

SENATE, No. 884

STATE OF NEW JERSEY 219th LEGISLATURE

INTRODUCED JANUARY 27, 2020

Sponsored by:

Senator JOSEPH P. CRYAN

District 20 (Union)

SYNOPSIS

Requires initial Medicaid and NJ FamilyCare eligibility determinations to be made not later than 21 days following application submission; provides that NJ FamilyCare coverage is terminated whenever required premium is not paid for three consecutive months.

CURRENT VERSION OF TEXT

As introduced.



1 AN ACT concerning the Medicaid and NJ FamilyCare programs and
2 amending P.L.2005, c.156.

3

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

6

7 1. Section 5 of P.L.2005, c.156 (C.30:4J-12) is amended to
8 read as follows:

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

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

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

25 c. The commissioner:

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

30 (2) shall require that a parent or caretaker who is a qualified
31 applicant purchase coverage, if available, through an employer-
32 sponsored health insurance plan which is determined to be cost-
33 effective and is approved by the commissioner, and shall provide
34 assistance to the qualified applicant to purchase that coverage,
35 except that the provisions of this paragraph shall not be construed to
36 require an employer to provide health insurance coverage for any
37 employee or employee's spouse or dependent child;

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

42 (4) shall establish, by regulation, other requirements for the
43 program, including, but not limited to, premium payments and
44 copayments, and may contract with one or more appropriate
45 entities, including managed care organizations, to assist in

**EXPLANATION – Matter enclosed in bold-faced brackets [thus] in the above bill is
not enacted and is intended to be omitted in the law.**

Matter underlined thus is new matter.

1 administering the program. The period for which eligibility for the
2 program is determined shall be the maximum period permitted
3 under federal law.

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

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

9 (2) Require new applicants to submit one recent pay stub from
10 the applicant's employer, or, if the applicant has more than one
11 employer, one from each of the applicant's employers, to verify
12 income. In the event the applicant cannot provide a recent pay stub,
13 the applicant may submit another form of income verification as
14 deemed appropriate by the commissioner. If an applicant does not
15 submit income verification in a timely manner, before determining
16 the applicant ineligible for the program, the commissioner shall
17 seek to verify the applicant's income by reviewing available
18 Department of the Treasury and Department of Labor and
19 Workforce Development records concerning the applicant, and such
20 other records as the commissioner determines appropriate.

21 The commissioner shall establish retrospective auditing or
22 income verification procedures, such as sample auditing and
23 matching reported income with records of the Department of the
24 Treasury and the Department of Labor and Workforce Development
25 and such other records as the commissioner determines appropriate.

26 In matching reported income with confidential records of the
27 Department of the Treasury, the commissioner shall require an
28 applicant to provide written authorization for the Division of
29 Taxation in the Department of the Treasury to release applicable tax
30 information to the commissioner for the purposes of establishing
31 income eligibility for the program. The authorization, which shall
32 be included on the program application form, shall be developed by
33 the commissioner, in consultation with the State Treasurer;

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

38 (4) Continuous enrollment;

39 (5) Simplified renewal by sending an enrollee a preprinted
40 renewal form and requiring the enrollee to sign and return the form,
41 with any applicable changes in the information provided in the
42 form, prior to the date the enrollee's annual eligibility expires. The
43 commissioner shall establish such auditing or income verification
44 procedures, as provided in paragraph (2) of this subsection; **[and]**

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

47 (7) An eligibility determination timeliness standard that
48 provides for a new applicant's determination of eligibility as soon

1 as all factors of eligibility are met and verified, but not later than 21
2 days from the date of the initial application submission. When the
3 determination of eligibility is made later than 21 days from the date
4 of the initial application submission, the eligibility determination
5 agency responsible for the intake and processing of the application
6 shall provide the applicant written notification, immediately upon
7 the expiration of the 21-day processing period, setting forth the
8 specific reasons for the delay.

9 The commissioner shall report to the Governor, and to the
10 Legislature pursuant to section 2 of P.L.1991, c.164 (C.52:14-19.1),
11 on the application processing performance of eligibility
12 determination agencies pursuant to this paragraph and subsection g.
13 of section 9 of P.L.2005, c.156 (C.30:4D-3b), and make any
14 recommendations the commissioner deems appropriate, no later
15 than one year following the enactment of P.L. , c. (C.)
16 (pending before the Legislature as this bill), and annually thereafter.

17 e. The commissioner shall take, or cause to be taken, any
18 action necessary to secure for the State the maximum amount of
19 federal financial participation available with respect to the program,
20 subject to the constraints of fiscal responsibility and within the
21 limits of available funding in any fiscal year. In this regard,
22 notwithstanding the definition of "qualified applicant," the
23 commissioner may enroll in the program such children or their
24 parents or caretakers who may otherwise be eligible for the
25 Medicaid program in order to maximize use of federal funds that
26 may be available pursuant to 42 U.S.C. s.1397aa et seq.

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

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

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

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

47 (3) The parent or caretaker of a child deemed presumptively
48 eligible pursuant to this subsection shall be required to submit a

1 completed application for the program no later than the end of the
2 month following the month in which presumptive eligibility is
3 determined;

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

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

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

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

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

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

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

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

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

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

6 j. The commissioner shall establish a NJ FamilyCare coverage
7 buy-in program through which a parent or caretaker whose family
8 income exceeds 350【%】 percent of the poverty level may purchase
9 coverage under NJ FamilyCare for a child under the age of 19, who
10 is uninsured and was not voluntarily disenrolled from employer-
11 sponsored group insurance coverage within six months prior to
12 application to the program. The program shall be known as NJ
13 FamilyCare Advantage.

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

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

24 l. Subject to federal approval, the Commissioner of Human
25 Services shall establish a hardship waiver for part or all of the
26 premium for an eligible child under the NJ FamilyCare program. A
27 parent or caretaker may apply to the commissioner for a hardship
28 waiver in a manner and form established by the commissioner. If
29 the parent or caretaker can demonstrate to the satisfaction of the
30 commissioner, pursuant to regulations adopted by the
31 commissioner, that payment of all or part of the premium for the
32 parent or caretaker's child presents a hardship, the commissioner
33 shall grant the waiver for a prescribed period of time.

34 m. A failure to pay required monthly plan premiums for three
35 consecutive months shall result in the termination of NJ FamilyCare
36 coverage, effective as of the month following the third coverage
37 month for which a required premium has not been received.

38 (cf: P.L.2008, c.53, s.2)

39

40 2. Section 9 of P.L.2005, c.156 (C.30:4D-3b) is amended to
41 read as follows:

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

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

3 b. Require new applicants to submit one recent pay stub from
4 the applicant's employer, or, if the applicant has more than one
5 employer, one from each of the applicant's employers, to verify
6 income. In the event the applicant cannot provide a recent pay stub,
7 the applicant may submit another form of income verification as
8 deemed appropriate by the commissioner. If an applicant does not
9 submit income verification in a timely manner, before determining
10 the applicant ineligible for the program, the commissioner shall
11 seek to verify the applicant's income by reviewing available
12 Department of the Treasury and Department of Labor and
13 Workforce Development records concerning the applicant and such
14 other records as the commissioner determines appropriate.

15 The commissioner shall establish retrospective auditing or
16 income verification procedures, such as sample auditing and
17 matching reported income with records of the Department of the
18 Treasury and the Department of Labor and Workforce Development
19 and such other records as the commissioner determines appropriate.

20 In matching reported income with confidential records of the
21 Department of the Treasury, the commissioner shall require an
22 applicant to provide written authorization for the Division of
23 Taxation in the Department of the Treasury to release applicable tax
24 information to the commissioner for the purposes of establishing
25 income eligibility for the program. The authorization, which shall
26 be included on the program application form, shall be developed by
27 the commissioner, in consultation with the State Treasurer;

28 c. Online enrollment and renewal, in addition to enrollment
29 and renewal by mail. The online enrollment and renewal forms
30 shall include electronic links to other State and federal health and
31 social services programs;

32 d. Continuous enrollment;

33 e. Simplified renewal by sending a recipient a preprinted
34 renewal form and requiring the recipient to sign and return the
35 form, with any applicable changes in the information provided in
36 the form, prior to the date the recipient's annual eligibility expires.
37 The commissioner shall establish such auditing or income
38 verification procedures as provided in subsection b. of this section;
39 **[and]**

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

42 g. An eligibility determination timeliness standard that
43 provides for a new applicant's determination of eligibility as soon
44 as all factors of eligibility are met and verified, but not later than 21
45 days from the date of the initial application submission. When the
46 determination of eligibility is made later than 21 days from the date
47 of the initial application submission, the eligibility determination
48 agency responsible for the intake and processing of the application

1 shall provide the applicant written notification, immediately upon
2 the expiration of the 21-day processing period, setting forth the
3 specific reasons for the delay.

4 The commissioner shall report to the Governor, and to the
5 Legislature pursuant to section 2 of P.L.1991, c.164 (C.52:14-19.1),
6 on the application processing performance of eligibility
7 determination agencies pursuant to this subsection and paragraph
8 (7) of subsection d. of section 5 of P.L.2005, c.156 (C.30:4J-12),
9 and make any recommendations the commissioner deems
10 appropriate, no later than one year following the enactment of
11 P.L. , c. (C.) (pending before the Legislature as this bill), and
12 annually thereafter.

13 (cf: P.L.2008, c.53, s.1)

14
15 3. This act shall take effect on the first day of the seventh
16 month next following the date of enactment, but the commissioner
17 may take such anticipatory action in advance thereof as shall be
18 necessary for the implementation of this act.

21 STATEMENT

22
23 This bill requires the Commissioner of Human Services to
24 establish an eligibility determination timeliness standard for
25 determining initial eligibility of families and children under the
26 Medicaid and NJ FamilyCare programs. This bill also extends the
27 period of time in which a beneficiary may fail to pay a premium
28 required for NJ FamilyCare coverage before coverage is terminated.

29 Specifically, this bill requires the eligibility determination
30 timeliness standard to provide for a new applicant's determination
31 of eligibility as soon as all factors of eligibility are met and verified,
32 but not later than 21 days from the date of the initial application
33 submission. When the determination of eligibility is made later
34 than 21 days from the date of the initial application submission, the
35 eligibility determination agency responsible for the intake and
36 processing of the application must provide the applicant written
37 notification, immediately upon the expiration of the 21-day
38 processing period, setting forth the specific reasons for the delay.

39 The commissioner is further required to report to the Governor
40 and the Legislature on the application processing performance of
41 eligibility determination agencies pursuant to this bill and make any
42 recommendations the commissioner deems appropriate no later than
43 one year following the bill's enactment, and annually thereafter.

44 This bill also provides that a failure to pay a premium required
45 for NJ FamilyCare coverage for three consecutive months will
46 result in the termination of coverage. By current regulation,
47 N.J.A.C. 10:49-9.2 and 10:79-6.7, coverage is terminated the month
48 after a monthly plan premium payment is missed.

1 The current law, as modified by federal regulation, provides that
2 an individual may be “locked out” or ineligible to apply for
3 coverage if that person was “voluntarily disenrolled” from coverage
4 within three months of their application to the program. This bill,
5 by providing that coverage be terminated after three consecutive
6 missed premium payments, instead of after one missed premium
7 payment, will reduce the number of individuals who lose coverage,
8 and accordingly, prevent individuals from being “locked-out” of or
9 ineligible to apply for reinstatement of coverage due to a single
10 missed premium payment.