16, 1996;
33 (2) Is a recipient of Supplemental Security Income for the Aged,
34 Blind and Disabled under Title XVI of the Social Security Act;
35 (3) Is an "ineligible spouse" of a recipient of Supplemental Security
36 Income for the Aged, Blind and Disabled under Title XVI of the Social
37 Security Act, as defined by the federal Social Security Administration;
38 (4) Would be eligible to receive Supplemental Security Income
39 under Title XVI of the federal Social Security Act or, without regard
40 to resources, would be eligible for the temporary assistance for needy
41 families program under the State Plan for Title IV-A of the federal
42 Social Security Act as of July 16, 1996, except for failure to meet an
43 eligibility condition or requirement imposed under such State program
44 which is prohibited under Title XIX of the federal Social Security Act
45 such as a durational residency requirement, relative responsibility,
46 consent to imposition of a lien;

1 (5) (Deleted by amendment, P.L.2000, c.71).
2 (6) Is an individual under 21 years of age who, without regard to
3 resources, would be, except for dependent child requirements, eligible
4 for the temporary assistance for needy families program under the
5 State Plan for Title IV-A of the federal Social Security Act as of July
6 16, 1996, or groups of such individuals, including but not limited to,
7 children in resource family placement under supervision of the Division
8 of Youth and Family Services whose maintenance is being paid in
9 whole or in part from public funds, children placed in a resource family
10 home or institution by a private adoption agency in New Jersey or
11 children in intermediate care facilities, including developmental centers
12 for the developmentally disabled, or in psychiatric hospitals;
13 (7) Would be eligible for the Supplemental Security Income
14 program, but is not receiving such assistance and applies for medical
15 assistance only;
16 (8) Is determined to be medically needy and meets all the eligibility
17 requirements described below:
18 (a) The following individuals are eligible for services, if they are
19 determined to be medically needy:
20 (i) Pregnant women;
21 (ii) Dependent children under the age of 21;
22 (iii) Individuals who are 65 years of age and older; and
23 (iv) Individuals who are blind or disabled pursuant to either 42
24 C.F.R.435.530 et seq. or 42 C.F.R.435.540 et seq., respectively.
25 (b) The following income standard shall be used to determine
26 medically needy eligibility:
27 (i) For one person and two person households, the income
28 standard shall be the maximum allowable under federal law, but shall
29 not exceed 133 1/3% of the State's payment level to two person
30 households under the temporary assistance for needy families program
31 under the State Plan for Title IV-A of the federal Social Security Act
32 in effect as of July 16, 1996; and
33 (ii) For households of three or more persons, the income standard
34 shall be set at 133 1/3% of the State's payment level to similar size
35 households under the temporary assistance for needy families program
36 under the State Plan for Title IV-A of the federal Social Security Act
37 in effect as of July 16, 1996.
38 (c) The following resource standard shall be used to determine
39 medically needy eligibility:
40 (i) For one person households, the resource standard shall be
41 200% of the resource standard for recipients of Supplemental Security
42 Income pursuant to 42 U.S.C. s.1382(1)(B);
43 (ii) For two person households, the resource standard shall be
44 200% of the resource standard for recipients of Supplemental Security
45 Income pursuant to 42 U.S.C. s.1382(2)(B);
46 (iii) For households of three or more persons, the resource

1 standard in subparagraph (c)(ii) above shall be increased by $100.00
2 for each additional person; and
3 (iv) The resource standards established in (i), (ii), and (iii) are
4 subject to federal approval and the resource standard may be lower if
5 required by the federal Department of Health and Human Services.
6 (d) Individuals whose income exceeds those established in
7 subparagraph (b) of paragraph (8) of this subsection may become
8 medically needy by incurring medical expenses as defined in 42
9 C.F.R.435.831(c) which will reduce their income to the applicable
10 medically needy income established in subparagraph (b) of paragraph
11 (8) of this subsection.
12 (e) A six-month period shall be used to determine whether an
13 individual is medically needy.
14 (f) Eligibility determinations for the medically needy program shall
15 be administered as follows:
16 (i) County welfare agencies and other entities designated by the
17 commissioner are responsible for determining and certifying the
18 eligibility of pregnant women and dependent children. The division
19 shall reimburse county welfare agencies for 100% of the reasonable
20 costs of administration which are not reimbursed by the federal
21 government for the first 12 months of this program's operation.
22 Thereafter, 75% of the administrative costs incurred by county welfare
23 agencies which are not reimbursed by the federal government shall be
24 reimbursed by the division;
25 (ii) The division is responsible for certifying the eligibility of
26 individuals who are 65 years of age and older and individuals who are
27 blind or disabled. The division may enter into contracts with county
28 welfare agencies to determine certain aspects of eligibility. In such
29 instances the division shall provide county welfare agencies with all
30 information the division may have available on the individual.
31 The division shall notify all eligible recipients of the Pharmaceutical
32 Assistance to the Aged and Disabled program, P.L.1975, c.194
33 (C.30:4D-20 et seq.) on an annual basis of the medically needy
34 program and the program's general requirements. The division shall
35 take all reasonable administrative actions to ensure that
36 Pharmaceutical Assistance to the Aged and Disabled recipients, who
37 notify the division that they may be eligible for the program, have their
38 applications processed expeditiously, at times and locations convenient
39 to the recipients; and
40 (iii) The division is responsible for certifying incurred medical
41 expenses for all eligible persons who attempt to qualify for the
42 program pursuant to subparagraph (d) of paragraph (8) of this
43 subsection;
44 (9) (a) Is a child who is at least one year of age and under 19 years
45 of age and, if older than six years of age but under 19 years of age, is
46 uninsured; and

1 (b) Is a member of a family whose income does not exceed 133%
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);
5 (10) Is a pregnant woman who is determined by a provider to be
6 presumptively eligible for medical assistance based on criteria
7 established by the commissioner, pursuant to section 9407 of
8 Pub.L.99-509 (42 U.S.C. s.1396a(a));
9 (11) Is an individual 65 years of age and older, or an individual who
10 is blind or disabled pursuant to section 301 of Pub.L.92-603 (42
11 U.S.C. s.1382c), whose income does not exceed 100% of the poverty
12 level, adjusted for family size, and whose resources do not exceed
13 100% of the resource standard used to determine medically needy
14 eligibility pursuant to paragraph (8) of this subsection;
15 (12) Is a qualified disabled and working individual pursuant to
16 section 6408 of Pub.L.101-239 (42 U.S.C. s.1396d) whose income
17 does not exceed 200% of the poverty level and whose resources do
18 not exceed 200% of the resource standard used to determine eligibility
19 under the Supplemental Security Income Program, P.L.1973, c.256
20 (C.44:7-85 et seq.);
21 (13) Is a pregnant woman or is a child who is under one year of age
22 and is a member of a family whose income does not exceed 185% of
23 the poverty level and who meets the federal Medicaid eligibility
24 requirements set forth in section 9401 of Pub.L.99-509 (42 U.S.C.
25 s.1396a), except that a pregnant woman who is determined to be a
26 qualified applicant shall, notwithstanding any change in the income of
27 the family of which she is a member, continue to be deemed a qualified
28 applicant until the end of the 60-day period beginning on the last day
29 of her pregnancy;
30 (14) (Deleted by amendment, P.L.1997, c.272).
31 (15) (a) Is a specified low-income Medicare beneficiary pursuant to
32 42 U.S.C. s.1396a(a)10(E)iii whose resources beginning January 1,
33 1993 do not exceed 200% of the resource standard used to determine
34 eligibility under the Supplemental Security Income program, P.L.1973,
35 c.256 (C.44:7-85 et seq.) and whose income beginning January 1,
36 1993 does not exceed 110% of the poverty level, and beginning
37 January 1, 1995 does not exceed 120% of the poverty level.
38 (b) An individual who has, within 36 months, or within 60 months
39 in the case of funds transferred into a trust, of applying to be a
40 qualified applicant for Medicaid services in a nursing facility or a
41 medical institution, or for home or community-based services under
42 section 1915(c) of the federal Social Security Act (42 U.S.C.
43 s.1396n(c)), disposed of resources or income for less than fair market
44 value shall be ineligible for assistance for nursing facility services, an
45 equivalent level of services in a medical institution, or home or
46 community-based services under section 1915(c) of the federal Social

1 Security Act (42 U.S.C. s.1396n(c)). The period of the ineligibility
2 shall be the number of months resulting from dividing the
3 uncompensated value of the transferred resources or income by the
4 average monthly private payment rate for nursing facility services in
5 the State as determined annually by the commissioner. In the case of
6 multiple resource or income transfers, the resulting penalty periods
7 shall be imposed sequentially. Application of this requirement shall be
8 governed by 42 U.S.C. s.1396p(c). In accordance with federal law,
9 this provision is effective for all transfers of resources or income made
10 on or after August 11, 1993. Notwithstanding the provisions of this
11 subsection to the contrary, the State eligibility requirements
12 concerning resource or income transfers shall not be more restrictive
13 than those enacted pursuant to 42 U.S.C. s.1396p(c).
14 (c) An individual seeking nursing facility services or home or
15 community-based services and who has a community spouse shall be
16 required to expend those resources which are not protected for the
17 needs of the community spouse in accordance with section 1924(c) of
18 the federal Social Security Act (42 U.S.C. s.1396r-5(c)) on the costs
19 of long-term care, burial arrangements, and any other expense deemed
20 appropriate and authorized by the commissioner. An individual shall
21 be ineligible for Medicaid services in a nursing facility or for home or
22 community-based services under section 1915(c) of the federal Social
23 Security Act (42 U.S.C. s.1396n(c)) if the individual expends funds in
24 violation of this subparagraph. The period of ineligibility shall be the
25 number of months resulting from dividing the uncompensated value of
26 transferred resources and income by the average monthly private
27 payment rate for nursing facility services in the State as determined by
28 the commissioner. The period of ineligibility shall begin with the
29 month that the individual would otherwise be eligible for Medicaid
30 coverage for nursing facility services or home or community-based
31 services.
32 This subparagraph shall be operative only if all necessary approvals
33 are received from the federal government including, but not limited to,
34 approval of necessary State plan amendments and approval of any
35 waivers;
36 (16) Subject to federal approval under Title XIX of the federal
37 Social Security Act, is a dependent child, parent or specified caretaker
38 relative of a child who is a qualified applicant, who would be eligible,
39 without regard to resources, for the temporary assistance for needy
40 families program under the State Plan for Title IV-A of the federal
41 Social Security Act as of July 16, 1996, except for the income
42 eligibility requirements of that program, and whose family earned
43 income beginning January 1, 2006 does not exceed 133% of the
44 poverty level, beginning January 1, 2007 does not exceed 150% of the
45 poverty level and beginning January 1, 2008 does not exceed 200% of
46 the poverty level, plus such earned income disregards as shall be

determined according to a methodology to be established by regulation of the commissioner. In the case of dependent children and parents or specified caretaker relatives whose family earned income is at least 150% and does not exceed 200% of the poverty level, the commissioner shall seek a federal waiver to permit the department to require copayments and premium contributions based on a sliding income scale;

(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 resource family 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;

(18) Is a person between the ages of 16 and 65 who is permanently disabled and working, and:

(a) whose income is at or below 250% of the poverty level, plus other established disregards;

(b) who pays the premium contribution and other cost sharing as established by the commissioner, subject to the limits and conditions of federal law; and

(c) whose assets, resources and unearned income do not exceed limitations as established by the commissioner; [or]

(19) Is an uninsured individual under 65 years of age who:

(a) has been screened for breast or cervical cancer under the federal Centers for Disease Control and Prevention breast and cervical cancer early detection program;

(b) requires treatment for breast or cervical cancer based upon criteria established by the commissioner;

(c) has an income that does not exceed the income standard established by the commissioner pursuant to federal guidelines;

(d) meets all other Medicaid eligibility requirements; and

(e) in accordance with Pub.L.106-354, is determined by a qualified entity to be presumptively eligible for medical assistance pursuant to 42 U.S.C. s.1396a(aa), based upon criteria established by the commissioner pursuant to section 1920B of the federal Social Security Act (42 U.S.C. s.1396r-1b); or

(20) Subject to federal approval under Title XIX of the federal Social Security Act, is a single adult or couple, without dependent children, whose income in 2006 does not exceed 50% of the poverty level, in 2007 does not exceed 75% of the poverty level and in 2008 and each year thereafter does not exceed 100% of the poverty level; except that a person who is a recipient of Work First New Jersey general public assistance, pursuant to P.L.1947, c.156 (C.44:8-107 et seq.), shall not be a qualified applicant.

j. "Recipient" means any qualified applicant receiving benefits

1 under this act.
2 k. "Resident" means a person who is living in the State voluntarily
3 with the intention of making his home here and not for a temporary
4 purpose. Temporary absences from the State, with subsequent returns
5 to the State or intent to return when the purposes of the absences have
6 been accomplished, do not interrupt continuity of residence.
7 l. "State Medicaid Commission" means the Governor, the
8 Commissioner of Human Services, the President of the Senate and the
9 Speaker of the General Assembly, hereby constituted a commission to
10 approve and direct the means and method for the payment of claims
11 pursuant to this act.
12 m. "Third party" means any person, institution, corporation,
13 insurance company, group health plan as defined in section 607(1) of
14 the federal "Employee Retirement and Income Security Act of 1974,"
15 29 U.S.C. s.1167(1), service benefit plan, health maintenance
16 organization, or other prepaid health plan, or public, private or
17 governmental entity who is or may be liable in contract, tort, or
18 otherwise by law or equity to pay all or part of the medical cost of
19 injury, disease or disability of an applicant for or recipient of medical
20 assistance payable under this act.
21 n. "Governmental peer grouping system" means a separate class
22 of skilled nursing and intermediate care facilities administered by the
23 State or county governments, established for the purpose of screening
24 their reported costs and setting reimbursement rates under the
25 Medicaid program that are reasonable and adequate to meet the costs
26 that must be incurred by efficiently and economically operated State
27 or county skilled nursing and intermediate care facilities.
28 o. "Comprehensive maternity or pediatric care provider" means
29 any person or public or private health care facility that is a provider
30 and that is approved by the commissioner to provide comprehensive
31 maternity care or comprehensive pediatric care as defined in
32 subsection b. (18) and (19) of section 6 of P.L.1968, c.413
33 (C.30:4D-6).
34 p. "Poverty level" means the official poverty level based on family
35 size established and adjusted under Section 673(2) of Subtitle B, the
36 "Community Services Block Grant Act," of Pub.L.97-35 (42 U.S.C.
37 s.9902(2)).
38 q. "Eligible alien" means one of the following:
39 (1) an alien present in the United States prior to August 22, 1996,
40 who is:
41 (a) a lawful permanent resident;
42 (b) a refugee pursuant to section 207 of the federal "Immigration
43 and Nationality Act" (8 U.S.C. s.1157);
44 (c) an asylee pursuant to section 208 of the federal "Immigration
45 and Nationality Act" (8 U.S.C. s.1158);
46 (d) an alien who has had deportation withheld pursuant to section

1 243(h) of the federal "Immigration and Nationality Act" (8 U.S.C.
2 s.1253 (h));
3 (e) an alien who has been granted parole for less than one year by
4 the U.S. Citizenship and Immigration Services pursuant to section
5 212(d)(5) of the federal "Immigration and Nationality Act" (8 U.S.C.
6 s.1182(d)(5));
7 (f) an alien granted conditional entry pursuant to section 203(a)(7)
8 of the federal "Immigration and Nationality Act" (8 U.S.C.
9 s.1153(a)(7)) in effect prior to April 1, 1980; or
10 (g) an alien who is honorably discharged from or on active duty in
11 the United States armed forces and the alien's spouse and unmarried
12 dependent child.
13 (2) An alien who entered the United States on or after August 22,
14 1996, who is:
15 (a) an alien as described in paragraph (1)(b), (c), (d) or (g) of this
16 subsection; or
17 (b) an alien as described in paragraph (1)(a), (e) or (f) of this
18 subsection who entered the United States at least five years ago.
19 (3) A legal alien who is a victim of domestic violence in
20 accordance with criteria specified for eligibility for public benefits as
21 provided in Title V of the federal "Illegal Immigration Reform and
22 Immigrant Responsibility Act of 1996" (8 U.S.C. s.1641).
23 (cf: P.L.2004, c.130, s.93)
24
25 9. (New section) No later than January 1, 2006, the Commissioner
26 of Human Services shall, at a minimum, establish the following
27 enrollment simplification practices for dependent children and their
28 parents or specified caretaker relatives who are applicants for or
29 recipients of the Medicaid program:
30 a. A streamlined application form as established pursuant to
31 subsection k. of section 5 of P.L. , c. (C.)(pending before the
32 Legislature as this bill);
33 b. Self declaration of income for new applicants. The commissioner
34 may establish such retrospective auditing or income verification
35 procedures as he deems appropriate, such as sample auditing and
36 matching reported income with records of the Department of the
37 Treasury or the Department of Labor. If the commissioner elects to
38 match reported income with confidential records of the Department of
39 the Treasury, the commissioner shall require an applicant to provide
40 written authorization for the Division of Taxation in the Department
41 of the Treasury to release applicable tax information to the
42 commissioner for the purposes of establishing income eligibility for the
43 program. The authorization, which shall be included on the program
44 application form, shall be developed by the commissioner, in
45 consultation with the State Treasurer;
46 c. Online enrollment and renewal, in addition to enrollment and

renewal by mail. The online enrollment and renewal forms shall include electronic links to other State and federal health and social services programs;

d. Continuous enrollment;

e. Automatic, passive renewal if a recipient does not indicate any change in circumstances or if the recipient has established eligibility for another income-tested State or federal program, such as Food Stamps or the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), whose income eligibility limits are equal to or less than that of the Medicaid program. The commissioner may establish such auditing or income verification procedures as he deems appropriate, as provided in subsection a. of this section; and

f. Provision of program eligibility-identification cards that are issued no more frequently than once a year.

10. (New section) The commissioner shall apply for such State plan amendments or waivers as may be necessary to implement the provisions of this act and to secure federal financial participation for State Medicaid expenditures under the federal Medicaid program and for NJ FamilyCare expenditures under the State Children's Health Insurance Program pursuant to 42 U.S.C.s.1397aa et seq.

11. (New section) The Commissioner of Human Services shall report to the Chairman of the Senate Health, Human Services and Senior Citizens Committee and the Chairmen of the Assembly Health and Human Services and Assembly Family, Women and Children's Issues committees on the implementation of this act.

The commissioner shall issue an interim report six months after the effective date of this act and shall issue an annual report six months later and once each year thereafter.

The report shall include the number of persons who are enrolled in the Medicaid and NJ FamilyCare programs pursuant to the provisions of this act, the cost of providing coverage for these persons, the status of any Medicaid plan amendments or waivers necessary for implementation of this act, the status of implementing the enrollment simplification practices for both the NJ FamilyCare and Medicaid programs, and such other information as the commissioner deems appropriate. The commissioner may also include any recommendations for legislation he deems necessary to further the purposes of this act.

12. (New section) a. Within one year of the effective date of this act, the Commissioner of Human Services shall:

(1) establish a plan to develop and implement a universal identification card that can be issued to and used by recipients of Medicaid, Work First New Jersey, NJ FamilyCare, food stamps and

1 other public social service and health programs; and
2 (2) prepare a request for proposal to develop an online, interactive
3 database that can be used by health care facilities for enrolling, or
4 determining the status of an application for, children and their parents
5 or caretakers and adults without dependent children who present
6 themselves at the health care facility for services and who may be
7 eligible for NJ FamilyCare or Medicaid. The database shall enable the
8 health care facility to notify a county welfare agency or the appropriate
9 office in the Department of Human Services about a program applicant
10 so that the agency or office can follow-up on the application and
11 complete the eligibility determination process.
12 b. The commissioner shall include in his reports to the Legislature
13 required pursuant to section 11 of P.L. , c. (C.)(pending before the
14 Legislature as this bill) the status of the commissioner's plan for a
15 universal identification card and the request for proposals for an
16 interactive database.
17
18 13. (New section) The commissioner, pursuant to the
19 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
20 seq.), shall adopt rules and regulations to effectuate the purposes of
21 this act. The rules and regulations shall provide for a transition from
22 enrollment in the NJ FamilyCare program to the Medicaid program of
23 children and their parents or caretakers who become eligible for
24 Medicaid in 2006 as a result of the changes in the Medicaid income
25 eligibility levels provided for in this act.
26
27 14. P.L.1997, c.272 (C.30:4I-1 et seq.) and P.L.2000, c.71
28 (C.30:4J-1 et seq.) are repealed.
29
30 15. This act shall take effect on the 180th day after enactment.
31
32
33 STATEMENT
34
35 This bill, the "Family Health Care Coverage Act," reforms the NJ
36 FamilyCare Program and provides for an expansion of NJ FamilyCare
37 and Medicaid eligibility for parents and adults without dependent
38 children, in order to fulfill the original promise of the NJ FamilyCare
39 program to provide health care coverage for low income children, their
40 parents and adults without dependent children.
41 The bill also consolidates the State's NJ KidCare and NJ
42 FamilyCare programs into the NJ FamilyCare Program, and requires
43 the Commissioner of Human Services to adopt various enrollment
44 simplification practices in both the NJ FamilyCare and Medicaid
45 programs, in order to eliminate unnecessary barriers to enrollment for
46 new applicants and renewal of enrollment for persons who are already

participating in the program. The bill takes effect 180 days after its enactment.

Expansion of Eligibility for Health Care Coverage:

- Children up to age 19 whose family gross income is up to 350% of the federal poverty level (FPL) will continue to be eligible for either Medicaid or NJ FamilyCare, based on their family's income.
- Effective January 1, 2006, parents of eligible children whose family earned income does not exceed 133% of the FPL will be eligible for Medicaid (under current law, eligibility for parents is limited to persons whose income does not exceed approximately 34% of the FPL).
- Effective January 1, 2007 parents of eligible children whose family earned income does not exceed 150% of the FPL will be eligible for Medicaid.
- Effective January 1, 2008 parents of eligible children whose family earned income does not exceed 200% of the FPL will be eligible for Medicaid.
- Effective 180 days after the date of enactment, the commissioner shall establish a NJ FamilyCare coverage "buy-in" program through which a parent or caretaker whose family gross income exceeds 350% of the poverty level may purchase coverage under NJ FamilyCare for a child under the age of 19, who is uninsured and was not voluntarily disenrolled from employer-sponsored group insurance coverage within six months prior to application to the program. The premium for coverage shall not exceed the amount the program pays per month to a managed care organization under NJ FamilyCare for a child of comparable age whose family income is between 200% and 350% of the FPL, plus a reasonable processing fee.
- Pending approval from the federal government, adults without dependent children whose income does not exceed 100% of the FPL will be eligible for Medicaid. The income eligibility limit will be phased in over a three-year period.

NJ FamilyCare Program:

The bill reestablishes the NJ FamilyCare program in the Department of Human Services to provide subsidized health insurance coverage for children under 19 years of age and their parents and other adults without dependent children who were enrolled in the program on the effective date of this bill and do not qualify for Medicaid.

Program Requirements:

- Families would be required to pay copayments and premium contributions, based upon a sliding income scale.
- Services covered by the program will include: well-child and other preventive services, hospitalization, physician care, laboratory and

1 x-ray services, prescription drugs, mental health services, and other
2 services as determined by the commissioner.
3 C A parent or caretaker who is a qualified applicant must purchase
4 coverage, if available, through an employer-sponsored health
5 insurance plan which is determined to be cost-effective and is
6 approved by the commissioner.
7 C Subject to federal approval, a child shall be determined ineligible
8 for the program if the child was voluntarily disenrolled from
9 employer-sponsored group insurance coverage within six months
10 prior to application to the program.
11 C Presumptive eligibility is authorized for children who present
12 themselves for treatment at a general hospital, federally qualified or
13 community health center, local health department that provides
14 primary care or other State licensed health care provider if a
15 preliminary determination by hospital, health center, local health
16 department or health care provider staff indicates that the child
17 meets program eligibility standards. The child's parent or caretaker
18 would be required to submit a completed application for the
19 program no later than the end of the month following the month in
20 which presumptive eligibility is determined in order to maintain the
21 child's eligibility for the program.
22 C The Commissioner of Human Services may contract with one or
23 more appropriate entities, including managed care organizations, to
24 assist in administering the NJ FamilyCare Program.
25 C The Commissioner of Human Services, in consultation with the
26 Commissioner of Education, shall administer an ongoing enrollment
27 initiative to provide outreach to children throughout the State who
28 may be eligible for the program.
29 --The initiative shall include a school lunch "express
30 enrollment" program whereby a parent or guardian who signs the
31 school lunch application form can give consent for information to
32 be shared with the Department of Human Services for the purpose
33 of determining eligibility for the NJ FamilyCare and Medicaid
34 programs. The bill also requires the commissioners to establish
35 procedures for schools to transmit enrollment information to the
36 Department of Human Services, in order to enable the department
37 to determine eligibility for the programs.
38 -- The Commissioner of Human Services or the Commissioner
39 of Education, as applicable, also shall make available to each
40 elementary and secondary school, licensed child care center,
41 registered family day care home, unified child care agency, local
42 health department that provides primary care, and community-based
43 primary care provider, informational materials about the program,
44 including instructions for applying online or by mail, as well as
45 copies of the program application form. The entity would be
46 required to make the informational and application materials

available, upon request, to persons interested in the program and to distribute a notice at least annually to households of children attending or receiving its services or care, informing them about the program and the availability of informational and application materials.

NJ FamilyCare and Medicaid Enrollment Reforms:

The Commissioner of Human Services will be required to implement certain enrollment simplification practices for the NJ FamilyCare and Medicaid programs. Implementation of these reforms in the NJ FamilyCare Program will begin 180 days after enactment of the bill, and in the Medicaid program no later than January 1, 2006. The enrollment simplification practices include:

- A streamlined application form that will be developed by the commissioner, in consultation with the Rutgers Center for State Health Policy;
- Self declaration of income for new applicants. In order to verify the income of applicants, the commissioner may establish such retrospective auditing or income verification procedures as he deems appropriate, such as sample auditing and matching reported income with records of the Department of the Treasury or the Department of Labor;
- Online enrollment and renewal, in addition to enrollment and renewal by mail. The online enrollment and renewal forms shall include electronic links to other State and federal health and social services programs;
- Continuous enrollment;
- Automatic, passive renewal if an enrollee does not indicate any change in circumstances or if the enrollee has established eligibility for another income-tested State or federal program, such as Food Stamps or the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), whose income eligibility limits are equal to or less than that of NJ FamilyCare. In order to verify the income of enrollees, the commissioner may establish such auditing or income verification procedures as he deems appropriate, as specified above; and
- Provision of program eligibility-identification cards that are issued no more frequently than once a year.

Implementation:

In order to implement the expansion of eligibility and administrative reforms provided in this bill, and to monitor the implementation, the bill directs the Commissioner of Human Services to:

- Apply for such State plan amendments or waivers as may be necessary to implement the provisions of the bill and to secure federal financial participation for State Medicaid expenditures under

1 the federal Medicaid program and for NJ FamilyCare expenditures
2 under the State Children's Health Insurance Program.
3 C Within one year of the effective date of the bill, establish a plan to
4 develop and implement a universal identification card that can be
5 issued to and used by recipients of Medicaid, Work First New
6 Jersey, NJ FamilyCare, food stamps and other public social service
7 and health programs.
8 C Within one year of the effective date of the bill, prepare a request
9 for proposal to develop an online, interactive database that can be
10 used by health care facilities for enrolling, or determining the status
11 of an application for, children and their parents or caretakers and
12 adults without dependent children who present themselves at the
13 health care facility for services and who may be eligible for NJ
14 FamilyCare or Medicaid. The database shall enable the health care
15 facility to notify a county welfare agency or the appropriate office
16 in the Department of Human Services about a program applicant so
17 that the agency or office can follow-up on the application and
18 complete the eligibility determination process.
19 C Report to the Chairman of the Senate Health, Human Services and
20 Senior Citizens Committee and the Chairmen of the Assembly
21 Health and Human Services and Assembly Family, Women and
22 Children's Issues committees on the implementation of this bill. The
23 commissioner shall issue an interim report six months after the
24 effective date and shall issue an annual report six months later and
25 once each year thereafter.
26
27 Finally, the bill repeals N.J.S.A.30:4I-1 et seq. and 30:4J-1 et
28 seq., which established the NJ KidCare and NJ FamilyCare
29 programs, since these programs are consolidated and reestablished
30 under the provisions of this bill.

ASSEMBLY HEALTH AND HUMAN SERVICES COMMITTEE

STATEMENT TO

ASSEMBLY, No. 3724

with committee amendments

STATE OF NEW JERSEY

DATED: FEBRUARY 7, 2005

The Assembly Health and Human Services Committee reports favorably and with committee amendments Assembly Bill No. 3724.

As amended by the committee, this bill, which is designated the "Family Health Care Coverage Act," reforms the NJ FamilyCare Program and provides for an expansion of NJ FamilyCare and Medicaid eligibility for parents and adults without dependent children, in order to fulfill the original promise of the NJ FamilyCare program to provide health care coverage for low-income children and their parents, and adults without dependent children.

The bill also consolidates the State's NJ KidCare and NJ FamilyCare programs into the NJ FamilyCare Program, and requires the Commissioner of Human Services to adopt various enrollment simplification practices in both the NJ FamilyCare and Medicaid programs, in order to eliminate unnecessary barriers to enrollment for new applicants and renewal of enrollment for persons who are already participating in the program. (The bill repeals N.J.S.A.30:4I-1 et seq. and 30:4J-1 et seq., which established the NJ KidCare and NJ FamilyCare programs, respectively, since these programs are consolidated and reestablished under the provisions of the bill.)

The bill takes effect on the 180th day after enactment.

Expansion of Eligibility for Health Care Coverage:

- Children up to age 19 whose family gross income is up to 350% of the federal poverty level (FPL) will continue to be eligible for either Medicaid or NJ FamilyCare, based on their family's income.
- Effective January 1, 2006, parents of eligible children whose family earned income does not exceed 133% of FPL will be eligible for Medicaid (under current law, eligibility for parents is limited to persons whose income does not exceed approximately 34% of FPL).
- Effective January 1, 2007, parents of eligible children whose family earned income does not exceed 150% of FPL will be eligible for Medicaid.
- Effective January 1, 2008, parents of eligible children whose family earned income does not exceed 200% of FPL will be eligible for Medicaid.

- Effective 180 days after the date of enactment, the commissioner is to establish a NJ FamilyCare coverage "buy-in" program through which a parent or caretaker whose family gross income exceeds 350% of FPL may purchase coverage under NJ FamilyCare for a child under the age of 19 who is uninsured and was not voluntarily disenrolled from employer-sponsored group insurance coverage within six months prior to application to the program. The premium for coverage is not to exceed the amount that the program pays per month to a managed care organization under NJ FamilyCare for a child of comparable age whose family income is between 200% and 350% of FPL, plus a reasonable processing fee.
- Pending approval from the federal government, adults without dependent children whose income does not exceed 100% of FPL will be eligible for Medicaid. This income eligibility limit will be phased in over a three-year period.

NJ FamilyCare Program:

The bill reestablishes the NJ FamilyCare program in the Department of Human Services (DHS) to provide subsidized health insurance coverage for children under 19 years of age and their parents and other adults without dependent children who were enrolled in the program on the effective date of the bill and do not qualify for Medicaid.

- Families would be required to pay copayments and premium contributions, based upon a sliding income scale.
- Services covered by the program are to include: well-child and other preventive services, hospitalization, physician care, laboratory and x-ray services, prescription drugs, mental health services, and other services as determined by the commissioner.
- A parent or caretaker who is a qualified applicant must purchase coverage, if available, through an employer-sponsored health insurance plan which is determined to be cost-effective and is approved by the commissioner.
- Subject to federal approval, a child is to be determined ineligible for the program if the child was voluntarily disenrolled from employer-sponsored group insurance coverage within six months prior to application to the program.
- Presumptive eligibility is authorized for children who present themselves for treatment at a general hospital, federally qualified or community health center, local health department that provides primary care or other State licensed community-based primary care provider if a preliminary determination by hospital, health center, local health department or health care provider staff indicates that the child meets program eligibility standards. The child's parent or caretaker is required to submit a completed application for the program no later than the end of the month following the month in which presumptive eligibility is determined in order to maintain the child's eligibility for the program.

- The Commissioner of Human Services may contract with one or more appropriate entities, including managed care organizations, to assist in administering the NJ FamilyCare Program.
- The Commissioner of Human Services, in consultation with the Commissioner of Education, is to administer an ongoing enrollment initiative to provide outreach to children throughout the State who may be eligible for the program.

  -- The initiative is to include a school lunch "express enrollment" program whereby a parent or guardian who signs the school lunch application form can give consent for information to be shared with DHS for the purpose of determining eligibility for the NJ FamilyCare and Medicaid programs. In addition, the commissioners are to establish procedures for schools to transmit enrollment information to DHS, in order to enable DHS to determine eligibility for the programs.

  -- The Commissioner of Human Services or the Commissioner of Education, as applicable, is to make available to each elementary and secondary school, licensed child care center, registered family day care home, unified child care agency, local health department that provides primary care, and community-based primary care provider, informational materials about the NJ FamilyCare program, including instructions for applying online or by mail, as well as copies of the program application form. The entity is required to make the informational and application materials available, upon request, to persons interested in the program and to distribute a notice at least annually to households of children attending or receiving its services or care, informing them about the program and the availability of informational and application materials.

NJ FamilyCare and Medicaid Enrollment Reforms:

The Commissioner of Human Services is required to implement certain enrollment simplification practices for the NJ FamilyCare and Medicaid programs. The implementation of these reforms in the NJ FamilyCare program will begin 180 days after enactment of the bill, and in the Medicaid program no later than January 1, 2006. The enrollment simplification practices include:

- A streamlined application form that will be developed by the commissioner, in consultation with the Rutgers Center for State Health Policy;
- Self declaration of income for new applicants. In order to verify the income of applicants, the commissioner may establish such retrospective auditing or income verification procedures as the commissioner deems appropriate, such as sample auditing and matching reported income with records of the Department of the Treasury or the Department of Labor;
- Online enrollment and renewal, in addition to enrollment and renewal by mail. The online enrollment and renewal forms are to

include electronic links to other State and federal health and social services programs;

- Continuous enrollment;
- Automatic, passive renewal if an enrollee does not indicate any change in circumstances or if the enrollee has established eligibility for another income-tested State or federal program, such as Food Stamps or the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), whose income eligibility limits are equal to or less than that of NJ FamilyCare or Medicaid, as applicable. In order to verify the income of enrollees, the commissioner may establish such auditing or income verification procedures as the commissioner deems appropriate, as specified above; and
- Provision of program eligibility-identification cards that are issued no more frequently than once a year.

Implementation:

In order to implement the expansion of eligibility and administrative reforms provided in the bill, and to monitor its implementation, the Commissioner of Human Services is directed to:

- apply for such State plan amendments or waivers as may be necessary to implement the provisions of the bill and to secure federal financial participation for State Medicaid expenditures under the federal Medicaid program and for NJ FamilyCare expenditures under the State Children's Health Insurance Program.
- within one year of the effective date of the bill, establish a plan to develop and implement a universal identification card that can be issued to and used by recipients of Medicaid, Work First New Jersey, NJ FamilyCare, food stamps and other public social service and health programs.
- within one year of the effective date of the bill, prepare a request for proposal to develop an online, interactive database that can be used by health care facilities for enrolling, or determining the status of an application for, children and their parents or caretakers and adults without dependent children who present themselves at the health care facility for services and who may be eligible for NJ FamilyCare or Medicaid. The database is to enable the health care facility to notify a county welfare agency or the appropriate office in DHS about a program applicant so that the agency or office can follow-up on the application and complete the eligibility determination process.
- report to the Chairmen of the Senate Health, Human Services and Senior Citizens Committee, the Assembly Health and Human Services Committee and the Assembly Family, Women and Children's Issues Committee on the implementation of the bill (including an interim report six months after the effective date of the bill, and an annual report six months later and once each year thereafter).

As reported by the committee, this bill is identical to Senate Bill No. 2236 (1R) (Vitale/Buono), which is pending in the Senate Budget and Appropriations Committee.

COMMITTEE AMENDMENTS

The committee amendments to the bill provide that:

- Presumptive eligibility for the NJ FamilyCare program is authorized for children who present themselves for treatment at a State-licensed community-based primary care provider (as well as at a general hospital, federally qualified or community health center or local health department that provides primary care) if a preliminary determination by staff indicates that the child meets program eligibility standards; and
- In addition to directing the Commissioner of Human Services to seek a federal Medicaid waiver to permit DHS to require copayments and premium contributions for parents and children with incomes between 150% and 200% of the poverty level who will be phased-in under the Medicaid expansion in 2007 and 2008 (as is currently required in the FamilyCare program), the commissioner is to seek a waiver to provide a benefit package that is comparable to that provided to parents and children under the current NJ FamilyCare Program.

ASSEMBLY BUDGET COMMITTEE

STATEMENT TO

ASSEMBLY COMMITEE SUBSTITUTE FOR
ASSEMBLY, No. 3724

STATE OF NEW JERSEY

DATED: JUNE 27 , 2005

The Assembly Budget Committee reports favorably an Assembly Committee Substitute for Assembly Bill No. 3724.

This Assembly Committee Substitute for Assembly Bill No. 3724,. the "Family Health Care Coverage Act," reforms the NJ FamilyCare Program and provides for an expansion of NJ FamilyCare and Medicaid eligibility for parents and adults without dependent children, in order to fulfill the original promise of the NJ FamilyCare program to provide health care coverage for low income children and their parents, and adults without dependent children.

The substitute also consolidates the State's NJ KidCare and NJ FamilyCare programs into the NJ FamilyCare Program, and requires the Commissioner of Human Services to adopt various enrollment simplification practices in both the NJ FamilyCare and Medicaid programs, in order to eliminate unnecessary barriers to enrollment for new applicants and renewal of enrollment for persons who are already participating in the program.

Expansion of Eligibility for Health Care Coverage:

C Children up to age 19 whose family gross income is up to 350% of the federal poverty level (FPL) will continue to be eligible for either Medicaid or NJ FamilyCare, based on their family's income.

C Effective September 1, 2005, parents of eligible children whose family earned income does not exceed 100% of the FPL will be eligible for Medicaid (under current law, eligibility for parents is limited to persons whose income does not exceed approximately 34% of the FPL).

C Effective September 1, 2006, parents of eligible children whose family earned income does not exceed 115% of the FPL will be eligible for Medicaid.

C Effective September 1, 2007, parents of eligible children whose family earned income does not exceed 133% of the FPL will be eligible for Medicaid.

C Effective 180 days after the date of enactment, the commissioner shall establish a NJ FamilyCare coverage "buy-in" program through which a parent or caretaker whose family gross income exceeds

350% of the poverty level may purchase coverage under NJ FamilyCare for a child under the age of 19, who is uninsured and was not voluntarily disenrolled from employer-sponsored group insurance coverage within six months prior to application to the program. The premium for coverage shall not exceed the amount the program pays per month to a managed care organization under NJ FamilyCare for a child of comparable age whose family income is between 200% and 350% of the FPL, plus a reasonable processing fee.

- Pending approval from the federal government, adults without dependent children whose income does not exceed 100% of the FPL will be eligible for Medicaid. The income eligibility limit will be phased in over a three-year period.

NJ FamilyCare Program:

The substitute reestablishes the NJ FamilyCare program in the Department of Human Services to provide subsidized health insurance coverage for children under 19 years of age and their parents and other adults without dependent children who were enrolled in the program on the effective date of this substitute and do not qualify for Medicaid.

Program Requirements:

- Families would be required to pay copayments and premium contributions, based upon a sliding income scale.
- Services covered by the program will include: well-child and other preventive services, hospitalization, physician care, laboratory and x-ray services, prescription drugs, mental health services, and other services as determined by the commissioner.
- A parent or caretaker who is a qualified applicant must purchase coverage, if available, through an employer-sponsored health insurance plan which is determined to be cost-effective and is approved by the commissioner.
- Subject to federal approval, a child shall be determined ineligible for the program if the child was voluntarily disenrolled from employer-sponsored group insurance coverage within six months prior to application to the program.
- Presumptive eligibility is authorized for children who present themselves for treatment at a general hospital, federally qualified or community health center, local health department that provides primary care or other State licensed community-based primary care provider if a preliminary determination by hospital, health center, local health department or health care provider staff indicates that the child meets program eligibility standards. The child's parent or caretaker would be required to submit a completed application for the program no later than the end of the month following the month in which presumptive eligibility is determined in order to maintain the child's eligibility for the program.
- The Commissioner of Human Services may contract with one or more appropriate entities, including managed care organizations,

to assist in administering the NJ FamilyCare Program.

- C The Commissioner of Human Services, in consultation with the Commissioner of Education, shall administer an ongoing enrollment initiative to provide outreach to children throughout the State who may be eligible for the program.

  --The initiative shall include a school lunch "express enrollment" program whereby a parent or guardian who signs the school lunch application form can give consent for information to be shared with the Department of Human Services for the purpose of determining eligibility for the NJ FamilyCare and Medicaid programs. The substitute also requires the commissioners to establish procedures for schools to transmit enrollment information to the Department of Human Services, in order to enable the department to determine eligibility for the programs.

  -- The Commissioner of Human Services or the Commissioner of Education, as applicable, also shall make available to each elementary and secondary school, licensed child care center, registered family day care home, unified child care agency, local health department that provides primary care, and community-based primary care provider, informational materials about the program, including instructions for applying online or by mail, as well as copies of the program application form. The entity would be required to make the informational and application materials available, upon request, to persons interested in the program and to distribute a notice at least annually to households of children attending or receiving its services or care, informing them about the program and the availability of informational and application materials.

NJ FamilyCare and Medicaid Enrollment Reforms:

The Commissioner of Human Services will be required to implement certain enrollment simplification practices for the NJ FamilyCare and Medicaid programs. Implementation of these reforms in the NJ FamilyCare Program will begin 180 days after enactment of the substitute, and in the Medicaid program no later than January 1, 2006. The enrollment simplification practices include:

- C A streamlined application form that will be developed by the commissioner, in consultation with the Rutgers Center for State Health Policy;
- C Require new applicants to submit no more than one recent pay stub from the applicant's employer or, if the applicant has more than one employer, no more than one from each of the applicant's employers, to verify income. In the event the applicant cannot provide a recent pay stub, the applicant may submit another form of income verification as deemed appropriate by the commissioner. If an applicant does not submit income verification in a timely manner, before determining the applicant ineligible for the program, the commissioner shall seek to verify the applicant's

income by reviewing available Department of the Treasury or Department of Labor records concerning the applicant, or such other records as the commissioner determines appropriate.

In order to further verify the income of applicants, the commissioner may establish such retrospective auditing or income verification procedures as he deems appropriate, such as sample auditing and matching reported income with records of the Department of the Treasury or the Department of Labor or such other records as the commissioner deems appropriate;

- Online enrollment and renewal, in addition to enrollment and renewal by mail. The online enrollment and renewal forms shall include electronic links to other State and federal health and social services programs;
- Continuous enrollment;
- Simplified renewal by sending an enrollee a preprinted renewal form and requiring the enrollee to sign and return the form, with any applicable changes in the information provided in the form, no later than 30 days after the date the enrollee's annual eligibility expires. In order to verify the income of enrollees, the commissioner may establish such auditing or income verification procedures as he deems appropriate, as specified above; and
- Provision of program eligibility-identification cards that are issued no more frequently than once a year.

Implementation:

In order to implement the expansion of eligibility and administrative reforms provided in this substitute, and to monitor the implementation, the substitute directs the Commissioner of Human Services to:

- Apply for such State plan amendments or waivers as may be necessary to implement the provisions of the substitute and to secure federal financial participation for State Medicaid expenditures under the federal Medicaid program and for NJ FamilyCare expenditures under the State Children's Health Insurance Program.
- Within 60 days of the date of enactment of the substitute, report to the chairmen of the Senate Health, Human Services and Senior Citizens, Assembly Health and Human Services and Assembly Family, Women and Children's Issues committees regarding the department's plans for implementation of the NJ FamilyCare buy-in for children whose income is greater than 350% of the poverty level.
- Within one year of the effective date of the substitute, establish a plan to develop and implement a universal identification card that can be issued to and used by recipients of Medicaid, Work First New Jersey, NJ FamilyCare, food stamps and other public social service and health programs.
- Within one year of the effective date of the substitute, prepare a

request for proposal to develop an online, interactive database that can be used by health care facilities for enrolling, or determining the status of an application for, children and their parents or caretakers and adults without dependent children who present themselves at the health care facility for services and who may be eligible for NJ FamilyCare or Medicaid. The database shall enable the health care facility to notify a county welfare agency or the appropriate office in the Department of Human Services about a program applicant so that the agency or office can follow-up on the application and complete the eligibility determination process.

- Report to the chairmen of the Senate Health, Human Services and Senior Citizens, Assembly Health and Human Services and Assembly Family, Women and Children's Issues committees on the implementation of this substitute. The commissioner shall issue an interim report six months after the effective date and an annual report six months later and once each year thereafter.

Pharmaceutical Rebates for General Public Assistance Program, Program Funding:

- The Commissioner of Human Services is directed to contract with manufacturers of pharmaceutical products to provide rebates for pharmaceutical products covered under the Work First New Jersey General Public Assistance program (WFNJ-GA), established pursuant to N.J.S.A.44:8-107 et seq. on the same basis as is required under the PAAD, Senior Gold and Medicaid programs. A manufacturer would be required to contract with the State as a condition of continued participation in the WFNJ-GA program. These rebates are not intended to establish a new federal "best price," as that term is used in the federal Medicaid law.
- The monies from the rebates would be used to fund, in part, the expansion of eligibility in the Medicaid program provided in this substitute.
- The substitute provides that any unexpended balances for the NJ FamilyCare Program shall be appropriated to carry out the purposes of the substitute. Any transfer of NJ FamilyCare appropriations to other accounts shall be subject to the approval of the Joint Budget Oversight Committee.

Repealer and Effective Date of Substitute:

- The substitute repeals N.J.S.A.30:4I-1 et seq. and 30:4J-1 et seq., which established the NJ KidCare and NJ FamilyCare programs, since these programs are consolidated and reestablished under the provisions of this substitute.
- The substitute takes effect 180 days after enactment, except that: the Medicaid expansion for parents and caretaker relatives to 100% of the poverty level takes effect on September 1, 2006; the directive that the commissioner apply for such Medicaid State plan amendments and waivers as are necessary to implement the

substitute takes effect immediately; and the WFNJ-GA pharmaceutical rebates and related funding language takes effect immediately.

- The commissioner is directed to take such anticipatory administrative action in advance of the effective date as may be necessary to carry out the purposes of the substitute.

As substituted and reported by the committee, this substitute is identical to Senate Bill No. 2236 as also reported by the committee.

FISCAL IMPACT:

The Office of Legislative Services (OLS) is unable to estimate the cost of the legislation because State costs will depend on the number of children and adults who apply for and qualify for the NJ FamilyCare and Medicaid programs, respectively, and whether the federal government approves the various State Medicaid Plan amendments or waivers that may be necessary to implement the legislation.

The OLS, however, notes the following:

- In the NJ FamilyCare program, the State spends approximately: $113 per month for each child; $200 per month for each parent; and $390 per month on each adult without dependent children enrolled in the program.
- For every 10,000 additional children determined eligible for NJ FamilyCare, annual gross costs would be about $13.6 million, or between $4.8 - $6.8 million State share, depending on the federal matching rate. The Rutgers Center for State Health Policy (CSHP) provided estimates that indicates, based on data from the 2004 Current Population Survey (CPS) conducted by the US Census Bureau and the 2001-02 New Jersey Family Health Survey, an additional 101,000 children may be eligible for Medicaid or NJ FamilyCare than are currently enrolled in the programs.
- For every 10,000 additional parents determined eligible for Medicaid, annual gross costs would be around $24.0 million, or $12.0 million State share, based on a 50% federal matching rate.
- If a federal Medicaid waiver to cover adults without dependent children is obtained, the annual gross cost of covering 10,000 such adults who are not on General Assistance would be approximately $47.0 million, or $23.5 million State share; however, it is uncertain whether the federal government will approve the waiver, as federal Medicaid law does not recognize this population as being categorically eligible for the program. (NOTE: coverage of these adults will not go into effect unless the waiver is obtained.)

Additionally:

- The substitute requires pharmaceutical manufacturers to pay rebates for drugs provided under the WFNJ-GA program and appropriates the revenues from the rebates to the Medicaid

expansion established in the substitute. The rebates could produce approximately $12 million annually in revenue.

- Federal revenue (S-CHIP funds), including the recent award of $172 million in redistribution funds, should be sufficient to cover the enrollment of additional children at least for the next year.
- Costs associated with the legislation should also be offset by reduced State appropriations for Charity Care in future years, as hospitals should experience a reduction in the number of uninsured persons who currently use their facilities to access health care. Other cost offsets may result from administrative simplification procedures in the NJ FamilyCare and Medicaid programs that are established in the substitute.

PO BOX 004
TRENTON, NJ 08625

Contact: Kelley Heck
609-777-2600

RELEASE: July 13, 2005

Codey Signs Bill to Dramatically Expand Health Coverage for Uninsured Children and Parents in New Jersey

(TRENTON) – Acting Governor Richard J. Codey today signed S2236/A3724, legislation that will expand eligibility for the NJ Familycare program.

"Today, we will reopen the NJ FamilyCare program to parents for the first time in three years," Codey said. "We are another step closer to making health care in New Jersey affordable and available to everyone."

The bill signing was held at the Children's Specialized Hospital in Hamilton. Codey was joined by bill sponsors Senator Joseph F. Vitale (D-Middlesex) and Assemblyman Robert Lewis Morgan (D-Mercer and Middlesex) and the Commissioner of the Department of Human Services James M. Davy.

The bill's primary sponsors are Senator Joseph F. Vitale (D-Middlesex),Senator Barbara Buono (D-Middlesex), Senator Wayne R. Bryant (D-Camden and Gloucester), Assemblyman Robert Lewis Morgan (D-Mercer and Monmouth), Loretta Weinberg (D-Bergen), Robert M. Gordon (D-Bergen), John S. Wisniewski (D-Middlesex), Joan M. Voss (D-Bergen), Mary T. Previte (D-Camden) and Bonnie Watson Coleman (D-Mercer).

"With NJ FamilyCare, we are meeting our humanitarian obligation of providing accessible, quality health care to all New Jerseyans," said Vitale (D-Middlesex). "Health care is not a privilege for the financially secure -- it is a right that we must defend for every resident of this State, regardless of personal income. All of our State's children and New Jersey's working-class families deserve decent health coverage, and a revamped NJ FamilyCare will put us within reach of that goal."

"We really should commend everyone who has worked over the last year to make it possible to pass this law today," said Buono (D-Middlesex). "Because of their work, the program is more efficient, more responsive and better able to provide free and low-cost health care to New Jersey's working families. A year from now, tens of thousands more New Jerseyans will be leading better lives because FamilyCare has the resources to provide the preventative care needed for a healthy lifestyle."

"As the author many of the State's laws to help provide a hand-up to many of New Jersey's low income families, I am proud to be a sponsor of this legislation," said Bryant (D-Camden, Gloucester). "This Family Care law is a step forward in New Jersey's fight to help keep its families safe and healthy."

"Our goal in creating this legislation was to allow for streamlined enrollment of eligible children; more efficient retention of children within the system, and the extraction of administrative savings so that we spend less on bureaucracy and more on health care for children and their families," said Morgan (D-Mercer, Middlesex). "The signing of this bill into law represents a significant turn for the better for healthcare in New Jersey."

New Jersey's FamilyCare program began as NJ KidCare in 1998. It was expanded and renamed NJ FamilyCare in 2000. The goal of this program is to provide health insurance for low-income children and parents whose family incomes are too high for them to be eligible for traditional Medicaid but also too low for them to be able to participate in a private or employer-sponsored health insurance program. In June of 2002 budgetary concerns forced the state to freeze enrollment for parents and adults.