

HEALTH

Scope of the Problem and Indicators of Need

Being in good health provides a solid foundation for engaging in society and carrying out basic responsibilities, including work. There exists a clear relationship between household incomes and health outcomes. Data shows that, as income rises, so does the level of good health among children and their mothers. In contrast, poor health becomes more prevalent within families with lower household incomes. The following information attempts to assess the need for government funding aimed at improving the health of New Jersey's low-income residents. It begins with an overview of the link between health and income and then assesses the health needs of people on welfare. It follows with a closer look at the percentage of people around the state without health insurance, their health needs and the places within the state that have higher rates of uninsured persons. Finally, it looks at the issue of persons who are underinsured.

The table below outlines the health status of children and their mothers based on their household income. As it shows, 83 percent of mothers and 92 percent of children with household income above 400 percent of the federal poverty line report being in excellent or very good health. Mothers and children living below the federal poverty line, on the other hand, report lower rates of excellent or very good health. Only 36 percent of mothers categorize themselves this way, while 62 percent report their children's health as excellent or very good.

New Jersey Mother and Child Health Status by Household Income, 2003						
Income	Mother's Health			Child's Health		
	Excellent/ Very Good	Good	Fair/Poor	Excellent/ Very Good	Good	Fair/Poor
0-99% fpl	36.3%	35.6%	28.0%	62.0%	28.1%	9.9%
100-199% fpl	51.8%	35.5%	12.8%	74.5%	18.6%	6.9%
200-399% fpl	69.2%	24.9%	5.9%	88.3%	9.7%	1.9%
400% fpl or more	82.5%	13.7%	3.9%	92.3%	6.3%	1.3%
Source: National Survey of Children's Health, 2003						

Single mothers on welfare are also more vulnerable to illness and disease. Research shows that these women particularly face ill health as a result of welfare reform. For women who have left welfare and face continued economic deprivation, any preexisting health condition has worsened after they returned to work, due to poor

neighborhood conditions, work and family pressures, as well as economic stress.¹ Given these circumstances, being a single woman with a health condition who previously received public assistance has been associated with an increased risk of job loss.² Additionally, mandated work requirements under welfare reform have caused many women on welfare to take low-wage jobs that lack fringe benefits such as employer-provided health insurance. As a result, former welfare recipients, particularly women, are twice as likely to be uninsured and more likely to delay preventive care, and fewer have a regular source of health care than non-recipients. Additionally, more than half report having at least one health problem. Others who leave welfare are covered by Medicaid for a period of time, but due to welfare reform, Medicaid coverage has significantly declined, thus leaving this population without access to health care.³ This has contributed to an increasing lack of health insurance among low-income women and their children.⁴

All people without health insurance face similar health consequences. They are less likely to receive preventive services, regular care, and higher quality treatment and medication, leading to higher mortality rates, worse health outcomes and economic instability.⁵ National data reveals that over one-third (34 percent) of uninsured non-elderly adults postpone needed health care due to financial constraints.⁶ The loss of health care coverage may occur for a variety of reasons, including changes in work status, health care program eligibility cuts, or administrative barriers. Gaps in health care coverage, whether for brief or extended periods of time, are strongly associated with poor health status, and the consequences of being uninsured are likely to affect all individuals in a family even if some family members are insured.⁷

Mirroring national trends, the number of individuals and families lacking continuously available, quality health care is growing in New Jersey. Statewide, the health care uninsured rate was 14.8 percent in 2004-2005, leaving an estimated 1,324,000 individuals of all ages without insurance coverage.⁸ As the chart below illustrates, the number of working age adults without health insurance has grown between 1987 and 2002. In 2004, New Jersey residents between the ages of 19-24 had the highest rate of

¹ Kaplan, G.A., Siefert, K., Ranjit, N., Raghunathan, T.E., Young, E.A., Tran, D., Danziger, S., Hudson, S., Lynch, J.W., and Tolman, R. 2005. "The Health of Poor Women Under Welfare Reform." *American Journal of Public Health*, 95(7):1252-1258.

² Earle, A. and Heymann, S.J. 2002. "What Causes Job Loss Among Former Welfare Recipients: The Role of Family Health Problems." *Journal of American Medicals Women Association*, 57(1):5-10.

³ Women Who Left Welfare: Health Care Coverage, Access and Use of Health Services, Kaiser Commission on Medicaid and the Uninsured, June 2002.

⁴ Mann, C., Hudman, J., Salganicoff, A., and Folsom, A. 2002. "Five years later: Poor Women's Health Care Coverage After Welfare Reform." *Journal of American Medical Womens Association*, 57(1):16-22.

⁵ *Insuring America's Health: Principles and Recommendations*, Institute of Medicine of the National Academies, 2004.

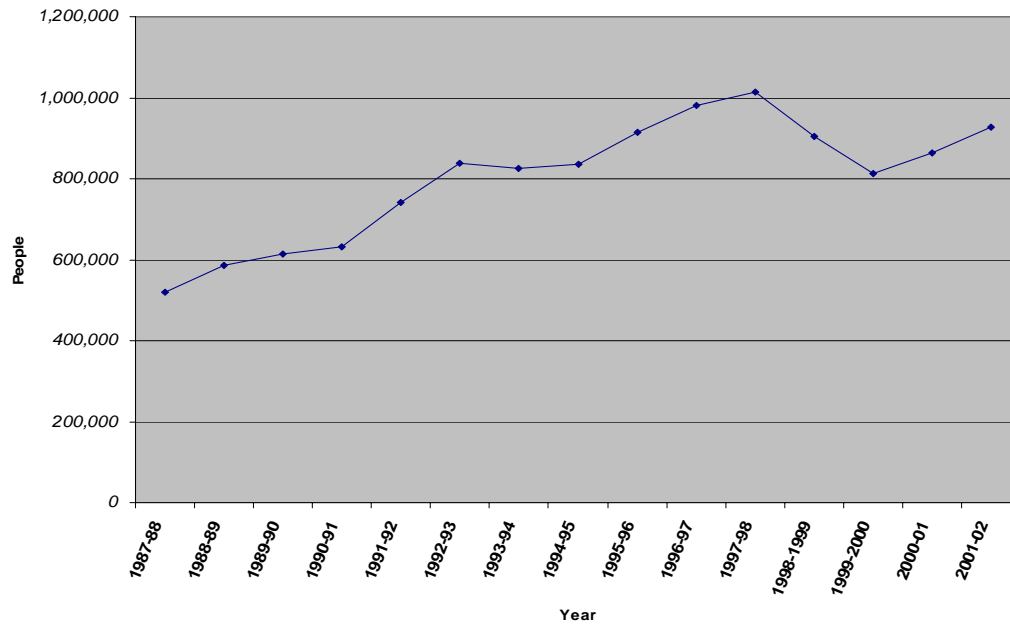
⁶ *Uninsured in America: A Chart Book*, The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, March 2000, p 58.

⁷ *Insuring America's Health: Principles and Recommendations*, Institute of Medicine of the National Academies, 2004.

⁸ Mills, Robert J. and Shailesh Bhandari, *Health Insurance Coverage in the United States: 2002*, Current Population Reports, U. S. Census Bureau, September 2003.

being without health insurance, while seniors 65 and over had the lowest. Of children, those between ages 13 to 18 also had the highest uninsured rates when compared to children younger than 12. In 2004, single adults, part-time workers and the unemployed were also more likely to be uninsured in New Jersey. It is important to note, however, that at least 14 percent of the uninsured were full-time workers, while 32 percent worked part-time and 35 percent did not work.⁹ In 2004, approximately half of the uninsured population in New Jersey was Hispanic, followed by Blacks, Whites and Asian/Pacific Islanders.

Number Uninsured New Jersey Adults 18-64



There are also county to county disparities in health care coverage across the state. According to the U.S. Census Bureau, in 2000 Hudson County had the highest uninsured population rates in the state, at 18.9 percent. Cumberland County (16.7 percent), Passaic County (16.6 percent) and Essex County (15.3 percent) had the next highest rates. Hunterdon County had the lowest number of uninsured residents. Also, urban areas in New Jersey had higher rates of uninsured populations than non-urban areas.¹⁰

One barrier to receiving health insurance is that many small businesses that employ low-wage workers can't afford the cost of insuring their employees. In particular, companies with fewer than 10 employees were less likely to offer health insurance to their employees when compared to companies with 1,000 employees or more. In all, 38.4 percent of small companies and 93.4 percent of large companies

⁹ Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimated based on Census Bureau's March 2004 and 2005 Current Population Survey (CPS: Annual Social and Economic Supplements).

¹⁰ *Disparity in Health Insurance Coverage: Urban versus Non-urban Areas of New Jersey*, State of New Jersey Department of Human Services in collaboration with Rutgers' Center for State Health Policy, April 2006

offered insurance. In other cases, employees are unable to afford the health insurance options their employer does offer, because of high health insurance premiums. This occurs particularly in the small business sector and is more prevalent in New Jersey than in the nation.¹¹

The table below details the status of health insurance coverage for children and working age adults who were living in poverty in 2003-2004. It reveals that the largest share of working age adults living in poverty were uninsured—48 percent. The second largest share were covered by Medicaid, and the third largest share were covered by employer-provided health care. For children, the largest portion of those living in poverty - 49 percent - were covered by Medicaid while one-fifth remained uninsured.

Health Insurance Coverage of Children and Working Age Adults Living in Poverty (under 100% FPL), New Jersey 2003-2004		
Coverage Type	Children (0-18 years old)	Working Age Adults (19-64)
Employer	20%	19%
Individual	2%	6%
Medicaid	49%	22%
Other Public	0	5%
Uninsured	20%	48%
Total	100%	100%

Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimated based on Census Bureau's March 2004 and 2005 Current Population Survey (CPS: Annual Social and Economic Supplements)

Being underinsured also has a significant negative impact on many individuals and families in poverty. Underinsured is often defined as having high out-of-pocket costs for care, such as high co-pays, high deductibles, or sporadic coverage, so that cost-related factors limit a person's ability to receive adequate care despite having insurance. According to national data, individuals purchasing their own private health care insurance have coverage for fewer health care needs than those who have employer-sponsored group plan benefits or insurance through some government programs. This often results in less coverage for maternity benefits, mental health care and prescription medication.¹² The unavailability of coverage for these services has been linked to receipt of less appropriate or inappropriate care. Tragically, uninsured hospitalized patients are more likely to die, receive fewer services, and receive inappropriate services.¹³

¹¹ Employer Sponsored Health Insurance in New Jersey: Firm Characteristics, Offer Rates, Workforce Enrollment Premiums, and Employee Contributions, Rutgers' Center for State Health Policy, October 28, 1999.

¹² *Underinsured in America: Is Health Coverage Adequate?*, Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, July 2002.

¹³ *Care Without Coverage: Too Little, Too Late*, Executive Summary, Institute of Medicine, National Academy of Sciences, National Academy Press, 2002.

Overall, being in good health is an important factor in the ability to work and effectively care for one's family. In New Jersey, income has a direct impact on the health status of both women and children. For women leaving welfare, there is an even greater risk of worsening health conditions. Many New Jerseyans end up going without any health insurance at all and the rate has been on the rise since 1987. People without insurance are also concentrated in particular counties more than others; for example, nearly one-fifth of Hudson County goes without insurance. Many small employers in the state, often with low-wage workers, are either unable to offer health insurance or offer insurance too expensive for their workers to afford. All of this results in varied health insurance coverage for residents. Additionally, the underinsured in the state face low benefit levels and health risks due to an inability to afford the health insurance they do have. In the end, a picture emerges of limited access to health care and poor health among low-income state residents.

Health Programs

New Jersey administers many different programs to provide important health care services to address the health needs of its residents. These programs are funded with either state or federal monies, or with a mix of both. In addition, there are health care programs provided by counties, municipalities and private organizations that receive funding directly from public and/or private sources to serve the needs of children and adults in New Jersey. This report section is not meant to include all health care programs, but is an overview of major state and federal programs that are affected by the FY07 New Jersey State Budget.

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Note: Some services that intersect with Health, including Mental Health and Substance Abuse, are available specifically through Corrections and Re-entry services to individuals involved with the Department of Corrections and are covered in that chapter of this report.

Detailed Program Information

Medicaid

Program Purpose and Description:

Medicaid is a federal program, created in 1965 as Title XIX of the Social Security Act. It provides matching funds to states to provide health care coverage for very low-income children and their parents, pregnant women, the elderly, and people with disabilities. Every state now participates in Medicaid. New Jersey initiated its Medicaid program in 1970.

Medicaid is an entitlement program; therefore, children and adults who meet the strict income and categorical requirements are entitled to its benefits. The program covers a broad range of health care services intended to provide comprehensive preventive and treatment care for the most vulnerable members of our society. In New Jersey, Medicaid is administered by the Division of Medical Assistance and Health Services, which is in the Department of Human Services.

Until 1995, Medicaid beneficiaries accessed their covered health care services directly from providers who were indemnified by Medicaid at an agreed-upon reimbursement rate (fee-for-service). Over the years, the level of Medicaid reimbursement did not rise at the same rate as that of the cost of providing medical care and administering the program. As a result, there were not a sufficient number of physicians and other health care providers to serve the growing number of Medicaid beneficiaries. States began to look at other systems of health care delivery to make the cost of administering the program affordable, and to ensure that beneficiaries had access to medically necessary services. Beginning in 1995, New Jersey contracted with managed care companies and began requiring low-income families with Medicaid coverage to enroll in a Medicaid-participating health maintenance organization (HMO) to access covered services. Since that time, most Medicaid beneficiaries who are not institutionalized have been required to enroll in a Medicaid-participating HMO for coverage.

Medicaid contracts with these HMOs (there are currently five Medicaid-participating HMOs in New Jersey) and pays them a set fee per beneficiary (capitation rate), regardless of the number of health care services that the beneficiary receives. Currently, more than 600,000 people are covered by Medicaid in New Jersey. Some beneficiaries, such as most beneficiaries who also have Medicare, continue to have Medicaid coverage on a fee-for-service basis.

Medicaid coverage in New Jersey includes the following services:

- Inpatient and Outpatient Hospital Treatment
- Laboratory Tests and X-rays
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- Home Health Care
- Physician Services
- Nurse-Midwife Services

- Family Planning
- Nursing Facilities for Persons 21 and Over
- Treatment in Residential Treatment Centers
- Prescription Medicines
- Dental Care
- Eyeglasses and Optometrist Services
- Podiatrist Services
- Prosthetic Devices and Medical Equipment
- Rehabilitative and Physical Therapy Services
- Home and Community Based Waiver Program
- Hospice Care
- Personal Care Services
- Necessary Transportation to Medical Care
- Private Duty Nursing
- Inpatient Psychiatric Care for Persons Under 21 and Over 65
- Intermediate Care Facilities for the Mentally Retarded.

The federal Medicaid statute requires states to provide medical, vision, hearing and dental screening and treatment for all eligible children who are under the age of 21. This is the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, which includes immunizations, laboratory tests (including lead blood tests) and health education. Especially important is that treatment under EPSDT must include all necessary health care to correct or ameliorate any physical or mental conditions, whether or not such services are covered in the state's Medicaid program.

Despite this mandate and federal matching funds, New Jersey has historically had poor EPSDT screening and participation rates. However, in the last few years the state has raised the participation rate from a low of 5% in 1997 to over 50% in 2005. Screening and treatment for lead poisoning are also important benefits of the EPSDT program for children living in poverty. Young children under the age of 6, living in low-income families, are at the greatest risk of being poisoned. Lead poisoning, if untreated, can cause serious behavioral problems, learning disabilities, seizures, coma, and severe brain damage. Lead poisoning can be discovered through a simple blood test and, because of state and federal legislation that bans the sources of most lead in the environment in the United States (e.g., in house paint and automobile fuel), it should be virtually eliminated.

There are approximately 140,000 Medicaid beneficiaries in New Jersey who also receive coverage for health care needs through Medicare. These beneficiaries are referred to as "Dual Eligibles" and Medicaid, as the payer of last resort, covers the costs of their necessary health care services that are not covered by Medicare. In some cases, depending on income level, Medicaid pays only for their Medicare premiums. The Dual Eligibles are among the most vulnerable Medicaid beneficiaries: Medicare beneficiaries with the lowest incomes and significant disabilities, many with serious mental illness, and the elderly. Although the cost to the State of their overall health care is unknown, their utilization of health services is necessarily high.

Budget Performance and Trends:

Medicaid Schedule 1 (denotes state revenue)				
	FY05 Actual	FY06 Estimated	FY07 Estimated	FY07 Actual Appropriation
Medicaid uncompensated care-acute	\$226,573,000	\$275,799,000	\$236,325,000	\$137,726,000
Medicaid uncompensated care-mental health	\$34,186,000	\$33,055,000	\$33,055,000	\$33,420,000
Medicaid uncompensated care-psychiatric	\$189,966,000	\$184,458,000	\$178,685,000	\$178,685,000
Medical assistance – federal match on PAAD/Medicaid dual ¹⁴ eligibilities	\$1,000	\$1,200,000	---	---
Payments for medical assistance recipients-prescription drugs	\$294,421,000	---	---	\$342,718,000
School-based Medicaid	\$4,583,000	\$7,126,000	\$7,126,000	\$3,500,000
Source: State FY07 Budget Book (p. C-13) & State FY07 Appropriations Bill S2007 (p.4 & 250) & FY07 Appropriations Handbook (p. A-3)				

¹⁴ In FY06 New Jersey’s PAAD program received a one-time federal Medicaid funding grant to conduct outreach for the then-new federal Medicaid Part D prescription drug program, which likely explains the one-time spike in funding for this line-item, which is missing in the FY07 budget materials.

**Medicaid Title XIX
Schedule 2 (denotes federal revenue)**

	FY05 Actual	FY06 Estimated	FY07 Estimated	FY07 Actual Appropriation
Title XIX Medical Assistance	\$3,172,512,000	\$3,600,285,000	\$3,570,063,000	\$3,904,319,000
Title XIX – Child Residential*	\$42,699,000	\$77,983,000	\$82,560,000	\$81,695,000
Title XIX Community Waiver	\$230,744,000	\$262,235,000	\$268,654,000	\$268,654,000
Title XIX ICF/MR	\$297,053,000	\$282,111,000	\$314,562,000	\$314,562,000

Source: State FY07 Budget Book (p. C-28) & State FY07 Appropriations bill S2007 (p. 10 & 15)
***Now under the New Department of Children and Family Services State FY07 Budget Book (p. C-24)**

Medicaid Grants-In-Aid						
	Orig. & -- Supple. FY05	Total FY05 Available	Expended FY05	FY06 Adjusted Approp.	Request/ Recomm. FY07	Actual Approp. FY07
Personal care ¹⁵	\$14,060,000	\$15,217,000	\$15,217,000	\$16,230,000	\$23,771,000	\$23,771,000
Other treatment facilities	\$5,900,000	\$4,673,000	\$4,673,000	\$6,372,000	\$6,691,000	\$6,691,000
Inpatient hospital ¹⁶	\$215,575,000	\$222,867,000	\$220,231,000	\$237,990,000	\$58,376,000	\$282,376,000
Prescript. Drugs	\$468,449,000	\$756,235,000	\$756,235,000	\$536,378,000	\$540,291,000	\$554,494,000
Outpatient Hospital	\$176,571,000	\$163,814,000	\$163,814,000	\$172,681,000	\$167,774,000	\$168,874,000
Physician	\$34,204,000	\$30,133,000	\$30,133,000	\$36,244,000	\$33,000,000	\$33,000,000
Home health	\$17,728,000	\$14,591,000	\$14,590,000	\$17,733,000	\$10,639,000	\$10,639,000
Medicare premiums	\$85,437,000	\$89,689,000	\$89,689,000	\$113,964,000	\$127,991,000	\$127,991,000
Dental	\$11,520,000	\$12,293,000	\$12,293,000	\$13,483,000	\$14,159,000	\$14,159,000
Psychiatric hospitals	\$13,959,000	\$9,816,000	\$9,816,000	\$13,634,000	\$11,054,000	\$11,054,000
Medical supplies	\$15,996,000	\$20,216,000	\$20,216,000	\$21,236,000	\$20,489,000	\$20,489,000
Clinics	\$41,445,000	\$58,215,000	\$58,215,000	\$57,294,000	\$74,152,000	\$74,152,000
Transport.	\$45,616,000	\$45,159,000	\$45,159,000	\$45,397,000	\$53,685,000	\$55,485,000
Other	\$2,369,000	\$7,503,000	\$7,503,000	\$6,786,000	\$20,868,000	\$20,868,000
Managed care initiative*	\$525,217,000	\$548,348,000	\$548,348,000	\$605,522,000	\$674,659,000	\$674,659,000
Hospital relief offset payment**	\$70,845,000	\$91,500,000	\$91,500,000	\$70,845,000	\$70,845,000	\$70,845,000
Source: State FY07 Budget Book (p. D-204 - D-205) & FY07 Appropriations Bill S2007 (p.105-106)						

¹⁵ The increase in personal care funding in FY07 is apparently due to a reallocation of \$6,635,000 from the Community Care line item within the Division of Mental Health Services (State FY07 Budget Book, p. D-206).

¹⁶ In past fiscal years funding for the inpatient hospital line-item was subsidized by transfer funding from the Health Care Subsidy Fund (Charity Care) in the amounts of \$48.4 million in FY04 and \$50 million in FY05 and FY06. The FY07 budget ended the trend of diversions from the Unemployment Compensation Trust Fund to fund Charity Care, and instead proposed a new tax on Hospital Beds (the New Jersey Acute Care Hospital Licensed Bed Assessment) to cover the costs of Charity Care. The FY07 Budget Book proposed \$215 million from this revenue to offset the reduction in line-item appropriation and the transfer of unemployment compensation trust fund money.

* A note linked to this line item in the Budget Book (p. D-206) indicates that the state share of expenditures on behalf of pregnant women and infants between 133% and 185% of the federal poverty standard are funded from the Health Care Subsidy Fund.

**A note linked to this line-item in the Budget Book (p. D-206) indicates that the Hospital Relief Offset Payments account includes appropriations from the Department of Health and Senior Services through the Health Care Subsidy Fund.

Additional Analysis:

The federal government provides New Jersey with a 50% match of federal dollars for the cost of services in most of its Medicaid programs. A state's federal financial participation rate is based on the state's per capita income. Poorer states have higher matching rates. For certain programs, Medicaid provides an enhanced matching rate. For example, New Jersey receives a 65% match of federal dollars for the majority of children in its state children's health insurance program, NJ FamilyCare, and for women covered in the Breast and Cervical Cancer program.

Since January 1, 2006,¹⁷ states no longer receive a federal financial match for prescription medicines for their Medicaid beneficiaries who are also eligible for Medicare. (Note: Beneficiaries continue to receive Medicaid-covered services for the rest of their medically necessary health care.) These "dually eligible" Medicaid beneficiaries are automatically enrolled into a Medicare approved "preferred drug plan" (PDP) and they may change to a different PDP if they choose. Although New Jersey's Medicaid program saves millions of dollars because Medicare now pays most prescription costs for Dual Eligibles, the federal government requires each state to pay the federal government a substantial percentage of the money that the state would have paid each year for these beneficiaries' prescription costs if the federal government had not taken over this coverage under Medicare. New Jersey estimates that any savings for the state's Medicaid program from the Medicare Part D Drug Benefit is negligible because of this federal requirement.

¹⁷ Some states, including New Jersey, received federal matching funds until March 31, 2006, for their Dual Eligibles because of problems with the initial implementation of the Medicare Part D Drug Benefit program.

NJ FamilyCare

Program Purpose and Description

The NJ FamilyCare Program provides coverage for medically necessary health care for low-income children in families with income up to 350% fpl, some low-income parents, and some severely poor adults without dependent children. Currently, there are approximately 125,000 children and 79,000 adults enrolled in NJ FamilyCare.¹⁸

Background. In 1998, the federal government established the State Children's Health Insurance Program (SCHIP), a block-grant program to provide funding to states to expand health coverage for uninsured children. Using federal SCHIP funds, which match New Jersey dollars at the enhanced Medicaid rate of 65%, the state created the NJ KidCare program for low-income children who were ineligible for Medicaid because their family's income was above the financial limit but still too meager to afford health insurance.

In July 2000, using funds from the Tobacco Settlement, New Jersey expanded the KidCare program to include low-income parents/caretakers of dependent children with incomes up to 200% fpl, and adults and couples without dependent children up to 100% fpl. Families with children at the higher end of the income guidelines paid premiums and co-pays for some services. When an eligible individual also had the option of group insurance through an employer, FamilyCare compared the coverage offered and paid the premium for the employee if the coverage was comparable and the employer paid at least half of the total premium cost.

The program was renamed the NJ FamilyCare program and also covered recipients of General Assistance (GA), described in the income security section of this report, for necessary health care services, as well as legal permanent residents who were financially and categorically eligible regardless of their date of entry. However, a year later, in September 2001, enrollment for adults without dependent children was closed. In June 2002, enrollment was closed for parents as well.

While FamilyCare has primarily provided health care coverage through health maintenance organizations (HMOs), in July 2002 coverage for GA recipients was substantially changed from HMO coverage to a "fee-for-service" program. Some services that were previously covered, including hospitalization and substance abuse treatment, were eliminated. GA recipients can access outpatient health care services only from those health care providers who accept fee-for-service Medicaid, and who agree to accept the GA recipient as a patient. GA recipients can access substance abuse treatment only

¹⁸ The Division of Medical Assistance and Health Services (DMAHS), within the NJ Department of Human Services, administers the state's Medicaid program (Title XIX). The Division is now using the term "NJ FamilyCare" to encompass all Medicaid programs in the state, in addition to the New Jersey State Children's Health Insurance Program (SCHIP/Title XXI), "NJ FamilyCare." These FamilyCare enrollment numbers include only those children and adults who are enrolled in the SCHIP/Title XXI and were reported by DMAHS as of October, 2006.

through the WFNJ Substance Abuse Initiative. The Charity Care program remains available for GA recipients for most, but not all, necessary inpatient hospital services.

FamilyCare was restructured again in 2003. Coverage for adults without dependent children and certain immigrant parents was changed from an HMO delivery system to a Managed Care Services Administration (MCSA). Under the MCSA system, health care was to be provided by physicians from one of three participating HMOs, but coverage and payments would be handled by a single MCS Administrator instead of the HMO. The Division of Medical Assistance and Health Services (DMAHS), the agency in the state that administers the Medicaid and FamilyCare programs, acknowledged that there would not necessarily be long-term savings in this model but expected that cost savings would be realized by shifting payments for services from a prepay capitated system to a system that pays medical providers after the delivery of the health services. However, this system was never put in place and recipients of GA continue to be limited under their NJ FamilyCare coverage (Plan G) to outpatient care from Medicaid fee-for-service providers and inpatient hospital care that is covered by Charity Care.¹⁹

Budget and Performance Trends:

FamilyCare – Adults*				
Evaluation Data				
	Actual FY04	Actual FY05	Revised FY06	Estimated FY07
Est. Yr-end enrollment	94,152	72,204	87,694	98,694
State share	\$135,869,497	\$119,364,308	\$117,511,739	\$134,251,443
Fed. share	\$140,104,732	\$108,525,805	\$117,511,130	\$158,410,899
Employers/ individual share	\$3,549,096	\$1,553,649	\$1,123,355	\$978,057
Total costs	\$279,523,325	\$229,443,762	\$236,146,224	\$293,640,399
Source: State FY07 Budget Book (p. D-203)				

* Note: NJ FamilyCare expenditures exclude costs of Childless Adult expansion that is pending a federal waiver. (Budget Book FY07 p. D-204)

¹⁹ As noted in the Charity Care section of this chapter, many providers who practice surgery, anesthesiology, and many other specialties are not covered by Charity Care and, therefore, will not provide the services required when a GA patient is hospitalized.

FamilyCare – Children* Evaluation Data				
	Actual FY04	Actual FY05	Revised FY06	Estimated FY07
Estimated enrollment	286,313	291,832	307,206	357,206
State share	\$45,160,607	\$48,588,731	\$56,020,157	\$70,492,650
Fed. share	\$77,607,264	\$83,023,218	\$104,037,034	\$130,914,922
Individual share	\$10,240,466	\$11,722,435	\$13,567,853	\$15,392,309
Total costs	\$133,008,607	\$143,334,384	\$173,625,044	\$216,799,881
Source: State FY07 Budget Book (p. D- 203)				

* Note: The NJ FamilyCare – Children’s Health Insurance Program was formerly referred to as NJ KidCare. Enrollment includes children funded under Medicaid -- Title XIX. The enrollment figure for fiscal year 2006 is as of January 2006, and the enrollment figure for fiscal year 2007 is the June 2007 projection. Costs do not include children that are funded under Medicaid -- Title XIX. (Budget Book FY07 p. D-204)

Title XXI Children’s Health Care Insurance Program Schedule 2 (denotes federal revenue)			
Actual FY05	Estimated FY06	FY07 Estimated	Actual Appropriation FY07
\$201,979,000	\$205,019,000	\$231,645,000	\$261,435,000
Source: State FY07 Budget Book (p. C-28) & FY07 Appropriations Bill S2007 (p. 15)			

FamilyCare Appropriations Data (Grants-in-Aid)					
Orig. & --Supple. FY05	Total FY05 Available	Expended FY05	FY06djusted Appropriation	Request/ Recommend FY07	Actual Approp. FY07
\$130,776,000	\$119,365,000	\$119,365,000	\$113,161,000	\$120,469,000	\$120,469,000
Source: State FY07 Budget Book (p. D-205) & FY07 Appropriations Bill S2007 (p. 106)					

Additional Analysis:

As a federal block grant-funded program for low-income children and their parents, New Jersey receives an enhanced match of a set amount of federal dollars each year for NJ FamilyCare, well above its normal 50% match for its Medicaid program, which is an entitlement program with no federal cap. This means that the state receives approximately \$1.86 in federal dollars to match each state dollar spent in the NJ FamilyCare program. This federal match applies to both the children and many of their parents that the state enrolled when they expanded FamilyCare coverage.

The remainder of the federal SCHIP funding that is provided to states that do not spend their annual allocation has been distributed annually after three years to states that have fully spent their allocation. New Jersey has consistently spent its yearly SCHIP allocation and has benefited tremendously from this re-distribution of SCHIP funds. However, each year more states are fully spending their federal allocation and there is less redistribution funding available. In addition, the federal SCHIP legislation expires in 2007.

The Family Health Care Coverage Act was signed into law on July 13, 2005. Besides eliminating many of the enrollment and retention barriers in the NJ FamilyCare program, it re-opens the program to parents of children below the age of nineteen with family income at or below 133% fpl in three stages (to 100% fpl as of September 1, 2005, to 115 % fpl as of September 1st 2006, and to 133% fpl as of September 1, 2007). The new Act also increases the income eligibility limit for AFDC-related Medicaid for parents to 135 fpl over three years, pursuant to the same schedule as NJ FamilyCare. Therefore, if the annual NJ FamilyCare allotment is fully spent (which provides a 65% federal match), additional eligible parents can be covered under New Jersey's Medicaid program with a 50% federal match.

The state pledged to enroll an additional 10,000 eligible children into NJ FamilyCare in 2006. It expected the caseload for children to increase by about 7,300 in FY05; however, it is estimated that the program increased by less than half that number of children in 2005.

New Jersey Hospital Care Payment Assistance Program (Charity Care Assistance)

Program Purpose and Description:

The New Jersey Hospital Care Payment Assistance Program (Charity Care) provides free or reduced charge care to patients who receive inpatient and outpatient services at acute care hospitals throughout New Jersey. This assistance is available only for what is “necessary” hospital care. Some services, such as physician fees, anesthesiology fees, radiology interpretation, and outpatient prescriptions, are separate from hospital charges and may not be eligible for reduction.

The New Jersey Department of Health and Senior Services administers the Charity Care program. Payment assistance is limited to New Jersey residents who have no health care coverage or have coverage, such as Medicare, that pays for only part of the bill, and who are not eligible for private or public benefits, such as Medicaid and NJ FamilyCare. There is also an income and asset limit for eligibility. An applicant’s income must not exceed 200% fpl for full payment or up to 300% fpl for a payment obligation on a sliding scale. Applicants may not have individual assets that exceed \$7,500 or family assets worth more than \$15,000. For patients between 200% and 300% fpl, Charity Care will pay for medical expenses that exceed 30% of the patient’s annual income, and patients may spend down their assets on hospital charges to become eligible for Charity Care. Hospital assistance is also available to non-New Jersey residents in certain circumstances.

Funding for Charity Care is authorized through the Health Care Subsidy Fund, administered under Public Law 1997, Chapter 263. This special revenue fund is composed of monies from employee and employer contributions, cigarette and tobacco taxes, hospital assessments, interest, and penalties.

Budget Performance and Trends:

Funding information in the state budget materials regarding the Charity Care program underwent significant changes in FY07 that make it difficult to track funding trends. At least in part these reporting changes are likely due to the decision to end diversions from the Unemployment Compensation Trust Fund,²⁰ which has provided a substantial portion of Charity Care funding in recent years, and replace it with a new assessment on hospital beds. This proposed surcharge, however, was not adopted into law. The budget line items do not clearly distinguish the revenue source shifting, so it is not clear whether the final appropriation of almost \$116 million represents a true reduction in funding from FY05 funding levels. Language in the Appropriations Handbook, however, suggests that FY07 funding is held stable from FY06 funding levels.

²⁰ See the discussion of the Unemployment Insurance program in the Income Security chapter of this report for a fuller discussion of past diversion activities and the problems this created for the fund’s solvency.

Health Care Subsidy Fund Payments Appropriation Data					
Orig. & --Supple. FY05	Total FY05 Available	Expended FY05	FY06 Adjusted Approp.	Request/Recommend FY07	Actual Approp. FY07
\$309,025,000	\$319,025,000	\$319,025,000	\$44,725,000	\$369,462,000	\$115,962,000
Source: State FY07 Budget Book (p. D-165) & State FY07 Appropriations Bill S2007 (p. 86)					

Note: Language in the Budget Book (p. D-150) indicates that the recommended appropriation of \$369 million consists of \$267.5 million in general fund revenue funding for the Health Care Subsidy Fund for Charity Care payments and \$66.5 million to fund the Hospital Relief Subsidy Fund and DHSS's state share of the FamilyCare health insurance program.

Health Care Subsidy Fund (P.L. 1992, c.160) Special Revenue Funds			
	FY05 Actual	FY06 Estimated	FY07 Estimated
Total Revenues	\$369,189,000	\$639,225,000	\$288,247,000
Other Financing Sources – Total Available	\$694,116,000	\$695,364,000	\$660,334,000
Total Expenditures and Other Financing Uses	\$694,102,000	\$692,739,000	\$657,767,000
Fund Balance June 30 th	\$14,000	\$2,625,000	\$2,567,000
Source: State FY07 Budget Book (p. H-16)			

Note: This fund is composed of revenues from employee and employer contributions, cigarette and tobacco taxes, hospital assessments, interest, and penalties. Monies in the fund shall be used to distribute charity and other uncompensated care disproportionate share payments to hospitals; provide subsidies for the New Jersey Kid Care program; and provide financial assistance for hospitals, other health care initiatives, and hospital bond assistance. (Budget Book FY07 p. H-49)

Additional Analysis:

Charity Care pays for the costs of uninsured patients from three sources: the Supplemental Charity Care Fund, the Health Care Systems Analysis, and the Health Care Subsidy Fund. This relief is also referred to as “uncompensated care.” Charity Care reimburses hospitals at the Medicaid-allowed payment rate. State and federal law require that all acute care hospitals provide care to patients, regardless of their ability to pay. For many hospitals, Charity Care reimbursement funds represent a significant amount of cash flow to their institutions.

Hospitals receive Charity Care reimbursements based on the amount of care provided; however, the hospitals are not fully reimbursed. Charity Care discussions inevitably lead to a comparison of the amount and cost of care provided to patients versus the amount of reimbursement provided by the state.

The Charity Care distribution formula was last revised in August 2004 (P.L. 2004, Chapter 113). Under this formula, hospitals were funded at not less than 75% of the Medicaid-priced amounts of Charity Care, plus the Medicaid payments to the hospitals for Graduate and Indirect Medical Education. The formula ranks hospitals according to the amount of Charity Care they provide in relation to their total revenues to provide the highest rate of reimbursement for the hospitals serving the most uninsured and located in municipalities with the lowest median household incomes. The revision also mandates that in 2005 no hospital will receive Charity Care in an amount less than it received in 2004.

The Hospital Relief Subsidy Fund distributes funds to urban area hospitals, which serve a large number of high risk populations with tuberculosis, HIV/AIDS, substance abuse, complex neonatal problems, or mental health and developmental disabilities problems.²¹

²¹ Information provided via e-mails/conversations with the Senate Majority Staff between December 2003 and February 2004.

Assisted Living

Program Purpose and Description:

New Jersey has seen the rapid growth of assisted living facilities over the past several years. For many persons, this form of housing for seniors and persons with disabilities fills the gap as an appropriate alternative to nursing home care. In addition to housing, assisted living facilities offer meals for residents. Most facilities also offer such services as housekeeping, assistance with eating, bathing, transportation, medication management, social and recreational activities, and they may charge for most of their personal support services. However, assisted living facilities are less expensive than nursing homes and are a cost-effective alternative for publicly funded programs such as Medicaid to cover those who need this level of care.

There are basically three types of assisted living facilities in New Jersey regulated by the Department of Health and Senior Services (DHSS). An “assisted living program” usually provides meals and services to tenants who are residing in publicly subsidized housing. An “assisted living residence” is a licensed facility that provides apartment-style housing with congregate dining for four or more residences; at a minimum, the apartments must offer one unfurnished room, a private bathroom, kitchenette and a lockable entrance door. A “comprehensive personal care home” is licensed to provide room, board and assisted living services to four or more adults; the residential units can not house more than two people, must have a lockable entrance door, and a common dining area where meals are served three times a day.

Budget Performance and Trends:

Community Care Programs (Including Assisted Living) Evaluation Data				
Community Care Programs (CCP)	Actual FY04	Actual FY05	Revised FY06	Estimated FY07
CCP for elderly and disabled -clients served	5,200	5,200	5,200	5,200
CCP for elderly and disabled – amount expended*	\$56,257,208	\$57,780,159	\$58,605,778	\$60,716,000
Assisted Living / Alternative family – clients served	2,450	3,200	3,575	3,575
Source: State FY07 Budget Book (p. D- 168)				

*Note: “Includes resources from the Casino Revenue Fund, Grants-in-Aid, the Health Care Subsidy Fund, and matching federal funds.” (FY07 Budget Book p.D-170).

Assisted Living Program Grants-in-Aid					
Orig. & --Supple. FY05	Total FY05 Available	Expended FY05	FY06 Adjusted Approp.	Request/ Recommend FY07	Actual Appropriation FY07
\$23,540,000	\$20,767,000	\$20,767,000	\$23,540,000	\$23,540,000	\$23,540,000
Source: State FY07 Budget Book (p. D-172) & State FY07 Appropriations Bill S2007 (p. 89)					

Note: "The amounts hereinabove appropriated for Nursing Home, Assisted Living, Community Care Alternatives, Medical Day Care Services, Global Budget Long-Term Care Initiative, and Medicaid High Occupancy are conditioned upon the Commissioner of the Department of Health and Senior Services making changes to such programs to make them consistent with the Deficit Reduction Act of 2005." (FY07 Budget Book p. D-177)

Nursing Homes & Alternatives

Program Purpose and Description:

The state and federal governments regulate compliance with standards that all facilities must meet in providing high-quality nursing care, food, social services, recreation, therapy, and individualized treatment for every resident. These standards also specify the rights that all nursing home residents are guaranteed, including freedom from abuse, clear explanations of medical treatment, respect for resident dignity, privacy, quarterly financial statements, and more. The manual that lists these regulations is called the [*Licensing Standards for Long-Term Care Facilities*](#).

All New Jersey nursing homes are licensed by the Department of Health and Senior Services (DHSS). Nursing homes that also participate in the federal Medicare program are called Skilled Nursing Facilities. Those that participate only in the Medicaid program are called Nursing Facilities. Most nursing homes participate in both of these programs. All Medicaid and Medicare certified facilities must meet federal and state standards to operate in New Jersey.

All licensed nursing homes are not equally equipped to take care of residents with [special needs](#) (for example, dialysis, head trauma, oxygen therapy, tracheotomy). All nursing homes meet the needs of residents who require minimal nursing services. Some nursing homes provide more comprehensive care, such as nasogastric tube feeding or oxygen therapy. Sometimes residents must be transferred from one nursing home to another if their medical condition changes and the first facility is no longer able to provide the type of care they need. A number of facilities have approval from DHSS or a contract with the Medicaid program to accept individuals whose age or condition requires [specialized services and equipment](#). This type of specialized care may be provided to individuals who are comatose, or require respirators, or have suffered brain injury. Special units have also been established at some nursing homes for young adults and children who need long-term care.

Another type of specialized care provided at some nursing homes in New Jersey is the long-term care treatment of HIV positive individuals (AIDS). Facilities with Medicaid contracts to treat HIV positive residents can provide increased nursing care, psychiatric counseling, infection-control procedures, and medications for these individuals. Every licensed nursing home in New Jersey is required to accept HIV positive individuals if the facility has the capacity to meet the individual's treatment needs. Discrimination against individuals who are HIV positive is not permitted under state regulation.²²

²² <http://www.state.nj.us/health/ltc/guide/nurshome.shtml>.

Budget Performance and Trends:

Nursing Homes Evaluation Data				
Nursing Home Services	Actual FY04	Actual FY05	Revised FY06	Estimated FY07
Per diem	\$131.67	\$155.06	\$157.23	\$162.18
Patient days	10,645,163	10,665,698	10,680,084	10,480,084
Gross annual costs	\$1,401,648,612	\$1,653,825,228	\$1,679,200,000	\$1,699,700,000
Source: State FY07 Budget Book (p. D- 168)				

Nursing Homes Grants-in-Aid						
	Orig. & --Supple. FY05	Total FY05 Available	Expended FY05	FY06Adjusted Approp.	Request/ Recommend FY07	Actual Appropriation FY07
Payments for Medical Assistance recipients	\$702,917,000	\$710,324,000	\$705,038,000	\$676,500,000	\$660,700,000	\$672,700,000
Medicaid high occupancy	\$9,000,000	\$9,000,000	\$9,000,000	\$9,000,000	\$9,000,000	\$9,000,000
Source: State FY07 Budget Book (p. D-172) & State FY07 Appropriations Bill S2007 (p. 89)						

Note – New Jersey Medicaid distributes additional funding as a per diem adjustment to nursing facilities with Medicaid patient day occupancy at or above 75%.

Note – Language in the introductory section of the DHSS department budget for FY07 (Budget Book, p. D-150) indicates two additional budgetary factors relating to these line items. First, the FY07 Budget reflects the elimination of inflation adjustments for Nursing Homes and Medical Day Care providers, which is projected to save the state \$26 million. Second, state revenue was reduced by \$8.5 million in FY06 due to a reduction in Nursing Home non-Medicare patient days on which provider assessments are levied, and payments are being reduced in FY07 to cover this lost revenue. The state also made a one-time supplemental appropriation to nursing homes in FY06. These initiatives are offsetting \$45.9 million of the FY07 budget entitlement growth for nursing home and alternative programs.

Supplemental Health Programs:

Local Health Departments
(Public Health Protection Services & Public Health Priority Funding)

Program Purpose and Description:

Historically, local public health departments in New Jersey have been the primary educators and providers of essential public health services in the municipalities. They provide a broad range of health services based on the needs of their community. The local departments provide services and distribute information about health issues that affect a broad number of residents, such as new Medicare programs, disease prevention, inoculations, environmental hazards, childhood illness, injury prevention and many more. They also develop policies and readiness plans on a larger scale to respond to disasters and to assist their communities with recovery.

Local public health departments are also responsible for enforcing public health and safety laws and regulations. As an example, state law and New Jersey Department of Health and Senior Services regulations require local health departments to investigate all reported cases of lead poisoning in their jurisdiction and to order the abatement of all lead paint hazards.²³ The local health departments must also arrange for a home visit by a public health nurse who is responsible for providing ongoing case management services for the family to obtain necessary medical treatment and social services.

Budget Performance and Trends:

Public Health Protection Services Evaluation Data				
Public Health Protection Services	Actual FY04	Actual FY05	Revised FY06	Estimated FY07
Cancer and Epidemiological Services - Number of new cancer cases reported	80,000	125,033	125,000	125,000
Cancer and Epidemiological Services -Number of cumulative cancer reports in master file	1,509,383	1,868,366	1,933,300	2,068,300
Tuberculosis Control (TBC)- TB cases on register as of June 30	493	512	500	500

Source: State FY07 Budget Book (p. D- 155)

Note: Additional evaluation data is available in the FY07 State Budget Book, details on p. D-155.

²³ N.J.S.A. 24:14A; N.J.A.C. 8:51.

Public Health Protection Services Appropriations Data						
	Orig. & --Supple. FY05	Total FY05 Available	Expended FY05	FY06 Adjusted Approp.	Request/ Recommend FY07	Actual Approp. FY07
Direct State	\$32,226,000	\$34,442,000	\$34,141,000	\$30,706,000	\$30,706,000	\$30,706,000
Grants-in-Aid	\$53,645,000	\$53,701,000	\$52,281,000	\$67,926,000	\$40,626,000	\$120,194,000
State Aid	\$2,400,000	\$2,400,000	\$2,727,000	\$2,400,000	\$2,400,000	\$2,400,000
Federal funds	\$70,768,000	\$81,100,000	\$52,819,000	\$68,336,000	\$69,933,000	\$76,472,000
All other funds	---	\$17,977,000	\$11,989,000	\$13,350,000	\$14,337,000	---
Source: State FY07 Budget Book (p.D-151-160) & State FY07 Appropriations Bill S2007 (p. 80, 82, 85 & 247)						

Note – The Appropriations Handbook provides a breakdown of \$115.7 million in grants-in-aid Public Health Protection Services funding by grant recipient (p. B-77). The largest grants are \$32 million for unspecified Cancer Research, \$25.7 million to Jersey City Medical Center, \$22.25 million to the Cancer Institute of New Jersey and \$12 million for Tamiflu Prescription Medication.

Public Health Priority Funding Appropriations Data					
Orig. & --Supple. FY05	Total FY05 Available	Expended FY05	FY06 Adjusted Approp.	Request/ Recom FY07	Actual Approp. FY07
\$2,400,000	\$2,400,000	\$2,400,000	\$2,400,000	\$2,400,000	\$2,400,000
Source: State FY07 Budget Book (p. D-148) & State FY07 Appropriations Bill S2007 (p. 85)					

Additional Analysis:

In 1966, the State Legislature enacted legislation that provides for state funding to support priority health services to local health departments. Local health departments are required by state statute to routinely submit reports on the provision of public health services and related activities, as well as budget and expenditure reports pertaining to public health priorities, to the Office of Local Health. Eligibility for state funding is restricted to local health agencies serving a minimum population of 25,000. Public Health Priority Funding (PHPF) amounts for each of the state's 566 municipalities is calculated according to a formula set forth by law,²⁴ including population and taxation data for the most current year. Local departments must apply annually.

²⁴ N.J.S.A. 26:2F-6.1.

For CY 2005, PHPF funding for local health departments ranged from approximately \$2,000 for more affluent jurisdictions to over \$200,000 for those with greater need. County health departments were expected to realize an additional \$2.4 million through realty transfer funds for priority health services. County funding was estimated to range from approximately \$31,000 for more affluent counties to more than \$330,000 based on need.²⁵

The Public Health Protection Services (PHPS) is the account that provides for various state-funded public health services. Although both the PHPS and the PHPF are listed as line-item appropriations, the PHPF funding of \$2.4 million that is distributed to eligible local health departments is funded from the PHPS appropriation of \$25.8 million.

²⁵ New Jersey Department of Health and Senior Services, Public Health Priority Funding, Office of Local Health.

Pharmaceutical Assistance to the Aged & Disabled (PAAD)

Program Purpose and Description:

The PAAD is state-funded program. Eligibility is determined both by income and by category. To be eligible in 2006, a person must be a New Jersey resident with income of less than \$21,850.00, if single, and \$26,791.00, if married. To be accepted, a person must also be at least 65 years of age or at least 18 and receiving Social Security Disability benefits. Medicaid beneficiaries or persons with comparable prescription coverage are not eligible.

The program helps low-income adults pay for FDA-approved prescription medicines, including insulin, insulin needles, certain diabetic testing materials, and syringes and needles for injectable medicines used for the treatment of multiple sclerosis. PAAD recipients make a \$5.00 co-payment for each prescription. The program will not cover drugs purchased outside of the U.S. or from any manufacturer who has not agreed to provide rebates to the State of New Jersey.

Some PAAD beneficiaries must reapply every year, although most beneficiaries must only submit a renewal application every two years. The State of New Jersey has established a list of generic drugs that must be dispensed whenever a brand name drug has been prescribed. Prescribing physicians must write "brand medically necessary" on the prescription to require the dispensing of some brand name drugs when a generic is available.

Since November 1, 1998, legislation has required the initial prescription to be limited to a 34-day supply and subsequent refills to be dispensed up to a 34-day supply or 100 doses, whichever is greater. The state has established an enhanced Drug Utilization Review (DUR) component for the PAAD program to safeguard against harmful drug/drug interactions, doses that are too small or too large, over-extended drug therapy or drug duplication.

Budget Performance and Trends:

Pharmaceutical Assistance to the Aged & Disabled (PAAD)				
Evaluation Data				
	Actual FY04	Actual FY05	Revised FY06	Estimated FY07
Aged:				
Average monthly eligible	148,349	148,280	147,508	146,790
Average monthly prescriptions per eligible	3.08	3.30	3.37	2.45
Annual prescriptions	5,477,045	5,838,243	5,965,224	4,315,626
Cost per prescription (excludes co-payment)	\$71.07	\$66.45	\$66.47	\$71.04
Gross cost PAAD program (aged only)	\$389,266,584	\$387,922,270	\$396,487,454	\$306,583,853
Recoveries*	(\$5,638,260)	(\$12,058,310)	(\$6,857,250)	(\$838,634)
PAAD manufacturers' rebates*	(\$95,940,109)	(\$107,673,783)	(\$146,250,000)	(\$11,181,968)
Net annual cost	\$287,648,215	\$268,190,176	\$243,380,204	\$294,563,250
Disabled:				
Average monthly eligibles	27,902	28,274	28,921	29,583
Average monthly prescriptions per eligible	3.99	3.94	3.98	2.88
Annual prescriptions	1,334,832	1,396,133	1,381,267	1,022,382
Cost per prescription (excludes co-payments)	\$97.20	\$92.62	\$95.68	\$99.96
Gross cost PAAD program (disabled only)	\$129,742,195	\$129,307,423	\$132,162,485	\$102,194,618
Recoveries*	(\$1,879,420)	(\$4,019,437)	(\$2,285,750)	(\$279,545)
PAAD manufacture's rebates*	(\$31,980,036)	(\$35,891,261)	(\$48,750,000)	(\$3,727,323)
Net annual cost	\$95,882,738	\$89,396,725	\$81,126,735	\$98,187,750
Total General Fund	\$161,411,859	\$71,186,073	\$49,943,938	\$151,511,000
Total Casino Revenue Fund	\$254,646,953	\$309,005,018	\$304,398,000	\$271,075,000
Source: State FY07 Budget Book (p. D-169)				

*Note: "Rebates and recoveries earned by all portions of the PAA/PAAD program; rebates are applied to the PAAD program only" (SFY07 Budget Book p. D – 170).

Pharmaceutical Assistance to the Aged & Disabled (PAAD) Appropriations Data						
	Orig. & --Supple. FY05	Total FY05 available	Expended FY05	FY06 Adjusted Approp.	Request/ Recommend FY07	Actual Approp. FY07
Direct State Services	\$8,560,000	\$13,829,000	\$11,034,000	\$3,751,000	\$8,606,000	\$8,606,000
Grants - In - Aid (from General Fund)	\$130,064,000	\$147,691,000	\$94,750,000	\$105,095,000	\$176,456,000	\$163,916,000
Grants-in-Aid (from Casino Revenue)	\$309,086,000	\$452,651,000	\$452,570,000	\$304,398,000	\$271,075,000	\$271,075,000
Federal funds	\$93,836,000	\$93,836,000	\$3,740,000	\$11,366,000	\$3,842,000	\$3,842,000
Source: State FY07 Budget Book (p. D-171-173) & State FY07 Appropriations Bill S2007 (p. 88,89 & 248)						

Additional Analysis:

As a result of the federal Medicare Prescription Drug, Improvement and Modernization Act of 2003, the Medicare Drug Discount Card program was implemented in June 2004. This interim federal program provided a \$600 credit toward prescription costs in 2004 and 2005 for certain low-income Medicare beneficiaries who enrolled in a Medicare-sponsored discount drug card plan.

The New Jersey Department of Health and Senior Services negotiated with the federal government (the Centers for Medicare and Medicare Services within the U.S. Department of Health and Human Services) to allow New Jersey to contract with one Medicare-approved drug plan, Medco, and to automatically enroll into Medco all PAAD recipients eligible for the \$600 credit. Approximately 81,000 PAAD recipients were eligible for the \$600 prescription discount card/credit in 2004 and 2005. Thus, the PAAD program spent \$600 less per year in 2004 and 2005 for each of these low-income PAAD recipients and realized savings of approximately \$45 million in each of these two years.

On January 1, 2006, the federal Medicare Part D Drug Benefit Program was implemented and Medicare beneficiaries who do not also have Medicaid coverage due to their low income²⁶ may enroll in a Prescription Drug Plan (PDP) for their drug coverage. Medicare pays the cost of participants' prescription medications, but subject to premiums, co-pays and deductibles. In addition, the PDPs have more restrictive drug formularies or preferred drug lists than the PAAD program. However, Medicare beneficiaries with low income and asset levels will be subsidized by Medicare.

²⁶ See Section on Pharmacy Costs for Dual Eligibles in the Medicaid Section.

For all Medicare beneficiaries in New Jersey who are eligible for Part D and who are income and otherwise eligible for PAAD, the State now requires enrollment into Medicare Part D and the selection of a PDP as a prerequisite for PAAD eligibility. Beneficiaries who decline enrollment in Medicare Part D will be barred from PAAD benefits. As a result, the PAAD program saved approximately \$90 million in the first half of CY06 because Medicare covered the bulk of the prescription costs of PAAD participants who are also enrolled in Medicare Part D.

Since January 1, 2006,²⁷ PAAD provides wraparound coverage for its enrollees in Medicare Part D and maintains their out-of-pocket cost at \$5.00 per prescription. PAAD is developing a process for determining the extent of its wraparound coverage for the cost of medically necessary drugs that may not be covered by their enrollees' PDPs.²⁸

²⁷ Because of problems in the first three months of the federal Medicare Part D program, PAAD paid the costs for its enrollees with Medicare Part D coverage until March 31, 2006. The federal government reimbursed New Jersey for these costs.

²⁸ FY06 Appropriations Bill S3000, p. B-81, B-83-84.

Senior Gold Prescription Plan

Program Purpose and Description:

The Senior Gold Program is also administered by the Department of Health and Senior Services (DHSS). The program provides coverage for prescription medicines, insulin, insulin supplies and diabetic testing materials for residents of New Jersey who are 65 years of age or older, or recipients of disability benefits under Title II of the Social Security Act with incomes up to \$10,000 greater than the income levels for the Pharmaceutical Assistance for the Aged and Disabled (PAAD) program. Eligible persons may purchase drugs for \$15 per prescription plus one half of the cost of the prescription. Senior Gold participants with out-of-pocket prescription costs that exceed \$2,000 a year for an individual or \$3,000 a year for a married couple will have 100% of their prescription costs paid for the remainder of the year after paying the \$15 co-payment per prescription.

This program integrates the New Jersey Ease Program into the Senior Gold Program by charging the county Ease agency with assisting seniors and the disabled to find a prescription drug program that best fits their needs and financial resources. Pharmacies are reimbursed at the same rate as under the existing PAAD program.²⁹

²⁹ <http://www.state.nj.us/health/seniorbenefits/seniorgolddiscount.htm>.

Budget Performance and Trends:

Senior Gold Evaluation Data				
	Actual FY04	Actual FY05	Revised FY06	Estimated FY07
Aged:				
Average monthly eligible	28,257	28,591	28,750	28,910
Average monthly prescriptions per eligible	2.08	2.09	2.11	2.16
Annual prescriptions	688,696	705,295	717,062	727,950
Cost per prescription (excludes cost sharing)	\$27.13	\$29.39	\$31.57	\$31.97
Gross cost Senior Gold program (aged only)	\$19,135,019	\$21,596,430	\$23,331,189	\$25,274,550
PAAD manufacturers' rebates	(\$4,028,510)	(\$5,677,173)	(\$6,000,000)	(\$6,500,000)
Net annual cost	\$15,106,509	\$15,919,257	\$17,331,189	\$18,774,550
Disabled:				
Average monthly eligibles	1,461	1,672	1,839	2,023
Average monthly prescriptions per eligible	2.34	2.30	2.25	2.18
Annual prescriptions	41,025	46,080	49,653	52,962
Cost per prescription (excludes cost sharing)	\$38.00	\$42.70	\$43.14	\$43.81
Gross Cost Senior Gold program (disabled only)	\$1,558,839	\$1,967,549	\$2,142,057	\$2,320,450
Total General Fund	\$16,665,348	\$17,886,805	\$19,473,246	\$21,095,000
Source: State FY07 Budget Book (p. D-169)				

Senior Gold Appropriations Data						
	Orig. & --Supple. FY05	Total avail. FY05	Expended FY05	FY06 Adjusted Approp.	Request/ Recommend FY07	Actual Approp. FY07
Direct State Services	---	\$3,850,000	\$2,848,000	---	---	---
Grants- in-Aid	\$24,947,000	\$26,774,000	\$23,564,000	\$24,022,000	\$24,945,000	\$25,240,000
Source: State FY06 Budget Book (p. D-171-172) & State FY07 Appropriations Bill S2007 (p. 90) & Appropriations Handbook FY2006-2007 (B-83)						

Additional Analysis:

Many Senior Gold participants are also Medicare beneficiaries and they have had the option of enrolling in the Medicare Part D Drug Benefit since January 1st 2006. However, DHSS is not requiring Part D enrollment for eligibility in Senior Gold.

AIDS Drug Distribution Program (ADDP)

Program Purpose and Description:

ADDP is the state drug assistance program in New Jersey that provides HIV/AIDS prescription drugs to residents who are living with HIV/AIDS and who are not insured or who are under-insured. It is administered within the Department of Health and Senior Services. Applicants for ADDP must have been state residents for at least 30 days, have no other way to pay for the medications, and have income that does not exceed 500% fpl. They must also present a letter from a physician that attests to the medical necessity of receiving the covered medication. Once enrolled in the program, the participant must obtain prescription medicines from a Medicaid-participating pharmacy. There are other programs in the state, supported with federal funding, that focus on prevention, health, housing, support, corrections, data collection, and other issues related to the disease.

As of the end of 2005, the State had 48,431 reported AIDS cases and remained one of the 5 states that combine for more than half of all reported cases in the nation.³⁰ However, it is estimated that undiagnosed and unreported cases comprise approximately one-third of all estimated infections.³¹ Ninety percent of those reported to be living with HIV or AIDS in New Jersey are between the ages of 20 and 49, and approximately 31% are female, which is the highest proportion in the country. The State also ranks third in the number of children below the age of 13 living with AIDS. In addition, 75% of those individuals living with HIV/AIDS in New Jersey are Hispanics or African Americans.

Combination therapy and the introduction of new prescription treatments to extend the lives of persons with HIV/AIDS add to the program’s high costs. The program plays a critical role in providing needed care to individuals with HIV who have limited or no access to prescription coverage.

Budget and Performance Trends:

ADDP Evaluation Data				
	Actual FY04	Actual FY05	Revised FY06	Estimated FY07
Clients served	7,200	6,899	7,200	7,500
Source: State FY07 Budget Book (p. D-157)				

³⁰ *HIV/AIDS Surveillance Report: Cases of HIV Infection and AIDS in the United States and Dependent Areas, 2005*, Vol 17, Centers for Disease Control.

³¹ Jannsen, R. *et al.*, *AJPH*, July 2001, vol. 91, no. 7, p. 1019.

**ADDP
(Grants-in-Aid)
Appropriations Data**

Orig. & --Supple. FY05	Total avail. FY05	Expended FY05	FY06 Adjusted Approp.	Request/ Recommend FY07	Actual Approp. FY07
\$11,700,000	\$11,700,000	\$11,700,000	\$9,000,000	\$8,800,000	\$9,000,000

Source: State FY06 Budget Book (p. D-160) & State FY07 Appropriations Bill S2007 (p. 84)

Note - In addition to the line-item funding information in the State Budget materials, the State Budget Book includes language in the introduction to the DHSS departmental budget that indicates a new \$2 co-pay, with a monthly cap of \$10, for all ADDP participants with incomes above the federal poverty level. The co-pay was intended to offset \$200,000 in rising program costs (p. D-149). The Appropriations Bill does not include this language and the restoration of \$200,000 in the final appropriation indicates that the co-pay was not instituted.

Additional Analysis:

Similar programs exist in all states to assist qualified individuals with the cost of necessary medications.³² ADDP was primarily supported with federal funding until 2005, when the federal funding became inadequate. The state allocation for the ADDP program in FY05 was approximately \$14 million. The FY06 budget for ADDP is approximately \$9 million and assumes savings through changes to the program's drug formulary and increasing revenues from pharmaceutical rebates. There may also be savings to the State from the Medicare Part D program, although it is expected that not many ADDP beneficiaries also have Medicare coverage.

³² The federal Title II funding for these programs is from the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act; most states refer to their programs as ADAPs (AIDS Drug Assistance Programs).

Federally Qualified Health Centers (FQHCs)

Program Purpose and Description:

Federally Qualified Health Centers (FQHCs) are nonprofit, consumer-directed corporations that provide primary outpatient treatment to the underserved and the uninsured. FQHCs include Community Health Centers (CHCs), Migrant Health Centers, Health Care for the Homeless programs, Public Housing Primary Care programs, and Urban Indian and Tribal Health Centers.

Funding for health centers comes from a variety of public and private sources. According to the National Association of Community Health Centers, health centers receive half of their funds from state and local sources, such as Medicaid (35%), state and local funds (12%) and, to a small extent, the Children's Health Insurance Program (3%). The remainder comes from federal grants, which make up approximately 26% of total funds, followed by private insurance (11%), Medicare (6%) and patients themselves (7%).³³

In order to be designated as a Federally Qualified Health Center, a Health Center must:

- Serve a federally designated health professional shortage area, medically underserved area or medically underserved population;
- Provide services to patients regardless of insurance status;
- Use a sliding fee scale for uninsured patients, based on income status; and
- Operate as a nonprofit corporation governed by a board of directors of which a majority are users of the Health Center.

In New Jersey, there are essentially two types of Federally Qualified Health Centers: 1) Section 330 Health Centers, authorized under section 330 of the Health Centers Consolidation Act of 1996; and 2) FQHC "Look-alikes."

Section 330 Health Centers can be one of the following:

- Community and Migrant Health Centers
- Health Care for the Homeless Programs
- Public Housing Primary Care Programs
- School-Based Health Centers.

The FQHC Look-alikes are organizations that meet all of the federally funded Community Health Center program expectations, but do not receive federal operating grants under the Section 330 Public Health Service Act. Such organizations are formally designated Federally Qualified Health Center Look-alikes by the U.S. Department of Health and Human Services.

³³ National Conference of State Legislators. <http://www.ncsl.org/programs/health/communityhc.htm>.

In New Jersey, the major providers of comprehensive community-based primary health care are nineteen community health centers and their satellite sites, federally funded/qualified by Sections 330/329 of the United States Public Health Service. Although somewhat different in composition and in the nature of services offered, the FQHCs all target the health care needs of the medically underserved within their respective service areas.

Budget Performance and Trends:

Approximately 1,000,000 patient visits are made to New Jersey's Federally Qualified Health Centers annually by almost 289,000 clients.³⁴ Typical services include internal medicine, obstetrics, gynecology, pediatrics, geriatrics, medical and surgical subspecialties, laboratory, podiatry, pharmacy, x-ray, dental, and mental health services.³⁵

The FQHCs provide care in underserved neighborhoods with clinic hours that include nights and weekends. They utilize the services of physicians from the National Health Service Corps on a full-time basis, with admitting privileges to local hospitals. However, many of the provider specialists that the FQHCs use for referrals are not on the FQHC staffs and do not give free care or reduced cost care to low-income, uninsured patients. The FQHCs are able to provide care at costs that are substantially lower than in other settings.

Federally Qualified Health Centers (FQHCs) (Services to Family Care Clients*) Grants-In-Aid					
Orig. & --Supple. FY05	Total avail. FY05	Expended FY05	FY06 Adjusted Approp.	Request/ Recommend FY07	Actual Approp. FY07
---	\$10,000,000	\$9,973,000	\$26,000,000	\$5,000,000	\$5,000,000
Source: State FY07 Budget Book (p. D-159) & State FY07 Appropriations Bill S2007 (p. 83)					

*Note: "In addition to the amount recommended in fiscal year 2007, \$35,000,000 is funded from the Health Care Subsidy Fund." (FY07 Budget Book p. D-161)

³⁴ <http://www.njpc.org>, The New Jersey Primary Care Association Home page August 8th, 2005.

³⁵ The New Jersey Primary Care Association, <http://www.njpc.org>.

Maternal, Child and Community Health (various programs)

Program Purpose and Description:

The Maternal Child and Community Health program of the Division of Family Health Services (within the Department of Health and Senior Services) comprises a variety of health services, including Perinatal Health, Reproductive Health, and the Child and Adolescent Health Programs. This program administers state and federal funding support and technical assistance for the provision of preventive and primary health care services for New Jersey residents in partnership with the Maternal and Child Health Consortia, Healthy Mothers/Healthy Babies coalitions, and a network of specialized perinatal services for pregnant women at risk. Specific services include family planning and adolescent pregnancy prevention; breast, cervical, prostate and colorectal cancer screening and follow-up; prevention-oriented early childhood health services, including lead screening, oral health education, and injury prevention; school and adolescent services, including parenting training, violence and unintentional injury prevention; services to reduce social disparities; and primary care for uninsured residents through community health centers.³⁶ These are private, non-profit organizations which include, as members, any group or individual with an interest in services for families. Consumer and professional education programs are available through New Jersey's system of Maternal and Child Health Consortia. These regional consortia can provide information on how to find a pediatrician, obstetrician or hospital, pediatric or prenatal care, the Women, Infants and Children's centers (WIC), immunization services, and the location of neonatal intensive care services in their regions.³⁷

The Healthy Mothers, Healthy Babies Coalitions are community-based groups within the Maternal and Child Health Consortia, providing services within the eleven highest risk cities in New Jersey. The coalitions provide outreach to help women find prenatal and pediatric services, and educational services to encourage women to take care of themselves during pregnancy. They also provide special programs for fathers and adolescents.³⁸

³⁶ <http://www.state.nj.us/health/fhs/chshome.htm>.

³⁷ Information provided by Senate Majority Staff via e-mail, February 11, 2004.

³⁸ <http://www.state.nj.us/health/fhs/mchfact.htm>.

Budget and Performance Trends:

Maternal and Child Health Services Evaluation Data				
	Actual FY04	Actual FY05	Revised FY06	Estimated FY07
Infant mortality rate/1,000 live births	6.2	5.7.	5.7	5.7
Infant born to mothers w/no prenatal care/1,000 live births	1.2	1.2	1.2	1.2
Newborns screened for metabolic & genetic disorders	113,404	110,473	114,000	118,000
Number of infants to be followed	6,395	5,945	6,400	7,200
Number of infants in early intervention	15,829	16,000	18,000	19,750
HealthStart (prenatal)	35,000	36,500	37,000	37,000
Women assessed for alcohol use/abuse during pregnancy	29,892	34,000	35,000	40,000
Source: State FY07 Budget Book (p. D- 154-155)				

Maternal and Child Health Services Grants-in-Aid					
Orig. & --Supple. FY05	Total FY05 available	Expended FY05	FY06 Adjusted Approp.	Request/ Recommend FY07	Actual Appropriation FY07
\$3,403,000	\$3,403,000	\$3,403,000	\$5,587,000	\$5,587,000	\$5,587,000
Source: State FY07 Budget Book (p. D-159) & State FY07 Appropriations Bill S2007 (p. 82)					

Catastrophic Illness in Children Relief Fund

Program Purpose and Description:

In 1988, the Legislature created the Catastrophic Illness in Children Relief Fund as a dedicated, non-lapsing trust fund to provide families with help for high, uncovered medical expenses for their children. There is no income limit for eligibility. A family is eligible if a child’s un-reimbursed medical and related expenses total 10% of the family’s income below \$100,000 plus 15% of any excess income above \$100,000. Families must be New Jersey residents and the children must have been 21 or younger when medical expenses were incurred. All uncovered medical and related expenses qualify, including hospital and physician bills, medications, medical equipment, psychiatric care, home health care and specialized home and vehicle modifications.³⁹

The Fund is administered by a Commission made up of 11 members, 7 of whom are non-salaried. The Commission is established in the New Jersey Department of Human Services. The Program is funded by an annual surcharge of \$1 per employee, levied on all employers who are subject to the New Jersey unemployment compensation law.

Budget and Performance Trends:

Catastrophic Illness in Children Relief Fund Schedule 2 (denotes dedicated revenue)			
FY05 Actual	FY06 Estimated	FY07 Estimated	FY07 Actual
\$1,208,000	\$925,000	\$1,041,000	\$125,000
Source: State FY07 Budget Book (p. C-20) & State FY07 Appropriations Bill (p. 223)			

Note: This revenue line reflects anticipated revenue from the \$1 annual surcharge per employee on all employers that are subject to the New Jersey Unemployment Compensation Law.

³⁹ <http://www.state.nj.us/humanservices/catill/holidayevent12-1-02.htm>.

Catastrophic Illness in Children Relief Fund (Special Revenue Funds)			
	FY05 Actual	FY06 Estimated	FY07 Estimated
Fund Balance July 1	\$3,836,000	\$5,844,000	\$3,631,000
Total Revenues	\$6,889,000	\$6,467,000	\$6,425,000
Total Available	\$13,725,000	\$12,311,000	\$10,056,000
Total Expenditures & other financing uses	\$7,881,000	\$8,680,000	\$9,140,000
Fund Balance June 30	\$5,844,000	\$3,631,000	\$916,000
Source: State FY07 Budget Book (p. H-5)			

Additional Analysis:

Two years ago year, the Legislature amended the law retroactively to January 1, 2002, to increase the age limit from 18 to 21 years and to *require* the Fund to grant awards to all eligible children with catastrophic illness whose un-reimbursed medical costs meet the guidelines, subject to availability of funding in the program. It was estimated that an additional 50 children a year will be assisted by the Fund, with a first year cost of \$300,000 and an annual cost thereafter of \$1.2 million.⁴⁰

The Fund has assisted families with extraordinary medical debts in every county in New Jersey.⁴¹ Since its inception, the Fund has distributed more than \$90 million to more than 3,600 families in amounts that ranged from \$476 to \$907,585.

⁴⁰ State of New Jersey Senate Bill No. 1965, January 18, 2004.

⁴¹ *Atlantic Highlands Herald*, December 25, 2003.
http://www.ahherald.com/news/2003/1225/catastrophic_illness.htm.

Lead-based Paint Abatement Program

Program Purpose and Description:

The Department of Community Affairs (DCA) administers the Lead-Based Paint Abatement Program with funds from the U.S. Department of Housing and Urban Affairs. The program’s mission is to create affordable housing units that satisfy code requirements and are free from lead-based paint. The program provides deferred-payment loans and grants through local government entities to rental property owners and low-income owner-occupants for reducing lead-based paint hazards in conjunction with the rehabilitation of substandard low-income housing units.⁴² Since remodeling and renovation of units with lead-based paint can release dust into the air that is potentially harmful, the funding is used to ensure lead-safe work practices. The Abatement Program also provides education to property owners, tenants and homeowners on how to maintain lead-safe housing.⁴³

Budget and Performance Trends:

Lead Hazard Control Assistance Fund Schedule 2 (dedicated)			
FY05 Actual	FY06 Estimated	FY07 Estimated	FY07 Actual
\$66,000	\$500,000	\$545,000	---
Source: State FY07 Budget Book (p. C-18)			

Lead Hazard Control Assistance Fund Grants-in-Aid					
Orig. & --Supple. FY05	Total FY05 available	Expended FY05	FY06 Adjusted Approp.	Request/ Recommend FY07	Actual Appropriation FY07
\$10,000,000	\$10,000,000	\$3,300,000	\$10,000,000	\$6,000,000	\$6,000,000
Source: State FY07 Budget Book (p. D-56) & State FY07 Appropriations Bill S2007 (p. 40)					

Note – Language in the FY07 Budget Book (p. D-57) states that the funding appropriated for the Lead Hazard Control Assistance Fund is payable from the portion of the sales tax dedicated to this purpose, and that up to an additional \$8 million may be appropriated.

⁴² <http://www.nj.gov/dca/programsbook/programsbook.pdf>.

⁴³ <http://www.state.nj.us/dca/dhcr/lead.shtml>.

Lead-Based Paint Abatement Program Schedule 2 (denotes federal revenue)			
FY05 Actual	FY06 Estimated	FY07 Estimated	FY07 Actual
\$271,000	\$3,000,000	\$3,000,000	\$3,000,000
Source: State FY07 Budget Book (p. C-24) & State FY07 Appropriations Bill S2007 (p. 10)			

Federal Lead Abatement Program Schedule 2 (denotes federal revenue)			
FY05 Actual	FY06 Estimated	FY07 Estimated	FY07 Actual
\$365,000	\$461,000	\$467,000	\$498,000
Source: State FY07 Budget Book (p. C-27) & State FY07 Appropriations Bill S2007 (p. 13)			

Additional Analysis:

The New Jersey Legislature passed Senate Bill No. 1348, which created the Lead Hazard Control Assistance Fund, to be administered through a program under the auspices of DCA. The program will also maintain a registry of lead-safe housing throughout the state. This registry can be used to identify such housing and to track the progress of the state’s lead hazard control work programs.

The program requires DCA to inspect every multiple dwelling under the “Hotel and Multiple Dwelling Law” for lead-based paint. The Department has trained its inspectors in the identification of lead hazards and the obligations of the owners of properties under the law to remediate. In addition, the program creates the Emergency Lead Poisoning Relocation Fund for emergency relocation assistance for lead poisoned children. The law seeks to allocate \$7 million of the sales tax on the sale of containers of paint for deposit annually into the Lead Hazard Control Assistance Fund.

Medicare (Federal)

Program Purpose and Description:

Medicare is a federal Health Insurance Program for people 65 years of age and older; some people with disabilities under age 65; people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant), and some people with Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig disease). Medicare now has four parts: Part A (Hospital Insurance), Part B (Medical Insurance), Part C (Medicare Advantage, formerly “Medicare+Choice” or Medicare Managed Care), and Part D (Drug Benefit Program to be fully implemented in January 2006).

Part A (Hospital Insurance)

Helps Pay For: Care in hospitals on an inpatient basis; critical access hospitals (small facilities that give limited outpatient and inpatient services to people in rural areas); skilled nursing facilities; hospice care; and some home health care.⁴⁴

Cost: Most people get Part A automatically when they turn age 65. They do not have to pay a monthly payment (premium) for Part A because they or a spouse paid Medicare taxes while they were working. However, they must pay a deductible for each benefit period and cost sharing if a hospitalization lasts more than 60 days. If an individual (or their spouse) did not pay Medicare taxes while they worked and are age 65 or older, they still may be able to “buy” Part A by paying a premium of \$226.00 per month in 2007 if they have 30-39 Medicare-covered work quarters, or approximately \$410.00 per month if they have less than 30 Medicare-covered work quarters.

Part B (Medical Insurance)

Helps Pay For: Doctors' services, outpatient hospital care, and some other medical services that Part A does not cover, such as the services of physical and occupational therapists, and some home health care. Part B helps pay for these covered services and supplies when they are medically necessary.

Cost: Enrolling in part B is optional. The Medicare Part B premium may be \$93.50 per month in 2007.⁴⁵ Except in special circumstances, individuals who did not choose Part B when they first became eligible for Medicare are charged an additional 10% for each 12-month period that the individual could have had Part B but did not sign up for it. A Medicare beneficiary will have to pay this extra 10% for the rest of his/her life.

⁴⁴ A more detailed description of the coverage under the four Medicare Parts can be found in “Medicare and You,” which is published each year by the Centers for Medicare and Medicaid Services, the division within the U.S. Department of Health and Human Services that administers the Medicare program.

⁴⁵ Beginning January 1, 2007, the Medicare Part B monthly premium will be means-tested and based on the beneficiary’s individual or joint IRS tax return 2 years before (e.g., 2005 return for 2007 premium). In 2007, the premium amount will range from \$93.50 to \$161.40.

Similar to Medicare Part A, there is also an annual Part B Deductible (\$131.00 in 2007). Unlike Medicare Part A, however, Part B pays only 80% of the provider's allowable Medicare charge and the Medicare beneficiary may be responsible for the remaining 20%.

Part C (Medicare Advantage)

Helps Pay For: All Medicare covered benefits. A few Medicare managed care plans, mostly HMOs (the most common form of Medicare managed care) and Preferred Provider Organizations (PPOs) have offered drug coverage or other services that traditional Medicare A and B coverage does not cover. However, there are often annual caps for coverage of medications and restricted coverage of generic drugs only or formularies. Medicare reimburses Part C organizations at a capitation rate for Medicare Parts A and B services.

Cost: Most Medicare beneficiaries who are enrolled in Medicare Part C organizations have their Part B premium automatically deducted from their monthly Social Security payment and automatically paid to their Part C Plan. Some Part C organizations charge more than the monthly Part C rate, especially all those Part C organizations that provide prescription coverage, whether or not the drug coverage is limited.

Part D (Drug Benefit)

This benefit program, that covers the major portion of the costs of a beneficiary's prescription drug costs each year, began on January 1, 2006.

Budget Performance and Trends:

Medicare Schedule 2 (denotes federal revenue)				
	Actual FY05	Estimated FY06	Estimated FY07	Actual FY07
Medicare/Medicaid inspections of nursing facilities	\$9,629,000	\$16,660,000	\$16,660,000	\$16,660,000
Medicare Part A receipts for residential care and operational costs	\$3,513,000	\$5,042,000	\$6,108,000	\$6,108,000
Source: State FY07 Budget Book (p. C-27 & C-30) & State FY07 Appropriations Bill S2007 (p. 14 & 17)				

*Line items not listed in FY07 Budget Book revenue and expenditures section.

Additional Analysis:

The above information does not count all of the money that comes into the State of New Jersey from the federal government for this program. According to the New Jersey State Office of Legislative Services, this is just a small piece of the money that goes through the state. Other Medicare funds go directly from the federal government to

physicians individually and other health care providers that are eligible for funding. The amounts listed above do not account for all Medicare funds. The Medicare Premium Funds, for example, are those amounts put forth by the state to pay premiums for low-income residents who are also Medicare beneficiaries; the state gets reimbursed for this federally funded program.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), mandated changes and additions to Medicare coverage of benefits. The major change was the creation of the Medicare Part D Drug Benefit program and the interim creation of the Medicare Discount Drug Program for 2004 and 2005, until Part D was fully implemented in January 2006. As a result, the MMA had major budget implications for every state.

As of January 1, 2006, states no longer receive a federal match of funding for prescription coverage for their Medicaid beneficiaries who are also eligible for Medicare (Dual Eligibles). To fund Medicare Part D, states are required to pay the federal government each month the equivalent of the states' cost of providing prescription coverage for their lowest income Medicare beneficiaries, the Dual Eligibles. In 2006, states were required to pay 90% of what the State paid in 2003 for the cost of their Dual Eligibles' prescription costs. Over the next nine years, this percentage drops to 75% of the state's cost, and will remain at 75%.

The MMA also increased the reimbursement rates for Medicare managed care organizations and gave financial incentives to employers to retain prescription coverage for their enrollees who are eligible for Medicare (including retirement plans). It is expected that there will be an increase in the number of regional Medicare managed care organizations and hoped that private employers will continue to offer prescription coverage to their employer who are Medicare beneficiaries.

Recommendations

Medicaid

- The Division of Medical Assistance and Health Services (DMAHS) should intensify efforts to (1) enroll eligible parents into the expansion of Medicaid and NJ FamilyCare through statewide, targeted public education and awareness campaigns; (2) provide on-going training and oversight of staff, especially staff at county boards of social services who are commonly the first contacts of New Jersey residents in crisis seeking assistance; and (3) apply diligently for a federal waiver for health care coverage of low-income single adults and married couples without minor children.

The Family Health Care Coverage Act was signed by the Governor on July 13, 2005, and expanded the income eligibility for Medicaid low-income parents with minor children to 133% fpl over three years (to 100% fpl as of September 1, 2006; to 115% fpl as of September 1, 2006; and to 133% fpl as of September 1, 2008).

It is estimated that there are approximately 120,000 uninsured adults between the ages of 19 and 64, with no minor children, whose income is below 100% fpl (\$776/month for a single; \$1,041 for a married couple). These are adults with the lowest income who are not eligible for General Assistance (because their income is above \$140/month or \$210/month if chronically ill). They are also the majority of Charity Care users. They are currently not eligible for Medicaid but cannot *possibly* afford commercial health insurance. Medicaid eligibility should be expanded to include these adults.

- The state should also expand coverage for beneficiaries under Medicaid's Home and Community Based Waiver Program.

In many cases, people who are at risk of nursing home care can be treated more appropriately for less cost in their homes, if necessary services are provided for them. For many individuals, this is also personally preferable to moving to an institution. The state should increase the number of Medicaid beneficiaries who can be enrolled in waiver programs and actively work to enroll them and provide incentives to develop the necessary support services in the community.

- The state should enforce its contracts with participating providers and HMOs to increase the rate of participation in the Early and Periodic Screening, Diagnosis and Treatment program (EPSDT).

Although they increase slightly each year, the participation and screening rates for the EPSDT program remain low in New Jersey. The program mandates that the state provide Medicaid children with comprehensive physical examinations that include immunizations, physical and mental screening, and necessary referrals and treatment. Low-income children have a disproportionate occurrence of such conditions as asthma and lead poisoning. Medicaid-participating physicians are obligated to

provide EPSDT services to their Medicaid patients on a scheduled basis. However, reports show that these children are not receiving this care and Medicaid must use its authority to enforce providers' contractual obligations.

In addition, at the insistence of advocates, Medicaid conducted a successful pilot program in two communities that increased the number of New Jersey children screened for lead poisoning. This program proved the effectiveness of targeted education of parents and day care providers in the communities, and the use of a simple, on-site filter-paper blood test in physician's offices. Medicaid is currently expanding this pilot program to four additional communities and planning to replicate this successful model throughout the state. Medicaid must continue to devote staff to outreach and to educating parents and key stakeholders about the dangers of lead poisoning and the importance of screening.

NJ FamilyCare

- The State should re-open the FamilyCare program to parents of minor children with family income to 200% fpl., the original intent of the legislation.

The Family Health Care Coverage Act that was recently signed into law has re-opened the program (in phases over over three years) to parents of minor children with income to 133% fpl. This is a good start, but the State cannot afford not to expand subsidized FamilyCare coverage for parents to cover at least those under 200% fpl. Data has shown that Charity Care expenses to the State, especially expensive Emergency Department costs, are directly linked to the population of low-income, uninsured adults in New Jersey who are not being covered by FamilyCare. FamilyCare coverage saves the State money and can provide effective preventive health care for the majority of the vulnerable populations in New Jersey.

We strongly recommend that the state aggressively and promptly seek the Medicaid waiver for federal financial participation to cover low-income single adults from 18-64 in New Jersey with incomes not to exceed 100% fpl, as directed by Family Health Care Coverage Act. Until this Medicaid waiver is granted, the NJ FamilyCare program should immediately restore eligibility to this population. An adult with a maximum monthly income of \$798 a month cannot afford health insurance in New Jersey. As discussed above, without access to comprehensive health care, a person cannot maintain employment or achieve self-sufficiency.

- FamilyCare should restore comprehensive coverage for New Jersey residents who are on General Assistance (\$140/month; \$210/month for chronically unemployable).

The care that they now receive is fractured between inconsistent access to Medicaid outpatient providers (most of whom will not allow them in their office), long waits for basic care at community health centers, no access to specialists because of no cost coverage, and Charity Care for in-hospital care that does not cover many essential and very expensive, necessary services such as anesthesia and radiology.

- The State should provide transitional medical coverage for GA recipients who succeed in leaving the WFNJ/GA program for work and are no longer eligible for FamilyCare Plan G because of increase earned income.

For this population, many of whom have serious health conditions that impact their ability to join the workplace on a steady basis, health care coverage is vital to their job success. Losing their health coverage is a serious disincentive to finding employment.

Charity Care

- The solution to the growing cost of reimbursing New Jersey hospitals for the uncompensated care of low-income patients is comprehensive health care coverage of all uninsured residents in the state with incomes below 200% fpl. Savings from sharp reductions in Family Care can help fund re-expansion of Family Care.

This coverage makes economic sense and good social policy. Persons without insurance use the most expensive form of health care: the hospital emergency room. People who have health insurance seek necessary care on a regular basis and the cost to the state of their health care in both the short term and the long term is less.

Assisted Living

- The state should continue to maximize federal money by expanding its Medicaid waiver and increasing the number of beneficiaries who can be served in Comprehensive Personal Care Homes or Assisted Living facilities.

This is a cost-effective and appropriate health care solution for many more persons than are currently allowed this service. Many Medicaid beneficiaries have no in-home caregiver who can provide the services that they need, but assisted living facilities can provide these services for much less cost than a nursing home.

Local Public Health Departments

- As the officially designated frontline public health providers in each community, the state should utilize professionals at local public health departments to initiate and sustain effective programs of lead screening and follow-up treatment for children.

PAAD (Pharmaceutical Assistance for the Disabled and Aged)

- The state must continue to assist its PAAD enrollees with access to the new Medicare Drug Discount Card program.
- The state must commit continuing funding to the wraparound coverage of its PAAD enrollees in the Medicare Part D program.

Senior Gold

- PAAD recipients should be enrolled out automatically into the Senior Gold program when they become ineligible for PAAD due to increased income but are eligible for Senior Gold.

Implementing such a seamless process will save administrative dollars for the state as well as high out-of-pocket costs for low-income seniors and persons with disabilities who have an ongoing, critical need for prescription medicines.

ADDP (AIDS Drug Distribution Program)

- The state needs to provide supplemental funding to assure the availability of life-saving drugs for persons who are living with HIV/AIDS and who do not have prescription coverage for these medications.

Federally Qualified Health Centers

- New Jersey should maximize federal dollars available to states under President Bush's plan to increase the number of FQHCs nationally.

The FQHCs are the primary health care providers for a substantial number of low-income families in New Jersey. They are convenient and accessible, and they can be relied on for competent and consistent quality health care services. They are also a cost-effective way to target this population of underserved and vulnerable residents. Utilization of health center services for ambulatory care saves millions of state dollars compared to the alternative of paying the high costs of services in hospital emergency departments and reimbursements to hospitals with state dollars through the Charity Care program.

Maternal, Child and Community Health

- We recommend continued state support of these vital programs.

The Catastrophic Illness in Children Relief Fund

- Although this program has dedicated, non-lapsing funding, it is not well known and the Commission should allocate funding for broader education and outreach.

Medical treatment costs have skyrocketed and there are thousands of low-income New Jersey families with no health insurance or without adequate coverage. The Catastrophic Illness Fund is a critical safety net for families who face astronomical medical bills for their children. Families with such extraordinary medical bills can easily be financially devastated and never be able to get back on their feet again.

Lead-Based Paint Abatement Program

- The Lead Hazard Control Assistance Fund should be fully funded and staffed, and the state should continue to seek federal HUD funding.
- In addition to implementing the Abatement Program, the state must fund and diligently investigate and identify lead hazards, and ensure enforcement of laws and regulations already in effect.

This program must be recognized as an essential piece of the plan to eradicate the lead poisoning of children from housing sources in New Jersey.