



Health Care Coverage for All A Blueprint for New Jersey

By Joseph F. Vitale & David L. Knowlton

March 17, 2008



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Dear Friends,

For a long time we have both felt the need for meaningful and transformational health care reform in New Jersey. In the fall of 2006 we decided it was time, the need was real, and we could not wait any longer. We brought together a team of experts from around the State and we went to work.

Our mission was to guarantee health insurance coverage for all New Jersey residents. To us, that meant we must:

- Stop the escalating costs of health insurance in the private market;
- Cover New Jersey's growing uninsured population with an affordable, portable, universal, and sustainable health insurance product; and
- Change the landscape of health care delivery to secure the long-term cost-containment of New Jersey's limited financial resources.

This blue print outlines our proposal to achieve health care reform.

Thank you for your interest in our proposal. We know our aim is ambitious, but the time is now. We are eager to work with you toward enacting these reforms.

Sincerely,

Joseph F. Vitale
Senator, District 19

David L. Knowlton
President & CEO
New Jersey Health Care Quality Institute

Executive Summary

Effective and sustainable reform must be bold to impact the most concerning issues: the uninsured and affordability. This fundamental principle is required fiscally and demanded morally. Health care issues are vast and complex, requiring considerable attention to the human and economic impact of new policies. There is no simple solution, but the resounding call for change demands immediate action.

New Jersey and the entire nation are experiencing an economic downturn. The cost of transportation, food, and housing has grown considerably. Major financial institutions have required the intervention of the federal government. As the economy worsens, families will rely even more on the safety net provided by Medicaid and NJ FamilyCare to provide health insurance for their children. As it stands now, 17 million patients are treated by New Jersey hospitals through the Charity Care Program, another 2.6 million are emergency cases.¹

The cost of this system quickly approaches \$1 billion annually. Much of the charity care costs are incurred because New Jersey hospitals act as a safety net for individuals who are uninsured or who lack access to primary or preventative health care services. This plan will make this system more efficient. It sets out a plan to cover the uninsured by reallocating existing tax dollars in a manner that is much more fiscally responsible.

Initially, the focus is on *Kids First* to help New Jersey come closer to meeting federal enrollment guidelines for the State Children's Health Insurance Program, preserving additional matching federal dollars which were threatened to be cut last year. To aide in the enrollment of children and to make full use of available federal funds, NJ FamilyCare will enroll parents up to 200% of the federal poverty level. This combined with market reform will provide temporary relief while aligning resources to achieve the final stage

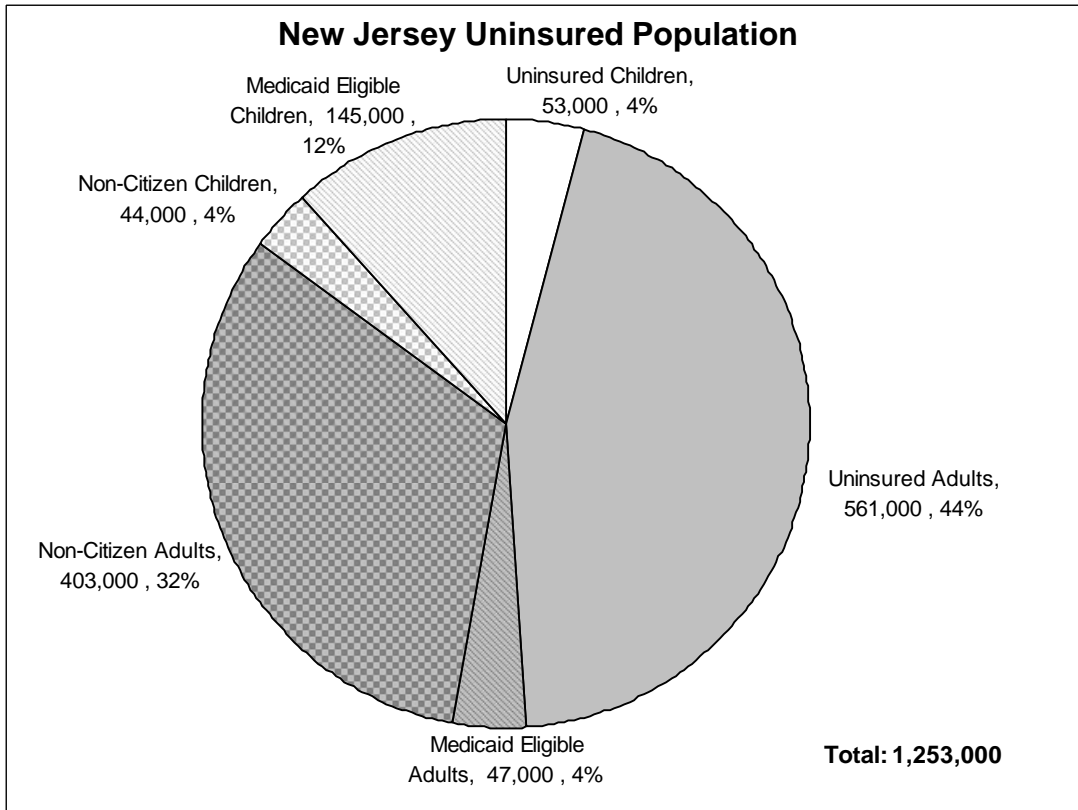
At the same time, the foundation will be constructed to facilitate the creation of an insurance product for the uninsured. This product will be made affordable by subsidizing the premiums of those with low incomes. Once affordable coverage is available, an individual mandate will be put in place. During this phase a Collaborative Care System will take shape, replacing the inefficient Charity Care Program.

This plan will require an initial investment in order to ensure the solvency of hospitals that have provided extensive amount of charity care. However, once the transition is made, this system will be a more efficient and cost effective use of taxpayer dollars. During a time of fiscal constraint we can not afford to continue to ignore the growing problems of our current system. During a time of economic uncertainty, New Jersey residents deserve to know that their tax dollars will be spent to ensure their health care needs are met.

¹ New Jersey Hospital Association.

Status of the Uninsured in New Jersey

There are currently 1.253 million uninsured people living in New Jersey, of which 242,000 are children.² Sixty percent of these children are eligible for State sponsored health coverage either through Medicaid or NJ FamilyCare. The remaining uninsured children are eligible to buy into the recently implemented NJ FamilyCare Advantage Plan: a full-cost, dependent-only health plan negotiated by the State for children in families whose income exceeds eligibility limits for NJ FamilyCare.³



Mercer Government Human Services Consulting

The Uninsured – A Shared Cost to Society

Applying research recently published by the Institute of Medicine, the uninsured of New Jersey cost our state an estimated \$2.9 billion annually.⁴ This far exceeds the expense the state would incur to provide health coverage to all uninsured New Jersey residents. The costly burden of the uninsured is shouldered by New Jersey's citizens, employers and health care providers.

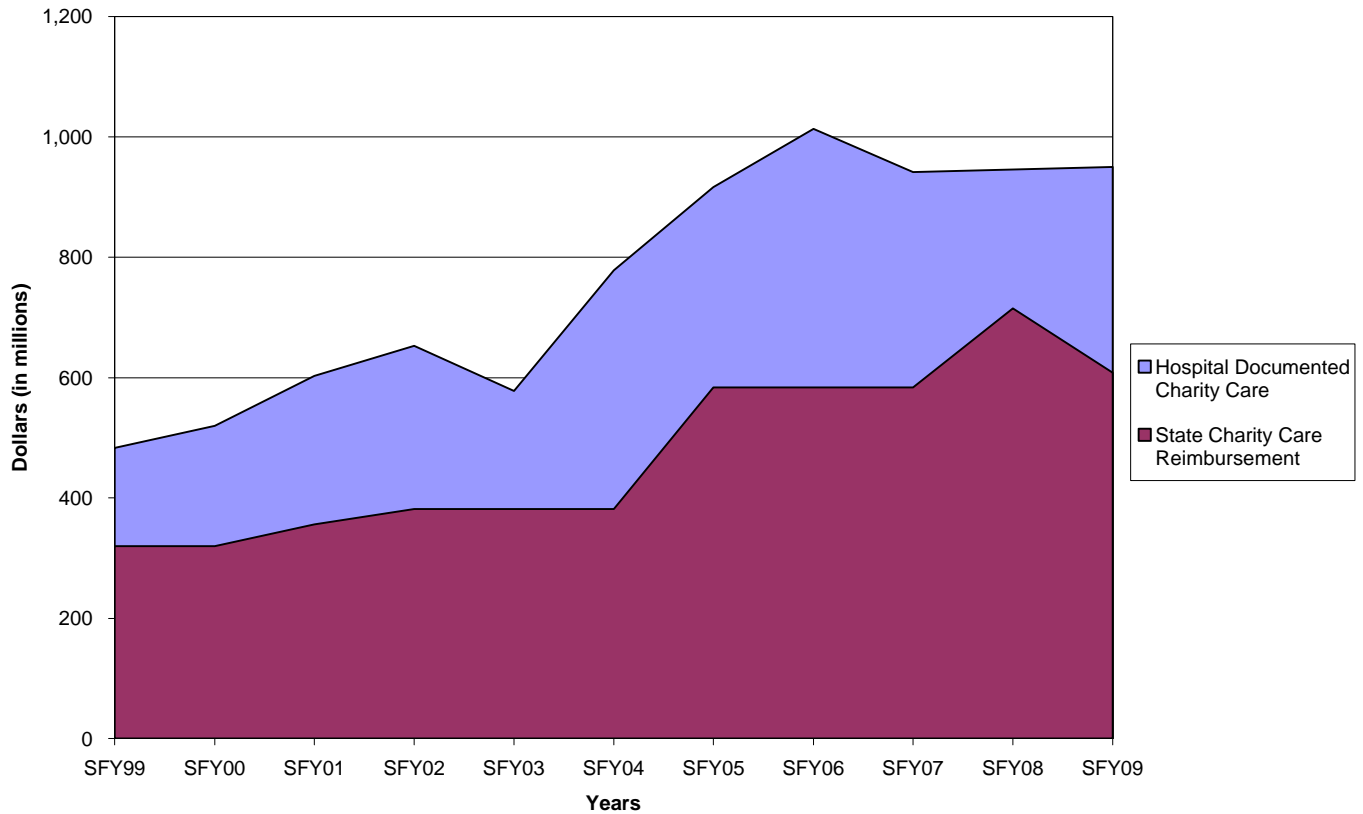
² Uninsured as reported by 2004 and 2005 Current Population Survey data.

³ Families above 350% of the federal poverty level; A family of three with an annual income greater than \$61,600.

⁴ Institute of Medicine. *Hidden Costs, Value Lost – Uninsurance in America*. The National Academy Press (2003). The IOM publication estimated the annual discounted present value of lost health up to age 65 due to lack of insurance ranged from \$1,645 to \$3,280 per uninsured person. Applying the midpoint range to the number of uninsured in NJ results in an estimated total value of improved health from covering the uninsured at \$2.9 billion.

Last year alone, New Jersey hospitals documented more than \$946 million in charity care to serve the uninsured.⁵ Of that total, the State provided \$715 million to hospitals, an increase of over \$131 million from the previous year. The Charity Care Program was created to offset the fiscal impact hospitals incur while meeting their legal obligation to treat everyone regardless of their ability to pay. The program is funded entirely with taxpayer dollars; an inadequate, inefficient use of limited resources.

Figure 1. Charity Care: An Unmet Burden, New Jersey (SFY 1999-2008)



This year it is anticipated that hospitals will provide more than \$950 million in charity care. However, the Governor’s proposed budget reduces charity care reimbursement by \$142 million. During the next three years, if nothing is done to reduce the number of uninsured, we can expect documented charity care to rise to over \$1.2 billion.⁶ The gap between the State reimbursement to hospitals and the actual cost of providing charity care continues to widen, forcing hospitals to shift a portion of the remaining cost on patients that have private insurance. As this cost shift escalates, the premiums of the privately insured rise exponentially. Unaffordable premiums push more people out of coverage, increase property taxes and only further exacerbate a broken system.⁷

⁵ New Jersey Department of Health and Senior Services. Documented charity care is based on CY 2007 data and was reimbursed in the SFY 2008 budget. Note that 96% of the working uninsured earn less than 200% FPL and that 25% of all charity care is spent on women of child bearing age.

⁶ New Jersey Department of Health and Senior Services.

⁷ The cost of caring for the uninsured is shifted to the insured. This cost-shift contributes largely to rising health care costs at every government level.

In addition to the Charity Care Program, millions of additional tax dollars are spent trying to meet the health care needs of New Jersey residents. Direct grants to hospitals alone account for about \$243 million of the State budget this year. This plan invests in New Jersey's future by reinvesting health care dollars in a manner that will leverage additional federal funding, while reducing the number of uninsured and improving health outcomes.

Blueprint for Health Care Reform in New Jersey

PHASE 1

- *Kids First* Health Insurance Mandate
- Expansion of NJ FamilyCare
- Health Insurance Market Reform

Kids First Health Insurance Mandate

One in ten New Jersey children is uninsured. These children account for nearly \$16 million of charity care, are four times more likely to be Hispanic and twice as likely to live in urban areas.⁸ To illustrate, one in five children living in Passaic, Bergen, Union, Essex and Hudson counties lack health coverage.⁹ And their lack of coverage is often prolonged for at least one year.¹⁰

The first phase of this comprehensive health care reform plan will require that all New Jersey children be insured. Rather than imposing penalties for non-compliance, a robust outreach and enrollment strategy will be implemented to ensure that children become insured. The Department of Human Services will continue to work with the Department of Education and other State agencies to identify and enroll uninsured children in our schools and other points of contact. Health care providers including clinics and hospitals will also serve as a point of enrollment. Through extensive outreach, parents will learn about the affordable health coverage options available in New Jersey for their children.

8 The Medically Uninsured in New Jersey: A Chartbook. August 2004. State of New Jersey Department of Human Services in collaboration with Rutgers Center for State Health Policy. NOTE: Percentage of Children in NJ without coverage by Race/Ethnicity: White (non-Hispanic) 6%; African American (non-Hispanic) 9%; Hispanic 24%, All Other (American Indian, Native Americans, Aleutian/Eskimo, Asian/Pacific Islander, or other unspecified race) 17%.

9 DeLia, Derek, Dina Belloff. Disparity in Health Insurance Coverage: Urban versus Non-Urban Areas of New Jersey. April 2006. State of New Jersey Department of Human Services in collaboration with Rutgers Center for State Health Policy. NOTE: based on 2001 data, when NJ FamilyCare was first opened to parents. It is expected that this disparity is even greater since the program currently only enrolls parents up to 133% FPL.

10 The Medically Uninsured in New Jersey: A Chartbook. August 2004. State of New Jersey Department of Human Services in collaboration with Rutgers Center for State Health Policy. NOTE: based on 2001 data, (63% of uninsured children lack coverage for at least a year).

Just this past December, New Jersey achieved its longstanding goal of creating universal access to affordable health coverage for all children by implementing NJ FamilyCare Advantage.¹¹ This is a full cost buy-in program to NJ FamilyCare. Families with incomes over 350% of the federal poverty level may purchase coverage for their children through this program.

The benefit package is the same as the NJ FamilyCare Plan D, without Medicaid fee-for-service wraparound services. However, unlike NJ FamilyCare, there is a six month crowd out period before a child can be enrolled. This period is intended to prevent employers from eliminating dependent coverage altogether. NJ FamilyCare Advantage has a three-tiered premium rate structure based on the number of children enrolled by a family. The monthly rates are as follows: One child \$137, Two children: \$274 and Three or more children: \$411.¹²

Coverage for Adults with Children

Recognizing that the participation of parents in NJ FamilyCare is critical to the success of enrolling children, one key component of this reform plan would take full advantage of federal funding available to New Jersey by immediately expanding NJ FamilyCare to parents whose family income falls below 200% of the federal poverty level. For example, this is a family of four with an income less than \$42,400.

The Federal State Children's Health Insurance Program (SCHIP), partners with New Jersey to provide sixty-five cents on every dollar invested in NJ FamilyCare. Instead of leaving these important funds untapped, the Family Health Care Coverage Act of 2005 was passed to streamline the application process and to once again begin to incrementally enroll parents. Today, parents with a family income up to 133% of the federal poverty level can enroll in NJ FamilyCare; that is a family of four with an income less than \$28,196.

The incremental expansion of eligibility for parents in NJ FamilyCare has had a direct impact on the cost of charity care. The expansion began in January 2006 and as of July 2007, more than 60,000 new parents enrolled in NJ FamilyCare. Documented charity care for this period decreased \$71 million and the rate of growth has become more stable.

Expansion of NJ FamilyCare to parents up to 200% of the federal poverty level is essential to the long term funding of major health care reform. The reason is twofold. First, 96.3% of all charity care is used to pay for the care of persons with income below 200% of the federal poverty level. By enrolling part of this population in health insurance, the State will be able to begin rededicating charity care funding toward further expansions of health coverage without causing an additional burden to hospitals. Second, New Jersey must use every possible opportunity to draw down federal dollars to help pay for health care reform and this provides that opportunity.

11 Family Health Care Coverage Act, P.L. 2005, c.156.

12 Appendix B provides two scenarios describing the cost to enroll in Medicaid, NJ FamilyCare and NJ FamilyCare Advantage

Health Insurance Market Reform

The commercial health market in New Jersey covers about 2.5 million people through individual and group contracts for a premium of \$8.9 billion. Of this amount, about 82% (\$7.3 billion) is paid in claims. The balance (\$1.6 billion) accounts for administrative costs and revenue.¹³

This proposed market reform attempts to reduce and stabilize costs for all those in the individual and small employer markets. Cost reductions and rate structure changes will help those buying in these markets today to continue to afford to do so, while also attracting new lives to the market because it will become more affordable. The changes described below are intended to provide temporary relief in the Individual Market during the time that it takes to implement the second phase of health care reform, and should provide ongoing stability to the Small Employer Market for years to come.

Individual Health Coverage Program

The New Jersey Individual Health Coverage Program (IHC) was created by the Legislature in 1992 and became fully operational on August 1, 1993. Carriers in this market are required to offer standardized, open-enrollment, community rated products. All carriers in New Jersey are required to either write policies in the IHC or share in the losses incurred by carriers that do offer coverage in this market.

These requirements were implemented to protect consumers and originally were coupled with a program that helped subsidize premium costs. Community rating, however, has been the main contributing factor to the decline of this market. Community rating means that an insurance plan may not take into account any factors such as ones age, health status or sex when deciding their premium. Over the years, those who continue to purchase on this market have become older and sicker.

In 1997, there were 154,000 individuals covered through this market. However, due to the combined impact of high claims and the increasing average age of enrollees, this market declined significantly and decreased to 69,000 at the end of 2005.¹⁴ This was offset by the introduction of basic and essential plans that are age, sex and geography rated (capped at a ratio of 3.5:1), with total enrollment in these plans reaching 8,000 by the end of 2005.¹⁵ With each rate increase, healthy risk is further driven out leaving poorer risks facing higher claims and perpetually increasing premiums.

Small Employer Health Benefit Program

The New Jersey Small Employer Health Benefit Program (SEH) covers approximately ten percent of the State population, above the national average of employees of small

13 New Jersey Department of Banking and Insurance

14 New Jersey Department of Banking and Insurance

15 New Jersey Department of Banking and Insurance

employers who have coverage.¹⁶ Employers with two to fifty employees have the opportunity to purchase health coverage in this market. The fundamental principles of this market include guaranteed issue, rating based on age, sex and geography (capped at a ratio of 2:1), standard products with the ability to apply riders to the standard products and a minimum loss ratio requirement of 75%. The minimum loss ratio means that seventy-five cents of each dollar paid in premium must be spent on delivering health care to the insured group. The SEH was also created by the Legislature in 1992 and it went into effect on January 1, 1994. This program has been very successful with current enrollment at 900,000, but premium rates have grown steadily.

Aspects of Market Reform

- *Provide for modified community rating capped at a ratio of 3.5:1 based on age only in the IHC. However, the basic and essential plans, would continue to rate based on age, sex, and geography.*

Young, healthy individuals have quickly been priced out of the individual market.¹⁷ An analysis performed by the Rutgers Center for State Health Policy found that moving from pure to modified community rating could reduce premiums for persons under the age of forty, increase their enrollment from under seven percent to fifty-one percent (46,000 new enrollees).¹⁸ Modified community rating may cause the premiums for the oldest citizens enrolled in the IHC to increase fifteen percent, however, this is consistent with recent increases experienced by this market and so should not result in many older enrollees becoming uninsured.

Recent rate increases filed for IHC Standard plans:¹⁹

<u>Plan</u>	<u>Lives</u>	<u>Effective</u>	<u>Percent Increase</u>
Aetna	8,000	4/1/07	25.6%
Amerihealth	3,000	4/1/07	16.5%
Horizon-Indemnity	8,000	2/1/07	15% (negative profit margin 22%)

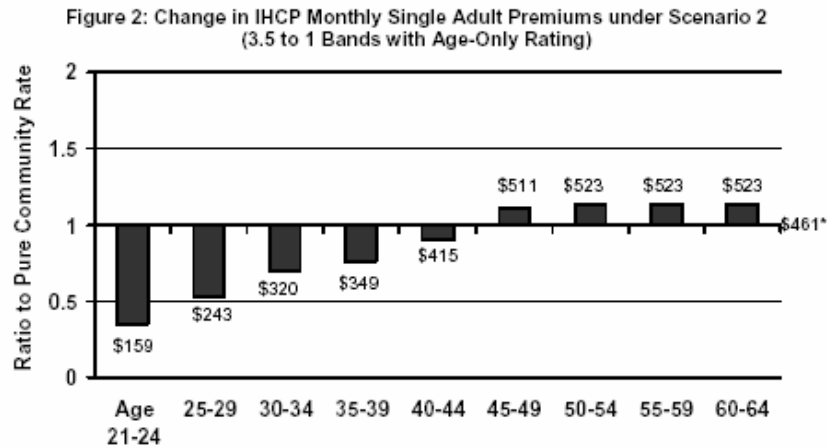
¹⁶ New Jersey Department of Banking and Insurance

¹⁷ Glied, Sherry. The Health Care System of New Jersey in 2005: A Snapshot. August 2005. Hall Institute of Public Policy.

¹⁸ Moheit, Alan C., Joel C. Cantor, Piu Banerjee. Assessing Policy Options for the Non-Group Health Insurance Market: Simulation of the Impact of Modified Community Rating on the New Jersey Individual health Coverage Program. March 2005. Rutgers Center for State Health Policy.

¹⁹ New Jersey Department of Banking and Insurance.

This graph, developed by the Rutgers Center for State Health Policy, depicts how modified community rating would impact rates in the IHC.



Source: Rutgers Center for State Health Policy, New Jersey Individual Health Insurance Market Simulation Model
 *Monthly premium for the lowest cost HMO product in the NJ IHCP (\$15 copay plan in October, 2004).

- *Require participation by carriers in the both IHC and SEH markets.*

There is currently a requirement that carriers either participate in the IHC or share in the losses of the carriers that do through an assessment. The IHC Board oversees this system, which has been the genesis of much litigation. This plan requires all carriers to participate in the IHC and eliminates the assessment prospectively.

- *Reduce the number of required standard plans from five to three in both the IHC and SEH markets. Allow riders, but require their price be listed separately.*

Standard plans were created to allow for consumers to compare prices for like products and remains a crucial consumer protection. The time and expertise that would be needed to fully research and compare plans without any standardization would overwhelm even the most educated consumer.

Consumers will be allowed to add riders to these plans, however, carriers will be required to price list any rider separate from the cost of the standard plan in order to ensure a consumer's ability to price compare against standard plans.

- *Modify the minimum loss ratio in both the IHC and SEH markets.*

The minimum loss ratio is the amount of each premium dollar required to be spent on medical costs. Currently, 75 cents on every dollar must be spent on health care services. The balance of the dollar is used to cover administrative costs and overhead for the insurance company. This plan would increase the current minimum loss ratio from 75% to 80% in both the IHC and SEH markets.

The innovation of new technology has brought greater efficiency and has stabilized administrative costs at or below the general inflation rate. At the same time, medical costs have grown at a rate much faster than inflation making it reasonable to dedicate more of the premium dollar toward direct health services and less toward administrative costs. Adjusting the minimum loss ratio will still give insurance companies twenty percent of each dollar to use toward administrative costs and other overhead.

- *Broker commission transparency in the SEH market.*

Broker commissions account for five to seven percent of small employer health benefit premiums. The amount of commission or other compensation paid to a broker or agent in connection with a health policy issued to a small employer would now be disclosed to that small employer. Brokers have an important role in the market and as such, their compensation would now be reviewed just as any other cost component of insurance coverage.

- *Eliminate the ability for small employer to purchase different plans for different employees.*

The SEH market currently allows small employers to buy different plans for different employees. This practice is inconsistent with the notion of group insurance and would be eliminated. Small employers would still be able to offer different benefit structures, such as an HMO and a PPO, but they would be with the same health plan.

- *Transfer regulatory oversight with respect to rate filings and other similar matters from the IHC Board to the Commissioner of the Department of Banking and Insurance, as is currently provided in the SEH Market.*

PHASE 2

- Garden State All-Care
- Individual Mandate for all New Jersey Residents
- Collaborative Care System for those that Remain Uninsured

Garden State All-Care

This reform plan would create a State-managed, commercial-grade health insurance product which would be available to all New Jersey residents regardless of their income or family size at a price that is affordable. Subsidies would be provided to low-income households to ensure its affordability.

The benefits in this State-sponsored commercial insurance plan would be similar to the most commonly offered small group products that exist today. It is a comprehensive medical plan that, among other benefits, would include hospitalization, preventive care and prescription drugs.

The decision to make this plan comprehensive instead of basic in benefit design is important. A basic plan typically has very high deductibles that must first be met before the insurance coverage begins to pay for care. Those high deductibles are concerning because people may forgo receiving primary care. If they are hospitalized, they may be unable to afford the deductible, which would increase bad debt for hospitals. A comprehensive plan will ensure consumers have access to the care they need to be healthy, while reimbursing providers for the care they deliver.

Consumers will have the choice between a HMO and a PPO plan design. Providers will be reimbursed at commercial rates, which will ensure consumers have an extensive network of providers from which to choose. This benefit structure will maximize the underwriting savings generated by grouping large numbers of people.

The savings achieved by grouping all individuals into one State-sponsored plan are considerable. On average, the annual cost for an individual plan with a \$1,000 deductible sold in New Jersey today is \$16,000. This reform plan aims to reduce these rates by 75%. Contracting with commercial insurers to administer this program under state sponsorship will be competitive and will require the plans to meet specified standards, such as comprehensive statewide provider networks. The State will oversee the program to generate even further savings.

Individual Mandate for all New Jersey Residents

To reduce the cost of health care, people must have access to the resources they need to be healthy. Health insurance coverage is essential to reach this goal. The cornerstone of this plan requires all New Jersey residents to have health insurance. With the creation of

Garden State All-Care, affordable health insurance would be available to all New Jersey residents. At that time, an individual mandate would become effective, requiring every New Jersey resident to have health insurance coverage. Insurance premiums can only be stabilized when all residents participate.

Under this plan, all those eligible for Medicaid or NJ FamilyCare will be enrolled. Residents receiving coverage from their employer will continue to do so, uninterrupted. All others will be required to enroll in Garden State All-Care. To ensure affordability, premiums for the new plan will be subsidized based on household income.

The small and large health insurance markets will remain intact. Those currently purchasing insurance in the individual market will merge into the new plan so that they may benefit from the reduced rates generated by a large risk pool.

With this reform, it is anticipated that 248,000 of the uninsured will qualify and enroll in Medicaid or NJ FamilyCare. That is, with the expectation that enrollment of parents in NJ FamilyCare is expanded to 200% of the federal poverty level in order to maximize federal matching funds. Approximately, 558,000 will utilize Garden State All-Care.

The remaining uninsured are non-citizens, homeless or otherwise difficult populations to insure. These populations will continue to avail themselves to care at clinics and hospitals. However, their care will be coordinated so that it meets their medical needs in the most cost-effective setting.

Collaborative Care System

Non-citizens will not be eligible for subsidized insurance through this plan. Citizens that are homeless or transient, even with the best efforts, are difficult to reach and will likely remain uninsured. As a significant portion of the uninsured population, their health needs must still be met.

Currently, hospitals and clinics throughout the nation provide this care as required by law. Care received in a hospital is free to those that are uninsured and fall under 200% of the federal poverty level, subsidized by the New Jersey Charity Care Program. Community health clinics throughout New Jersey provide primary care to the uninsured on an income based sliding fee scale. Since care in the hospital is perceived to be free, people who earn less than 200% of the federal poverty level turn to the hospital for all of their care, which is an inefficient use of limited resources. Non-emergent care should be provided in a clinic setting, not a hospital emergency room.

This plan will realign incentives so that care is delivered in the most proper, cost-effective way. Hospitals will remain obligated to triage and stabilize uninsured patients that arrive in their emergency departments, but then will refer patients to the appropriate level of care. Patients requiring primary care will be directed to clinics. Those requiring higher levels of non-emergent care will be referred to hospitals designated by the state to

treat the uninsured. Uninsured patients will be responsible to contribute to the cost of delivering their care, based on their income.

Hospitals will compete for this designation on various indicators. This plan envisions the creation of an electronic system accessible by all providers that logs and monitors the care delivered to the uninsured. The data captured by such a system will provide researchers an opportunity to evaluate and recommend innovative ways to contain costs for delivering care to this population.

The public often questions why services are provided to non-citizens at taxpayers expense. This is a legitimate question. In the case of providing health care, the answer is grounded in public health protection. Every citizen benefits when the people they come in contact with are healthy. This plan will make more efficient use of existing resources to keep the remaining uninsured healthy.

Partnering with Employers

Historically, employers began to include health insurance as a benefit to attract and retain employees. This remains an important incentive that will be sustained under this plan. Employers who currently provide coverage will likely continue to do so because premium costs should stabilize as more people become insured. The dynamics of the labor market will also change in the context of a mandate requiring individuals to have health coverage. Individuals will become more aware and price sensitive to the cost of health insurance leading many to negotiate higher wages or insurance as a benefit of employment.

Employers that do not offer health insurance will be required to establish Section 125 flexible spending accounts permitted under Federal tax law in order for their employees to obtain health coverage using pre-tax dollars. This will allow both full-time and part-time employees to reduce their taxable income and ultimately pay lower income taxes. Employers that only offer health coverage to full-time employees will also be required to set up these accounts for their part-time and seasonal employees. This will permit individuals working part-time for multiple employers to benefit by paying lower taxes. The money saved in these accounts will be used to purchase insurance through the State-sponsored plan.

Public opinion that employers be required to provide health insurance is strong. Federal law, however, severely limits states in their ability to force employers to provide benefits. Efforts made by other states to hold employers accountable have either been struck down by the legal system or fall short of addressing this issue directly and will most likely create unintended consequences.

This plan embraces New Jersey employers as partners. While never required, employers today can be credited for providing seventy percent of New Jersey residents with health coverage. Their reasons for doing so are expected to remain the same and, with the

enactment of an individual mandate to increase. Additionally, the impact this plan has on employer's decision to provide coverage will be closely monitored.

The Economics of Reform

An investment must be made to make any progress in providing for the health care needs of the state. Unlike other industries, an investment in health care is a direct investment in the economy of New Jersey. Health care is not a product that can be imported or outsourced. It is created, it is delivered and it is consumed right here in New Jersey.

<u>Phase 1</u>		
<u>FIRST YEAR COST</u>	Expected additional enrollment (cumulative)	State Cost
Kids First	52,166	\$20,500,000
Parents 200%	12,000	\$8,300,000
Outreach		\$1,000,000
Total	64,166	\$29,800,000
<u>FULL COST IF ALL ELIGIBLE ENROLL</u>		
Kids First	167,000	\$89,000,000
Parents 200%	46,947	\$33,300,000
Outreach		\$1,000,000
Total	214,000	\$123,300,000

The *Kids First* health insurance mandate takes effect one year after the date the bill is enacted into law. The New Jersey Department of Human Services projects that in the first year, 52,166 children will enroll for a total State cost of \$20.5 million.

Expanding eligibility in NJ FamilyCare to parents up to 200% of the federal poverty level will maximize federal funding and in the first year, the New Jersey Department of Human Services estimates 12,000 new parents will enroll at a cost of \$8.3 million to the State. The total State share to enroll parents and children in the first year is \$28.8 million. One million dollars will be added for outreach purposes, bringing the grand total to \$29.8 million in the first year.

The cost to enroll all children that are currently eligible for Medicaid or NJ FamilyCare is \$89 million. This is not an additional cost created by this proposal. It is the cost of fulfilling an existing obligation. Enrollment of all eligible parents will cost \$33.3 million.

Phase 2

Early actuarial estimates by Mercer Government Human Services Consulting indicate that the cost to insure 558,000 uninsured adults and children in the State-sponsored commercial insurance plan is \$1 billion. This figure contemplates participants paying a premium, based on their income.

A detailed affordability analysis, taking into account the cost of living in New Jersey is forthcoming. This information will be used to determine the level for which the state will subsidize premiums. Although the premiums collected will help to offset the cost, revenue sources must still be identified and dedicated in perpetuity for this purpose.

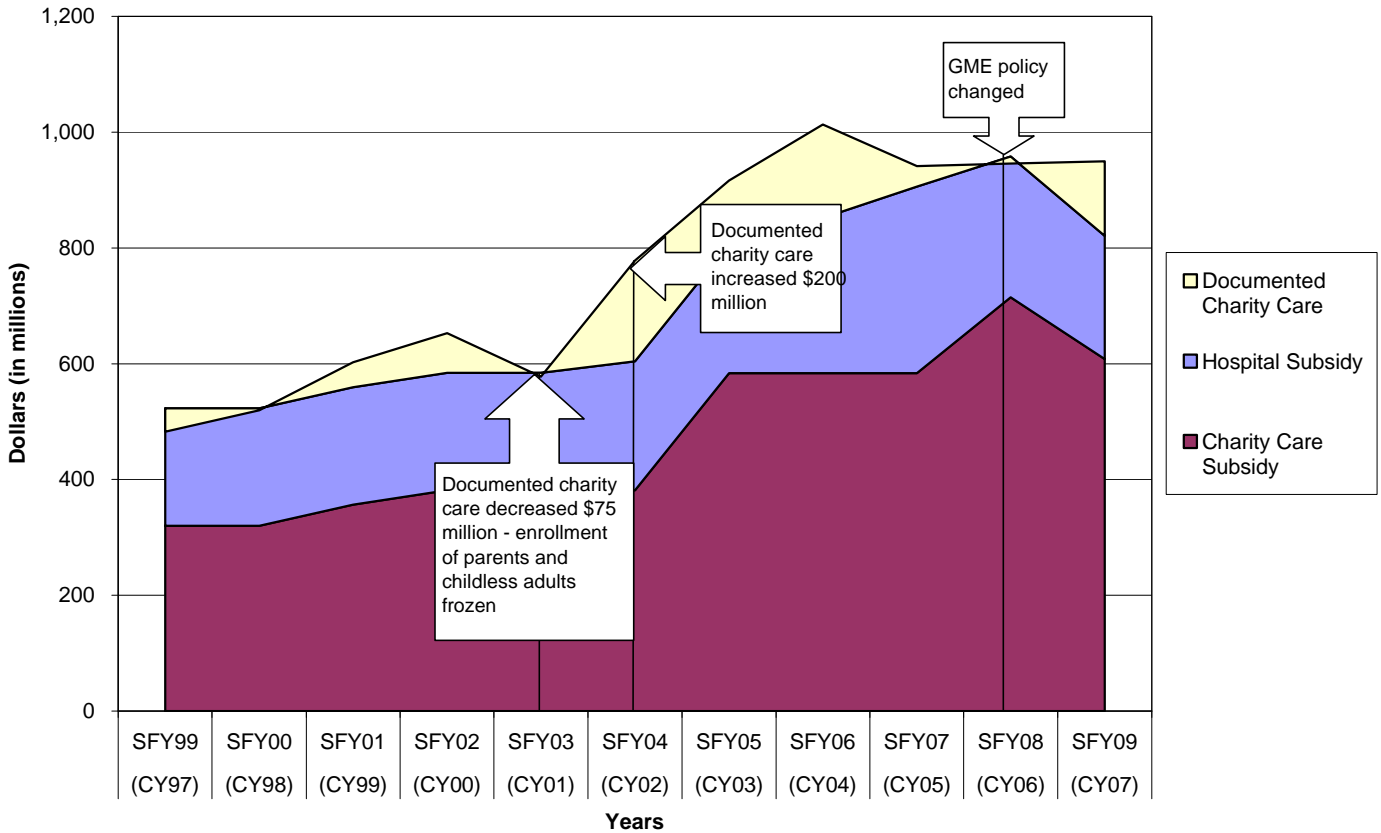
Creating a sustainable vision to meet the health care needs of our citizens is the goal that this plan seeks to achieve.

Appendix A

Charity Care and Hospital Subsidies

New Jersey FamilyCare began enrolling parents and childless adults in October 2000. In 2001, documented charity care fell \$75 million. The large number of applicants, along with the state and federal budget deficits, caused the state to decide to stop taking applications for childless adults as of September 1, 2001, and from parents as of June 15, 2002. Documented charity care rose more than \$200 million in 2002 and continues to rise exponentially.

**New Jersey Charity Care
SFY 1999 - 2009**



New Jersey’s reliance on charity care will be reduced by providing health insurance coverage to the uninsured. Charity care is a much more expensive model of care per capita and is only provided episodically whereas health insurance provides preventive

care and is less costly. The average cost of charity care per client is \$3,413 each year.²⁰ New Jersey can provide full health coverage to an adult in NJ FamilyCare at just \$2,500. There is a savings of \$913 per client per year.

In addition, the amount of disproportionate share dollars that New Jersey can leverage from the federal government to help fund charity care is capped and any additional state funding that is committed to charity care will not leverage any federal funding. By investing in Medicaid and NJ FamilyCare, New Jersey is sure to leverage federal funding to pay for the care that would have otherwise been paid for solely with state funds through charity care.

Appendix B

Kids First: What it Costs

Federal Poverty Level Range (2008)	Family of Three (1 Parent/2 Children)		Family of Four (2 Parents/2 children)	
	Maximum Annual Income	Monthly Premium and Co-Payments	Maximum Annual Income	Monthly Premium and Co-Payments
0-133% Medicaid	\$23,408	No Premium No Co-Payment	\$28,196	No Premium No Co-Payment
>133-150% NJFC	\$26,400	No Premium No Co-Payment	\$31,800	No Premium No Co-Payment
>150-200% NJFC	\$35,200	Premium: Children: 18.50 Parent: \$31.50 Co-Payment: \$5- \$10	\$42,400	Premium: Children: 18.50 Parents: \$44.50 Co-Payment: \$5- \$10
>200-250% NJFC	\$44,000	Premium: Children: \$37.50 Co-Payment: \$5 - \$35	\$53,000	Premium: Children: \$37.50 Co-Payment: \$5 - \$35
>250-300% NJFC	\$52,800	Premium: Children: \$74.50 Co-Payment: \$5 - \$35	\$63,600	Premium: Children: \$74.50 Co-Payment: \$5 - \$35
>300-350% NJFC	\$61,600	Premium: Children: \$125 Co-Payment: \$5 - \$35	\$74,200	Premium: Children: \$125 Co-Payment: \$5 - \$35
>350% NJFC Advantage	No Income Limit	Premium: 1 Child: \$137 2 Children: \$274 3 Children: \$411 Co-Payment: \$5 - \$35	No Income Limit	Premium: 1 Child: \$137 2 Children: \$274 3 Children: \$411 Co-Payment: \$5 - \$35

Appendix C

New Jersey Health Care Resources

- <http://www.nj.gov/njhealthlink/>
New Jersey HealthLink is a comprehensive source for health care information. Those that are uninsured or who want to learn more about the many ways New Jersey works to meet the health care needs of residents should visit this site.

- <http://www.state.nj.us/humanservices/dmahs/dhsmed.html>
Medicaid provides health insurance for more than 600,000 very low-income parents, children and people who are aged, blind or disabled. It pays for hospital, doctor, prescription drug, nursing home and many other health care benefits. To apply, contact your **local office**.
<http://www.state.nj.us/humanservices/dfd/dfdcwa39.html>

- <http://www.njfamilycare.org/>
NJ FamilyCare is a federal and state funded health insurance program created to help New Jersey's uninsured children and certain parents and guardians acquire affordable health coverage. It is not a welfare program. NJ FamilyCare is for families who do not have available or affordable employer insurance, and cannot afford to pay the high cost of private health insurance. Children in a family of four earning up to \$74,200 each year qualify for insurance through this program. You may download an application or apply online from their website.

- <http://www.state.nj.us/humanservices/catill/cicrf1.html>
The New Jersey Catastrophic Illness in Children Relief Fund is intended to be a financial resource for New Jersey families overwhelmed with their child's medical bills. Families with or without insurance are vulnerable to extraordinary costs associated with the catastrophic illness of a child and this fund provides direct monetary assistance to qualified families.