

# FALLING SHORT:

## Time to Keep the FamilyCare Promise

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### **BACKGROUND**

It's a fact of life: people with health insurance have a better chance to be healthy.

They can pay for doctor visits, medicine and the other things that go into taking care of one's physical condition. But, with the US in the midst of a health care crisis, a growing number of Americans have no health insurance. As a result, their decision-making process is different from the rest of us. They go without routine care. They wait until minor ailments become dangerous problems. They don't get prescriptions filled. And when the uninsured do get medical attention, it often comes at the emergency room, where everything costs more and the bill is either passed on to insured patients or taxpayers or written off by hospitals increasingly in financial trouble.

In the other industrialized nations, government plays the major role in providing health coverage. Such a system was rejected in the US when President Harry Truman proposed it in the 1940s; instead, the nation chose to rely for the most part on employers paying to insure workers and their families. Over the years, though, policymakers have in some cases recognized the need to offer more protection. In 1965, two major government programs were created to cover specific groups less likely to have employer-based healthcare: Medicare for most Americans

over 65 years old and Medicaid for families on welfare, the elderly, the blind and persons with disabilities.

In 1997, efforts were made to enlarge the healthcare umbrella to include more children. The rationale was obvious. Preventive care and other health services for youngsters reduce the likelihood of developmental delays and can positively influence educational attainment and promote well-being in later life. Such care costs less and can promote life-long good health habits.

The vehicle established by Congress was the State Children's Health Insurance Program (SCHIP). The program doesn't directly provide services. Rather, its primary purpose is to send money to state governments to insure low-income children. To claim newly available federal SCHIP money and expand health coverage for children, New Jersey quickly established NJ KidCare, opening enrollment in January 1998. The program makes health insurance available at no cost to the lowest income families and at low cost to those whose income is higher but still below a certain level. In 2000, New Jersey replaced NJ KidCare with NJ FamilyCare (NJFC). As the name change suggests, the program was opened to some parents too, with the expectation that allowing parents in can increase the likelihood they will enroll their children.<sup>1</sup>

## KEY FINDINGS

- Though New Jersey FamilyCare (NJFC) has many positive features, it is falling short in the effort to provide health insurance coverage to children in New Jersey.
- The number of children in New Jersey without health insurance rose by 37% between 2000 and 2005 while the national rate was dropping by 9%.
- New Jersey's overall ranking for insured children fell to 33rd in the nation from 16th and for the lowest income children the state ranked near the bottom.
- Most children in New Jersey without health insurance are eligible for NJFC, but were not participating.
- The number of minority children without health insurance in New Jersey is rising at the same time the racial divide nationally is narrowing.
- Though most children without insurance in New Jersey are from low-income families, the greatest percentage increase in children without insurance is among middle class families; the rate nearly doubled.
- The number of children with private health insurance decreased by 37,000 and the percentage of small employers offering coverage dropped to 82% from 92%.
- In 2006, 75% of private sector employers took some action to reduce health care costs, mostly by requiring that employees pay more for coverage.
- Budget cuts and rules changes in 2002 are a main reason why so many low-income children lack insurance today. These policies resulted in 45,000 fewer children being enrolled in NJFC and a decrease of 49,000 enrolled parents, the loss of over \$1 billion in federal funds and \$750 million in increased charity care costs at hospitals. They also had a major impact on the state economy, including thousands of lost jobs.
- The high rate (37%) of low-income parents without insurance is resulting in fewer children being enrolled.
- NJFC requires many families to pay significantly more for coverage than New York or Pennsylvania in spite of the state's higher cost of living. This places a burden on low-income families and likely results in lower participation in the program.
- New Jersey needs to adopt the 8-step Action Plan this report proposes. Recommendations include guaranteed access to affordable, comprehensive health coverage for all insurable children within two years and fully restoring eligibility for parents to prior levels in NJFC. This is a crucial first step toward universal health coverage in New Jersey.

The program has accomplished a lot. According to a 2002 study, NJ FamilyCare "...dramatically improves access to healthcare. Parents who are provided with the necessary resource—health insurance—prove to be effective managers of their children's healthcare."<sup>2</sup>

Among NJFC's positive features:

- Families with higher income than in any other state are eligible for New Jersey's program, appropriate for such a high-cost state though New York will have higher limits starting in September (New Jersey's limit is 3.5 times the Federal Poverty Level—\$72,275 in annual income for a family of four—and New York's will be four times FPL—\$82,600).
- It claims the second highest amount of federal funds unspent by other states' SCHIPs.<sup>3</sup>
- It is one of 11 state SCHIPs allowing parents into the program.<sup>4</sup> This is important not only for the coverage it provides parents but also because data show that parents are more likely to enroll their kids if the whole family can be covered.

- Since 2000, child enrollment has increased each year but one (the reason enrollment of children dropped in that year was because the state temporarily stopped enrolling new parents.)<sup>5</sup>

### FALLING SHORT

Our assessment of NJ FamilyCare<sup>6</sup> makes use of six years of Census and other data, from 2000 to 2005, and seven years of data on participation in the program. This analysis of the extent to which New Jersey has been effective in insuring children involves gauging not only effort, but also outcomes. The bottom line is that, as noteworthy as NJFC's accomplishments are, when it comes to the overall mission of bringing health coverage to kids who cannot get it elsewhere, New Jersey is falling short.

The number of uninsured children in New Jersey grew by 37% from 2000 to 2005—to 243,000 from about 178,000—far greater than the 9% increase in the number of children in the state.

During the same period, the national rate of children without insurance *decreased* about 9%, though the national unemployment rate was twice that of New Jersey's.<sup>7</sup> Over this time, the national average SCHIP enrollment rate for children was about twice that of New Jersey, and the state's ranking for percentage of children insured fell to 33rd from 16th.<sup>8</sup>

### STATE LAGS IN COVERING LOWEST INCOME CHILDREN

Of particular concern is New Jersey's record for serving the lowest income children:

- Just over a quarter of children below the federal poverty level in New Jersey (currently \$20,650 for a family of four) lacked health insurance in 2005. The national average was 20%. New Jersey ranked 44th in the nation for covering children in this income group.<sup>9</sup>
- For children in families with income between the federal poverty line and twice that amount (up to \$41,300 for a family of four), New Jersey's record was similar: 21% in New Jersey lacked insurance compared to a national average of 18%. New Jersey ranked 45th in covering this group.

- Among children whose families are between two and three times the federal poverty line (up to \$61,950 for a family of four), 16% were uninsured compared to a national average of 11%. Here, New Jersey ranked 47th.

For the most part, the problem isn't that the uninsured children aren't eligible for FamilyCare. Up to 75% of uninsured children in the state, depending on the accuracy of Census data, meet the program's income requirements, though some might be ineligible for other reasons, such as they are unauthorized immigrant children, or they have not satisfied the waiting period of three months after their family lost its health insurance.

### RACIAL DIVIDE WIDENS

Another prominent feature of the past six years is a significant increase in racial disparity among uninsured children in New Jersey. At the same time that SCHIP has reduced the racial and ethnic divide among uninsured children nationally, that gap has widened in New Jersey.

Between 2000 and 2004<sup>10</sup>, the rate of black and Hispanic children without health insurance rose in the state, while decreasing nationally. The number of black children without health insurance in New Jersey increased by 67%; the increase among Hispanic kids was 37%.

During the same period, white children in New Jersey without health insurance decreased by 1%.

The state's high rate of children lacking insurance cannot be explained simply by the size of the Hispanic population in the state. While Hispanic children often do face barriers that many others do not—such as language, culture and restrictive immigration policies—the percentage of children who are Hispanic in New Jersey was below the national average in four of the six years studied.<sup>11</sup> Also, unlike New Jersey, 31 states which had an increase in the overall population of Hispanic children were able to reduce their overall rates of uninsured children during that period.<sup>12</sup>

### RANKS OF MIDDLE-CLASS KIDS WITHOUT INSURANCE GROWING

The percentage of children in New Jersey who are low-income changed little over the six years studied for this report. And there was a 17% increase in those whose family incomes would classify them mostly as middle class. But, this had a less than

positive aspect: the greatest percentage increase in the number of children without insurance was also in families above 3.5 times the federal poverty level (\$72,275 for a family of four). The number of additional kids in this group—27,000—lacking insurance nearly doubled from 2000 to 2005, a rate five times higher than the increase in the child population at that income level.<sup>13</sup>

One obvious reason for the increase in the rate of uninsured children is that their families exceed the income requirements for NJFC. To address this problem, the NJFC statute was changed to require that the state establish a buy-in program that would allow these parents to purchase NJFC insurance for their children. Though the law required this to be effective a year ago, it still has not been carried out by the state. Another reason why these families are losing coverage is that they are squeezed by higher health insurance premiums or a lack of employer-provided coverage.

New Jersey also saw a 35% decrease—35,500 children—in insurance among those with family income between \$20,650 and \$72,275, compared to the 2% population increase in the number of children, overall, in that income range.<sup>14</sup>

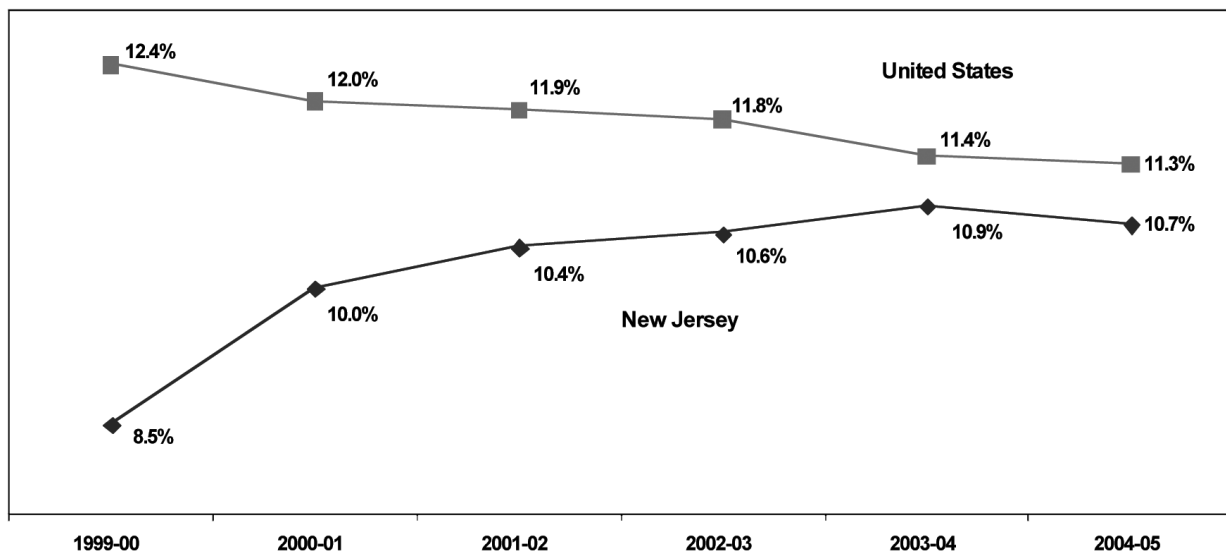
For children with family incomes below \$20,650, there was a 1% decrease in insurance coverage—500 children—which, while better, should have been lower because the number of children below that income level decreased by about 4.6%.<sup>15</sup>

**IMPACT OF STATE POLICIES**

New Jersey’s declining levels of insured children at most income levels and the widening racial disparity suggest systemic causes.

One factor is that employer-based health coverage and direct purchase of insurance by individuals and families continued to decrease as the cost of health insurance rose. Premiums increased by an estimated 80% in the last five years in the New Jersey private sector<sup>16</sup> while average wages increased by only 8.7%.<sup>17</sup> New Jersey’s average premium for a family was \$11,966 in 2005, the fourth highest in the nation—and higher than the annual salary from a full time minimum wage job that year.<sup>18</sup> Since 2000, the number of New Jersey children with employer-based insurance decreased by about 4.5%—31,000 fewer children.<sup>19</sup>

**Uninsured Children in New Jersey, 1999-00 through 2004-05**



Source: Current Population

Also, a recent survey showed that small employers providing health coverage in New Jersey decreased from 92% in 2003 to 82% in 2006. It was also reported that 75% of all employers (regardless of size) took some action to control health costs in 2006, such as increasing employee co-payments (32%), deductibles (32%) or premiums (19%).<sup>20</sup> Such actions make it difficult, if not impossible, for many low-income families to continue their coverage.

National research shows that about 26% of the decrease in employer sponsored health benefits for families with incomes between two and four times the poverty level (\$41,300 to \$82,600 for a family of four) is attributable to employers dropping coverage, and about 30% due to a decrease in the participation of the employees.<sup>21</sup> Other research shows that about 52% of employees who elected not to participate did so because it was too expensive.<sup>22</sup> In 2003, a third of the poor were found to have out-of-pocket expenses for insurance premiums and health care exceeding 10% of after-tax family income.<sup>23</sup>

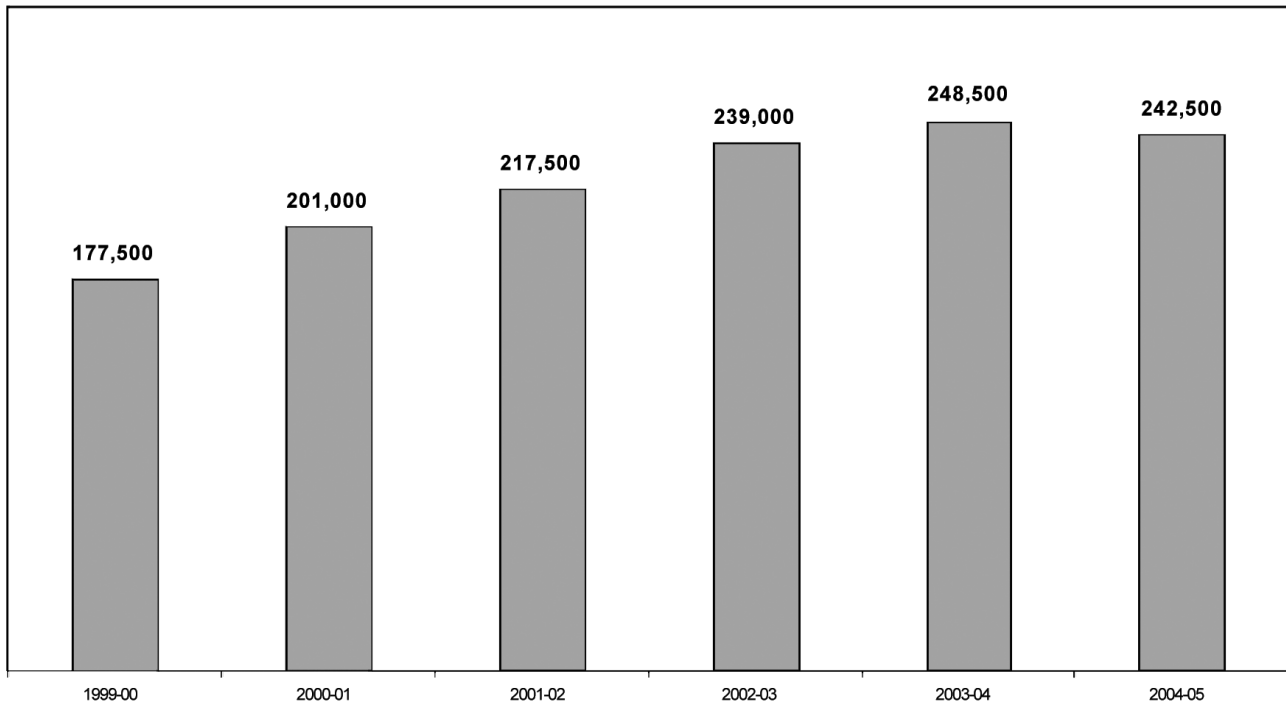
Direct purchase of insurance decreased by about 19%, or 6,000 fewer children, since 2000 in New Jersey.<sup>24</sup> This shows that many parents who traditionally had to pay for their child's insurance rather than rely on an employer are also unable to obtain insurance.

Other big-picture issues are federal immigration policies—such as citizenship documentation requirements in SCHIP—that intimidate Hispanic families from seeking help, failure of the state economy to bring prosperity to minority and ethnic groups and a tax system that calls on low- and moderate-income households to pay a greater share of their income in state and local taxes than do the wealthy.

But it is clear that policies undertaken by the state of New Jersey also have contributed to this situation.

One important example is the cuts in state funding NJFC sustained in 2002. The intent was to save money by closing

**Uninsured Children in New Jersey, 1999-00 through 2004-05**



Source: Current Population Survey Annual Social and Economic Supplements for children below age 19

Two-year averages are used to improve the reliability of the data which is based on a limited national sample used in the annual Current Population Surveys.

enrollment to parents not already in NJFC, because of the rapid rise in the enrollment of parents and because adult coverage costs the state almost twice as much as for children. But the impact included limiting enrollment of children—most likely because parents are more likely to put their kids in programs that cover the entire family. By 2006, there were 49,000 fewer parents in NJFC/SCHIP than before the 2002 cuts.<sup>25</sup>

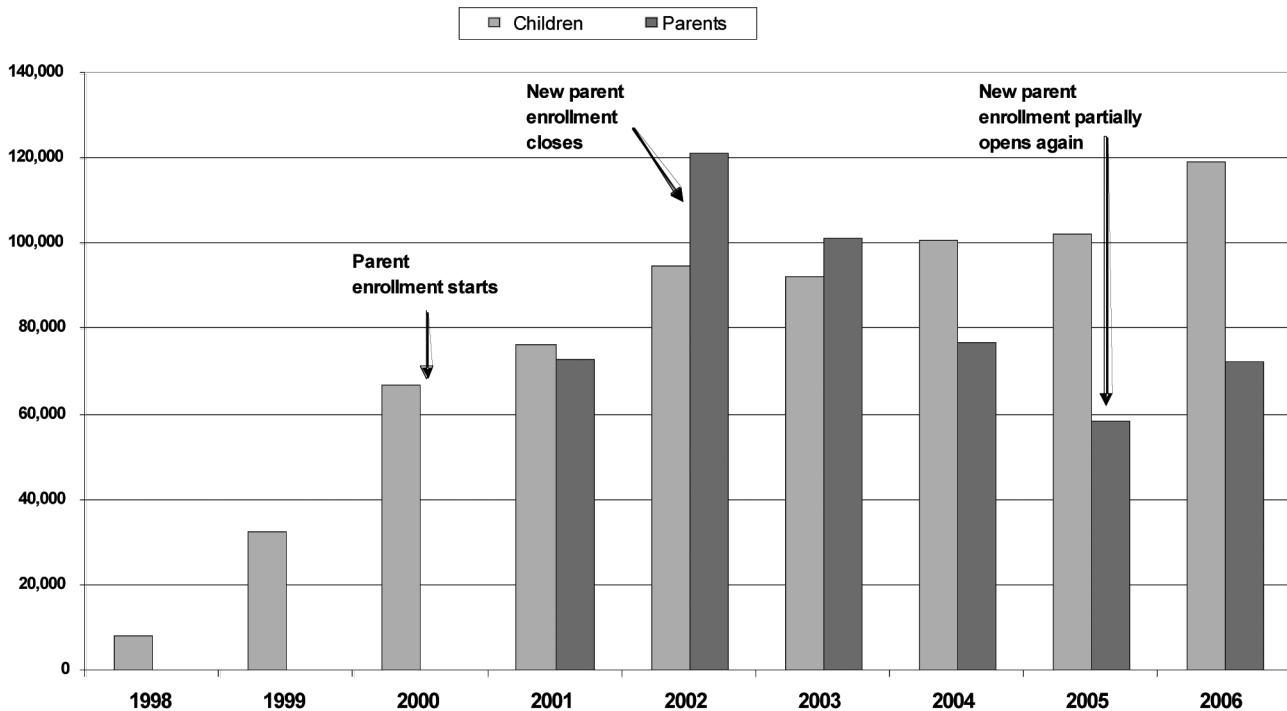
And, a projection based on previous enrollment shows that there were 45,000 fewer children in the program in 2006 than there would have been had parents not been stopped from enrolling.

In terms of the overall impact on the state, cutting a program like NJFC/SCHIP, which brings in such a high level

of federal matching funds was shortsighted. SCHIP generates \$1.86 in federal funds for every \$1 the state spends. This is a much higher matching rate than for most federal programs. The state budget cuts actually cost New Jersey more money than it saved, in terms of lost federal funds, reduced business activity, fewer jobs and increased charity care costs for treatment the uninsured receive at hospitals.

The math on federal funding is telling. Since SCHIP was enacted, the federal government has always fully matched state funds spent by every state either through reallocated funds or additional authorized funds. New Jersey would have received additional federal money if it spent more state money—but it did the reverse. Reducing the state budget by \$690 million cost New Jersey about \$1.2 billion in federal money that would have been allocated under existing formulas based on how much a

**Impact of Enrolling Parents on Child Enrollment in NJFC/SCHIP, 1998-2006**



\*Enrollment as of June of each year; enrollment figures are for those funded with SCHIP funds only and do not include Aliens or Childless Adults.

Source: New Jersey Department of Human Services

state spends. That’s a net loss of \$556 million to the state—and nearly \$2 billion in unspent health care dollars that could have benefited children and parents. The estimated cumulative loss to hospitals was about \$750 million, triggering increased charity care costs. The table below details the financial impact of NJFC cutbacks.<sup>26</sup>

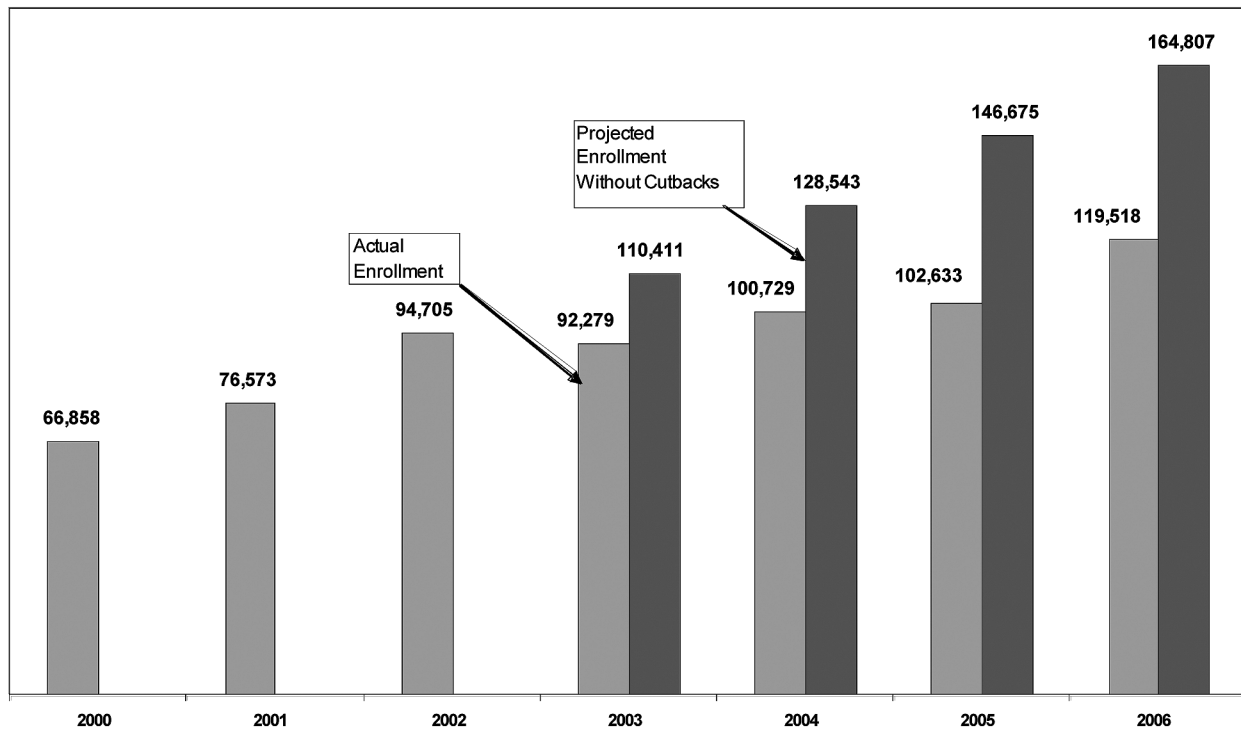
This lack of funding has consequences beyond health. The US Department of Commerce uses data from more than 500 industries to determine the “multiplier effect” of federal funds: the extent to which government spending contributes to the overall economy. It reflects the reality that government spending—like private sector spending—goes to salaries, purchases and other such activity. Applying Commerce’s input-output model to NJFC cuts shows they resulted in about \$1.1 billion in lost business activity, 8,403 fewer jobs and \$390 million in lost wages in New Jersey.<sup>27</sup>

In addition to these prior cutbacks that are still affecting enrollment in NJFC/SCHIP, the state Division of Medical Assistance and Health Services has identified about 27,000 children and 3,300 parents who either have not paid their premiums or are not complying with program rules and might face termination.

Other barriers to health insurance access in New Jersey involve the money some low-income families are required to pay for care under NJFC, as well as other restrictions.

New Jersey, for example, requires families with an income as low as 1.5 times the FPL (\$25,755 for a family of three) to pay some of the costs of coverage. Neither New York nor Pennsylvania imposes such co-payments below twice the poverty level (\$34,340 for a family of three).

**Projected NJFC/SCHIP Enrollment of Children if Parent Enrollment Was Not Closed**



Source: NJPP analysis of Department of Human Services data. Projections assume increase in enrollment prior to cutbacks continue in subsequent years on a constant basis.

Unlike either of those two states, New Jersey requires families with incomes at 1.5 times the FPL (\$25,755 for a family of three) to pay insurance premiums. Also the premiums charged in New York for families with incomes above twice the poverty level are much lower than in New Jersey (for example, a typical parent with two children with an annual income of \$41,500 would pay \$18 a month in New York compared to \$38 a month in New Jersey; for two adults and one child, the premium would be \$9 in New York compared to \$38 in New Jersey).<sup>29</sup>

And, New Jersey is the only state of the three to require a waiting period for children with family incomes under twice the FPL (\$34,340 for a family of three). New York requires no waiting period for any income level.

Research has shown that requiring low-income persons to share costs can contribute to lower rates of coverage and less access to medical care. In 2003 when Oregon increased premiums and co-payments in a component of the state Medicaid program, there was a 46% drop in enrollment within six months.<sup>25</sup> About half of those who lost coverage reported the reason was higher cost-sharing requirements; six months later, four-fifths of them reported they had not found alternative insurance.

Connecticut also has extensive experience with adverse affects from excessive cost-sharing. The state increased SCHIP premiums in 2004 and 2005, only to reverse the decision soon after because it found that thousands of children would have lost coverage.<sup>30</sup>

**Impact of Cutbacks in NJFC on Federal, State and Charity Care Funds**

| Year         | Federal Funds Claimed | Projected Federal Funds Without Cutbacks | Lost Federal Funds     | State Funds Saved Due to Cutbacks | Net Loss to State    | Benefits Lost to Children and Parents | Increase in Charity Costs to Hospitals |
|--------------|-----------------------|--|------------------------|-----------------------------------|----------------------|---------------------------------------|--|
| 2003         | \$256,000,000         | \$ 367,000,000                           | \$ 111,000,000         | \$ 62,000,000                     | \$ 49,000,000        | \$ 173,000,000                        | —                                      |
| 2004         | \$218,000,000         | \$ 478,000,000                           | \$ 260,000,000         | \$142,000,000                     | \$118,000,000        | \$ 402,000,000                        | \$ 125,000,000                         |
| 2005         | \$192,000,000         | \$ 589,000,000                           | \$ 397,000,000         | \$218,000,000                     | \$179,000,000        | \$ 615,000,000                        | \$ 250,000,000                         |
| 2006         | \$222,000,000         | \$ 700,000,000                           | \$ 478,000,000         | \$268,000,000                     | \$210,000,000        | \$ 746,000,000                        | \$ 375,000,000                         |
| <b>Total</b> | <b>\$888,000,000</b>  | <b>\$2,134,000,000</b>                   | <b>\$1,246,000,000</b> | <b>\$690,000,000</b>              | <b>\$556,000,000</b> | <b>\$1,936,000,000</b>                | <b>\$750,000,000</b>                   |

**Economic Benefits Lost in New Jersey Due to State Cutbacks in NJFC**

| Year         | Reduced State Spending | Business Activity Multiplier | Lost Business Activity | Jobs Lost Per \$1 million | Jobs Lost Due to Reduced State Spending | Wages Lost Due to Reduced State Spending |
|--------------|------------------------|------------------------------|------------------------|---------------------------|---|--|
| 2003         | \$ 62,000,000          | 4.2                          | \$ 260,400,000         | 31.40                     | 1,947                                   | \$ 90,380,190                            |
| 2004         | \$ 80,300,000          | 4.2                          | \$ 337,260,000         | 31.40                     | 2,522                                   | \$ 117,056,924                           |
| 2005         | \$ 75,600,000          | 4.2                          | \$ 317,520,000         | 31.40                     | 2,374                                   | \$ 110,205,522                           |
| 2006         | \$ 49,700,000          | 4.2                          | \$ 208,740,000         | 31.40                     | 1,561                                   | \$ 72,449,927                            |
| <b>Total</b> | <b>\$267,600,000</b>   |                              | <b>\$1,123,920,000</b> |                           | <b>8,403</b>                            | <b>\$390,092,562</b>                     |

This issue is particularly important given the large number of children who will be losing NJFC benefits because their parents cannot pay the premiums. New Jersey will lose much more in federal SCHIP funds than it would have gained in premiums, and face higher taxpayer-funded costs in hospitals and community health clinics.

**LOOKING FORWARD**

New Jersey needs a more ambitious, comprehensive state policy and strategy for providing children with health insurance. The reasons are as obvious as they are numerous.

- ✓ For every dollar spent on immunizing children, \$16 is saved in medical costs.<sup>31</sup>
- ✓ Healthy children are likely to become more productive, tax-paying adults
- ✓ Insured children are more likely to do much better in school.<sup>32</sup>

**SCHIP Cost Sharing in New Jersey and its Neighboring States**

|  | New York | Pennsylvania  | New Jersey        |
|--|----------|---|-------------------|
| Income Level at which State begins Requiring Premium for a Family of 3         | \$27,472 | \$34,340  | \$25,755          |
| Effective Annual Premiums for a Family of 3                                    |          |   |                   |
| \$17,342   | \$0      | \$0   | \$0               |
| \$25,928   | \$0      | \$0   | \$216             |
| \$34,340   | \$216    | \$432   | \$432             |
| Co-payments for selected services when family income is at \$25,925            |          |   |                   |
| Non-preventive Physician Visit   | \$0      | \$0   | \$5               |
| Emergency Room Visit   | \$0      | \$0   | \$10              |
| Inpatient Hospital Visit   | \$0      | \$0   | \$0               |
| At \$34,340  |          |   |                   |
| Non-preventive Physician Visit   | \$0      | \$0*  | \$5               |
| Emergency Room Visit   | \$0      | \$0*  | \$35              |
| Inpatient Hospital Visit   | \$0      | \$0   | \$0               |
| Co-payments for Prescriptions  | \$0      | \$0*  | \$1.00 to \$10.00 |
| Length of time a Child is Required to Be Uninsured Prior to Enrolling in SCHIP | None     | None, except for families above \$34,340, which is 6 months | 3 months          |

Source: Resuming the Path to Health Coverage for Children and Parent: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2006, Kaiser Commissioner on Medicaid and the Uninsured, January 2007. Premium costs were updated for Pennsylvania.

\*As part of the “Cover All Kids” legislation signed last year, Pennsylvania has the authority to charge co-payments for families with income above 200% of the poverty level, but this has not been done yet.

- ✓ Helping parents get their children health insurance provides valuable support to low- and middle- income families, reduces parental stress and helps make families economically independent.
- ✓ Overall health costs and premiums for other families and individuals will be less.<sup>33</sup>
- ✓ Racial and ethnic disparities in health care for children could be eliminated.<sup>34</sup>
- ✓ The cost of insuring children is almost half the cost for insuring adults in New Jersey.<sup>35</sup>
- ✓ Children in New Jersey are more than twice as likely not to have doctors if they do not have insurance or to receive any medical care compared to children who have insurance.<sup>36</sup>

Public sentiment for such policy goals is strong. A February 2007 *New York Times*/CBS poll found major support to expand SCHIP to all uninsured children: 84% of those surveyed agreed. In a 2005 survey of likely voters by Public Opinion Strategies and Hart Research, 85% said that “all children having basic health care” is their most important health care issue. This was true for Democrats (92%), Independents (84%) and Republicans (77%).

By no means is a far higher coverage rate out of reach. New Jersey has the infrastructure in place to greatly expand children’s health coverage. NJFC is an effective program; without it, the rate of uninsured children would have been 30% higher than it was in 2005.<sup>37</sup> But in failing to keep pace with New Jersey’s declining rate of insured children, NJFC has not lived up to its potential.

Calling NJFC a priority of his administration, Gov. Jon S. Corzine in his 2006 budget message set the goal of enrolling an additional 50,000 children. The state is more than halfway there. But New Jersey can and should not stop at 50,000. It should aim for meeting the *full demand for all children likely to enroll if their family were reached*. Based on Rutgers University methodology for estimating the number of these children and using the latest Current Population Census, this would mean adding up to 67,000 more children to NJFC.<sup>38</sup> It could be accomplished within two years based on current

enrollment rates<sup>39</sup> by enrolling 33,500 children in Fiscal Year 2008 (July 1, 2007 through June 30, 2008) and up to an additional 33,500 the following fiscal year.

The Governor has already taken a step in this direction by including funds in his proposed FY 2008 Budget to increase enrollment during that year by 18,000 children. The money needed to reach up to 67,000 children is less than might be expected because many of them will be eligible for Medicaid, which the state has been required to provide in any case for many years prior to the establishment of NJFC.

Historically, NJFC and its predecessor NJ KidCare referred to children in the program as being covered under SCHIP and, in fact, the current NJFC law still does. Recently, to promote seamlessness and reduce the stigma some persons feel about Medicaid, the state Department of Human Services decided to refer to children covered under Medicaid as being in NJFC too. Nevertheless, Medicaid and SCHIP are two very different programs. SCHIP is smaller (128,000 children compared to 406,000 in Medicaid as of February 2007), more flexible in setting eligibility standards and cost-sharing, has more limited health coverage, has a higher federal matching rate (Washington pays 65% of SCHIP and 50% of Medicaid), is not an individual entitlement and is not guaranteed federal funding to serve all children who participate. Referring to children participating in Medicaid as also being covered under NJFC does not abrogate the state’s responsibility to assist them regardless of the state cost as required by federal law.

When the state increased enrollment toward the Governor’s goal, about 48% of the new children were found to be eligible for Medicaid instead of SCHIP. Many of them—the poorest of the poor, who need medical assistance the most—should have already been covered by Medicaid. That so many children were identified as needing Medicaid is not surprising, given that 43,000 children fall below the poverty level and that the state ranks 47th in insuring them.

As a result of this, only about 52% of the 67,000 uninsured children—34,840—would need to be covered with SCHIP funds. And, because of the high federal matching rate, it would cost New Jersey only about \$525 to insure a child for a year; the federal government would contribute the other \$975.<sup>40</sup> To insure all these children would cost about \$18 million in state

funds and trigger about \$34 million in federal money. However, the full cost would not occur until 2010 because it would probably take two years to enroll this many children. The first year's cost would be \$4.6 million in state money and \$8.5 million from Washington to enroll 17,420 more children in SCHIP.

Accelerating enrollment will also avoid a loss in federal funds that would have occurred due to the termination of families in NJFC/SCHIP. Because of the multiplier effect of federal SCHIP funds coming into New Jersey, a loss of about \$77 million to the state's economic activity, including an estimated 574 jobs and almost \$26.7 million in wages, will have been avoided.<sup>41</sup> And, it would help reduce an increase in the kind of hospital usage that requires state reimbursement for care to the uninsured. Unless enrollment is accelerated to more than compensate for the terminated children, New Jersey's national ranking for insured children will likely not improve, and could even get worse.

New Jersey should also immediately comply with its own law that allows families whose incomes are too high to qualify for NJFC to purchase the full cost of coverage through the program for their children. Pennsylvania recently implemented a similar health insurance buy-in and New York has done so for about 15 years. Officials from both states interviewed for this report said they could not see where there would be a problem implementing such a worthwhile program in New Jersey since the family, not the state, pays the full cost for the insurance.

Taking these steps would put New Jersey in a position to announce an "All Kids" health insurance policy that would send a clear signal that every child in the state is guaranteed access to affordable, quality health coverage. An "All Kids" message, other states have found, is both simple and powerful enough to overcome the sense many parents have that their children are not eligible for help with health insurance coverage.<sup>42</sup> Without such a campaign, the state probably could not reach all potential enrollees.

In the interim, New Jersey needs to immediately develop a plan for doing a better job of getting word about NJFC to the parents of the lowest-income children in urban areas. Activities toward this objective must be monitored to make sure outreach efforts are effective in enrolling the poorest children until all children are reached.

## **CONCLUSION:**

### **NJ FAMILY CARE ACTION AGENDA**

#### **"All Kids" policy on health insurance**

New Jersey can provide access to affordable, quality health insurance for all children. A simple, all-inclusive message can have a major effect on increasing enrollment. A clear goal should be established to reach all families who would enroll in NJFC by 2009 if contacted. Providing access to health care coverage for all children should be a springboard toward insuring everyone in New Jersey.

#### **Improve outreach to lowest-income children and minorities**

The wealthiest state in the nation should not rank among the nation's lowest for insuring low-income children, nor should it see a widening of racial disparities that are closing nationwide. The state Division of Medical Assistance and Hospital Services has an extensive outreach plan that includes schools, hospitals and many other agencies which has resulted in establishing about 600 sites where kids can enroll in NJFC. Along with this broad, comprehensive approach in outreach, additional resources should be allocated to develop more targeted outreach—mainly in poor urban areas,—focusing on Hispanic, black and other minority children. The Division should review model community-based programs in other states and in New Jersey that have been effective in reaching the lowest-income and minority children and use those strategies as it phases in an "All Kids" policy.

#### **Let parents whose income exceeds NJFC requirements purchase this health insurance for their children**

The state law requiring this has yet to be fully implemented. Many middle-income families cannot afford private insurance; their children are the fastest growing group of uninsured kids in the state. Because of the low administrative costs and large number of children served in NJFC, the average per child cost should be relatively low, so parents most likely could be charged less for NJFC coverage than under private policies. Putting this reform into effect would complete the missing link needed to bring access to health insurance to all New Jersey children.

#### **Fully restore cutbacks in NJFC eligibility for parents**

Current state law restricts eligibility for parents coming into NJFC to those at no more than \$27,465 income for a family of four, starting in September. That is two-thirds lower income than what was in effect prior to the 2002 freeze in enrollment.

The freeze was “penny wise and pound foolish” because it also reduced enrollment of children, increased what the state had to pay hospitals for care to the uninsured and cost New Jersey millions of federal dollars, far exceeding the state budget savings. These parents are eligible for federal matching funds, which would make universal coverage less costly to the state.

Increasing eligibility for parents to twice the poverty level (\$41,300 for a family of four) also would likely result in more children below that level enrolling in NJFC. New Jersey has one of the lowest insurance rates in the nation for the poorest children, and with so many minority children in that income group following this recommendation also could help reduce the state’s growing racial and ethnic gap in children’s health insurance. It would also help ameliorate the major problem of a lack of health insurance for low-income parents. About 37% of all parents with incomes below twice the poverty level are uninsured in New Jersey, compared to 9% of all parents in the state above that level.<sup>43</sup>

#### **Make NJFC more accountable and transparent**

The website for NJFC, maintained by the state Department of Human Services (DHS), provides user-friendly information to potential applicants. But there is no information on the DHS or Governor’s office website that explains the vision, goals and objectives of NJFC or data measuring the extent to which the state is achieving any objective. Doing so would be an important part of a state policy aimed at reaching all children likely to enroll in NJFC if they were contacted, and enrolling families above the program’s income eligibility levels who want to buy coverage—as well as increasing the number of families that receive premium assistance in order to maintain their coverage with an employer.

An advisory committee should be established to help formulate those objectives and recommend ways to improve outreach, particularly to uninsured low-income minority children. This committee also should commission and oversee an independent study on why the state is not reaching all the neediest children. This committee should consist of representatives of major minority populations and ethnic groups in New Jersey, community-based organizations from low-income sections of the state, the state Office of Minority and Multicultural Health, the Department of Children and Families, the Secretary of State, advocacy organizations, Federally Qualified Health

Centers (state and federally funded providers of comprehensive health services to impoverished individuals and families) and low-income parents. Their findings and recommendations should be included in a report to the Legislature and Governor and posted online.

#### **Make state and federal funds available to expand health care coverage for children**

Given the urgency of the child insurance problem in New Jersey, the 18,000 new children who would get NJFC coverage under the proposed Fiscal Year 2008 state budget are not enough. The budget should include funding to insure 33,500 more children, with the goal of enrolling up to 67,000 by July 2009 as part of the state’s All Kids policy. Almost half of these children are expected to be enrolled in Medicaid and so must be served under federal and state law. This means it would cost the state about \$4.6 million in Fiscal Year 2008 to insure the remaining 17,420 children eligible for SCHIP.

New Jersey should not be deterred by criticism from some in Washington who contend the state has gone too far in setting its eligibility for children at 3.5 times the Federal Poverty Line. New Jersey’s eligibility standard is appropriate for a state with a one-third higher cost of living than the national average (for example, it costs a family of four in Fort Worth, Texas \$48,937 a year to maintain a standard of living that would require \$72,275 in Newark.)<sup>44</sup>

As the state targets resources more to the lowest income children, New Jersey’s Congressional delegation should push for federal SCHIP reauthorization this year that does the following: includes expanded funding to meet the full need in each state over the next five years; increases funds to those which have higher than average child and adult enrollment rates; provides more flexibility to use SCHIP funds for outreach and to assist families to maintain their employer-based health insurance; strengthens performance and quality standards; provides federal funding for all legal immigrant children; and continues to allow states to decide who should be eligible for SCHIP.

#### **Eliminate all cost-sharing requirements and the waiting period for lower income children, and reduce premiums**

Neither New York nor Pennsylvania requires families making 1.5 times the Federal Poverty Level to pay toward health care

premiums or to wait three months before they can be enrolled. Neither requires co-payments for lower income children. New Jersey does. Instead, the state should consider the real poverty level to be twice the FPL because of the state’s high cost of living and not charge families in that income group. Also, premiums for families with incomes above twice the poverty level should be reduced what New York charges. These reforms would ease the economic burden on families struggling to get by and could mean more parents enroll their children in NJFC and fewer families lose eligibility due to inability to pay.

**Set policies to address the decline in employer-based health insurance for children**

New Jersey took a positive step with a law last year requiring the Department of Human Services to report annually on which large employers have workers or dependents in NJFC or that received charity care, and how many. This legislation followed the recommendations of an August 2005 New Jersey Policy Perspective report.<sup>45</sup> But more needs to be done. Such employ-

ers should be required to pay into a state fund to help cover these employees and dependents. And, state and federal policies should be changed to strengthen New Jersey’s ability to use NJFC funds to help parents to purchase their employer’s health insurance plan.<sup>46</sup> Policies also are needed to address the alarming decrease in health coverage provided by small employers, and the use of part time workers by many employers, regardless of size, to avoid having to pay for health coverage.

\* \* \*

New Jersey is at a critical juncture in its history regarding health insurance for children. The elements are in place to reach those who need help the most, and make the dream of guaranteed health coverage for all children a reality. This is more than a moral obligation. It is an investment in the future of the state that makes economic sense as well.

**SCHIP Funding and Enrollment in New Jersey**

|       | State         | Federal         | Total           | Children | Parents | Total   |
|-------|---------------|-----------------|-----------------|----------|---------|---------|
| 1998  | \$ 640,000    | \$ 1,190,000    | \$ 1,830,000    | 8,341    | 0       | 8,341   |
| 1999  | \$ 13,140,000 | \$ 24,400,000   | \$ 37,540,000   | 32,495   | 0       | 32,495  |
| 2000  | \$ 23,150,000 | \$ 43,000,000   | \$ 66,150,000   | 66,858   | 0       | 66,858  |
| 2001  | \$ 68,611,538 | \$ 127,420,000  | \$ 196,031,538  | 76,573   | 72,749  | 149,322 |
| 2002  | \$130,503,846 | \$ 238,690,000  | \$ 369,193,846  | 94,705   | 121,461 | 216,166 |
| 2003  | \$138,930,000 | \$ 256,280,000  | \$ 395,210,000  | 92,279   | 101,212 | 193,491 |
| 2004  | \$120,598,462 | \$ 217,710,000  | \$ 338,308,462  | 100,729  | 76,795  | 177,524 |
| 2005  | \$107,029,231 | \$ 191,550,000  | \$ 298,579,231  | 102,633  | 58,641  | 161,274 |
| 2006  | \$119,294,615 | \$ 221,550,000  | \$ 340,844,615  | 119,518  | 72,363  | 191,881 |
| TOTAL | \$721,897,692 | \$1,321,790,000 | \$2,043,687,692 | NA       | NA      | NA      |

## ENDNOTES

- <sup>1</sup> P.L. 2000, c.70.
- <sup>2</sup> Nancy Southerland, Daniel Hart, and Robert Atkins, *Does Health Insurance Improve Children's Lives? A Study of New Jersey's FamilyCare Program*, January 2, 2002, p.2.
- <sup>3</sup> *State Children's Health Insurance Program (SCHIP): A Brief Overview*, CRS Report to Congress, updated September 21, 2006.
- <sup>4</sup> Jocelyn Guyer, Cindy Mann, Michael Odeh, Georgetown University Health Policy Institute, *States Affected by Proposals to Restrict SCHIP Coverage Options*, revised April 2, 2007.
- <sup>5</sup> NJ Department of Human Services Data.
- <sup>6</sup> Children in this report are defined as anyone under the age of 19 consistent with the definition in SCHIP.
- <sup>7</sup> Bureau of Labor Statistics. During this period, the national unemployment rate increased by 29.9% compared to 12.2% for New Jersey.
- <sup>8</sup> Center on Budget and Policy Priorities analysis of Current Population Survey. All Current Population Survey data has a degree of sampling error with it.
- <sup>9</sup> Center on Budget and Policy Priorities analysis of Current Population Survey data for 2003-2005, ranked by NJPP. Due to sampling error, New Jersey may actually have a slightly higher or lower ranking on a particular indicator than is shown in the report.
- <sup>10</sup> Because of the small sample size for race and ethnicity, three-year averages were used: 1999, 2000 and 2001 for the year 2000 and 2003, 2004 and 2005 for 2004.
- <sup>11</sup> Center on Budget and Policy Priorities analysis of Current Population Survey
- <sup>12</sup> Ibid.
- <sup>13</sup> Current Population Survey, 2000-01 and 2004-05.
- <sup>14</sup> Ibid.
- <sup>15</sup> Ibid.
- <sup>16</sup> New Jersey Business & Industry Association, 2007 Health Benefits Survey – "Small Companies Forced to Drop Health Coverage," May 2007, p.12. This survey covers only NJBIA members.
- <sup>17</sup> NJ Department of Labor, *New Jersey Employment and Wages Covered by Unemployment Insurance*, for the third quarter of 2006 and the annual rate in 2001 in *New Jersey Wages 1980-2002*.
- <sup>18</sup> Families USA, *Paying a Premium, the Added Cost of Care for the Uninsured* June, 2005.
- <sup>19</sup> NJPP analysis of Current Population Survey data, 1999-00 to 2004-05.
- <sup>20</sup> New Jersey Business & Industry Association, *2007 Health Benefits Survey Small Companies Forced to Drop Health Coverage*, May 2007.
- <sup>21</sup> Urban Institute analysis of the February 2001 and 2005 Contingent Work Supplement of the Current Population Survey as reported by the Kaiser Family Commission in *Health Care: Squeezing the Middle Class With More Costs and Less Coverage*, January 31, 2007, p.5-6.
- <sup>22</sup> Kaiser Family Commission in *Health Care: Squeezing the Middle Class With More Costs and Less Coverage*, January 31, 2007, p.6.
- <sup>23</sup> Banthin and Bernard, 2006 as reported in Kaiser Family Commission in *Health Care: Squeezing the Middle Class With More Costs and Less Coverage*, January 31, 2007, p.9.
- <sup>24</sup> NJPP analysis of Current Population Survey data, 1999-00 to 2004-05.
- <sup>25</sup> The reason the chart shows more parents in 2002 and 2003 is that some parents in SCHIP have children in Medicaid; those children are not counted in this chart.
- <sup>26</sup> Methodology: Federal funds claimed are the actual funds that were received by the state. Projected federal funds are estimated by assuming that the increase in federal funds that occurred one year prior to the cutback in 2002 would continue each year thereafter. Lost federal funds are calculated by subtracting the projected funds from the actual funds. The same basic methodology is used to calculate state funds saved and the increase in charity care costs. The net loss to the state is determined by subtracting state funds saved from lost federal funds. Benefits lost are calculated by adding state funds saved and federal funds lost.
- <sup>27</sup> Methodology: Analysis is extrapolated from RIMS II input-output economic model created by the US Department of Commerce, which was used by Families USA to determine aggregate impact of Medicaid spending on each state's economy in *Medicaid: Good Medicine for State Economies*, 2004 update. The reason for the major impact in lost economic activity is that the state lost \$1.86 in federal SCHIP matching funds for each \$1 in state funds. Since federal funds come from outside the state, they have a multiplier effect on the state's economy. For example, a new federal dollar is given to a physician, who gives it to as fuel dealer to pay for heat in the office, and the fuel dealer uses the dollar to pay for a meal at a restaurant, and so on. Because over time these dollars go outside New Jersey (i.e. the owner of the restaurant uses part of the dollars to pay a vendor located outside the state), the multiplier effect diminishes.

- <sup>28</sup> State of New Jersey and New York websites for NJFC and CHIP.
- <sup>29</sup> Leighton Ku, Center on Budget and Policy Priorities, *New Research Sheds Light on Risks from Increasing Medicaid Cost-Sharing and Reducing Medicaid Benefits*, July 18, 2005.
- <sup>30</sup> Connecticut Voices for Children, *Covering Connecticut's Children: How Policy Changes Affect HUSKY Program Enrollment*, November 2006.
- <sup>31</sup> Children's Defense Fund, *Top 10 Facts about Children's Health Coverage in the U.S.*, February, 2007.
- <sup>32</sup> Ibid.
- <sup>33</sup> Families USA, *Paying a Premium, the Added Cost of Care for the Uninsured*, June 2005.
- <sup>34</sup> Leighton Ku, Mark Lin, and Matthew Broaddus, *Improving Children's Health: A Chartbook about Roles of Medicaid and SCHIP* 2007 Edition.
- <sup>35</sup> Department of Human Services data.
- <sup>36</sup> State Health Assistance Center, *The State of Kids' Coverage*, August 9, 2006.
- <sup>37</sup> NJPP analysis of New Jersey Department of Human Services data and the Current Population Surveys for 2004 and 2005.
- <sup>38</sup> Methodology was included in a November 2, 2004 memo to the Division of Medical Assistance and Hospital Services and updated in an email from Rutgers University to the author. The methodology takes into account the cap on eligibility (3.5 times poverty level), parents who would likely decide not to enroll their children based on the New Jersey Family Health Survey, and households that include non-citizens who would probably not apply or may be ineligible if the child is an unauthorized immigrant. Estimate also deducted 23,000 children who are remaining to be enrolled in NJFC to meet the Governor's goal of enrolling 50,000 children this year. Also, the percentage of children who were determined ineligible because they had not met the six-month waiting requirement was reduced by half to take into account that the law was changed to require only a three-month waiting period.
- <sup>39</sup> Enrollment rates were based on a high SCHIP enrollment rate from January 2006 to August 2006 and a lower enrollment rate from January 2006 to December 2006.
- <sup>40</sup> NJ Department of Human Services.
- <sup>41</sup> The RIMS II input-output economic model that was used earlier in this report to estimate the impact of the NJFC cutbacks was used here as well.
- <sup>42</sup> Kaiser Commission, *Resuming the Path to Health Coverage for Children and Parents*, January 2007. According to this report, three quarters of the children applying for the *All Kids* program in Illinois were eligible for the previous program before it was expanded.
- <sup>43</sup> Center on Budget and Policy Priorities analysis of Current Population Survey.
- <sup>44</sup> Families USA, *When One Size Doesn't Fit all: The Importance of State Flexibility*, April 2007.
- <sup>45</sup> Mary Forsberg, *Attention Shoppers: You Pay the Health Insurance Bills for Some of the Largest Employers*, August 2005.
- <sup>46</sup> Legislation is expected to be introduced soon in the US Senate to address this issue. New Jersey has such a program in place and some progress has been made to improve it but the number of families participating is still relatively low.

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