CHAPTER 71

AN ACT establishing the FamilyCare Health Coverage Program, supplementing Title 30 of the Revised Statutes and amending P.L.1968, c.413 and P.L.1997, c.13.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

C.30:4J-1 Short title.

1. This act shall be known and may be cited as the "FamilyCare Health Coverage Act."

C.30:4J-2 Findings, declarations regarding FamilyCare Health Coverage Program.

2. The Legislature finds and declares that:

a. The most serious health problem facing over one million New Jersey residents is their lack of access to affordable health care coverage, and this lack of coverage forces too many families to go without needed preventive and other care until serious illness requires expensive hospital care;

b. Research has shown that affordable and accessible health care coverage for parents has a positive impact upon children, since, by having a connection to ongoing health coverage, these parents are more likely to ensure that their children get necessary immunizations and regular checkups from their primary care physicians;

c. Providing health care coverage for uninsured adults encourages continued work efforts, reduces dependence on welfare and other State-subsidized programs, and alleviates reliance on hospital charity care funding;

d. The FamilyCare Health Coverage Program established pursuant to this act builds on New Jersey's long-standing commitment to assure access to quality health care provided in an efficient and effective manner and at reasonable cost; and

e. It is appropriate that the FamilyCare Health Coverage Program utilize resources from the funds that the State receives under the Master Settlement Agreement between the State and tobacco product manufacturers, and other State resources, to establish the foundation for assuring health care coverage for low and moderate-income, uninsured adults.

C.30:4J-3 Definitions regarding the FamilyCare Health Coverage Program.

3. As used in this act:

"Commissioner" means the Commissioner of Human Services.

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

"Program" means the FamilyCare Health Coverage Program established pursuant to this act.

"Qualified applicant" means a person who: is a resident of this State; is a citizen of the United States, or has been lawfully admitted for permanent residence into and remains lawfully present in the United States; has no health insurance coverage; and is ineligible for the Medicaid program established pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.) and the Children's Health Care Coverage Program established pursuant to P.L.1997, c.272 (C.30:4I-1 et seq.).

C.30:4J-4 The FamilyCare Health Coverage Program.

4. a. The FamilyCare Health Coverage Program is established in the Department of Human Services. The purpose of the program shall be to provide subsidized private health insurance coverage, and other health care benefits as determined by the commissioner, within the limits of funds appropriated or otherwise made available for the program, to any qualified applicant who is: a parent or caretaker relative of a child whose gross family income does not exceed 200% of the poverty level, a child whose gross family income does not exceed 350% of the poverty level,or a single adult or couple without dependent children whose gross family income does not exceed 100% of the poverty level.

b. For the purposes of this program, the commissioner:

(1) shall require that a qualified applicant purchase coverage , if available to the qualified applicant,through an employer-sponsored health insurance plan which is determined to be cost-effective and is approved by the commissioner, and shall provide assistance to the qualified applicant to purchase that coverage;

(2) shall by regulation establish standards for determining eligibility and other requirements

for the program, including, but not limited to, restrictions on voluntary disenrollments from existing health insurance coverage;

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

(4) may contract with one or more appropriate entities to assist in administering the program;

(5) may require premium contributions and copayments from qualified applicants as determined by the commissioner; and

(6) shall take, or cause to be taken, any action necessary to secure for the State the maximum amount of federal financial participation available with respect to the program, subject to the constraints of fiscal responsibility and within the limits of available funding in any fiscal year.

c. The provisions of this section shall not be construed to require an employer to provide health insurance coverage for any employee or any employee's spouse or dependent child.

d. A qualified applicant who is a single adult or couple without dependent children shall be ineligible to receive health care services that are covered by the program from any other State-funded program for which the qualified applicant is eligible.

C.30:4J-5 Process to provide presumptive eligibility.

5. a. In order to provide persons in need of health care services with an efficient transition into the program, the commissioner, in consultation with the Commissioner of Health and Senior Services, may establish, for such period of time as the commissioner determines necessary, a process to provide for presumptive eligibility for the program in accordance with the provisions of this section:

(1) A person without health insurance coverage who presents for treatment at an acute care hospital or a federally qualified health center shall be deemed presumptively eligible for the program if a preliminary determination by hospital or health center staff indicates that the person meets the eligibility requirements of this act and the program eligibility standards established by regulation of the commissioner;

(2) During the period in which the person is presumptively eligible for the program, coverage shall be limited to inpatient and outpatient hospital and federally qualified health center services and prescription drug benefits designated by the commissioner;

(3) A person shall be limited to a single period of presumptive eligibility for the program. The presumptive eligibility period shall begin with the month in which presumptive eligibility is determined and expire at the end of the following month; except that an extension of the presumptive eligibility period may be authorized until the person's application for the program is approved or denied, subject to the person's cooperation with the application process during the presumptive eligibility period. The person's failure to provide such cooperation within a period of time determined by the commissioner shall result in a denial of the application; and

(4) A person without health insurance coverage who presents for treatment at an acute care hospital and is determined to not qualify for presumptive eligibility or for the program shall be evaluated for eligibility for charity care pursuant to P.L.1992, c.160 (C.26:2H-18.51 et al.).

b. Notwithstanding the provisions of this act, or any rule or regulation adopted pursuant thereto, to the contrary, the commissioner may:

(1) within the limits of funds appropriated or otherwise made available for the program, reallocate such funds in order to increase the amount available for covered health care services received by persons who are presumptively eligible for the program, for which purpose the commissioner shall cause a notice of such reallocation of funds to be published in the New Jersey Register; and

(2) terminate the presumptive eligibility process, upon the commissioner's finding that all monies appropriated for the program will be expended for covered health care services received by persons enrolled in the program, for which purpose the commissioner shall cause a notice of termination of the presumptive eligibility process to be published in the New Jersey Register.

C.30:4J-6 Rules, regulations.

6. The commissioner shall adopt rules and regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) to effectuate the purposes of this act;

except that, notwithstanding any provision of P.L.1968, c.410 to the contrary, the commissioner may adopt, immediately upon filing with the Office of Administrative Law, such regulations as the commissioner deems necessary to implement the provisions of this act, which shall be effective for a period not to exceed six months and may thereafter be amended, adopted or readopted by the commissioner in accordance with the requirements of P.L.1968, c.410.

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

C.30:4D-3 Definitions.

3. Definitions. As used in this act, and unless the context otherwise requires:

a. "Applicant" means any person who has made application for purposes of becoming a "qualified applicant."

b. "Commissioner" means the Commissioner of Human Services.

c. "Department" means the Department of Human Services, which is herein designated as the single State agency to administer the provisions of this act.

d. "Director" means the Director of the Division of Medical Assistance and Health Services.

e. "Division" means the Division of Medical Assistance and Health Services.

f. "Medicaid" means the New Jersey Medical Assistance and Health Services Program.

g. "Medical assistance" means payments on behalf of recipients to providers for medical care and services authorized under this act.

h. "Provider" means any person, public or private institution, agency or business concern approved by the division lawfully providing medical care, services, goods and supplies authorized under this act, holding, where applicable, a current valid license to provide such services or to dispense such goods or supplies.

i. "Qualified applicant" means a person who is a resident of this State, and either a citizen of the United States or an eligible alien, and is determined to need medical care and services as provided under this act, and who:

(1) Is a dependent child or parent or caretaker relative of a dependent child who would be, except for resources, eligible for the aid to families with dependent children program under the State Plan for Title IV-A of the federal Social Security Act as of July 16, 1996;

(2) Is a recipient of Supplemental Security Income for the Aged, Blind and Disabled under Title XVI of the Social Security Act;

(3) Is an "ineligible spouse" of a recipient of Supplemental Security Income for the Aged, Blind and Disabled under Title XVI of the Social Security Act, as defined by the federal Social Security Administration;

(4) Would be eligible to receive Supplemental Security Income under Title XVI of the federal Social Security Act or, without regard to resources, would be eligible for the aid to families with dependent children program under the State Plan for Title IV-A of the federal Social Security Act as of July 16, 1996, except for failure to meet an eligibility condition or requirement imposed under such State program which is prohibited under Title XIX of the federal Social Security Act such as a durational residency requirement, relative responsibility, consent to imposition of a lien;

(5) (Deleted by amendment, P.L.2000, c.71);

(6) Is an individual under 21 years of age who, without regard to resources, would be, except for dependent child requirements, eligible for the aid to families with dependent children program under the State Plan for Title IV-A of the federal Social Security Act as of July 16, 1996, or groups of such individuals, including but not limited to, children in foster placement under supervision of the Division of Youth and Family Services whose maintenance is being paid in whole or in part from public funds, children placed in a foster home or institution by a private adoption agency in New Jersey or children in intermediate care facilities, including developmental centers for the developmentally disabled, or in psychiatric hospitals;

(7) Would be eligible for the Supplemental Security Income program, but is not receiving such assistance and applies for medical assistance only;

(8) Is determined to be medically needy and meets all the eligibility requirements described below:

(a) The following individuals are eligible for services, if they are determined to be medically

needy:

(i) Pregnant women;

(ii) Dependent children under the age of 21;

(iii) Individuals who are 65 years of age and older; and

(iv) Individuals who are blind or disabled pursuant to either 42 C.F.R.435.530 et seq. or 42 C.F.R.435.540 et seq., respectively.

(b) The following income standard shall be used to determine medically needy eligibility:

(i) For one person and two person households, the income standard shall be the maximum allowable under federal law, but shall not exceed 133 1/3% of the State's payment level to two person households under the aid to families with dependent children program under the State Plan for Title IV-A of the federal Social Security Act in effect as of July 16, 1996; and

(ii) For households of three or more persons, the income standard shall be set at 133 1/3% of the State's payment level to similar size households under the aid to families with dependent children program under the State Plan for Title IV-A of the federal Social Security Act in effect as of July 16, 1996.

(c) The following resource standard shall be used to determine medically needy eligibility:

(i) For one person households, the resource standard shall be 200% of the resource standard for recipients of Supplemental Security Income pursuant to 42 U.S.C.s.1382(1)(B);

(ii) For two person households, the resource standard shall be 200% of the resource standard for recipients of Supplemental Security Income pursuant to 42 U.S.C.s.1382(2)(B);

(iii) For households of three or more persons, the resource standard in subparagraph (c)(ii) above shall be increased by $100.00 for each additional person; and

(iv) The resource standards established in (i), (ii), and (iii) are subject to federal approval and the resource standard may be lower if required by the federal Department of Health and Human Services.

(d) Individuals whose income exceeds those established in subparagraph (b) of paragraph (8) of this subsection may become medically needy by incurring medical expenses as defined in 42 C.F.R.435.831(c) which will reduce their income to the applicable medically needy income established in subparagraph (b) of paragraph (8) of this subsection.

(e) A six-month period shall be used to determine whether an individual is medically needy.

(f) Eligibility determinations for the medically needy program shall be administered as follows:

(i) County welfare agencies and other entities designated by the commissioner are responsible for determining and certifying the eligibility of pregnant women and dependent children. The division shall reimburse county welfare agencies for 100% of the reasonable costs of administration which are not reimbursed by the federal government for the first 12 months of this program's operation. Thereafter, 75% of the administrative costs incurred by county welfare agencies which are not reimbursed by the federal government shall be reimbursed by the division;

(ii) The division is responsible for certifying the eligibility of individuals who are 65 years of age and older and individuals who are blind or disabled. The division may enter into contracts with county welfare agencies to determine certain aspects of eligibility. In such instances the division shall provide county welfare agencies with all information the division may have available on the individual.

The division shall notify all eligible recipients of the Pharmaceutical Assistance to the Aged and Disabled program, P.L.1975, c.194 (C.30:4D-20 et seq.) on an annual basis of the medically needy program and the program's general requirements. The division shall take all reasonable administrative actions to ensure that Pharmaceutical Assistance to the Aged and Disabled recipients, who notify the division that they may be eligible for the program, have their applications processed expeditiously, at times and locations convenient to the recipients; and

(iii) The division is responsible for certifying incurred medical expenses for all eligible persons who attempt to qualify for the program pursuant to subparagraph (d) of paragraph (8) of this subsection;

(9) (a) Is a child who is at least one year of age and under 19 years of age and, if older than six years of age but under 19 years of age, is uninsured; and

(b) Is a member of a family whose income does not exceed 133% of the poverty level and

who meets the federal Medicaid eligibility requirements set forth in section 9401 of Pub.L.99-509 (42 U.S.C. s.1396a);

(10) Is a pregnant woman who is determined by a provider to be presumptively eligible for medical assistance based on criteria established by the commissioner, pursuant to section 9407 of Pub.L.99-509 (42 U.S.C. s.1396a(a));

(11) Is an individual 65 years of age and older, or an individual who is blind or disabled pursuant to section 301 of Pub.L.92-603 (42 U.S.C. s.1382c), whose income does not exceed 100% of the poverty level, adjusted for family size, and whose resources do not exceed 100% of the resource standard used to determine medically needy eligibility pursuant to paragraph (8) of this subsection;

(12) Is a qualified disabled and working individual pursuant to section 6408 of Pub.L.101-239 (42 U.S.C. s.1396d) whose income does not exceed 200% of the poverty level and whose resources do not exceed 200% of the resource standard used to determine eligibility under the Supplemental Security Income Program, P.L.1973, c.256 (C.44:7-85 et seq.);

(13) Is a pregnant woman or is a child who is under one year of age and is a member of a family whose income does not exceed 185% of the poverty level and who meets the federal Medicaid eligibility requirements set forth in section 9401 of Pub.L.99-509 (42 U.S.C. s.1396a), except that a pregnant woman who is determined to be a qualified applicant shall, notwithstanding any change in the income of the family of which she is a member, continue to be deemed a qualified applicant until the end of the 60-day period beginning on the last day of her pregnancy;

(14) (Deleted by amendment, P.L.1997, c.272).

(15) (a) Is a specified low-income Medicare beneficiary pursuant to 42 U.S.C. s.1396a(a)10(E)iii whose resources beginning January 1, 1993 do not exceed 200% of the resource standard used to determine eligibility under the Supplemental Security Income program, P.L.1973, c.256 (C.44:7-85 et seq.) and whose income beginning January 1, 1993 does not exceed 110% of the poverty level, and beginning January 1, 1995 does not exceed 120% of the poverty level.

(b) An individual who has, within 36 months, or within 60 months in the case of funds transferred into a trust, of applying to be a qualified applicant for Medicaid services in a nursing facility or a medical institution, or for home or community-based services under section 1915(c) of the federal Social Security Act (42 U.S.C. s.1396n(c)), disposed of resources or income for less than fair market value shall be ineligible for assistance for nursing facility services, an equivalent level of services in a medical institution, or home or community-based services under section 1915(c) of the federal Social Security Act (42 U.S.C. s.1396n(c)). The period of the ineligibility shall be the number of months resulting from dividing the uncompensated value of the transferred resources or income by the average monthly private payment rate for nursing facility services in the State as determined annually by the commissioner. In the case of multiple resource or income transfers, the resulting penalty periods shall be imposed sequentially. Application of this requirement shall be governed by 42 U.S.C. s.1396p(c). In accordance with federal law, this provision is effective for all transfers of resources or income made on or after August 11, 1993. Notwithstanding the provisions of this subsection to the contrary, the State eligibility requirements concerning resource or income transfers shall not be more restrictive than those enacted pursuant to 42 U.S.C. s.1396p(c).

(c) An individual seeking nursing facility services or home or community-based services and who has a community spouse shall be required to expend those resources which are not protected for the needs of the community spouse in accordance with section 1924(c) of the federal Social Security Act (42 U.S.C. s.1396r-5(c)) on the costs of long-term care, burial arrangements, and any other expense deemed appropriate and authorized by the commissioner. An individual shall be ineligible for Medicaid services in a nursing facility or for home or community-based services under section 1915(c) of the federal Social Security Act (42 U.S.C. s.1396n(c)) if the individual expends funds in violation of this subparagraph. The period of ineligibility shall be the number of months resulting from dividing the uncompensated value of transferred resources and income by the average monthly private payment rate for nursing facility services in the State as determined by the commissioner. The period of ineligibility shall begin

with the month that the individual would otherwise be eligible for Medicaid coverage for nursing facility services or home or community-based services.

This subparagraph shall be operative only if all necessary approvals are received from the federal government including, but not limited to, approval of necessary State plan amendments and approval of any waivers.

(16) Subject to federal approval under Title XIX of the federal Social Security Act, is a dependent child, parent or specified caretaker relative of a child who is a qualified applicant, who would be eligible, without regard to resources, for the aid to families with dependent children program under the State Plan for Title IV-A of the federal Social Security Act as of July 16, 1996, except for the income eligibility requirements of that program, and whose family earned income does not exceed 133% of the poverty level plus such earned income disregards as shall be determined according to a methodology to be established by regulation of the commissioner; or

(17) Is an individual from 18 through 20 years of age who is not a dependent child and would be eligible for medical assistance pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.), without regard to income or resources, who, on the individual's 18th birthday was in foster care under the care and custody of the Division of Youth and Family Services and whose maintenance was being paid in whole or in part from public funds. j. "Recipient" means any qualified applicant receiving benefits under this act.

k. "Resident" means a person who is living in the State voluntarily with the intention of making his home here and not for a temporary purpose. Temporary absences from the State, with subsequent returns to the State or intent to return when the purposes of the absences have been accomplished, do not interrupt continuity of residence.

l. "State Medicaid Commission" means the Governor, the Commissioner of Human Services, the President of the Senate and the Speaker of the General Assembly, hereby constituted a commission to approve and direct the means and method for the payment of claims pursuant to this act.

m. "Third party" means any person, institution, corporation, insurance company, group health plan as defined in section 607(1) of the federal "Employee Retirement and Income Security Act of 1974," 29 U.S.C. s.1167(1), service benefit plan, health maintenance organization, or other prepaid health plan, or public, private or governmental entity who is or may be liable in contract, tort, or otherwise by law or equity to pay all or part of the medical cost of injury, disease or disability of an applicant for or recipient of medical assistance payable under this act.

n. "Governmental peer grouping system" means a separate class of skilled nursing and intermediate care facilities administered by the State or county governments, established for the purpose of screening their reported costs and setting reimbursement rates under the Medicaid program that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated State or county skilled nursing and intermediate care facilities.

o. "Comprehensive maternity or pediatric care provider" means any person or public or private health care facility that is a provider and that is approved by the commissioner to provide comprehensive maternity care or comprehensive pediatric care as defined in subsection b. (18) and (19) of section 6 of P.L.1968, c.413 (C.30:4D-6).

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

q. "Eligible alien" means one of the following:

(1) an alien present in the United States prior to August 22, 1996, who is:

(a) a lawful permanent resident;

(b) a refugee pursuant to section 207 of the federal "Immigration and Nationality Act" (8 U.S.C. s.1157);

(c) an asylee pursuant to section 208 of the federal "Immigration and Nationality Act" (8 U.S.C. s.1158);

(d) an alien who has had deportation withheld pursuant to section 243(h) of the federal "Immigration and Nationality Act" (8 U.S.C. s.1253 (h));

(e) an alien who has been granted parole for less than one year by the federal Immigration and Naturalization Service pursuant to section 212(d)(5) of the federal "Immigration and Nationality Act" (8 U.S.C. s.1182(d)(5));

(f) an alien granted conditional entry pursuant to section 203(a)(7) of the federal "Immigration and Nationality Act" (8 U.S.C. s.1153(a)(7)) in effect prior to April 1, 1980; or

(g) an alien who is honorably discharged from or on active duty in the United States armed forces and the alien's spouse and unmarried dependent child.

(2) An alien who entered the United States on or after August 22, 1996, who is:

(a) an alien as described in paragraph (1)(b), (c), (d) or (g) of this subsection; or

(b) an alien as described in paragraph (1)(a), (e) or (f) of this subsection who entered the United States at least five years ago.

(3) A legal alien who is a victim of domestic violence in accordance with criteria specified for eligibility for public benefits as provided in Title V of the federal "Illegal Immigration Reform and Immigrant Responsibility Act of 1996" (8 U.S.C. s.1641).

8. Section 7 of P.L.1997, c.13 (C.44:10-40) is amended to read as follows:

C.44:10-40 Medical assistance allowed, certain.

7. a. Single adults and couples without dependent children shall not be eligible for medical assistance for inpatient or outpatient hospital care or long-term care under the program, except that medical assistance shall be provided for the following, in accordance with regulations adopted by the commissioner:

(1) inpatient hospitalization costs for a recipient of general public assistance pursuant to P.L.1947, c.156 (C.44:8-107 et seq.) who is admitted to a special hospital licensed by the Department of Health and Senior Services which is not eligible to receive a charity care subsidy from the Health Care Subsidy Fund established pursuant to P.L.1992, c.160 (C.26:2H-18.51 et al.) and to which payments were made prior to July 1, 1991 on behalf of patients receiving general public assistance;

(2) nursing home costs for a person residing in a non-Medicaid certified nursing facility prior to July 1, 1995, whose income is above the Medicaid institutional cap and who does not otherwise qualify for State-funded nursing home care as a medically needy person pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.), to be paid for out of a separate account from the Medicaid program; which assistance shall continue until the person is no longer eligible for long-term care; and

(3) nursing home costs for an alien residing in a Medicaid certified nursing facility prior to the effective date of this act who is not Medicaid-eligible under Pub.L.104-193; which assistance shall continue until the person is no longer eligible for long-term care.

b. The provisions of this section shall not affect the eligibility of a single adult or a couple without dependent children for the New Jersey FamilyCare Health Coverage Program established pursuant to section 4 of P.L.2000, c.71 (C.30:4J-4).

9. This act shall take effect immediately.

Approved July 13, 2000.