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Congressionally Mandated Evaluation of the State Children's Health Insurance Program

Site Visit Report: The State of New Jersey's FamilyCare Program

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I. PROGRAM OVERVIEW

New Jersey's Title XXI program, known as "NJ FamilyCare," boasts the most generous SCHIP eligibility standards in the nation, covering children with family incomes up to 350 percent of the Federal Poverty Level (FPL) as well as pregnant women and parents of Medicaid- and SCHIP-eligible children with family incomes up to 200 percent of the FPL. In addition, New Jersey uses state funds to cover single adults and childless couples with incomes up to 100 percent of the FPL, as well as legal immigrants who do not qualify for Medicaid- or SCHIP-funded benefits because they entered the country less than five years ago. Launched in September 2000, the expansion of coverage to adults brought 155,000 new enrollees into the program within a sixteen-month period. Overwhelmed by the enrollment surge and having exceeded the allotted state funding, the state ended enrollment of childless adults into the program in September 2001.[1]

Until then, the history of New Jersey's Title XXI program had been one of steady eligibility expansion but relatively slow enrollment growth. In early 1998, New Jersey launched its combination Title XXI program, initially called "NJ KidCare," to cover children through age 18 with family incomes up to 200 percent of the FPL (Table I.1). Children with family incomes at or below 133 percent of the FPL are covered under a Medicaid expansion (referred to in the state plan as "Plan A"), while those with incomes up to 200 percent of the FPL are covered under a separate child health program that provides a package of benefits only slightly less generous than the package provided under Medicaid (Table I.2). Children with family incomes at or below 150 percent of the FPL (Plan B) are not subject to cost sharing, while those with family incomes

[1]New enrollment of parents was ended June 14, 2002.

between 151 and 200 percent of the FPL (Plan C) pay modest premiums and copayments. To be eligible for either Plan B or Plan C, children initially had to be uninsured for

TABLE I.1

SCHIP STATE PLAN AND AMENDMENTS

Document	Dates			Description
	Submitted	Approved	Effective	
Original Submission	2/6/98	4/27/98	2/1/98 (Medicaid expansion) 3/1/98 (separate child health program)	Implemented a Medicaid expansion, (NJ KidCare Plan A) and a separate child health program (NJ KidCare Plans B and C) to cover children through age 18 with family incomes at or below 200% of the FPL. (Plan A covers children with family incomes at or below 133% of the FPL, Plan B covers children with family incomes from 134 to 150% of the FPL, and Plan C covers children with family incomes from 151 to 200% of the FPL.) Plans B and C provide benchmark coverage equal to the FEHBP Blue Cross/Blue Shield plan. The two plans differ only in that Plan C requires cost sharing, while Plan B does not.
Amendment 1	2/9/99	5/5/99	1/13/99	Reduced waiting period in Plans B and C from 12 months to 6 months.
Amendment 2	5/6/99	8/3/99	7/1/99	Implemented NJ KidCare Plan D, expanding coverage to children with family incomes up to 350% of the FPL, through the use of income disregards. Plan D provides benchmark coverage equal to the most widely sold commercial HMO coverage in the state.
Amendment 3	9/21/99	7/7/00	7/26/99	Created exemptions from the 6-month waiting period for children who are involuntarily disenrolled from employer-sponsored insurance or who lose coverage through a parent's job change to a firm that does not offer affordable coverage (Plans B, C and D) or who had only individual or COBRA coverage prior to application for NJ KidCare (Plans B and C only).
Amendment 4	12/18/99	3/16/00	1/1/00	Authorized presumptive eligibility determinations by acute care hospitals, federally-qualified health centers and local health departments for Plans A, B and C.

TABLE I.1 (*continued*)

Document	Dates			Description
	Submitted	Approved	Effective	
Section 1115 Demonstration	10/2/00	1/18/01	1/18/01	Implemented a five-year demonstration to cover parents of Medicaid- and SCHIP-eligible children in families with incomes up to 200% of the FPL and pregnant women with incomes between 185 and 200% of the FPL. (At the same time, the state raised the income standard for Section 1931 Medicaid coverage to 133% of the FPL through an earned income disregard.) Pregnant women receive the Medicaid benefit package, while parents receive a package similar to the Plan D package for children. The demonstration also includes a premium assistance program that requires families to enroll in employer group health plans when it is cost-effective and the employer contributes at least 50% of the cost.

SOURCE: Centers for Medicare & Medicaid Services (CMS), *New Jersey Title XXI Program Fact Sheet.* CMS web site http://www.hcfa.gov/init/chnjfact.htm

NOTES: SCHIP=State Children's Health Insurance Program. FPL=Federal Poverty Level. FEHBP=Federal Employees Health Benefits Plan.

TABLE I.2

MEDICAID AND SCHIP INCOME ELIGIBILITY STANDARDS,
EXPRESSED AS A PERCENTAGE OF THE FEDERAL POVERTY LEVEL

	Age (in Years)			
	Up to 1	1-5	6-18[a]	18[b]
Medicaid standards in effect August 1997	185%	133%	100%	41%
SCHIP Medicaid expansion (NJ KidCare Plan A)	NA	NA	133%	133%
SCHIP separate child health program (NJ KidCare Plans B and C)	200%	200%	200%	200%
SCHIP separate child health program (NJ KidCare Plan D)	350%	350%	350%	350%

SOURCES: Centers for Medicare & Medicaid Services (CMS), "Eligibility Standards in the 50 States and District of Columbia," January 2001; CMS, "New Jersey Title XXI State Plan and Amendment Summary," March 2001.

NOTES: SCHIP=State Children's Health Insurance Program (Title XXI); FPL = federal poverty level; NA = not applicable.

[a]Children born after September 30, 1983, who are more than 5 years of age. The eldest children in this group are now age 18. In February 1998, when NJ KidCare was implemented, the age range covered under Title XIX Medicaid up to 100 percent of the FPL was 6-14 years.

[b]Children born on or before September 30, 1983, who are less than 19 years of age. The youngest children in this group are now age 18. In February 1998, when NJ KidCare was implemented, the age range covered under Title XIX Medicaid up to 41 percent of the FPL was 14-18.

at least 12 months, but in January 1999, this waiting period was reduced to 6 months, with some exemptions.

In July 1999, 16 months after the launch of NJ KidCare, the state raised the income threshold for children to 350 percent of the FPL—the highest SCHIP threshold in the nation—through the use of income disregards. (Families' income between 201 and 350 percent of the FPL is disregarded.) Children in this eligibility category (Plan D) receive a benefit package equivalent to the most widely sold commercial HMO product in the state and pay higher premiums and copays than are charged in Plan C. The same month, the state implemented a series of exemptions from the six-month waiting period, further broadening access to coverage. Despite these efforts, only 46 percent of the 160,452 children estimated to be eligible for the program were enrolled by September 30, 2000.

On September 1, 2000, New Jersey expanded coverage to parents, pregnant women and childless adults, and rechristened the program "NJ FamilyCare."[2] In January 2001, the Centers for Medicare & Medicaid Services (CMS) approved the state's Section 1115 demonstration proposal, authorizing the state to claim Title XXI matching funds for coverage of parents with incomes between 134 and 200 percent of the FPL and pregnant women with incomes between 186 and 200 percent of the FPL. (With the implementation of NJ FamilyCare, the state raised the income threshold for Section 1931 Medicaid parental coverage to 133 percent of the FPL through the use of disregards, so parents with incomes at or below this level are covered under Title XIX Medicaid.) New Jersey is one of only six states that have implemented Title XXI

[2]For the sake of simplicity, we will generally refer to the Title XXI program as "NJ FamilyCare" throughout this report. The state receives federal matching funds under Title XXI to cover most parents and children enrolled in NJ FamilyCare and uses state-only funds to cover childless adults and legal immigrants who would qualify for Title XIX- or Title XXI-funded coverage but for the fact that they entered the U.S. less than five years ago and are therefore ineligible for federally funded assistance.

Section 1115 demonstrations, and one of only four that cover parents with SCHIP dollars. (The other three states that do so are Minnesota, Rhode Island and Wisconsin.)

Since its inception, New Jersey's SCHIP program has been administered by the New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS), which is also the state Medicaid agency. Responsibility for eligibility determination in Medicaid and NJ FamilyCare Plan A (the Medicaid component) is shared between DMAHS (assisted by the eligibility vendor) and county boards of social services. Eligibility determination and managed care enrollment in the separate child health program were initially handled by two separate contractors, but shortly after the implementation of the adult coverage expansion, the state consolidated the two functions under a single contract with the firm that originally administered managed care enrollment for the state Medicaid program.

In hindsight, the transfer of responsibility to the new vendor could not have happened at a worse time. Almost from the day Governor Christine Todd Whitman announced the NJ FamilyCare expansion on statewide television, applications began pouring in to the offices of then contractor Birch & Davis. The new contract was awarded in September 2000 and the vendor assumed its new responsibilities when application rates were at an all-time high, and a sizeable backlog had already built up. The result was an overwhelmed application processing system. As late as August 2001, New Jersey newspapers were still reporting a backlog of over 30,000 applications, many of which had been filed months earlier.

In early 2001, policymakers began debating ways to control spiraling costs in NJ FamilyCare. The first step was to suspend the advertising campaign. The next was to eliminate presumptive eligibility for adults, as the original goal of this provision had been met. Finally, in fall 2001, the Republican administration of Donald DiFrancesco, who replaced Whitman when she left to head the U.S. Environmental Protection Agency, ended enrollment of childless adults

into the program. By the end of November, enrollment in NJ FamilyCare stood at 230,123, with adults comprising nearly two-thirds (64 percent) of enrollees. Now, faced with a deepening budget crisis, New Jersey's new Democratic administration, under Governor James McGreevey, confronts the painful prospect of further trimming NJ FamilyCare.

This case study is based primarily on a visit to New Jersey conducted between January 7 and 11, 2002, as part of the Congressionally Mandated Evaluation of the State Children's Health Insurance Program. The visit included interviews with DMAHS administrators, vendor executives of the state's eligibility and enrollment vendor (Maximus), county social services staff, health care providers, child health advocates, and staff of organizations involved in outreach and application assistance. (See Appendix A for a list of informants.) Our time on site was divided between the state capitol (Trenton), Hudson County in the northeastern corner of the state, and Cumberland and Gloucester counties in the southwestern corner.

As of November 30, 2001, Hudson County accounted for about 12 percent of total NJ FamilyCare enrollment, while Cumberland and Gloucester together accounted for about 6 percent. Hudson County is the most densely populated county in the most densely populated state in the nation. Comprising 12 contiguous municipalities, including Jersey City, West New York and Bayonne, Hudson County is home to more than 600,000 New Jerseyans. The county has a sizeable minority population (14 percent African American and 40 percent Hispanic) (Census Bureau 2000a) and, at 17 percent, nearly twice the state poverty rate of 9 percent (Census Bureau 2000b). Cumberland and Gloucester counties, by contrast, are highly agricultural, leading the Garden State in pig farming and the production of apples, peaches, tomatoes, asparagus, and other fruits and vegetables. Cumberland is the more rural and poorer of the two counties, with a poverty rate of 16 percent, compared with 7 percent for Gloucester (Census Bureau 2000a). Cumberland also has a larger minority population than Gloucester, with

African Americans comprising 20 percent of the population (versus 9 percent) and Hispanics comprising 19 percent (versus 3 percent) (Census Bureau 2000b).

II. BACKGROUND AND HISTORY OF SCHIP POLICY

New Jersey has a long history of progressive health care policy, and when Republican Christine Todd Whitman was elected governor in 1992, the state already had in place a series of programs, still in operation today, to facilitate access to health care coverage or subsidize care for the uninsured. Unlike most states, for example, New Jersey operates a large charity care program, the New Jersey Hospital Care Payment Assistance Program, to subsidize inpatient and outpatient hospital care for low- to moderate-income individuals who are ineligible for other public insurance programs.

Whitman came into office with a strong commitment to expand coverage for the uninsured, and by 1994, her chief health policy advisor had convened a large working group, comprising representatives of DMAHS, the Department of Health and Senior Services and the Department of Banking and Insurance, to address the issue. The administration's first effort to broaden coverage was a program called Health Access New Jersey, which provided health care coverage on a sliding-fee scale to individuals or families with incomes up to 250 percent of the FPL who were ineligible for Medicaid or Medicare and had been uninsured for a year or more. Launched in April 1995 with the goal of covering 100,000 uninsured New Jerseyans in three years, the program was closed to new enrollment in December of the same year because the legislature did not fully fund it. At the time, just 22,000 people, including about 7,500 children, were enrolled. The administration's next move was to propose a program that would be modeled on Health Access but serve only children. However, the tobacco-tax increase proposed to fund the program was a non-starter in the legislature, and the proposal never came to a vote. It was at this time that Title XXI, the federal SCHIP legislation, was signed into law, making $40 billion available to the states over ten years to expand coverage for children.

The framework for New Jersey's Title XXI program was hammered out in meetings of the interdepartmental working group in the fall of 1997. Consensus quickly built around several key program parameters, including a combination model for the program. Policymakers opposed a broad expansion of the Medicaid entitlement but believed it made sense to "even out" the income thresholds for poverty-related Medicaid coverage of all children, regardless of age, at 133 percent of the FPL (the income threshold for mandatory Title XIX coverage of children under age six) and create a separate child health program for children with family incomes above this level. The upper income threshold for the separate program was set at 200 percent of the FPL, the limit specified in the Title XXI legislation. Cost sharing was imposed on families with incomes above 150 percent of the FPL (Plan C) but not below (Plan B).

The benefit package chosen for the separate child health program was a slightly reduced Medicaid package, with services to be delivered through the Medicaid managed care delivery system. According to the governor's health policy advisor, "basically, for this group, the state took away the fee-for-service card"—that is, entitlement to some services that were excluded from the state's Medicaid managed care contracts and covered on a fee-for-service basis. One rationale for not providing these services, which include personal care, medical day care, and non-emergency transportation, to this population was that the children who were likely to require them could qualify for SSI-related Medicaid coverage, which in New Jersey is available to disabled children with family incomes up to about 185 percent of the FPL (or even higher, with spend-down).

Placement of the program within DMAHS, the state Medicaid agency, was readily accepted by the other agencies at the table, in part because of DMAHS's recent success rolling out the state's mandatory Medicaid managed care program, New Jersey Care 2000. However, to avoid

any possible stigma associated with Medicaid, the working group recommended a mail-in application process administered by a private contractor.

Presented in January 1998 to the Republican-majority state legislature, the administration's plan "passed like a hot knife through butter," in the words of one legislator—not surprising in a state where the governor enjoys an unusually high level of control over the legislative process, and even the most powerful legislators serve only part-time and have very small staffs (Bovbjerg et al. 1997). As one assemblywoman explained with regard to the rapid passage of the NJ KidCare legislation, "Our sense was that the administration had done its homework, and this was what they felt was appropriate."

The Medicaid expansion program (Plan A) was implemented in February 1998 and the separate child health program (Plans B and C) in March 1998, but according to DMAHS administrators, promotion of the program did not begin in earnest until fall 1998. The following January, the governor announced in her state-of-the-state address that the SCHIP income threshold would be raised to 350 percent of the FPL. Although the administration had long intended to raise the income threshold, the timetable for the expansion (Plan D) was accelerated because initial enrollment had been slower than expected. Connecticut's use of disregards provided New Jersey policymakers with a model for claiming SCHIP matching funds for coverage provided to children with family incomes above the Title XXI ceiling of 200 percent of the FPL.

For this higher income group of uninsured children, whose families were thought to closely resemble those with employer-based coverage, the interdepartmental working group specified a benefit package that mirrored employer-based coverage and imposed higher cost sharing than in Plan C. In addition to allaying any concerns about the social equity of offering more generous coverage to the uninsured than similar families could obtain through their employers, these

program parameters were also expected to reduce the likelihood of substitution of public coverage for private ("crowd out"), as families would presumably have little reason to drop their existing coverage for similar coverage under SCHIP. To further reduce the risk of crowd out, the working group also recommended two premium assistance programs—one to serve uninsured children who were eligible for NJ KidCare and whose parents had access to employer-sponsored insurance, and another to serve children who would be eligible for NJ KidCare but for the fact that they were already enrolled in employer-sponsored insurance. However, these plans for premium assistance were tabled for further study, while the rest of the NJ KidCare expansion was signed into law in July 1999.

Tobacco settlement money and the possibility of accessing more of the state's federal SCHIP allotment made possible an even broader expansion of coverage the following year. In July 2000, CMS published guidelines for Section 1115 demonstrations in Title XXI and specified the circumstances in which states might cover parents of SCHIP- and Medicaid-eligible children under Title XXI. DMAHS staff immediately began drafting a demonstration proposal, with the hope of tapping millions of unspent federal dollars in the state's SCHIP allotment account. In her 2001 budget address, Governor Whitman announced a plan to dedicate about one-third of the annual tobacco settlement funds the state was due to receive to the new program, which she called "NJ FamilyCare." Although federal matching funds would be available only for coverage of parents and pregnant women, the governor proposed a broader response to the growing problem of uninsurance among adults in the state and included coverage for childless adults. The governor's plan, which included a premium assistance program, again passed easily through the legislature, and NJ FamilyCare was implemented in September 2000.

III. OUTREACH

A. INTRODUCTION

New Jersey launched each phase of its SCHIP program with an extensive statewide media campaign. In addition, the state partnered with state agencies and community-based organizations to conduct targeted outreach and community education for the program. The high-profile media campaign, combined with the efforts of community-based organizations, generated a huge volume of applications from adults when NJ KidCare transitioned to NJ FamilyCare. Overwhelmed by the influx of applications, the state discontinued its media campaign and directed community-based organizations to stop advertising the program. However, other efforts to reach and enroll children continued.

B. STATEWIDE/MEDIA EFFORTS

Like other states, New Jersey gave its SCHIP program a new name—NJ KidCare—partly to distinguish it from Medicaid and avoid any possible stigma. Over time, the messages about the program have also increasingly disassociated NJ FamilyCare from Medicaid. At first, the basic message about the program was, "It's available, it's free or low cost," said one DMAHS administrator, but program administrators later concluded that this message devalued the coverage in the eyes of the families the state was trying to reach and discouraged them from applying, as "calling something 'free' is sometimes a deterrent." Now all of the promotional materials for the program convey a consistent message, promoting NJ FamilyCare as "Affordable health coverage, quality care." Many outreach workers and advocates said that they specifically promote NJ FamilyCare as a program for working families to avoid the entitlement stigma associated with Medicaid, but representatives of the state's vendor said that they generally avoid making a distinction between working and non-working families for fear of

discouraging unemployed parents from applying. Vendor staff also emphasized the need to "convince families that insurance is important, because, for families in a financial crunch, even $15 a month is a lot."

Key components of the statewide outreach campaign include:

- ***Mass Media***. The state has used television, radio and newspaper advertisements, as well as billboard and bus posters, to promote the program. DMAHS contracted with a large advertising agency to conduct concurrent radio and print campaigns in October 1999, seven months after the launch of the program. A second mass media campaign, consisting of a series of television commercials and public service announcements, followed by print advertising, was conducted during the summer of 2000. A $2 million television campaign, featuring Governor Christine Todd Whitman, was conducted between October and December 2000 to announce the NJ FamilyCare expansion.

- ***Distribution of Promotional Materials***. All promotional materials used during the statewide media campaign, as well as in community-based outreach activities, have been developed and distributed by DMAHS with the assistance of the advertising agency that ran the media campaign. Materials include posters and flyers in eight different languages (English Polish, Korean, Spanish, Portuguese, Arabic, French, and Chinese) with the NJ FamilyCare toll-free hotline number and the NJ FamilyCare website address. Promotional materials are free to community-based organizations and other state agencies. Currently, agencies must complete and fax an order form to the state to request materials, but a web-based distribution system is under development.

- ***Hotline***. The state's eligibility and enrollment contractor staffs a toll-free hotline to answer families' questions about NJ FamilyCare and mail out applications on request. The hotline number is on the application and on all NJ FamilyCare brochures.

- ***School Outreach***. DMAHS has used several different strategies to promote NJ FamilyCare through the schools. Since fall 1999, each application packet for the Free and Reduced Lunch Program has included a NJ KidCare/NJ FamilyCare application; if families check a box on the school lunch application indicating that they would like more information about NJ FamilyCare, they will be contacted by a program representative. More recently, the state has sought to identify a point person at each school who will be responsible for coordinating outreach activities. Approximately 10,000 principals and school nurses in all public, charter, private, and parochial schools; District Health Services Directors; and directors of Early Childhood Centers were contacted. DMAHS also worked with Scholastic, Inc., to develop a school health curriculum for fourth and fifth graders that includes a section on the need for health insurance and the availability of NJ FamilyCare. The state has also collaborated with the New Jersey Interscholastic Athletic Association to develop seminars for high school coaches and athletic trainers, in an effort to target adolescents.

- ***Partnerships with Private Organizations***. As noted, educational publisher Scholastic, Inc., played a major role in developing outreach materials for educators. NJ FamilyCare has also partnered with supermarkets and pharmacies statewide. For example, the NJ FamilyCare brochure is available at Pathmark grocery stores and Eckerd Pharmacies statewide. DMAHS also collaborated with the Health Care Institute of New Jersey (HCINJ), the professional trade association of pharmaceutical and medical technology companies in New Jersey, to develop local outreach and enrollment activities with their members. Several pharmaceutical firms provided marketing and human resources support and graphic design assistance to simplify the joint Medicaid/SCHIP application and translate it into Spanish.

- ***Collaboration with Federally-Qualified Health Centers and State Agencies.*** DMAHS had performance-based agreements with federally qualified health centers (FQHCs) and with the Department of Health and Senior Services (DHSS) to promote NJ FamilyCare to their clients. For example, for 2001 and 2002, FQHCs were given $500,000 to conduct "in-reach" to their patient population. The state assessed the effectiveness of activities against predetermined measures and withheld funding to FQHCs that did not meet the enrollment benchmarks set in their contracts. In a separate memorandum of understanding during the same timeframe, DMAHS awarded $1.5 million to DHSS to perform in-reach through the Supplemental Nutrition program for Women, Infants and Children (WIC); the Special Health Services Program, which serves children with special health care needs; and the Maternal and Child Health Consortia. Funds were used primarily to hire outreach workers.

Managed care organizations that participate in NJ FamilyCare also conduct outreach, within limits set by the state. Under the state contract, the HMOs are allowed to conduct face-to-face marketing at outreach events approved by DMAHS, but prohibited from conducting direct marketing to Medicaid or Plan A enrollees or to NJ FamilyCare beneficiaries who are already enrolled in another HMO. Administrators of Horizon Mercy, the largest plan participating in NJ FamilyCare, reported that the HMO has begun targeting population subgroups through faith-based groups, schools and employers. The HMO has developed its own NJ FamilyCare promotional materials, including flyers and print and media advertisements. Targeted to working families, the materials describe the advantages of health insurance, in addition to promoting the NJ FamilyCare coverage available through Horizon Mercy. Families are encouraged to contact Horizon Mercy directly for further information or to request an NJ FamilyCare application.

DMAHS and the state Covering Kids program, operated by the New Jersey Hospital Association Health Research and Educational Trust, have collaborated on many statewide initiatives to promote NJ FamilyCare. With the assistance of the New Jersey Volunteer Association for Outreach Workers and DMAHS, the state Covering Kids program trained over 1,200 outreach workers on the application process for NJ FamilyCare. In addition, the project assembled a directory, arranged by county, listing all community-based organizations that provide application assistance and distributed county-specific sections of the directory to all community-based organizations. A DMAHS administrator described the relationship between the agency and Covering Kids as highly collaborative: "The state identifies the outreach needs, and Covering Kids provides the manpower to conduct these activities."

C. COMMUNITY-BASED EFFORTS

DMAHS has also collaborated with community-based organizations (CBOs) to promote NJ FamilyCare. In June 1999, the agency awarded two-year grants to 35 CBOs and 8 Head Start agencies to assist families with applications. Under the grant arrangement, DMAHS provided $1,000 to each organization to help defray start-up costs, and committed to pay $25 for each successful application they facilitated. In July 1999, the state legislature appropriated funds to provide the $25 bounty to schools, FQHCs, and local health departments. A DMAHS administrator explained that these arrangements were made to "jump-start" lagging enrollment. "We started with the attitude, 'build it and they will come,'" she said. "But that didn't happen." Although the grant arrangement with the CBOs and Head Start agencies has now ended and the state no longer offers the bounty to these organizations, most of the former grantees, as well as hundreds of other community partners, continue to help families complete applications.

DMAHS has made a concerted effort to promote NJ FamilyCare to the state's Hispanic population, which, at 13 percent, is proportionally the ninth largest in the U.S. In 1999, the state

awarded $373,500 in HRSA grant funds to five organizations to increase awareness of NJ FamilyCare among the Hispanic/Latino population in North Jersey. (After a mid-year evaluation, the state continued funding for just three of the five organizations.) Funds were used to develop culturally appropriate outreach and education materials and to hire bilingual outreach workers to conduct community outreach events and assist families with applications. This collaboration with community agencies was a key part of the state's efforts to address the "public charge" issue, that is, concerns among Hispanic/Latino parents that enrolling their children or themselves in NJ FamilyCare might jeopardize their prospects for citizenship. As one DMAHS administrator explained, "you need to get the appropriate people in the community to dispel the myths."

The state Covering Kids grantee oversees five community-based pilot projects, including a rural project implemented by the Tri-County Community Action Agency/WIC/Head Start in Cumberland County and a minority-focused project implemented by La Salud Hispana, which serves the Latino community in North Jersey. (The other pilots include an urban pilot project in Newark, a faith-based pilot project in Union County, and a hospital-based project in Passaic County.) To ensure that Covering Kids and the state provide a consistent message to families, all of the Covering Kids pilot projects use promotional materials developed by the state, in lieu of materials developed by the national Covering Kids program.

D. IMPLEMENTATION EXPERIENCES AND LESSONS LEARNED

To date, New Jersey's outreach efforts have been far more successful in reaching some eligibility groups than others. Within a year after the implementation of NJ FamilyCare, more adults had enrolled in the program than the state had originally estimated were eligible. Single adults and childless couples accounted for about one-quarter of adult enrollees. Enrollment of children into NJ FamilyCare also grew over the same timeframe, but at a much slower pace,

particularly among children in higher-income groups. In September 2000, 46 percent of children thought to be eligible for the program were enrolled. By January 2002, the proportion had increased to 56 percent, with the majority of children enrolled in Plans A, B, or C. Only 23 percent of the children thought to be eligible for Plan D were enrolled as of January 2002.

New Jersey has modified both the focus and the content of its outreach efforts over time, in response to enrollment trends. Initially, the state pursued a broad-based outreach program aimed at enrolling all eligible children into the program. As noted, a key component of the strategy was a series of collaborative agreements with other agencies, such as the Department of Health and Senior Services, to conduct "in-reach" to their clientele. As the populations served by these programs tend to be low-income, this collaboration brought into the NJ FamilyCare program primarily families who were eligible for Medicaid or NJ FamilyCare Plan A.

Media campaigns were also a key element of the state's outreach strategy until they proved too effective in reaching eligible adults. A study conducted by the state's media consultant in the fall of 2000 found that close to half of the families who called the state hotline or responded to a question on the joint Medicaid/SCHIP application between October 1999 and September 2000 learned of the program through television or radio advertising, and about a quarter learned of it through print advertising. Calls to the hotline also increased during and after the 1999 media campaign. The $2 million media campaign mounted from September to December 2000 to announce the NJ FamilyCare phase of the program was even more successful in reaching new eligibles. As one DMAHS administrator put it, "we blasted them, and it worked." Inundated by applications from adults, the state ended all media outreach at the end of 2000, and subsequently instructed community-based organizations and HMOs to discontinue outreach to adults.

Program administrators emphasized the importance of other outreach strategies. Asked whether state-wide media or community-based outreach were more important, a state

administrator explained that while the media campaigns increased awareness of NJ FamilyCare among the general population, the application assistance provided by community-based organizations was critical for getting many families enrolled. School-based outreach has also brought many children into the program. As of October 2000, over 4,370 families had requested NJ FamilyCare applications through the checkbox on the school lunch application. Of these, 46 percent returned the application, and 25 percent were enrolled. Some schools have also agreed to designate a point person to spearhead outreach for NJ FamilyCare, but the numbers were relatively small. Of the 10,000 schools contacted over the past two years, about 2,000 agreed to participate in the outreach campaign, with high schools and middle schools least likely to participate.

As enrollment of children eligible for NJ FamilyCare Plan D (children with family incomes between 201 and 350 percent of the FPL) has continued to lag well behind that of lower-income children, the state has once again revised its outreach strategy to reach this higher income group—for example, by promoting the fourth and fifth grade health curriculum to schools in moderate-income districts that are likely to have large numbers of Plan D-eligible children. In addition to targeting outreach more narrowly, the state has modified its message, to focus more on informing families about using their coverage. As one DMAHS administrator put it, families need to be educated about "what [they] are going to do once [they are] on the program." The new emphasis on preventive care and appropriate utilization of services is also viewed as a retention strategy, as administrators believe that families who use their health care coverage will be more likely to retain it.

IV. ENROLLMENT AND RETENTION

A. POLICY DEVELOPMENT

State administrators took several immediate steps to coordinate and streamline the application and enrollment process for SCHIP and children's Medicaid coverage, but faced with a short timeframe in which to implement the program and uncertain about the numbers of children who might enroll, administrators also instituted in SCHIP some of the more restrictive policies of the Medicaid and Health Access programs. When enrollment in NJ KidCare lagged well behind expectations, modifications were made to improve access to the program. Although state policymakers had always expected to revisit earlier policy decisions, the continued streamlining of the enrollment process in the first two years of the program was partly "a defense mechanism," in the words of one DMAHS administrator: "It was a struggle to get kids enrolled, and every day we were getting beaten up by the papers and the legislature for not doing more." Ironically, DMAHS and its eligibility contractor were soon struggling with the opposite problem—an enrollment surge that almost completely overwhelmed the application processing system.

With the implementation of NJ KidCare in February 1998, DMAHS introduced a joint Medicaid-SCHIP application form and dropped the face-to-face interview requirement for children applying for Title XIX Medicaid. Modeled on the existing application for the Medicaid poverty-level eligibility groups, the original joint form was subsequently revised with the help of design staff from several of the state's large pharmaceutical firms, and a colorful new tri-fold form was introduced in late 1998. With the elimination of the face-to-face interview requirement, families were no longer obliged to go to a County Board of Social Services (CBOSS) to apply for coverage for their children, although they could still do so if they chose.

To implement a mail-in submission process as quickly as possible, the state expanded existing contractual arrangements with Birch & Davis, the contractor that handled eligibility determination for Health Access New Jersey, and with Maximus, the contractor that handled managed care enrollment for the state's Medicaid managed care program. State staff were stationed at Birch & Davis to determine eligibility for Medicaid (Title XIX and NJ KidCare Plan A). From the beginning, the state planned to consolidate these functions, and in January 2001, Maximus was awarded the contract through a bid process and assumed responsibility for both eligibility determination and HMO enrollment, and state staff moved to the new location.

The state initially established documentation requirements for NJ KidCare that mirrored those for children's Title XIX Medicaid programs, and a waiting period that mirrored that for Health Access. (The latter is discussed further in Chapter V.) Families were expected to document three months' worth of income—a requirement that DMAHS administrators said was established partly to harmonize with Medicaid policy, which allows families to claim three months of retroactive coverage if they can demonstrate that they met eligibility requirements throughout the period. According to one DMAHS administrator, the three-month requirement also reflected "the old thinking that 'more is better'." In June 2000, the state reduced the income documentation requirement to one month and also dropped the requirement that applicants furnish proof of residency. (The latter change was made partly in recognition of the fact that other materials in the application—for example, the pay stubs included as proof of income—provide evidence of residency.)

In July 1999, the governor signed into law four pieces of legislation designed to boost enrollment in the program. One bill raised the income eligibility threshold to 350 percent of the FPL. Another created exemptions to the waiting period (described in Chapter V). The third piece of legislation authorized DMAHS to allow children with family incomes up to 200 percent

of the FPL (Plans A, B and C) to be presumed eligible for NJ KidCare by designated health care facilities, and a fourth established a $25 bounty to reward schools, FQHCs and local health departments for helping families complete applications.

B. ENROLLMENT PROCESSES

Eligibility policies for SCHIP and children's Medicaid coverage have converged over time (Table IV.1). Presumptive eligibility for children is now allowed in both programs (except in NJ FamilyCare Plan D), but was not authorized in SCHIP until January 2000, when policymakers' fears of explosive enrollment growth had been laid to rest. (Presumptive eligibility for adults followed the opposite trajectory: Implemented at the start of the NJ FamilyCare expansion, the policy was repealed in April 2001 because enrollment among adults had indeed exploded and the enrollment target of 125,000 adults had been met.) Both NJ FamilyCare and children's Medicaid programs now have 12-month eligibility periods, since the eligibility period for Medicaid was extended from 6 to 12 months in July 2000. Neither program offers continuous eligibility, but DMAHS administrators contend that the state's policy of relying on families to report changes in their circumstances amounts to "de facto" continuous eligibility. One key difference in the eligibility policies of the two programs is that eligibility for Medicaid (and Plan A) begins the first day of the month of application, with up to three months of retroactive coverage available for enrollees who incurred medical costs before they applied and were found eligible, while NJ FamilyCare coverage begins with enrollment in an HMO. Verification requirements for the two programs are virtually the same (Table IV.2). All applicants must provide proof of earned and unearned income, and, if applicable, full-time student status and pregnancy; Medicaid applicants who claim a childcare deduction must document these expenses. Qualified aliens must also document their immigration status.

TABLE IV.1

SCHIP AND MEDICAID ELIGIBILITY POLICIES

Policy	Separate SCHIP Child Health Program	Medicaid
Retroactive eligibility	No	Yes, up to 3 months prior to the date of the application
Presumptive eligibility	Yes, except in Plan D	Yes
Continuous eligibility	No	No
Asset test	No	No

SOURCE: Centers for Medicare and Medicaid Services (CMS), *Application and Enrollment Simplification Profiles: Medicaid for Children and SCHIP* (unpublished), November 2000.

NOTE: SCHIP=State Children's Health Insurance Program (Title XXI).

TABLE IV.2

APPLICATION AND REDETERMINATION FORMS,
REQUIREMENTS AND PROCEDURES

Characteristic	Separate SCHIP Child Health Program	Medicaid[a]
APPLICATION		
Form		
Joint form	Yes	Yes
Length	4 ½ pages[b]	4 ½ pages[b]
Languages	2 (English and Spanish)	2 (English and Spanish)
Verification Requirements		
Age	No	No
Income	Yes	Yes
Deductions	Yes	Yes
Assets	NA	NA
State residency	No[c]	No[c]
Immigration status	Yes[d]	Yes[d]
SSN	No	No
Enrollment Procedures		
Mail-in application	Yes	Yes
Phone application	No	No
Internet application	No	No
Hotline	Yes	Yes
Outstationing	No	Yes
Facilitated enrollment	Yes	Yes

TABLE IV.2 (*continued*)

Characteristic	Separate SCHIP Child Health Program	Medicaid[a]
REDETERMINATION		
Same form as application	No	Varies
Pre-printed form	Yes	Varies
Mail-in redetermination	Yes	Yes
Income verification required	Yes	Yes
Other verification required	No	No

SOURCE: Donna Cohen Ross and Laura Cox, *Making it Simple: CHIP Income Eligibility Guidelines and Enrollment procedures: Findings from a 50-State Survey*. Kaiser Commission on Medicaid and the Uninsured, October 2000.

NOTE: SCHIP=State Children's Health Insurance Program (Title XXI). NA=Not applicable.

[a]Children's programs.
[b]Plus 1 ½ pages of instructions.
[c]Required only of applicants who give a post office box as their mailing address.
[d]Qualified aliens only.

Plans B and C of the separate child health program use a gross income standard, while Plan D, as noted, allows a standard disregard of all income between 201 and 350 percent of the FPL. The Medicaid program, including NJ FamilyCare Plan A, uses a net income standard, allowing deductions for work-related expenses, childcare, and child support. Neither Medicaid nor NJ FamilyCare poses an asset test.

NJ FamilyCare applications are made available through a variety of channels. In May 2002, the state's eligibility and enrollment vendor mailed out about 550 applications per week (down from about 1,000 the previous month) in response to calls to the hotline. Application packets are also broadly distributed to FQHCs, WIC offices, and other community-based organizations, as well as to CBOSS offices. The application packet contains the tri-fold application; a descriptive flyer, which includes the hotline number; an HMO selection guide; a three-page, double-carbon HMO selection form; and a postage-paid envelope addressed to the state vendor's Trenton office or to the CBOSS office, if the application was obtained there. The three-page HMO enrollment form, originally just one page in length, was expanded at the request of the HMOs to include a series of questions about applicants' health status and any special needs.

Families eligible for NJ FamilyCare Plans B, C and D must select an HMO to be enrolled in the program. Families who are eligible for Title XIX Medicaid or NJ FamilyCare Plan A are given an opportunity to select an HMO but are auto-assigned to one if they do not make a selection within 45 days. The HMO selection guide offers a few simple guidelines for choosing a plan, indicates which plans are available in which counties, identifies any differences in benefits among plans, and directs families to call the hotline number to obtain additional assistance from a Health Benefits Coordinator (HBC). The state's eligibility vendor maintains a staff of about 40 HBCs in five regional offices to provide telephone and in-person assistance to families selecting a plan.

The state vendor determines eligibility for NJ FamilyCare Plans B, C and D and administers the HMO selection and assignment process for both Medicaid and NJ FamilyCare. State DMAHS staff are stationed at the vendor site. Whether Title XIX Medicaid and Plan A determinations are made by county CBOSS staff or by state DMAHS staff depends in large part on whether the applications were made at or sent to a county office or mailed to the state vendor.

Families can apply at an application assistance site (such as an FQHC, a WIC office or a CBO) or at a CBOSS office or can mail their applications directly to the state vendor. Children can also be deemed presumptively eligible by a designated provider. Each process is described below.

- ***Application assistance sites***. Unlike some other states, New Jersey does not include a list of application assistance sites in its application packet. Families are generally referred to an application assistor when they call the hotline or when they come to a WIC clinic, FQHC, local health department or hospital for services and intake staff determine that some or all members are uninsured. Families may be given an appointment and told what documentation to bring with them when they come, or they may be asked to start the application process and return at another time with the necessary documentation. Application assistors can mail the completed applications either to their local CBOSS office or to the state's eligibility vendor, and some assistors said they send applications from families who appear to be eligible for Medicaid or Plan A to the county and others to the vendor. As noted, schools, FQHCs, and local health departments are entitled to a $25 fee for every successful application they facilitate; selected CBOs and Head Start programs were eligible for the $25 fee until June 2001. CBOSS staff outstationed at many hospitals also help families complete applications and can determine eligibility for Title XIX Medicaid and Plan A on site.

- ***CBOSS offices***. Procedures vary somewhat across county offices. If a family contacts the CBOSS office by phone, staff may either mail out the application packet or set up an appointment to complete the application. (One CBOSS office we visited conducts a preliminary screening over the phone; families who appear eligible for NJ FamilyCare Plans B, C or D are mailed the packet, and families who appear eligible for Title XIX Medicaid or NJ FamilyCare Plan A are given an appointment and asked to come in.) CBOSS staff complete the application with the family, screen for Medicaid or NJ FamilyCare eligibility, make the eligibility determination for any applicants who appear to be eligible for Medicaid (including NJ FamilyCare Plan A), and forward all other NJ FamilyCare applications to the state's eligibility vendor. CBOSS staff provide the HMO enrollment forms but generally direct families to the Maximus Health Benefits Coordinators for help selecting a plan.

- ***Eligibility vendor***. If a family—or an organization that assists families with applications—mails an NJ FamilyCare application to the vendor, vendor staff first determine if the application is complete. If not, staff attempt to contact the family up to four times by mail and twice by telephone within a 45-day period to request the missing information before closing the application file. If the application is complete, staff first screen for Medicaid eligibility. If the applicant appears to be eligible for Title XIX Medicaid or NJ FamilyCare Plan A (the Medicaid expansion), vendor staff access the state's Medicaid enrollment system to determine whether the applicant is a member of a household with an open Title XIX case. If so, or if the applicant is a pregnant woman, the vendor forwards the application to the CBOSS office to make the eligibility determination. Applications from other individuals who appear to be Medicaid eligible are processed to the point of an eligibility determination and then transferred to on-site DMAHS staff, who formally sign off on the determination. If the applicant does not appear to be Medicaid-eligible, vendor staff determine eligibility for NJ FamilyCare Plans B, C or D. Those found eligible for Plans C or D are invoiced for their first month's premium payment. Families are enrolled in the HMO of their choice (or auto-assigned, if applicable) at the start of the month following their eligibility determination or, if premiums are due, receipt of their payment.

- ***Presumptive eligibility sites.*** A child can be deemed presumptively eligible for Medicaid or NJ FamilyCare Plans A, B, or C, by the staff of an acute care hospital, an FQHC or a local health department that provides primary care services, if the child meets Medicaid or NJ KidCare program eligibility standards and his or her family income is at or below 200 percent of the FPL. (However, as of April 2, 2001, presumptive eligibility is no longer available to legal immigrant children who entered the country on or after August 22, 1996.) The child receives a temporary card from the state which is good from the date of service until the end of the following month, during which time the family must complete a regular application for the child to retain eligibility. Children are allowed one continuous period of presumptive eligibility every 12 months. During this period, services are reimbursed by the state on a fee-for-service basis.

A sizeable number of applications are transferred from CBOSS offices to the vendor, but relatively few are transferred the other way. During the week of January 5, 2002, for example, 37 percent of the applications received by the vendor came from CBOSS offices. In contrast, only 5 percent of the applications received by the vendor from sources other than CBOSS offices were transferred to the counties.

C. REDETERMINATION PROCESSES

The renewal process for NJ FamilyCare varies by program and plan and by the site of the original eligibility determination. All Plan B, C or D renewals are currently handled by the state's eligibility vendor. Plan A and Title XIX Medicaid renewals are handled by the agency at which eligibility was initially determined. Thus, the state's eligibility vendor initiates the renewal process for Medicaid and Plan A enrollees who were determined eligible by state staff stationed at the vendor's Trenton office, and CBOSS offices initiate the renewal process for Medicaid and Plan A enrollees who were determined eligible by CBOSS staff. Each process is described below.

- ***Eligibility vendor procedures.*** Seventy-five days before a child's eligibility is due to expire, the vendor mails each family a preprinted form (currently available only in English) showing the information that is in their file (generally, the information provided by the family at application). Families are asked to make any necessary updates, document one month's income and any other changes that may affect eligibility (e.g., the birth of a new child), and return the signed form in the postage-paid envelope provided. Reminder notices are sent 45, 30 and 15 days before the termination date, and up to two calls are made to families who fail to return the form. Once received, the form is reviewed and processed in the same way as an initial application.
- ***CBOSS procedures.*** CBOSS offices do not have the technology to preprint forms and therefore use a blank application form as a renewal form. DMAHS generates and sends to each county a list of enrollees who are due for renewal about two months before their eligibility expires; the counties mail out the renewal packets shortly thereafter. The number of additional reminder notices varies by county. Renewal forms are generally reviewed, processed and forwarded in the same way as initial applications, except that CBOSS offices are permitted to redetermine eligibility for Plan A families who have become eligible for Plan B.

D. IMPLEMENTATION EXPERIENCES AND LESSONS LEARNED

Perhaps the most important lesson to be drawn from New Jersey's experience is that broad expansions of eligibility pose a risk of generating an overwhelming response. In New Jersey, the huge influx of applications from adults that followed the implementation of NJ FamilyCare unfortunately coincided with the transfer of responsibility from one eligibility contractor to

another, leading to enormous delays in application processing. According to several application assistors and others with whom we spoke, some applications filed in the months immediately after the implementation of NJ FamilyCare went unprocessed for over a year or were lost altogether. Although most observers agreed that the situation has improved considerably, at the time of our visit, many reported that the vendor was still processing applications and responding to inquiries too slowly. (DMAHS staff reported in October 2002 that the backlog no longer existed.)

Enrollment under NJ KidCare provided little warning of the demand that would surface under NJ FamilyCare. As of September 2000, more than two-and-a-half years after the implementation of the SCHIP program, the state had enrolled 74,000 children, or 46 percent of those believed to be eligible (State of New Jersey 2000). Enrollment rates among children in higher income families were particularly disappointing, with just 19 percent of the children believed to be eligible for Plan D participating. Enrollment was highest among the lowest income groups: Almost three-quarters (72 percent) of the children believed to be eligible for Plan A were enrolled in September 2000, and the state estimated that for every three children enrolled in NJ KidCare, two more were enrolled in Medicaid.

Enrollment skyrocketed with the implementation of NJ FamilyCare, more than tripling in just over one year (Table IV.3). Adults accounted for 90 percent of the increase. At their height, calls to the hotline reached 50,000 per day. "With NJ KidCare, we were begging people to come in," recalled one DMAHS administrator. "With NJ FamilyCare, they were coming out of the woodwork." By November 2001, the state had enrolled more adults than were previously believed to be eligible, despite having ended enrollment of childless adults two months earlier. Most of the adults, like the children, were lower income. Childless adults, who were eligible for

TABLE IV.3

ENROLLMENT TRENDS

Enrollment Measure	1998	1999	2000	November 2001
Number ever enrolled in federal fiscal year (FFY)		75,652	89,034	-
Number enrolled at year or month end (point in time)		55,430	69,075	230,123[a]
Percent change in point-in-time enrollment	—		25%	233%

SOURCE: Vernon K. Smith, *CHIP Program Enrollment: June 2000.* Kaiser Commission on Medicaid and the Uninsured, January 2001. Centers for Medicare and Medicaid Services (CMS), *State Children's Health Insurance Program (SCHIP) Aggregate Enrollment Statistics for the 50 States and the District of Columbia for Federal Fiscal Years (FFY) 2000 and 1999* website: http://www.hcfa.gov/init/fy99-00.pdf. *County Enrollments: Cumulative Enrollment Totals as of November 30, 2001.* NJNJ FamilyCare website: http://www.njNJ FamilyCare.org/pages/enroll_chart_print.html.

[a]This figure includes single adults and childless couples, who are covered with state dollars, and parents with incomes below 133 percent of the FPL, who are covered under Title XIX.

coverage only if their incomes were below 100 percent of the FPL, accounted for about one-quarter of adults enrolled, and parents with incomes below 133 percent of the FPL accounted for about one-half. (Childless adults are covered with state funds, and parents with incomes below 133 percent of the FPL are covered under Medicaid. Hence, only about one-quarter of adults enrolled in NJ FamilyCare are covered with Title XXI dollars.) Enrollment of children continued to lag, particularly in the plans that serve higher-income families. By January 2002, the overall enrollment rate for children was 55 percent, and the rate for Plan D, though rising, was just 23 percent. Although DMAHS staff could only speculate about why the expansion of coverage to adults did not significantly boost enrollment of children in NJ FamilyCare, there appear to be two reasons: many of the parents who enrolled already had children enrolled in NJ FamilyCare, and many of the others whose children were not already insured were lower-income and thus eligible for Medicaid along with their children.

Feedback about enrollment policies and procedures during the site visit consistently focused not on forms or policies but on processing delays and the difficulty of getting information and assistance from the state's eligibility vendor. Advocates and application assistors had few complaints about the NJ FamilyCare application form, although some said that many families need help completing it, because of language barriers and low-literacy levels. "Anytime someone sees a tri-fold form, it's intimidating," said one application assistor. "But there's not really a lot of information requested." Estimates of the time needed to complete the form averaged about 20 minutes. The requirement that families furnish documentation of one month's income was reported to be a barrier for some. About half of the applications received by the vendor are incomplete, and the item most commonly missing is documentation of income. Recognizing that some families (particularly farm workers) may not have pay stubs or may have difficulty finding four weeks' worth when they apply, the state agreed to accept in lieu of pay stubs a signed letter

from an application assistor, stating that she had verified the applicant's income by calling his or her employer. "We actually get very few of these letters," said one DMAHS administrator, "but it was a way to accommodate the community's concerns."

Vendor administrators reported that the application backlog is now gone, and that the company is on track to process applications in a timely manner. However, many of the application assistors with whom we spoke said that families still wait months to hear about the status of their application and even longer to be enrolled. Application processing delays have also made the presumptive eligibility process more onerous, as providers were obliged to seek repeated extensions of the presumptive eligibility period until applications were logged in by the contractor. Some application assistors said that they now forward all Medicaid and Plan A applications to their local CBOSS office, because the counties, although inundated themselves, are able to process the applications more quickly than the state's eligibility vendor. Premium requirements and cut-off dates for HMO enrollment contribute to enrollment delays. If a family submits its premium payment after January 20, for example, members will not be enrolled until the beginning of March. According to several of the advocates and application assistors we interviewed, the long waits have created the perception that it is difficult to get on the program and thus discouraged some families from applying. "If one person falls through the cracks, they tell others," said one assistor.

Complaints about the hotline were also common. Although the volume of calls has tapered off since the early months of NJ FamilyCare, callers are still put on hold for long periods of time. At the time of our visit, some respondents reported waits of 60 to 90 minutes, while one said that waits were down to about 15 minutes. The time of day when calls are placed may be a factor.

Families' experiences with the HMO enrollment process reportedly vary. Some respondents believe that because managed care is so widespread in New Jersey, most families are familiar

with the concept of HMOs and only need to be told which plan(s) their physicians are in to make a selection. Other respondents believe more guidance is needed, because many families do not understand that the affiliation of their physician is the key factor to consider and instead focus on the differences in plans benefits (described in the state brochure). Respondents who believe families need more help tend to think that having Health Benefits Coordinators available to answer questions over the phone or at few regional offices does not meet the need for community-based assistance. Moreover, several providers reported that even when families make an informed choice of plan and provider, selection forms may be lost or families misassigned.

Community-based organizations have played a significant role in helping families complete applications, but the level of their involvement varies considerably. As noted, none of the materials in the NJ FamilyCare application packet mention community-based assistance, but callers to the hotline will be referred to a local site if they request in-person help with the application. Training of application assistors has generally been provided through a collaboration with the state Covering Kids program. Staff of the community-based organizations we visited reported that their role in helping families enroll has diminished since the fall of 2000, when they stopped receiving monthly reports on the disposition of the applications they submitted. Without the reports, application assistors are unable to keep families informed about the status of their application or to follow up with the family or the contractor if problems are identified.

Relatively few community-based organizations have gotten any financial support from the state. Of the 500 organizations said to be helping with enrollment in some way in fiscal year 2000, only about a quarter (12 FQHCs, 65 local health departments, 43 CBOs, and 8 Head Start programs) were allowed to collect the $25 bounty [State of New Jersey 2000]. (Although

schools are also entitled to the $25 fee, very few have claimed it.) Only a handful of other organizations received lump-sum grants to provide outreach and application assistance in their communities. Payments to CBOs and Head Start programs were terminated when funding ran out at the end of the two-year grant period. State staff also pointed out that administering the payments had been burdensome, effectively "turning the outreach office into a fiscal entity," according to the state's outreach director. Surprisingly, not all community-based organizations were sorry to see the bounty program end. According to the director of one community-based organization in North Jersey, the incentive payment fostered such bitter competition for enrollees among CBOs that he asked DMAHS to end the program.

CBOSS offices continue to be important enrollment sites. Although concerns about Medicaid stigma and possible negative associations of CBOSS offices with "welfare" prompted state policymakers to adopt a mail-in application process for NJ FamilyCare, many families still choose to apply at their local CBOSS office. One DMAHS administrator questioned concerns about Medicaid stigma and characterized the CBOSS offices as "customer-service driven" and "more consumer friendly than they used to be."

As in many states, program administrators have only recently begun to address retention issues. Said one DMAHS administrator, "our early focus was on getting people into program. Renewal was the last thing we were thinking about." An analysis by researchers at Rutgers University found that 12 percent of children who enrolled between January 1998 and April 2000, disenrolled within 1 year, and 19 percent disenrolled within 18 months. Disenrollment was highest in Plans C and D, where families are required to pay premiums and some co-payments, and non-payment of premiums accounted for more than 60 percent of the disenrollments in these plans. However, the reasons for nonpayment are not known, and families may have disenrolled not because they were unwilling or unable to pay the premiums but because they got other

insurance coverage or no longer wanted NJ FamilyCare coverage for some other reason. Placement in other government programs accounted for about half the disenrollments in Plans A and B. About 15 to 20 percent of disenrollees in all plans reported having found other coverage.

DMAHS recently required its contractor to set up a new unit to assess renewal procedures and develop strategies to improve retention. Staff reported that plans are underway to add another "reminder" call to the renewal process, this one to be made a month or two before the end of the eligibility period to inform the family that the renewal packet will arrive soon. The state is also helping develop a short renewal form to be used by the CBOSS offices for the cases they manage. Perhaps most important, staff are focusing on ways to educate families throughout their enrollment about their coverage and the requirements for maintaining it. The state plans to add to all of its enrollee mailings a one-line reminder that families must renew their coverage annually, and is exploring ways to encourage families to access care—for example, through a mid-year call – in the belief that families who use their coverage will be more likely to retain it.

V. CROWD OUT

A. POLICY DEVELOPMENT

The possibility that coverage expansions might lead to substitution of public insurance for private ("crowd out") was an important consideration for policymakers during both the development and subsequent expansions of New Jersey's Title XXI program. Initially, the state imposed a 12-month waiting period on all children eligible for the separate child health program (Plans B and C), requiring that they to be uninsured for a full year before enrolling in NJ KidCare. Exceptions were made only for children whose prior coverage was Medicaid or whose employer-sponsored coverage was lost through no fault of their own—for example, because their parent was laid off, the employer went out of business, or insurance was not available at the parent's new place of employment.

The 12-month interval was chosen both for consistency with the earlier Health Access program, which had a 12-month waiting period, and out of a desire to proceed cautiously in the face of uncertainty. "No one really knew how much crowd out might occur," said one DMAHS administrator. A 12-month waiting period was the longest CMS would allow under Title XXI. Over time, as concerns about crowd out diminished, the state shortened the waiting period to six months and authorized additional exemptions, in January 1999 and July 1999, respectively. (One exemption was created largely in response to public outcry about a highly publicized case in which a family who was paying $800 a month for insurance in the individual market was denied NJ KidCare coverage.) Some legislators argued for eliminating the waiting period altogether, but were reportedly over-ruled by others who believed that this would tax state resources and undermine group plans by luring away a relatively low-cost population.

Substitution of coverage was considered more likely among the middle-income families targeted by Plan D, and fear of crowd out was one reason that the state chose to offer this group a benefit package modeled on commercial coverage. Policymakers also worried that some employers might decide not to offer dependent coverage, or to charge higher premiums for it, knowing that public coverage would be available. To reduce incentives for substitution, the interagency working group recommended that the state establish two premium assistance programs, one to help uninsured low- to moderate-income families (151 to 350 percent of the FPL) who work for small firms to take up the coverage available to them, and another to help lower-income families (134 to 200 percent of the FPL) who have taken up employer-based coverage pay for it. Only the former program was ever implemented. Plans for the latter were dropped on the grounds that it would be too costly to the state (because no federal match could be claimed) and would not insure more children.

B. PROGRAM CHARACTERISTICS

A six-month waiting period applies in Plans B, C and D. Certain exemptions are granted in all plans, and others only in Plans B and C. In addition to the exemptions adopted under the original state plan, the state grants exemptions to Plan B, C and D eligibles who were involuntarily disenrolled from employer-sponsored insurance or who lost their coverage through a parent's job change to a firm that does not offer affordable coverage, or because COBRA benefits expired. In addition, the state exempts from the waiting period Plan B and C eligibles who had only individual or COBRA coverage prior to application, based on the recognition that such coverage is typically quite costly. The application includes a series of questions about current health insurance coverage, coverage during the past six months, and reasons for loss of coverage. The application form also includes a question about whether the applicant could obtain health insurance through his or her employer, if desired.

The premium assistance program was implemented as part of the state's Section 1115 demonstration and is described in Chapter IX.

C. IMPLEMENTATION EXPERIENCES AND LESSONS LEARNED

Crowd out is not perceived to be occurring to any significant degree in New Jersey, and none of our respondents suggested that families or employers were more likely to drop coverage now that the waiting period was six months instead of twelve. The state has no data to assess whether the waiting period has discouraged crowdout, but state staff report that very few applicants have been denied because they had coverage during the six months prior to application. (DMAHS is awaiting reports from its eligibility vendor to assess the effects of the exemptions.) Policymakers believe the premium assistance program will help prevent crowd out by encouraging employers to continue offering dependent coverage, but the impact of the program on the commercial insurance market will be difficult to evaluate.

VI. BENEFITS

A. POLICY DEVELOPMENT

The benefit packages offered through NJ FamilyCare vary by eligibility group. NJ FamilyCare Plan A, the Medicaid expansion, provides the complete Medicaid benefit package. Plans B and C provide a package of benefits that is slightly more limited than the Medicaid package, and Plan D provides a significantly less generous package, modeled on coverage widely available in the commercial market. The desire to implement the program quickly was reportedly a key reason state policymakers established a benefit package for Plans B and C that closely resembles the Medicaid package. Policymakers had concluded that it would be quickest and most cost-effective to provide services through the existing Medicaid managed care system and believed that HMOs could not easily get the necessary structures in place to administer multiple benefit packages.

The reasoning behind the benefit structure for Plan D was different. Because the higher-income families whose children would be eligible for Plan D were thought to resemble families whose children were commercially insured, state policymakers believed that both equity and crowd-out considerations dictated a benefit package that mirrored employer-based coverage. Policymakers also hoped that using the benefit package offered by the HMO with the largest commercial enrollment as a benchmark for Plan D would facilitate the implementation of a premium assistance program in the future. The state also chose to offer this benefit package to lower-income parents (those with incomes between 134 and 200 percent of the FPL) when the NJ FamilyCare expansion was implemented, partly to control the cost of expanding coverage to adults.

B. BENEFIT PACKAGE CHARACTERISTICS

NJ FamilyCare Plan A offers the same benefits as the Medicaid program, providing full coverage of preventive services, inpatient and outpatient hospital services, lab and x-ray services, home- and community-based services, unlimited inpatient and outpatient mental health services and transportation services. In addition, Plan A enrollees receive complete dental benefits including orthodontia and dentures. Plan A also covers all EPSDT screenings, as well as any services deemed necessary to treat a health condition diagnosed through a screening.

The benefit package for Plans B and C is benchmarked against the standard Blue Cross/Blue Shield PPO option of the Federal Employee Health Benefit Plan (FEHBP). Like Plan A, the benefit package includes full coverage of preventive care and acute illness services, but Plans B and C do not cover several benefits—personal care services, medical day care, or non-emergency transportation—that may be used by children with chronic conditions. (As noted earlier, the latter services are also excluded from the HMO package and covered by the state on a fee-for-service basis for enrollees in Medicaid and Plan A.) Nor do Plans B and C include the EPSDT safeguard that grants children access to all needed services. (Children in these plans have access to all treatment services covered by the HMO.) The Plan D benefit package is benchmarked against the plan offered by Aetna U.S. HealthCare, the HMO with the largest non-Medicaid enrollment in New Jersey. Plan D offers the full range of primary care and emergency services. Plan D limits physical, occupational and speech therapies; optometric services; podiatry services; and inpatient and outpatient mental health services. Another major difference between the plans is that dental services in Plan D are limited to children under age 12 and restricted to preventive dental services. Some of the participating HMOs offer enhanced optometric coverage (e.g., eyeglasses) and over-the-counter drug benefits in addition to the basic benefit package.

C. IMPLEMENTATION EXPERIENCES AND LESSONS LEARNED

Respondents generally concurred that NJ FamilyCare benefits were generous, and the only significant criticism voiced by providers and advocates was that the dental benefit under Plan D is inadequate. One HMO representative stated that colleagues in other states regard the NJ FamilyCare benefit packages as the "best of the Cadillacs," and a provider representative suggested that the benefit packages might even be a little too rich. Although the state has no immediate plans to modify the benefit packages, advocates and legislative staff raised concerns about the possible ramifications of the state's budget crisis for benefit levels, and some suggested that reducing the benefit package might be preferable to capping enrollment or reducing the eligibility threshold.

VII. SERVICE DELIVERY AND PAYMENT ARRANGEMENTS

A. POLICY DEVELOPMENT

Managed care was slow to gain a foothold in New Jersey. When the state sought to implement a voluntary HMO program in Medicaid in the mid-1980s, it was obliged to create its own managed care plan and, for a decade, Medicaid enrollment in risk-based managed care remained low. The state's managed care environment rapidly changed when the state phased out hospital rate-setting in the early 1990s, freeing HMOs to negotiate their own hospital reimbursement rates. By the mid-1990s, New Jersey was a "hotbed" of managed care competition (Bovbjerg et al. 1997). It was in this environment that the state launched its mandatory Medicaid managed care program, New Jersey Care 2000.

The mandatory program was phased in for the AFDC-related eligibility groups over a two-year period, beginning in 1995. By 1997, Medicaid enrollment in HMOs had more than quadrupled, rising from 94,000 to 385,000. The implementation of the mandatory program increased HMOs' interest in the Medicaid market, and the number of participating plans also rose, reaching a high of 13 in 1996 (Centers for Medicare & Medicaid Services 1996 and 1997).

This strong managed care structure allowed the state to implement its SCHIP program within six months of the passage of Title XXI. That SCHIP-eligible children would be enrolled in HMOs was virtually a foregone conclusion. The smooth roll-out of Medicaid managed care gave state policymakers confidence that the new NJ KidCare enrollees could be quickly and easily absorbed into the existing managed care delivery system, simply by making participation in SCHIP a requirement for plans' continued participation in Medicaid.

The arrangement whereby mental health and substance abuse services are "carved out" from Medicaid HMO contracts was continued under NJ KidCare. Although HMOs were responsible

for some behavioral health services (up to specified limits) when enrollment in managed care was voluntary, these services were completely carved out under New Jersey Care 2000. The carve-out was intended both to ensure access to traditional Medicaid providers, who have the most extensive experience with this population, and to provide continuity of care for enrollees who require more than the short-term, episodic care offered by providers in plans' networks.

Since the implementation of the state's Title XXI program, New Jersey's managed care market has continued to evolve. For some plans, the competition proved too fierce, and between 1996 and 2001, through a series of mergers, sell-offs of Medicaid business, and financial failures, the number of plans participating in Medicaid and NJ FamilyCare dropped from 13 to 5. The latest exit occurred in July 2001, when Aetna U.S. Healthcare sold its Medicaid and NJ FamilyCare businesses, representing about 118,000 enrollees, to AmeriChoice, more than doubling AmeriChoice's share of the Medicaid/NJ FamilyCare market.

B. SERVICE DELIVERY SYSTEM

All NJ FamilyCare enrollees are enrolled in risk-based managed care plans and served by the same plans and many of the providers that participate in Medicaid. As noted, mental health and substance abuse services are carved out of the managed care contracts; plans are responsible for providing these services only to the "DDD" population (clients of the state Division of Developmental Disabilities). Physical, occupational and speech therapies, once the responsibility of the managed care plans, are now covered by the state on a fee-for-service basis, as are certain services that are available to Medicaid and Plan A enrollees, but not Plans B, C or D enrollees, including personal care assistant services, medical day care, and lower-mode transportation. Dental care is provided by the managed care plans.

DMAHS currently contracts with five HMOs to serve Medicaid and NJ FamilyCare enrollees in all 21 counties. Horizon Mercy is the largest of the five plans, with just over 40

percent of NJ FamilyCare enrollees. AmeriChoice, having purchased Aetna's Medicaid/NJ FamilyCare business, is now the second largest plan, with just over 30 percent of enrollees. The remaining HMOs—Health Net (formerly Physicians Health Services), Amerigroup New Jersey, and University Health Plans, Inc.—each serve between 7 and 15 percent of enrollees. Families have a choice of at least three plans in every county but one (where they have a choice of two). Horizon Mercy and AmeriChoice operate statewide. At the time of our visit, Amerigroup operated in all but three counties and had applied to enter those three. Health Net and University Health Plans were also expanding and were expected to become statewide by the end of FY 2003.

With the withdrawal of Aetna from the public insurance market, NJ FamilyCare enrollment has become more concentrated in plans that serve only Medicaid and NJ FamilyCare enrollees. Only the two smallest plans (Health Net and University Health Plans) serve commercial as well as public populations, although Horizon Mercy's parent company, Horizon Blue Cross Blue Shield of New Jersey, is a large commercial plan.

Under their contract with the state, HMOs must meet specified access standards and provider-enrollee ratios for every type of provider. For example, travel distances to a pediatrician cannot exceed 2 miles in urban areas and 10 miles in rural areas, and HMOs must maintain a ratio of at least 1 pediatrician to every 1500 enrollees. HMOs must submit lists of contracted providers to the state on a monthly basis. At one time, HMOs were required to contract with FQHCs, but HMO administrators reported that this requirement was loosened when some centers demanded terms that the HMOs and DMAHS deemed unreasonable (high fees and, in one case, equity in the HMOs). Currently, HMOs are mandated to, as one HMO executive put it, "make every effort" to contract with the centers, and most HMOs do contract with most of the 12 FQHCs. (With 36 sites in 11 counties, the FQHCs are often among the

largest primary care and dental providers in the medically underserved areas in which they are located.) An early proposal to require HMOs to contract with school-based health centers was also dropped, because none of the centers qualify as either primary or specialty care providers. HMOs are simply required to "develop relationships" with the school-based centers, as well as with Head Start programs, local health departments, and WIC programs.

C. PAYMENT ARRANGEMENTS

NJ FamilyCare capitation rates, like Medicaid rates, are set by the state and vary by age, eligibility category and, for Plan A, region of the state. For children age two or older, the state pays monthly capitation of $55 to $70 for Plan A, $72 for Plans B and C, and $65 for Plan D. (Rates for infants are significantly higher in Plan A than in the other plans.) For adults, the capitation rates range from $108 to $302 per member per month. The state pays risk-adjusted capitation rates for aged, blind and disabled enrollees and for enrollees with AIDS, and also makes supplemental payments for HIV/AIDS drugs, certain blood-clotting factors, services provided to pregnant women, and children's preventive health screenings. HMOs are required to pass the supplemental payments for the health screenings ($10 per screen) on to providers.

Some HMOs have partial risk contracts with primary care physicians, capitating them for primary care, while others have moved away from capitation. The largest HMO capitates all of its primary care providers, while the second largest capitates only those with higher volumes of Medicaid/NJ FamilyCare patients. Even those HMOs that capitate PCPs pay for selected procedures, such as blood draws, on a fee-for-service basis. Vaccines are provided by the state to the HMO providers through the Vaccines for Children (VFC) Program, and the HMOs pay providers an administration fee for each vaccination. Almost all of the HMOs contract with a single medical laboratory for lab services. Specialists are generally paid on a fee-for-service

basis, although dentists are capitated for some services by some HMOs. Hospitals are typically paid per diem rates for inpatient care.

D. IMPLEMENTATION EXPERIENCES AND LESSONS LEARNED

Given the identical delivery systems for children enrolled in Medicaid and NJ FamilyCare, access to care is the same for enrollees of the two programs. Most of the providers and advocates with whom we spoke believe that access to primary care is good, and that access to all services is better now than it was under the earlier fee-for-service Medicaid system. The reason given for this perceived improvement was that HMOs brought into the system many physicians who previously would not accept Medicaid patients. However, there is a widespread perception that access is beginning to decline, particularly for specialty care, as providers have become dissatisfied with reimbursement and begun to pull out of the managed care networks that serve Medicaid and NJ FamilyCare enrollees.

As in other states, providers reported that a two-tier system still exists to some extent, with some "clear Medicaid practices" that accept a sizeable number of Medicaid and NJ FamilyCare patients, while others accept none. Opinions differed regarding the availability of specialty care for Medicaid/NJ FamilyCare enrollees. Some PCPs said they had no difficulty making referrals, while others reported that referrals were a constant struggle, because many of the specialists on the HMOs' provider lists no longer accept new Medicaid/NJ FamilyCare patients or strictly limit the appointment times available to these patients, necessitating long waits for care. (DMAHS staff disputed these reports, noting that appointment availability studies and membership satisfaction surveys indicate that appointment wait times meet contract standards.)

Several respondents mentioned access to dental care as problematic for enrollees outside the service areas of the FQHCs, all but one of which provide dental services. Representatives of Horizon Mercy acknowledged that recruiting dentists for their network had been "a challenge,"

in part because the state has a proportionally low number of dentists. Access to mental health and substance abuse treatment appears to be adequate but is reportedly limited in many areas to traditional Medicaid providers, such as state-funded community mental health centers. Because mental health and substance abuse services are carved out of the managed care contracts, enrollees do not need to obtain a referral from their primary care providers to access this care.

Access for Medicaid and NJ FamilyCare enrollees has reportedly declined with the withdrawal of some managed care plans, particularly those that made provider participation in Medicaid and NJ FamilyCare a condition of participation in their commercial lines. Aetna's departure, in particular, has reportedly had a significant impact on access to care for Medicaid and NJ FamilyCare enrollees in South Jersey, because AmeriChoice has not succeeded in contracting with all of the providers in Aetna's network.

The flurry of mergers, sales, and failures among plans over the past five years was variously attributed to financial mismanagement, the inability of smaller plans to compete with larger, insufficient capitation rates, escalating pharmacy costs, and inexperience in dealing with the complex social needs of Medicaid enrollees. One former plan executive stated that plans must have at least 75,000 lives to be financially viable. The largest three plans now do, and all three concentrate on the Medicaid/NJ FamilyCare population, a focus that another plan executive contends is necessary to succeed in this arena.

Historically, New Jersey's Medicaid payment rates have been below the national average, despite the state's higher-than-average medical costs. A nationwide survey of pediatricians in 2001 by the American Academy of Pediatrics found that fee-for-service rates in New Jersey were about half the national average. For example, a preventive care visit for a new or established patient of any age was reimbursed at $22 in New Jersey, compared with a national average of $46 to $56. The HMO representatives we interviewed said that capitation rates for children were

adequate, but the Medicaid/NJ FamilyCare contract has become increasingly less attractive as the state has added higher risk populations. "We're getting wiped out on adults," said one HMO executive, citing loss ratios of more than 90 percent for these eligibility groups. Childless adults enrolled in Work First/General Assistance (GA) in particular, have proved much more expensive than expected, and the high utilization by GA enrollees, initially attributed to pent-up demand, shows no signs of tapering off.

From the provider perspective, payment for primary care has reportedly improved under managed care and by some accounts is now at least comparable to commercial rates. But payment for specialty care remains well below commercial levels. According to a former executive of Horizon Mercy, the primary care capitation rates paid by the HMO are higher than those of commercial plans. In Hudson County, for example, Horizon Mercy pays monthly capitation of $12 for children ages 6 to 11, compared with an average of $8 paid by commercial plans. (This assessment was disputed by some primary care providers in Gloucester County, who said that Horizon Mercy pays far less than commercial plans and that AmeriChoice is the only Medicaid/NJ FamilyCare plan that compensates providers adequately, at 75 to 90 percent of commercial rates.) Incentive payments for health screens and fee-for-service payment for other billable services improve PCP's payment, although several respondents pointed out that the cost of completing the paperwork demanded by the plans offsets the additional payment.

In contrast, there is a general consensus that payment rates for specialty care are well below commercial rates. (For example, we were told by the former Horizon Mercy executive that the HMO's rates are 20 to 30 percent of Medicare rates, while commercial plans pay 120 percent of Medicare rates.) Although the HMOs were forced to increase payment for some pediatric subspecialties (e.g., orthopedics and neurology) to meet network requirements, the Medicaid rates for these subspecialties remain below commercial rates.

Hospitals, in turn, are "getting clobbered" by Medicaid/NJ FamilyCare, in the words of one hospital administrator. While most commercial plans pay a percentage of charges, Medicaid/NJ FamilyCare plans reportedly pay per diem rates of about $800 per day (compared with the $1500 paid by one commercial plan that reimburses hospitals on a per-diem basis). In addition, "they kill you on denial of inpatient days," said one provider. The short-lived presumptive eligibility program for adult NJ FamilyCare enrollees also benefited hospitals less than expected and proved a "paperwork nightmare" for some. The state capped the amount that each hospital could claim under the presumptive eligibility program but did not immediately notify hospitals when they reached their limit. "This forced us to go back and reprocess these claims through the Charity Care system," said one hospital administrator. "It was difficult to get all the appropriate paperwork from patients who didn't understand why they were approved for NJ FamilyCare but their claim under presumptive eligibility was not." (To qualify for Charity Care, patients must be ineligible for private or government-sponsored coverage, have incomes below 300 percent of the FPL, and meet asset limits. Those with incomes below 200 percent of the FPL may have all of their hospital charges covered, while those with incomes between 200 and 300 percent of the FPL receive increasingly smaller subsidies.)

Emergency room staff complained of "downcoding" by plans that frequently results in payment of only a screening fee for visits that do not result in an admission. Non-emergency care in the ER is not covered at all. Said one emergency room physician, "MCOs almost encourage ER use because they're getting cheaper specialty care." A hospital administrator took a less sinister view, but noted that while HMOs can deny payment, hospitals can neither deny care nor bill the patient. Accordingly, "the Medicaid managed care patient has no incentive to follow the rules because they know they won't have to pay no matter whether the HMO pays or not."

The time involved in obtaining approval for services and making referrals was mentioned by many providers as a hidden cost of doing business. Two pediatric specialists reported that HMOs have significantly changed their formularies within the past year without informing physicians, resulting in denied prescriptions and lengthy calls from providers to HMOs' pharmacy managers to get patients the drugs they need. (Both specialists specifically mentioned having difficulties getting the HMOs to approve newer drugs for attention deficit disorder. Another pediatrician said that the Medicaid/NJ FamilyCare plans were no more restrictive than commercial plans in this regard.) Referrals are also time-consuming. "If you're dealing with a well child, an occasional referral isn't so bad," said one specialist. "But an academic medical practice is 80 percent very sick children."

Long delays in the credentialing of providers, particularly by AmeriChoice after its purchase of Aetna's Medicaid/NJ FamilyCare business, have prevented some providers from billing for their services. Denials of claims are also reported to be a significant problem ("If they can find a way not to pay, they will," said one provider). But it is unclear whether the Medicaid/NJ FamilyCare plans are more likely than commercial plans to refuse payment.

Little data exist to evaluate quality of care under NJ FamilyCare. The state has not yet reported on the utilization and quality measures specified in its state plan and the 2000 evaluation submitted to CMS, but is currently reviewing encounter data and medical records and plans to complete a report by the end of April. Both the provider and plan representative with whom we spoke believe that compliance with EPSDT screening requirements has improved over time, and Horizon Mercy administrators stated that improved compliance has had an impact on medical costs. Many providers believe that inappropriate use of the ER has diminished somewhat under managed care but remains a problem. "It's just a given," said one provider.

VIII. COST SHARING

A. POLICY DEVELOPMENT

Each of the three components of New Jersey's separate state program has a different cost-sharing structure, and the presence or absence of cost sharing is the sole difference between NJ FamilyCare plans B and C. Although federal rules would have permitted monthly premiums of $15 to $19 in Plan B, which covers children with family incomes between 134 and 150 percent of the FPL, state policymakers chose not to impose any cost sharing on families in this group, in the belief that their circumstances were little different from those of families in the Medicaid expansion (Plan A), who are exempted by federal law from all but nominal cost sharing.

For Plan C, which covers children with family incomes from 150 to 200 percent of the FPL, the state adopted small copays and monthly premiums ($15 per month per family). Copayments were included partly to provide incentives to providers, supplementing the payment they receive from the state or an HMO. The choice of a flat premium rate for families in this group was based partly on the state's experience under the Health Access program, which had a more complex cost-structure of sliding-scale premiums based on income, family size, and choice of plan. State policymakers chose not to vary the Plan C premium by income or by family size, in the interest of "affordability and simplicity" (State of New Jersey 1998) and to help ensure that larger families' annual out-of-pocket expenditures for covered services did not exceed the federal limit of 5 percent of family income. When coverage was extended to parents with incomes up to 200 percent of the FPL, however, the flat premium was replaced by a premium structure that does take into account the number of parents enrolled.

For Plan D, which covers children with family incomes up to 350 percent of the FPL, the state adopted a three-tier premium structure and copays that mirror those in the benchmark plan

(Aetna). For this group, a graduated premium structure was thought to be more equitable than a flat premium structure because of the broad range of incomes covered under the plan. According to one legislator, the high level of cost sharing by families in the highest income groups covered by Plan D also helped to sell the plan to legislators who were resistant to raising income thresholds to this level.

State policymakers strongly objected to the 5 percent limit on aggregate annual cost sharing being applied to families with incomes above 200 percent of the FPL and even considered seeking a waiver of the federal rule. Based on a simulation that showed that virtually no families would exceed the limit, the state argued that the costs to the state of establishing the administrative mechanisms to monitor and enforce the limit would far outweigh any possible benefit to the families in Plan D who, moreover, would not be entitled to such protection in most private insurance policies. At the time, CMS was not yet accepting waiver requests from the states, so plans to submit the waiver proposal were shelved.

B. PROGRAM CHARACTERISTICS

Families with incomes between 151 and 200 percent of the FPL are charged a flat monthly premium of $15 for all children in the family (regardless of the number enrolled), $25 for one parent and $35 for two, for a maximum monthly premium of $50 (Table VII.1). For families with incomes above 200 percent of the FPL, the monthly premium is $30, $60 or $100 for all children in the family, with the amount varying only by income. (Parents at this income level are not eligible.) Families are billed for their first month's premium after their application has been approved, and children are not enrolled until payment is made. If the family fails to pay the initial premium within 30 days after being notified of eligibility, their case will be closed. (It can be reopened without a new application if payment is received within 60 days.) Thereafter,

TABLE VII.1

COST-SHARING POLICIES

Policy	SCHIP
Enrollment fee	None
Premiums	
134-150% FPL (Plan B)	None
151-200% FPL (Plan C)	$15/family/month for all children; $25 for one parent, $35 for two[a]
201-350% FPL (Plan D)	$30, $60, or $100/family/month for families with incomes from 201-250% FPL, 251-300% FPL and 301-350% FPL, respectively
Co-payments	
Emergency Care	
134-150% FPL (Plan B)	None
151-200% FPL (Plan C)	$10
201-350% FPL (Plan D)	$35
Medical Office Visits	
134-150% FPL (Plan B)	None
151-200% FPL (Plan C)	$5
201-350% FPL (Plan D)	$5
Prescription Drugs	
134-150% FPL (Plan B)	None
151-200% FPL (Plan C)	$1 for generics, $5 for brand-name drugs
201-350% FPL (Plan D)	$5 ($10 for supplies over 34 days)
Deductibles	None

SOURCE: Centers for Medicare & Medicaid Services (CMS), *Framework for State Evaluation of Children's Health Insurance Plans Under Title XXI of the Social Security Act: New Jersey.* CMS web site http://www.hcfa.gov/init/chipnj.htm

NOTE: SCHIP=State Children's Health Insurance Program (Title XXI). FPL = Federal poverty level.

[a]Parents with incomes in this range receive the Plan D benefit package and are subject to Plan D copays.

the state's eligibility vendor issues monthly invoices, accompanied by postage-paid envelopes. Families are invoiced one month in advance for each month's payment and sent two reminder notices if they fail to pay within 45 days. Cases are terminated for non-payment of premiums at the end of a 30-day grace period. There is no "blackout" period for non-payment, and thus families who lose eligibility for non-payment of premiums can reapply and be reinstated as soon as they pay past-due premiums.

Copays for most office visits are the same in all plans—$5 per visit—but copays in Plan D are considerably higher than those in Plan C for emergency room care ($35 versus $10) and outpatient mental health visits ($25 versus no charge). Copays for prescription drugs range from $1 to $10 per prescription, depending on the plan, the drug type (generic or brand-name), and the amount.

The state uses the "shoebox" method to track aggregate out-of-pocket expenditures for covered services. In their eligibility notice, families who are subject to cost sharing are notified of the specific dollar limit that applies to them, the need to track their expenditures, and what to do if they exceed the limit. Once a family's cost sharing reaches at least 80 percent of the limit, they can request a special card that indicates their "no copayment" status and obtain a rebate of any excess cost sharing paid.

C. IMPLEMENTATION EXPERIENCES AND LESSONS LEARNED

The premiums and copays charged in NJ FamilyCare were deemed affordable and fair by almost everyone we interviewed. This view is supported by findings from focus groups conducted by the state in 1999 to assess the effect of cost sharing on participation. Although we can draw only limited conclusions from focus groups that did not include families who chose not to enroll or to remain in the program, those parents who did participate (all of whom had children in Plan C or D) indicated that premiums were "low or reasonable" and were not a barrier to

continued participation (State of New Jersey 2000). Although one or two people with whom we spoke suggested that a "more passive" approach, in which families did not have to make monthly payments to stay enrolled, might improve enrollment and retention, almost no one contended that premium levels were too high. According to the director of one community-based organization, "People are willing to pay the premium. They're very grateful and excited about the program."

Copays are seen as even more acceptable to families. Although a few providers reported that some enrollees do not understand their obligations and that a few try to avoid paying by presenting themselves as charity care patients, the general consensus was that copays are not a problem. Said one advocate, "People don't mind copays, because they're paying for a service they're actually using."

IX. PARENT COVERAGE AND PREMIUM ASSISTANCE PROGRAMS

A. POLICY DEVELOPMENT

New Jersey was among the first three states to have a Title XXI demonstration proposal approved by CMS and remains one of only four states that cover parents under SCHIP. Approved by CMS on January 18, 2001, NJ FamilyCare, then known as "NJ KidCare," was actually implemented almost five months earlier and initially funded solely by the state. (Coverage for some eligibility groups covered under the NJ FamilyCare umbrella continues to be solely state-funded.) The program includes a premium assistance program to subsidize eligible families' participation in employer-sponsored group health plans.

CMS began accepting proposals for Section 1115 demonstrations in July 2000, almost three years after Title XXI was signed into law. At the time, many states faced losing access to millions of federal matching dollars at the end of federal fiscal year (FFY) 2000, when unspent 1998 allotments were due to revert to the U.S. Treasury. Although the U.S. Congress was considering and subsequently passed legislation to extend the period of availability for the 1998 and 1999 allotments, policymakers in many states faced strong public pressure to expand SCHIP eligibility in order to access more federal funds. New Jersey anticipated losing about $10 million in 1998 matching funds at the end of FFY 2000 but a larger amount the following year, because less time remained to spend the 1999 allotment.

The availability of tobacco settlement dollars to supply the state match provided the impetus for the state to move forward with a broad expansion of coverage. In her 2001 budget address, Governor Whitman announced a plan to dedicate about one-third of the state's annual tobacco settlement funds to an expanded NJ KidCare program that she redubbed "NJ FamilyCare." Although federal matching funds would be available only to cover parents and pregnant women

with family incomes below 200 percent of the FPL, the governor proposed to extend coverage to nearly all poor adults, without regard to family status. The NJ FamilyCare legislation was signed into law in July 2000. The state began accepting applications in September and kicked off a statewide media campaign to advertise the program in October.

That same month, the state submitted its Section 1115 demonstration proposal to CMS. The proposal included a plan for a premium assistance program that would require eligible uninsured families who had access to employer-based coverage for which the employer paid at least 50 percent of the cost to enroll in that coverage if the state determined that paying the employee share would be more cost-effective than covering the family directly. (The administration's earlier plan to provide subsidies to families who were already participating in employer-based coverage was quashed by the state legislature.) At the time, CMS policy was to permit premium assistance under SCHIP only when such coverage was cost-effective and the employer paid at least 60 percent of the cost. The state argued that the cost-effectiveness test assured that SCHIP dollars would be well spent and managed to persuade CMS to accept a looser, 50 percent rule for the demonstration. Almost immediately thereafter, in the final SCHIP rules published on January 11, 2001, CMS dropped the requirement for any minimum employer contribution, but at that point, New Jersey's Section 1115 demonstration proposal was close to approval, so the state proceeded with the 50-percent requirement.

B. PROGRAM CHARACTERISTICS

New Jersey's Section 1115 demonstration covers parents with incomes between 134 and 200 percent of the FPL and pregnant women with incomes between 185 and 200 percent of the FPL. Parents and pregnant women with incomes below these levels are covered under Title XIX Medicaid. Under the NJ FamilyCare expansion, the state also uses state funds to cover three additional eligibility groups: childless single adults and couples (insured or uninsured) who are

eligible for the state's Work First/General Assistance program;[3] childless single adults and couples (uninsured) with incomes at or below 100 percent of the FPL; and legal immigrants who would qualify for Title XIX- or Title XXI-funded coverage but for the fact that they entered the U.S. less than five years ago and are therefore ineligible for federally funded assistance.

Parents covered under the Section 1115 demonstration receive a benefit package similar to that for Plan D. (Pregnant women covered under the demonstration are enrolled in Plan A.) Parents with incomes above 150 percent of the FPL pay monthly premiums of $25 for the first adult in the family and $10 for the second, with all regular Plan D copays. In the state-funded program, GA recipients and childless adults with incomes below 50 percent of the FPL receive a benefit package similar to Medicaid, while childless adults with incomes between 51 and 100 percent of the FPL receive a package similar to Plan D. Legal immigrants who are within the five-year ban receive whatever benefit package they would if they were not within the ban. All adults with incomes above 133 percent of the FPL must be uninsured for at least six months to qualify for coverage

Enrollment in the premium assistance program began on July 1, 2001. DMAHS is currently reviewing the records of all NJ FamilyCare enrollees and conducting outreach to determine whether families have access to employer-based insurance that meets program requirements, including the 50 percent employer contribution and benefits that meet the Plan D benchmark.

[3]Work First/General Assistance is a cash assistance program for single adults and childless couples who are disabled or unemployed and earn less than $50 a week.

C. IMPLEMENTATION EXPERIENCES AND LESSONS LEARNED

The state began its outreach for NJ FamilyCare with a statewide media campaign and mailings to GA recipients and parents of Medicaid and NJ KidCare enrollees. To jumpstart enrollment, the state also implemented a limited presumptive eligibility program for adults, which allowed them to receive hospital and FQHC services and related pharmacy coverage during the period of presumptive eligibility. As noted in earlier chapters, response was overwhelming, and 155,000 people, 90 percent of whom were adults, were added to the NJ FamilyCare rolls within 16 months. Funds the state had set aside to cover services provided during the presumptive eligibility period were soon exhausted, so presumptive eligibility was ended for adults in April 2001. The state stopped enrolling childless adults on September 1, 2001, and parents on June 14, 2002.

Advocates and others with whom we spoke during our visit generally agreed that the cost-sharing requirements for adults were fair and the benefit package adequate or better. A few mentioned, however, that parents with Plan D coverage are sometimes confused about why and how their benefits and copayments differ from those of their children, who are covered under Plan B or C.

The premium assistance program has proved a challenge to implement. As of May 2002, just 294 individuals, representing 88 families, were enrolled in the program, with another 290 individuals (84 families) waiting to be enrolled. (The most common reason families must wait is that they cannot enroll in their employer's insurance plan until the open enrollment period.) The state initially targeted families with incomes between 151 and 200 percent of the FPL for enrollment in the premium assistance program, and expects to start focusing on children with family incomes above 200 percent of the FPL in June 2002.

Enrollment has proceeded slowly for several reasons, including delays in the receipt of application and enrollment records from the state's eligibility vendor, lack of current information in the records about families' access to employer-sponsored insurance, and families' failure to respond to requests for information. To enroll a family, the state must first contact the parents to find out or confirm that their employers offer insurance. (Although the application requests this information, it may not be captured in the electronic record or may be out of date, since the state is contacting long-term enrollees, as well as new enrollees.) If the family does have access to employer-based coverage, the state then contacts the employer(s) to ascertain the employer contribution and, if it is at least 50 percent, obtain a summary of benefits. If the benefit package meets the benchmark for Plan D, the state conducts a cost-effectiveness test, using an actuarially weighted algorithm, to determine whether the family should be required to enroll in the employer plan or remain in the direct service program. If the employer plan offers fewer services or charges higher copayments than the NJ FamilyCare plan for which the family qualifies (which is often the case, particularly for families with members who qualify for plans A, B or C), the state must make arrangements to provide wraparound services and pick up the additional copayments.

DMAHS staff reported that the analysis of employer benefits is "almost a cursory process" for small-employer plans because many offer the standardized health benefit plans available through the Small Employer Health Benefits Program (SEH), a program created by the state in 1992 to guarantee small employers access to health coverage. (All but one of the plans available through the SEH program meet the Title XXI benchmark, and very few employers offer the one plan that does not.) Analysis of the benefit packages offered by large employers is much more complicated, but as information about each plan is added to the state's database, the number of packages that need to be examined should decrease over time. Another challenge for state staff

is identifying the appropriate person to speak with about the benefit package, particularly in the case of large employers that are headquartered out of state.

Although administrative costs have been high to date, state agency staff believe that the premium assistance program will generate savings once more families become enrolled and costs can be spread across a larger number of enrollees. The one change that DMAHS is currently considering is an amendment to the demonstration to drop the requirement for a 50 percent employer contribution.

X. FINANCING

New Jersey implemented its Title XXI program in February 1998 and for the seven months of FFY 1998 claimed only $3.5 million of its federal allotment, with total matchable expenditures of $5.4 million (Table X.1). Matchable expenditures rose to $30 million the next year and to $72 million the following year. By the end of the three-year period of availability, New Jersey had spent 79 percent of its 1998 allotment, compared with the national median of 57 percent. For FFY 2001—the first year in which the state was able to claim expenditures related to coverage of parents and pregnant women—annual expenditures rose to $196.6 million, an increase of 170 percent over the prior year (State of New Jersey 2002). In the first few years of operation, the state's administrative costs exceeded the 10-percent limit on federal financial participation for administrative spending, obliging the state to hold these claims until spending for health services increased. As of 2001, administrative spending is below the 10 percent cap.

New Jersey's enhanced federal matching rate for SCHIP is 65 percent, the minimum level established by the SCHIP legislation. Funding for the 35-percent state share is appropriated by the New Jersey Legislature each year. Tobacco settlement dollars have provided a large portion of the state share. New Jersey is entitled to almost 4 percent of the 25-year $206 billion settlement (Campaign for Tobacco-Free Kids et al. 2002). As of early 2002, the state had received about $900 million in settlement funds (Siegel 2002).

Like many states, New Jersey is now in the throes of a fiscal crisis, with a $2.9 billion budget shortfall projected for state fiscal year 2002, which ends June 30, and a $6 billion shortfall projected for the following year (Siegel 2002). According to one state legislator, New Jersey's budget gap is proportionally the worst in the nation. DMAHS staff, the governor's

TABLE X.1

SCHIP ALLOTMENTS AND EXPENDITURES, IN MILLIONS OF DOLLARS, 1998-2000

FFY	Federal Allotment	Federal Dollars Expended	Federal Dollars Expended as Percentage of Allotment for the Year	Percentage of Year's Allotment Spent by End of FFY 2000	Redistributed Amount
1998	88.4	3.5	4	79	-
1999	88.0	19.6	22	0	-
2000	96.9	46.9	48	0	NA

SOURCE: *State Children's Health Insurance Program (SCHIP); Redistribution and Continued Availability of Unexpended SCHIP Funds From the Appropriation for FY 1998*, Federal Register, Vol. 66, No. 120, June 21, 2001; Kenney et al., *Three Years into SCHIP: What States Are and Are Not Spending.* Urban Institute: September 2000.

NOTE: SCHIP=State Children's Health Insurance Program (Title XXI); FFY=federal fiscal year; NA=not applicable.

office, and state legislators have considered a number of options for trimming NJ FamilyCare costs, including cutting dental or mental health services, raising premiums on higher-income families, or moving the GA population out of managed care and into fee-for-service. According to Senator Joseph Vitale, who both this year and last introduced legislation to assure continued funding for the NJ FamilyCare program, cuts of this nature are off the table, and "NJ FamilyCare is safe for this year." However, Governor McGreevey plans to borrow against future tobacco settlement payments to close next year's budget gap, which could have ramifications for NJ FamilyCare in the coming years.

XI. LESSONS LEARNED

New Jersey's broad expansion of health care coverage to both adults and children under Title XXI was in some respects a natural extension of the state's earlier efforts to facilitate access to coverage and subsidize care for the uninsured. As noted, New Jersey is one of the few states with a generous charity care program that subsidizes hospital care costs for low- to moderate-income individuals who are ineligible for other public programs. Two years before the passage of Title XXI, the Whitman administration sought to make full insurance coverage available to these individuals through the Health Access subsidy program, and when the legislature failed to fully fund that program, the administration proposed another, focusing this time on children. When federal funds became available through Title XXI, obviating the need for a tobacco tax increase to support the new program, both the administration and the legislature were ready to move forward with a coverage expansion for children. The state's commitment to covering adults as well as children, demonstrated in both the charity care program and Health Access, primed New Jersey to be among the first three states to cover adults under a SCHIP Section 1115 demonstration.

The state's experience with the program has been marked to date by exceptional demand among some eligibility groups—notably, low-income adults—and problems with the application processing system that have threatened to undermine the program's successes. The enrollment surge that followed the NJ FamilyCare expansion in the fall of 2000 unfortunately coincided with a change in the state's eligibility contractor, leading to extraordinary delays in the processing of applications. At the time of our site visit, advocates and application assistors were still reporting hold-ups, and some contend that the delays have discouraged families from applying. Currently, the state has enrolled more adults than were thought to be eligible for the

program, but just 55 percent of eligible children and an even lower proportion (23 percent) of children eligible for Plan D.

Other key findings from the site visit include the following:

- ***The choice of a combination model for New Jersey's SCHIP reflected policymakers' interest in "evening out" Medicaid income eligibility thresholds while avoiding a broad expansion of the Medicaid entitlement***. Policymakers saw the wisdom of establishing a consistent income eligibility threshold for all age groups under Medicaid (at 133 percent of the FPL) but, like their counterparts in many other states, believed that creating a separate child health program for higher income groups would afford the state the flexibility it needed to establish an appropriate level of coverage for these families and control program costs. The fact that the state already had experience operating a state-funded insurance program undoubtedly eased any concerns policymakers might have had about the cost or difficulty of establishing the infrastructure to administer a separate child health program.

- ***The tight timeframe in which the state implemented NJ KidCare drove many initial decisions about enrollment policies, some of which were later relaxed***. Directed by the governor to implement the program within six months and uncertain how large the public response to the program would be, the interagency workgroup that developed NJ KidCare took a conservative approach, adopting some of the more restrictive policies that were in force in other programs. These included the 12-month waiting period that applied in the Health Access program and the Medicaid requirement that applicants document three months' worth of income. As the state gained more experience, and it became evident that enrollment would not exceed projections, these policies were relaxed.

- ***The state established a mail-in application process partly to disassociate SCHIP from Medicaid, but there is some evidence to suggest that fears of Medicaid stigma were overblown***. Many families still apply for coverage at the County Board of Social Services (CBOSS) offices, which handle most Medicaid eligibility determinations. During one week in January, for example, CBOSS offices accounted for over one-third of the NJ FamilyCare applications sent to the state's eligibility contractor. Some of these applications were sent to CBOSS offices by other organizations that provide application assistance, but others were completed at the CBOSS office by families who went to the office seeking help.

- ***Income verification requirements remain a barrier to enrollment***. The requirement that families document one month's income, though an improvement over the earlier three-month requirement, remains a stumbling block for some families. DMAHS staff reported that about half of the applications received by the state's eligibility contractor are incomplete, and the item most commonly missing is documentation of income. Staff are at times able to use other documentation and Department of Labor wage files to verify income.

- ***The screen-and-enroll process in New Jersey has been smooth due to the placement of state Medicaid workers at the vendor site and the close correspondence between Medicaid and SCHIP eligibility requirements***. State workers at the vendor's Trenton office can immediately finalize most Medicaid eligibility determinations. Because the requirements for SCHIP and Medicaid are virtually the same (apart from methodologies used to calculate income and the income standards themselves), families who provide all the information and documentation required for SCHIP can be found eligible for Medicaid and vice versa.

- ***Compared with some other states, New Jersey made only a small, time-limited investment in application assistance, but the lack of direct financial support from the state does not appear to have hurt enrollment through community-based organizations***. Only 43 organizations were provided with small start-up grants and authorized to collect the $25 bounty during the two-year period that the state made funds available, and only a handful of other organizations received lump-sum grants to provide outreach and application assistance. Lack of remuneration does not seem to have deterred many community organizations from helping families apply, since many organizations stand to gain from families' enrollment in NJ FamilyCare or view this type of assistance as part of their organizational mission.

- ***New Jersey was able to build upon its existing managed care infrastructure by requiring HMOs that participate in Medicaid to participate in SCHIP and establishing a benefit package for Plans B and C that closely resembles the Medicaid package***. The smooth roll-out of New Jersey Care 2000, begun in 1995, gave policymakers confidence that NJ KidCare enrollees could be easily absorbed into the Medicaid managed care delivery system. The desire to implement NJ KidCare quickly was reportedly one key reason the state established a benefit package for Plans B and C that closely resembled the package the HMOs were already providing to Medicaid enrollees.

- ***New Jersey is unusual in the extent of its efforts to tailor coverage to different income groups***. Like many states, New Jersey expanded Medicaid coverage for the lowest income groups, but rather than provide a package modeled on commercial coverage to children with family incomes just above this level, state policymakers chose to offer children with family incomes up to 200 percent an only slightly reduced Medicaid package, reserving the commercial-type benefit package for the highest income children (those with incomes up to 350 percent of the FPL). The state also adopted a multi-tier cost-sharing system in the separate child health program, again taking into account differences in family income. (Partly to contain costs, however, the state offers the less generous package with higher cost sharing to parents with incomes between 101 and 200 percent of the FPL.)

- ***Providing the highest income children covered under NJ FamilyCare (Plan D) with coverage equivalent to employer-based coverage was seen as a way to address both social equity and crowd-out concerns***. Although policymakers were willing to provide children with family incomes below 200 percent of the FPL (Plans B and C) with coverage similar to Medicaid, reasoning that these families resemble those covered by Medicaid, they were reluctant to offer families with higher incomes (Plan D) more generous coverage than similar families have through their employers.

- ***Crowdout is not perceived to be a problem in New Jersey***. The state launched its SCHIP program with a 12-month waiting period, the most stringent crowd-out prevention measure allowed by CMS. But as concerns about crowdout diminished, the waiting period was cut in half and a number of exceptions authorized. Although the state has no data to assess whether crowdout is occurring, respondents generally believe that families who have insurance have little incentive to drop it to qualify for NJ FamilyCare.

- ***Cost sharing in NJ FamilyCare is generally regarded as affordable and fair***. In the interest of vertical and horizontal equity, the state adopted a graduated cost-sharing structure, ensuring that families with greater ability to pay more and that families at the lowest and highest ends of the income range covered by SCHIP pay no more or less than their counterparts who are covered by Medicaid or private insurance.

- ***The state strongly objected to the 5 percent limit on aggregate annual cost sharing being applied to families with incomes above 200 percent of the FPL***. In the evaluation submitted to CMS in 2000, the state cited a simulation that showed that virtually no families in this income range would hit the limit and argued that the cost to the state of establishing the mechanisms to monitor and enforce the limit would far outweigh any benefit to families in Plan D. The state even considered seeking a waiver of the federal rule, but CMS was not accepting waiver requests at the time.

- ***Benefits under NJ FamilyCare Plans A, B and C are very generous, and criticism of the NJ FamilyCare benefit package focused on the dental benefit under Plan D***. While Plans A, B and C offer the same dental benefits as Title XIX Medicaid, Plan D provides only preventive dental services to children under age 12.

- ***Access to primary care is perceived to be good, but access to specialty care is thought by some to be declining because of low payment***. New Jersey's Medicaid rates have historically been below the national average, and although payment for primary care has reportedly improved under managed care and is now said by some to compare favorably to commercial rates, payment for specialty care remains well below commercial levels. According to some primary care providers we interviewed, referrals have become increasingly difficult, as specialists have closed their practices to new Medicaid/NJ FamilyCare patients or strictly limited the appointment times available to these patients. However, member satisfaction surveys indicate that appointment wait times are not a problem for most enrollees.

- ***The withdrawal of multiple HMOs from the Medicaid/NJ FamilyCare market has reportedly hurt access in some areas***. Since 1996, the number of plans participating in the public insurance market dropped from 13 to 5. With the departure of Aetna/U.S. Healthcare from the public insurance market in New Jersey, NJ FamilyCare enrollment has become largely concentrated in plans that serve only Medicaid and Family Care enrollees. Some providers and advocates contend that access has consequently declined, as the remaining plans do not have the same leverage with providers as did plans such as Aetna, which made provider participation in Medicaid/NJ FamilyCare a condition of participation in its commercial lines.

- ***Tobacco settlement money made possible the expansion of coverage to adults***. The state's share of the $206 billion settlement with the tobacco industry has been a key source of funding for the SCHIP program and allowed a much broader expansion of coverage than would otherwise have been possible.

- ***The state implemented a premium assistance program to leverage state and federal dollars, as well as to reduce the potential for crowd out, but savings will not be achieved until enrollment is high enough to offset the substantial cost of operating the program.*** Operating a premium assistance program within the constraints of Title XXI has been administratively challenging and costly. To determine whether to enroll a family into the premium assistance program, the state must ascertain whether the enrollee has access to insurance for which the employer pays at least 50 percent of the cost, obtain a schedule of benefits, and determine whether the package meets the Title XXI benchmark. In most cases, the state must also make arrangements to provide wraparound services and cover copayments in excess of the amounts allowed under Title XXI. To date, administrative costs have outweighed savings on benefit costs, but state administrators expect this to change when more families are enrolled.

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APPENDIX A

KEY INFORMANTS—NEW JERSEY SITE VISIT

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JANUARY 7-11, 2002

Trenton

State of New Jersey Department of Human Services
Division of Medial Assistance and Health Services
Michelle Walsky, Chief of Operations
Heidi J. Smith, Executive Director, NJ FamilyCare
Jill Simone, Executive Director, Office of Managed Health Care
Nancy Scarlata, Administrator, Bureau of Eligibility Operations
Elena Josephick, Administrator, Bureau of Eligibility Policy
John R. Guhl, Chief Financial Officer
Michael P. Keevey, Chief, Bureau of Budget and Accounting

New Jersey Department of Health and Senior Services
Celeste Wood, Assistant Commissioner of Family Health Services

New Jersey Legislature
John Pierro, Governor's Office of Management and Policy

MAXIMUS, Inc.
Marion E. Reitz, Vice President
Renee Roberson, Project Manager

New Jersey Primary Care Association, Inc.
Katherine Grant-Davis, Executive Director
Zupenda M. Davis, Director of Community Relations

Americhoice
John Kirchner, Director of Government Affairs
Kay Morrow, General Manager

Horizon Mercy
Radia Funna, Compliance Administrator
Len Kudgis, Marketing Director
Heather Watson, Project Coordinator, Regulatory Affairs
Jackie Moore, Member Relations

New Jersey Hospital Association, Health Research and Educational Trust
Dr. Firoozeh M. Vali, State Covering Kids Program Director

Bridgeton, Cumberland and Camden Counties

Gloucester County Department of Social Services
Carol Pirrotta, Director
Marg Biegalski, Administrative Supervisor of Income Maintenance
Rose Dougherty, Assistant Administrative Supervisor of Income Maintenance
Priscilla Flyn, Assistant Administrative Supervisor of Income Maintenance

Community Health Care, Inc.
Sabrina Cannady, Director of Financial Services
Angelica Garcia, NJ FamilyCare Outreach

South Jersey Health Systems
Julie Hills, Application Assistance Supervisor

Tri-Community Action Agency
Diana Sheridan, Cumberland County Covering Kids Program Coordinator

Kennedy Health Systems,
Eileen Testa,
Susan Santry

Private Practice Physicians
Dr. William Sharar
Dr. Russ Harris
Dr. Charles Scott
Dr. Tony Mischik

Advocates
Ruth Gubernick, NJ FamilyCare Coordinator for Camden County

Hudson County

North Hudson Community Action Center
Michael A. Leggiero, President/CEO

Hudson Perinatal Consortium
Mary Ann Moore, Executive Director

Hudson County Department of Social Services
Mary Ann Maguire, Administrative Supervisor
Linda Guzman, Assistant Administrative Supervisor
Anthony Paul, Administrative Supervisor

Office of the County Executive
Vanessa Reyes

Private Practice Physicians
Dr. Larry Laveman
Dr. Stephen G. Rice

American Academy of Pediatrics
Nancy Pinkin, Government Relations Consultant

La Salud Hispana
Dr. Rodrigo Cardenas, Bergen and Hudson Counties Covering Kids Project Coordinator

Association for Children of New Jersey
Frances Bazaz, Health Policy Analyst

Gateway Maternal and Child Health Consortium
Marijane Lundt

Health Care Access For the Uninsured Legal Services
Linda Garibaldi