CHAPTER 156

AN ACT concerning health care coverage for children and their parents and revising parts of the statutory law.

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

C.30:4J-8 Short title.

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

C.30:4J-9 Findings, declarations relative to family health care coverage.

2. The Legislature finds and declares that:

a. The most serious health problem facing approximately 1.2 million New Jersey residents, including approximately 264,000 children, is lack of access to affordable health care coverage, which forces too many New Jersey families to go without needed preventive and other nonemergency care until serious illness requires expensive hospital care.

b. Research has shown that affordable and accessible health care coverage for parents can benefit their children, since parents who have a connection to ongoing health care coverage are more likely to ensure that their children get necessary immunizations and regular checkups from a primary care provider. Adults and children who lack insurance coverage forgo care until medical conditions, which were either preventable or treatable at the outset, require more extensive and expensive intervention or treatment.

c. Children with health care coverage have a significantly greater opportunity to be healthier, realize their full educational and developmental potential and become productive citizens. Providing health care coverage for uninsured adults increases worker productivity and can reduce dependence on public assistance and other State-subsidized programs including hospital charity care.

d. The federal State Children's Health Insurance Program (SCHIP), established in 1997 as Title XXI of the federal Social Security Act, allows a state to establish a health insurance program for low-income children. In response to the enactment of SCHIP, New Jersey established the NJ KidCare program in 1997 and the NJ FamilyCare program in 2000 to provide subsidized private health insurance coverage to children whose family income does not exceed 350% of the federal poverty level (FPL) and to their parents if their income does not exceed 200% of the FPL. NJ FamilyCare also provided coverage for adults without children whose income did not exceed 100% of the FPL.

Upon the establishment of NJ FamilyCare, the two programs were combined and administered as NJ FamilyCare. Within a short time, enrollment of adults far exceeded expectations and available funding, and various changes were made to the program to contain costs, such as scaling back benefits, limiting eligibility to parents and other adults who were already enrolled in, or had applied for, the program as of June 14, 2002, and no longer accepting any new applications from parents or other adults.

e. Initially, NJ FamilyCare appreciably reduced the costs of charity care provided by hospitals, but when NJ FamilyCare coverage for parents and other adults was curtailed, charity care costs again increased.

f. In order to (1) ensure that the original purpose of NJ FamilyCare is realized, that is, low income parents as well as their children are given access to health insurance coverage, (2) increase enrollment of children, and (3) maximize federal financial participation under both the State Medicaid and NJ FamilyCare programs, it is necessary and appropriate to restore coverage for parents of children who qualify for Medicaid or NJ FamilyCare, by increasing income eligibility levels, over a three-year period, for parents under the Medicaid program to 133% of the FPL. Further, to provide for a more comprehensive health care system, it is also necessary and appropriate to restore coverage through the Medicaid program, over a three-year period, for adults without dependent children whose income is up to 100% of the FPL, subject to the availability of federal Medicaid funds.

g. Since 2002, the number of parents enrolled in NJ FamilyCare has steadily declined and the growth in coverage of children has slowed. Current application and renewal procedures create unnecessary barriers for applicants and enrollees, and have contributed to a decline in the enrollment of additional children and in the retention of enrollees. Experience in other states suggests that adopting certain enrollment simplification reforms in both the NJ FamilyCare and Medicaid programs can significantly increase enrollment and retention of eligible children and their parents.

h. The expanded health care coverage provided by this act builds on New Jersey's longstanding commitment to assure access to quality health care that is provided in an efficient and effective manner and at a reasonable cost.

C.30:4J-10 NJ Family Care Program.

3. The NJ FamilyCare Program is established in the Department of Human Services.

C.30:4J-11 Definitions relative to family health care coverage.

4. As used in this act:

"Commissioner" means the Commissioner of Human Services.

"Department" means the Department of Human Services.

"Medicaid" means the New Jersey Medical Assistance and Health Services Program established pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.).

"NJ FamilyCare" or "program" means the NJ FamilyCare Program established pursuant to sections 3 through 5 of P.L.2005, 156 (C.30:4J-10 though C.30:4J-12).

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

"Qualified applicant" means:

a. a child under 19 years of age: (1) whose family gross income does not exceed 350% of the poverty level; (2) who has no health insurance, as determined by the commissioner, and is ineligible for Medicaid; (3) who is a resident of this State; and (4) who is a citizen of the United States, or has been lawfully admitted for permanent residence into and remains lawfully present in the United States;

b. a parent or caretaker: (1) whose gross family income does not exceed 200% of the poverty level; (2) who is enrolled in NJ FamilyCare on the effective date of P.L.2005, c.156 (C.30:4J-8 et al.); (3) who has no health insurance, as determined by the commissioner, and is ineligible for Medicaid; (4) who is a resident of this State; and (5) who is a citizen of the United States, or has been lawfully admitted for permanent residence into and remains lawfully present in the United States; and

c. a single adult or couple without dependent children: (1) whose family gross income does not exceed 100% of the poverty level; (2) who is enrolled in NJ FamilyCare on the effective date of P.L.2005, c.156 (C.30:4J-8 et al.) and is ineligible for Medicaid; (3) who is a resident of this State; and (4) who is a citizen of the United States, or has been lawfully admitted for permanent residence into and remains lawfully present in the United States.

C.30:4J-12 Purpose of program.

5. a. The purpose of the program shall be to provide subsidized health insurance coverage, and other health care benefits as determined by the commissioner, to children under 19 years of age and their parents or caretakers and to adults without dependent children, within the limits of funds appropriated or otherwise made available for the program.

The program shall require families to pay copayments and make premium contributions, based upon a sliding income scale. The program shall include the provision of well-child and other preventive services, hospitalization, physician care, laboratory and x-ray services, prescription drugs, mental health services, and other services as determined by the commissioner.

b. The commissioner shall take such actions as are necessary to implement and operate the program in accordance with the State Children's Health Insurance Program established pursuant to 42 U.S.C.s.1397aa et seq.

c. The commissioner:

(1) shall, by regulation, establish standards for determining eligibility and other program requirements, including, but not limited to, restrictions on voluntary disenrollments from existing health insurance coverage;

(2) shall require that a parent or caretaker who is a qualified applicant purchase coverage, if available, 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, except that the provisions of this paragraph shall not be construed to require an employer to provide health insurance coverage for any employee or employee's spouse or dependent child;

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

(4) shall establish, by regulation, other requirements for the program, including, but not limited to, premium payments and copayments, and may contract with one or more

appropriate entities, including managed care organizations, to assist in administering the program. The period for which eligibility for the program is determined shall be the maximum period permitted under federal law.

d. The commissioner shall establish procedures for determining eligibility, which shall include, at a minimum, the following enrollment simplification practices:

(1) A streamlined application form as established pursuant to subsection k. of this section;

(2) Require new applicants to submit no more than one recent pay stub from the applicant's employer, or, if the applicant has more than one employer, no more than one from each of the applicant's employers, to verify income. In the event the applicant cannot provide a recent pay stub, the applicant may submit another form of income verification as deemed appropriate by the commissioner. If an applicant does not submit income verification in a timely manner, before determining the applicant ineligible for the program, the commissioner shall seek to verify the applicant's income by reviewing available Department of the Treasury or Department of Labor and Workforce Development records concerning the applicant, or such other records as the commissioner determines appropriate.

The commissioner may establish such retrospective auditing or income verification procedures as he deems appropriate, such as sample auditing and matching reported income with records of the Department of the Treasury or the Department of Labor and Workforce Development or such other records as the commissioner determines appropriate.

If the commissioner elects to match reported income with confidential records of the Department of the Treasury, the commissioner shall require an applicant to provide written authorization for the Division of Taxation in the Department of the Treasury to release applicable tax information to the commissioner for the purposes of establishing income eligibility for the program. The authorization, which shall be included on the program application form, shall be developed by the commissioner, in consultation with the State Treasurer;

(3) Online enrollment and renewal, in addition to enrollment and renewal by mail. The online enrollment and renewal forms shall include electronic links to other State and federal health and social services programs;

(4) Continuous enrollment;

(5) Simplified renewal by sending an enrollee a preprinted renewal form and requiring the enrollee to sign and return the form, with any applicable changes in the information provided in the form, no later than 30 days after the date the enrollee's annual eligibility expires. The commissioner may establish such auditing or income verification procedures as he deems appropriate, as provided in paragraph (1) of this subsection; and

(6) Provision of program eligibility-identification cards that are issued no more frequently than once a year.

e. The commissioner 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. In this regard, notwithstanding the definition of "qualified applicant," the commissioner may enroll in the program such children or their parents or caretakers who may otherwise be eligible for the Medicaid program in order to maximize use of federal funds that may be available pursuant to 42 U.S.C. s.1397aa et seq.

f. Subject to federal approval, a child shall be determined ineligible for the program if the child was voluntarily disenrolled from employer-sponsored group insurance coverage within six months prior to application to the program.

g. The commissioner shall provide, by regulation, for presumptive eligibility for the program in accordance with the following provisions:

(1) A child who presents himself for treatment at a general hospital, federally qualified or community health center, local health department that provides primary care, or other State licensed community-based primary care provider shall be deemed presumptively eligible for the program if a preliminary determination by hospital, health center, local health department or licensed health care provider staff indicates that the child meets program eligibility standards and is a member of a household with an income that does not exceed 350% of the poverty level;

(2) The provisions of paragraph (1) of this subsection shall also apply to a child who is deemed presumptively eligible for Medicaid coverage pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.);

(3) The parent or caretaker of a child deemed presumptively eligible pursuant to this subsection shall be required to submit a completed application for the program no later than the

end of the month following the month in which presumptive eligibility is determined;

(4) A child shall be eligible to receive all services covered by the program during the period in which the child is presumptively eligible; and

(5) The commissioner may, by regulation, establish a limit on the number of times a child may be deemed presumptively eligible for NJ FamilyCare.

h. The commissioner, in consultation with the Commissioner of Education, shall administer an ongoing enrollment initiative to provide outreach to children throughout the State who may be eligible for the program.

(1) With respect to school-age children, the commissioner, in consultation with the Commissioner of Education and the Secretary of Agriculture, shall develop a form that provides information about the NJ FamilyCare and Medicaid programs and provides an opportunity for the parent or guardian who signs the school lunch application form to give consent for information to be shared with the Department of Human Services for the purpose of determining eligibility for the programs. The form shall be attached to, included with, or incorporated into, the school lunch application form.

The commissioner, in consultation with the Commissioner of Education, shall establish procedures for schools to transmit information attached to, included with, or provided on the school lunch application form regarding the NJ FamilyCare and Medicaid programs to the Department of Human Services, in order to enable the department to determine eligibility for the programs.

(2) The commissioner or the Commissioner of Education, as applicable, shall:

(a) make available to each elementary and secondary school, licensed child care center, registered family day care home, unified child care agency, local health department that provides primary care, and community-based primary care provider, informational materials about the program, including instructions for applying online or by mail, as well as copies of the program application form.

The entity shall make the informational and application materials available, upon request, to persons interested in the program; and

(b) request each entity to distribute a notice at least annually, as developed by the commissioner, to households of children attending or receiving its services or care, informing them about the program and the availability of informational and application materials. In the case of elementary and secondary schools, the information attached to, included with, or incorporated into, the school lunch application form for school-age children pursuant to this subparagraph shall be deemed to meet the requirements of this paragraph.

i. Subject to federal approval, the commissioner shall, by regulation, establish that in determining income eligibility for a child, any gross family income above 200% of the poverty level, up to a maximum of 350% of the poverty level, shall be disregarded.

j. The commissioner shall establish a NJ FamilyCare coverage buy-in program through which a parent or caretaker whose family income exceeds 350% of the poverty level may purchase coverage under NJ FamilyCare for a child under the age of 19, who is uninsured and was not voluntarily disenrolled from employer-sponsored group insurance coverage within six months prior to application to the program.

The commissioner shall establish the premium and cost sharing amounts required to purchase coverage, except that the premium shall not exceed the amount the program pays per month to a managed care organization under NJ FamilyCare for a child of comparable age whose family income is between 200% and 350% of the poverty level, plus a reasonable processing fee.

k. The commissioner, in consultation with the Rutgers Center for State Health Policy, shall develop a streamlined application form for the NJ FamilyCare and Medicaid programs.

C.30:4J-13 Terms deemed to mean, refer to NJ Family Care Program.

6. Whenever the terms "Children's Health Care Coverage Program," "NJ KidCare," "FamilyCare Health Coverage Program" or "NJ FamilyCare" occur or any reference is made thereto in any law, contract or document, the same shall be deemed to mean or refer to the NJ FamilyCare Program established pursuant to P.L.2005, c.156 (C.30:4J-8 et al.).

7. Section 3 of P.L.1999, c.171 (C.18A:40-34) is amended to read as follows:

C.18A:40-34 Regulations adopted by Commissioner of Education relative to children's health care coverage.

3. The Commissioner of Education, in consultation with the Commissioner of Human

Services and pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt regulations to:

a. provide for the implementation by the board of education in each school district of such procedures by each public elementary and secondary school in the district as the commissioner deems necessary to effectuate the purposes of subsection h. of section 5 of P.L.2005, c.156 (C.30:4J-12); and

b. facilitate and provide for the participation of nonpublic elementary and secondary schools in the enrollment initiative created pursuant to subsection h. of section 5 of P.L.2005, c.156 (C.30:4J-12).

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

C.30:4D-3 Definitions.

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, with respect to whom the period for which eligibility to be a recipient is determined shall be the maximum period permitted under federal law, 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 temporary assistance for needy families 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 temporary assistance for needy families 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 temporary assistance for needy families 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 resource family 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 resource family 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 temporary assistance for needy families 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 temporary assistance for needy families 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 temporary assistance for needy families

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,

(a) if a dependent child, does not exceed 133% of the poverty level, and

(b) if a parent or specified caretaker relative, beginning September 1, 2005 does not exceed 100% of the poverty level, beginning September 1, 2006 does not exceed 115% of the poverty level and beginning September 1, 2007 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. The commissioner may increase the income eligibility limits for children and parents and specified caretaker relatives, as funding permits;

(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 resource family 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;

(18) Is a person between the ages of 16 and 65 who is permanently disabled and working, and:

(a) whose income is at or below 250% of the poverty level, plus other established disregards;

(b) who pays the premium contribution and other cost sharing as established by the commissioner, subject to the limits and conditions of federal law; and

(c) whose assets, resources and unearned income do not exceed limitations as established by the commissioner;

(19) Is an uninsured individual under 65 years of age who:

(a) has been screened for breast or cervical cancer under the federal Centers for Disease Control and Prevention breast and cervical cancer early detection program;

(b) requires treatment for breast or cervical cancer based upon criteria established by the commissioner;

(c) has an income that does not exceed the income standard established by the commissioner pursuant to federal guidelines;

(d) meets all other Medicaid eligibility requirements; and

(e) in accordance with Pub.L.106-354, is determined by a qualified entity to be presumptively eligible for medical assistance pursuant to 42 U.S.C. s.1396a(aa), based upon criteria established by the commissioner pursuant to section 1920B of the federal Social Security Act (42 U.S.C. s.1396r-1b); or

(20) Subject to federal approval under Title XIX of the federal Social Security Act, is a single adult or couple, without dependent children, whose income in 2006 does not exceed 50% of the poverty level, in 2007 does not exceed 75% of the poverty level and in 2008 and each year thereafter does not exceed 100% of the poverty level; except that a person who is a recipient of Work First New Jersey general public assistance, pursuant to P.L.1947, c.156 (C.44:8-107 et seq.), shall not be a qualified applicant.

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 U.S. Citizenship and Immigration Services 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).

C.30:4D-3b Establishment of enrollment simplification practices.

9. No later than January 1, 2006, the Commissioner of Human Services shall, at a minimum, establish the following enrollment simplification practices for dependent children and their parents or specified caretaker relatives who are applicants for or recipients of the Medicaid program:

a. A streamlined application form as established pursuant to subsection k. of section 5 of P.L.2005, c.156 (C.30:4J-12);

b. Require new applicants to submit no more than one recent pay stub from the applicant's employer, or, if the applicant has more than one employer, no more than one from each of the applicant's employers, to verify income. In the event the applicant cannot provide a recent pay stub, the applicant may submit another form of income verification as deemed appropriate by the commissioner. If an applicant does not submit income verification in a timely manner, before determining the applicant ineligible for the program, the commissioner shall seek to verify the applicant's income by reviewing available Department of the Treasury or Department of Labor and Workforce Development records concerning the applicant or such other records as the commissioner determines appropriate.

The commissioner may establish such retrospective auditing or income verification procedures as he deems appropriate, such as sample auditing and matching reported income with records of the Department of the Treasury or the Department of Labor and Workforce Development or such other records as the commissioner determines appropriate.

If the commissioner elects to match reported income with confidential records of the Department of the Treasury, the commissioner shall require an applicant to provide written authorization for the Division of Taxation in the Department of the Treasury to release applicable tax information to the commissioner for the purposes of establishing income eligibility for the program. The authorization, which shall be included on the program application form, shall be developed by the commissioner, in consultation with the State Treasurer;

c. Online enrollment and renewal, in addition to enrollment and renewal by mail. The online enrollment and renewal forms shall include electronic links to other State and federal health and

social services programs;

d. Continuous enrollment;

e. Simplified renewal by sending a recipient a preprinted renewal form and requiring the recipient to sign and return the form, with any applicable changes in the information provided in the form, no later than 30 days after the date the recipient's annual eligibility expires. The commissioner may establish such auditing or income verification procedures as he deems appropriate, as provided in subsection a. of this section; and

f. Provision of program eligibility-identification cards that are issued no more frequently than once a year.

10. The commissioner shall apply for such State plan amendments or waivers as may be necessary to implement the provisions of this act and to secure federal financial participation for State Medicaid expenditures under the federal Medicaid program and for NJ FamilyCare expenditures under the State Children's Health Insurance Program pursuant to 42 U.S.C.s.1397aa et seq.

C.30:4J-14 Reports by Commissioner of Human Services; requirements.

11. The Commissioner of Human Services shall report to the Chairman of the Senate Health, Human Services and Senior Citizens Committee and the Chairmen of the Assembly Health and Human Services and Assembly Family, Women and Children's Issues committees on the implementation of this act.

The commissioner shall issue an interim report six months after the effective date of this act and shall issue an annual report six months later and once each year thereafter.

The report shall include the number of persons who are enrolled in the Medicaid and NJ FamilyCare programs pursuant to the provisions of this act, the cost of providing coverage for these persons, the status of any Medicaid plan amendments or waivers necessary for implementation of this act, the status of implementing the enrollment simplification practices for both the NJ FamilyCare and Medicaid programs, and such other information as the commissioner deems appropriate. The commissioner may also include any recommendations for legislation he deems necessary to further the purposes of this act.

12. Within 60 days of the date of enactment of this act, the Commissioner of Human Services shall report to the Chairman of the Senate Health, Human Services and Senior Citizens Committee and the Chairmen of the Assembly Health and Human Services and Assembly Family, Women and Children's Issues committees regarding the department's plan to implement the NJ FamilyCare buy-in for children whose income is greater than 350% of the poverty level, as provided in subsection j. of section 5 of P.L.2005, c.156 (C.30:4J-12).

13. a. Within one year of the effective date of this act, the Commissioner of Human Services shall:

(1) establish a plan to develop and implement a universal identification card that can be issued to and used by recipients of Medicaid, Work First New Jersey, NJ FamilyCare, food stamps and other public social service and health programs; and

(2) prepare a request for proposal to develop an online, interactive database that can be used by health care facilities for enrolling, or determining the status of an application for, children and their parents or caretakers and adults without dependent children who present themselves at the health care facility for services and who may be eligible for NJ FamilyCare or Medicaid. The database shall enable the health care facility to notify a county welfare agency or the appropriate office in the Department of Human Services about a program applicant so that the agency or office can follow-up on the application and complete the eligibility determination process.

b. The commissioner shall include in his reports to the Legislature required pursuant to section 11 of P.L.2005, c.156 (C.30:4J-14) the status of the commissioner's plan for a universal identification card and the request for proposals for an interactive database.

C.44:8-159 Rebates for pharmaceutical products; requirements.

14. a. The Commissioner of Human Services shall contract with manufacturers of pharmaceutical products to provide rebates for pharmaceutical products covered under the Work First New Jersey General Public Assistance program (WFNJ-GA), established pursuant to P.L.1947, c.156 (C.44:8-107 et seq.) on the same basis as is required under the "Pharmaceutical

Assistance to the Aged and Disabled" program established pursuant to P.L.1975, c.194 (C.30:4D-20 et seq.) and "Senior Gold Prescription Discount Program" established pursuant to P.L.2001, c.96 (C.30:4D-43 et seq.) and in section 1927(a) through (c) of the federal Social Security Act, 42 U.S.C. s.1396r-8(a)-(c).

b. The contracts entered into pursuant to this section shall take effect on the date of enactment of P.L.2005, c.156 (C.30:4J-8 et al.).

(1) A manufacturer who is participating in the WFNJ-GA program on the date of enactment of P.L.2005, c.156 shall enter into a contract, as a condition of continued participation in the program.

(2) A manufacturer who was not participating in the WFNJ-GA program on the date of enactment of P.L.2005, c.156 may enter into a contract with the commissioner and become a participating manufacturer.

(3) A manufacturer who participates in the WFNJ-GA program pursuant to this section shall provide to the commissioner such information as the commissioner may request to carry out the purposes of this section.

C.30:4J-15 Funding for increased Medicaid eligibility.

15. a. Funding to carry out the expansion of eligibility in the Medicaid program as provided in this act shall include monies made available to the State from pharmaceutical manufacturers who agree to provide rebates to the State in the Work First New Jersey General Assistance program pursuant to section 14 of P.L.2005, c.156 (C.44:8-159). Amounts received as rebates under rebate agreements entered into pursuant to that section are appropriated to the Department of Human Services for the support of the Medicaid expansion.

b. Any unexpended balances for the NJ FamilyCare Program shall be appropriated to carry out the purposes of this act. Any transfer of NJ FamilyCare appropriations to other accounts shall be subject to the approval of the Joint Budget Oversight Committee.

C.30:4J-16 Rules, regulations.

16. The commissioner, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations to effectuate the purposes of this act. The rules and regulations shall provide for a transition from enrollment in the NJ FamilyCare program to the Medicaid program of parents or caretaker relatives who become eligible for Medicaid in 2006 as a result of the changes in the Medicaid income eligibility levels provided for in this act.

Repealer.

17. P.L.1997, c.272 (C.30:4I-1 et seq.) and P.L.2000, c.71 (C.30:4J-1 et seq.) are repealed.

18. This act shall take effect on the 180th day after enactment, except that section 8 shall take effect on September 1, 2005, sections 10, 14 and 15 shall take effect immediately, and the commissioner shall take such anticipatory administrative action in advance as may be necessary to carry out the purposes of this act.

Approved July 13, 2005.