

# GOOD MEDICINE

## The impact of the Patient Protection and Affordable Care Act on New Jersey's working families with children

**By Raymond Castro**

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### BACKGROUND

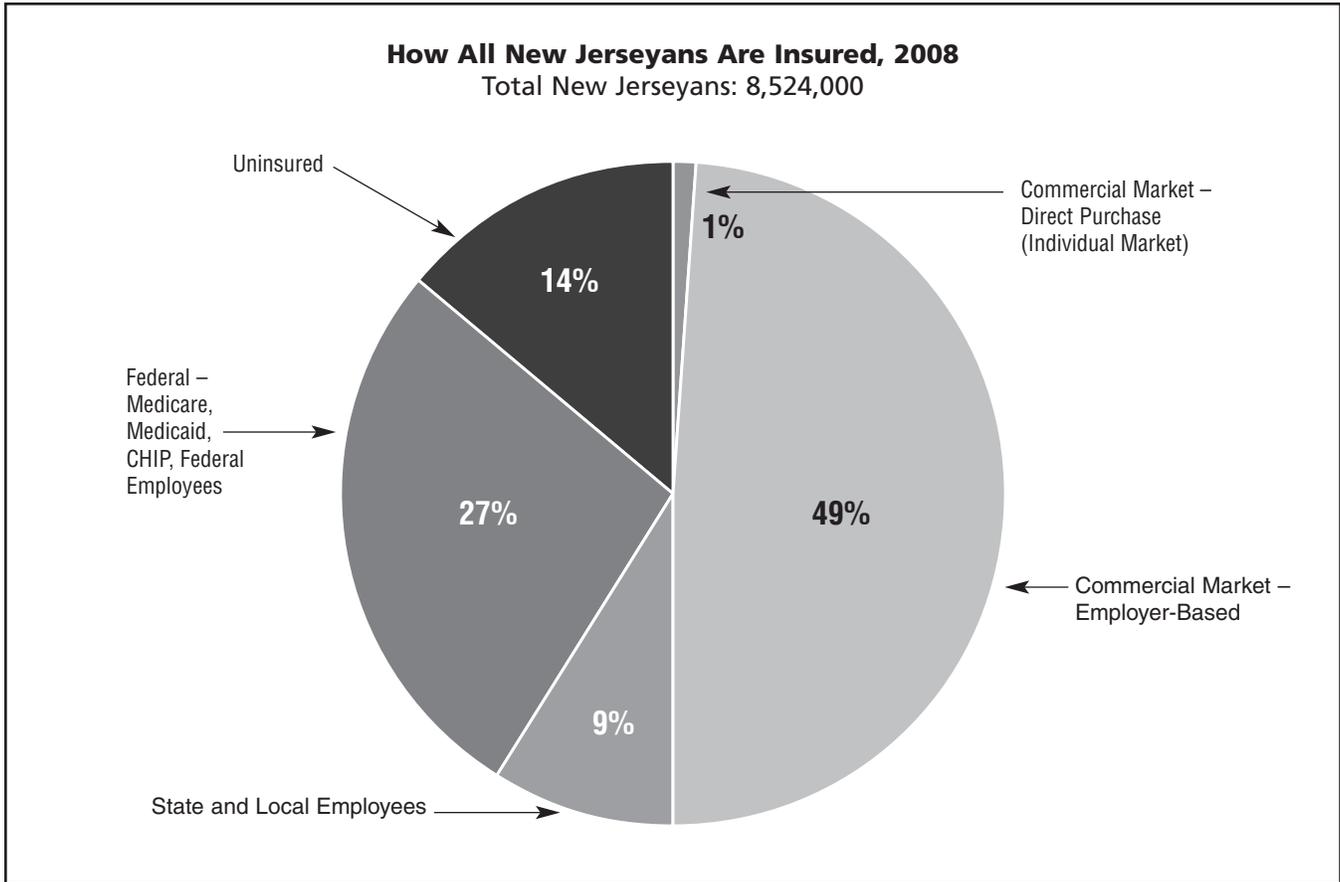
On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (ACA), which provides much needed reform of the nation's health care system. Among the goals of the new law are to provide affordable, comprehensive, quality health coverage for most of the uninsured and provide better coverage for many Americans who have insurance. This report will focus on the law's impact on working families with children because of their importance to the future of New Jersey.

Expanding health coverage to working families is a critical issue because so many are uninsured and the cost of insurance is very high in the state. There are about 1.3 million uninsured people in New Jersey, which ranks the state tenth highest in the nation.<sup>1</sup> Contrary to popular opinion, the overwhelming majority (78 percent) of uninsured individuals in New Jersey have a family member who works.<sup>2</sup> New Jersey's uninsurance rate among non-elderly persons was 15 percent in 2008-2009.<sup>3</sup> Even though New Jersey is the wealthiest state in the nation, 28 states have lower uninsurance rates. Moreover, by almost any measure, the cost of health insurance and health care in New Jersey is higher than in most states.

These daunting problems affect working families directly. About 40 percent of the uninsured in New Jersey are in families with children (284,000 parents<sup>4</sup> and 228,000 children<sup>5</sup>). About three million parents<sup>6</sup> and children<sup>7</sup> are insured through employer-sponsored coverage which varies greatly in benefits and cost sharing. The average annual total cost for employer-based, family health insurance is \$13,750, which is eleventh highest in the nation.<sup>8</sup> The cost to purchase insurance in the individual market is even higher. In most cases, the cost of insurance premiums is the greatest barrier to obtaining health coverage for parents and their children, especially in a state where the other costs of living are among the highest in the nation.

Implementation of the ACA will address many of these issues that affect families in several key ways: by providing the financial assistance needed to obtain affordable, comprehensive health coverage; by requiring consumer protections that will directly benefit parents and children; and by expanding community health services which will make health care much more accessible.

The ACA will also benefit families by requiring an exchange in every state where people can easily shop on-line for compre-



SOURCE: NJ Department of Banking and Insurance, *Projective Narrative, Consumer Assistance Program Grant*, 2010

hensive health insurance that meets high national standards. The exchange will also be responsible for outreach and make premium tax credits available for low and moderate-income individuals to reduce their cost for insurance to affordable levels.

In New Jersey, families will have a leg up because the ACA can build on the success of NJ FamilyCare, the state’s successful program to provide access to health coverage for low- and moderate-income children and low-income parents. New Jersey’s policies in this program have been far ahead of those in other states. In addition to having the second highest eligibility level for children in the nation, it has also adopted most of the policies recommended by the federal government to expedite the enrollment of children in health insurance plans. Governor Christie should be applauded for providing full funding to expand child enrollment in a very tough budget year and for not

joining 28 other governors (all but one of them Republicans) in a federal lawsuit challenging the constitutionality of the ACA.

Such support notwithstanding, challenges remain in the state’s efforts to assist these families. Although eligibility levels in NJ FamilyCare for children have been the same for about a decade, eligibility for the parents of these children has fluctuated widely depending on the availability of state matching funds. Last year was no exception. Also, the technology the state uses to process applications is outdated and has made it more difficult to apply for the program.

The ACA offers the state the opportunity and resources to make the necessary changes in the state’s current health care system needed to remedy most, if not all, of the gaps in current federal and state policy.

**THE IMPACT OF THE ACA**

- More working parents and their children will be insured and have much better coverage.
- The number of insured parents in working families is expected to increase from 86 to 94 percent in New Jersey by 2019, an increase of about 180,000 parents.
- Additional federal assistance for uninsured parents will eliminate a major shortcoming in NJ FamilyCare – the wide fluctuation caused by state budget shortfalls in the coverage of parents.
- Federal funding for NJ FamilyCare will be extended two more years, until 2015, and the federal matching rate will be increased from 65 to 88 percent, generating an additional \$175 million in federal funds annually if CHIP funds are extended. Funding for outreach and communication will also increase.
- Tax credits to cover the cost of insurance premiums will enable coverage of an estimated 6,000 uninsured children in working families with incomes that exceed the NJ FamilyCare income limit.
- Many of the 2.9 million children and parents who are already insured in the employer-based and individual market will also benefit from consumer protections such as a prohibition on denial of treatment for pre-existing conditions and a ban on cost sharing for preventive services such as vaccines, well child visits, and mammograms
- Families will also benefit from the “essential benefits” that will be required starting in 2014, such as maternity and newborn care, wellness services, and pediatric services, including oral and vision care.
- Major new funding opportunities for the state for information technology will make it easier for consumers to apply for assistance and shop for quality health insurance.
- A major investment in community health centers will greatly improve access to primary care for families in high-need areas of the state.
- The insurance mandate is a vast improvement over the mandate in current state law, which applies only to children and carries no penalty. According to the Urban Institute, without the mandate, the number of uninsured who obtain health coverage likely would drop by more than half.

**MOST UNINSURED PARENTS WILL OBTAIN HEALTH COVERAGE**

NJ FamilyCare consists of two federal programs: Medicaid and the Children’s Health Insurance Program (CHIP). Children are eligible for Medicaid if their family income is below 100 percent of the poverty level (\$18,310 annually for a family of three) or 133 percent (\$24,352) if they are under age six. Children are eligible for CHIP with family incomes up to 350 percent of the poverty level (\$64,000). Because of Medicaid and CHIP, most low and moderate-income children nationally and in New Jersey already are eligible for fully or partially subsidized health coverage. But about 83 percent nationally of the uninsured are adults<sup>9</sup> and many of them are the parents of children who have health coverage through Medicaid and CHIP. It is not surprising therefore that ACA focuses on making insurance affordable to these adults.

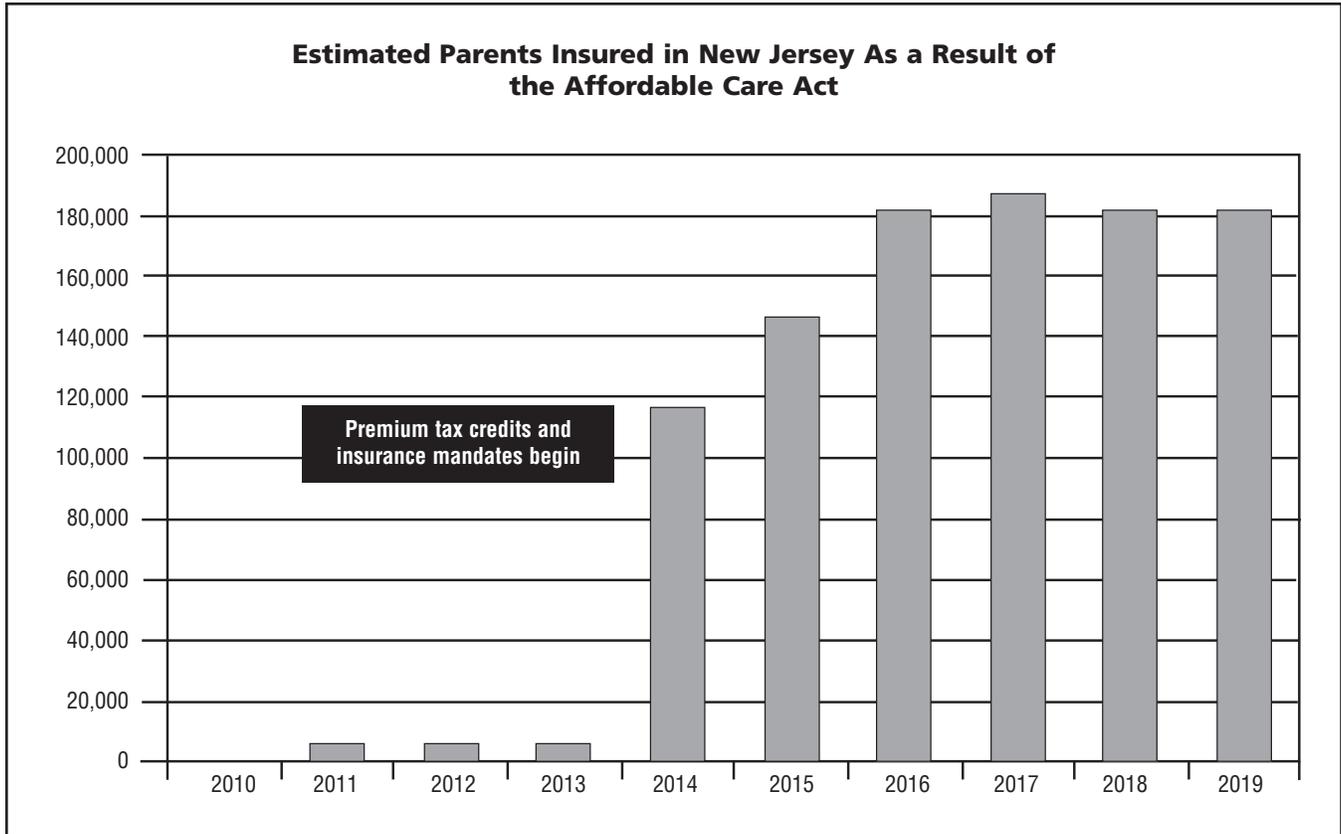
While NJ FamilyCare generally has been successful, its greatest challenge has been in covering parents. Currently about 253,000 parents participate in NJ FamilyCare, but that number often fluctuates because eligibility changes almost yearly depending on the availability of state funds (see table below). That has been confusing to many parents and has discouraged their participation in the program even if they are eligible.

**Changes in the Eligibility Level for Parents in NJ FamilyCare**

Year	Percent of the Poverty Level
2000	200%
2002	37%
2005	100%
2006	115%
2007	133%
2008	200%
2010	133%

SOURCE: Legal Services of New Jersey

The last eligibility rollback, in 2010, denied health care coverage to about 39,000 parents. In addition, for the first time, about 8,000 legal immigrant parents, who had been in this country



SOURCE: Based on New Jersey's share of the uninsured nationally in 2008-2009 applied to CBO national estimates for the Affordable Care Act in a March 20, 2010 letter to Speaker Nancy Pelosi.

fewer than five years, were removed from the program in New Jersey.<sup>10</sup> This was the first time that a single class of individuals based on their immigration status was targeted for termination from the program. Although health coverage for these individuals is completely state funded, the state maintained coverage for them in the past because it was considered important to treat everyone equitably. By making these parents ineligible for NJ FamilyCare, the state in effect has placed a residency requirement on legal immigrants (unauthorized immigrants have never been eligible in NJ FamilyCare). Recently this cutback has been challenged in court.<sup>11</sup>

For working families, the ACA will provide stability in their health care coverage because it guarantees premium tax credits for individuals and families with incomes up to four times the federal poverty level (\$73,240 annually for family of three).

The combination of premium tax credits, the insurance mandate and the exchange will result in a major increase in the number of parents who will become insured. It is estimated that nearly 100,000 additional parents will become insured in New Jersey in 2014, the first year the premium tax credits and the exchange take effect. By 2019 that number is expected to increase to 180,000 additional parents, upping the state's insurance rate for parents from 86 percent to 94 percent.

One challenge the state must confront is a shortage of primary and specialty doctors, particularly in low-income urban areas. The ACA has provisions meant to ameliorate this problem, including an increase in Medicaid reimbursement rates in 2013 and 2014 to primary care providers to 100 percent of the rate Medicare pays. The impact in New Jersey will be greater than in most states because New Jersey has the third lowest reimbursement rate in the nation.<sup>12</sup>

### **LOWER COST INSURANCE IS AVAILABLE UNDER THE ACA**

Not all uninsured parents need wait until 2014 to receive help to afford health coverage. New Jersey received federal funding last summer to create NJ Protect, which provides comprehensive quality health insurance for individuals with a preexisting condition at premium rates that are about 30 percent lower than what an individual would have to pay in the private market.

To qualify, an individual must be a New Jersey resident and have been without coverage for six months. There is no income or asset limit. To date, over 200 individuals have received coverage through this program,<sup>13</sup> and that number is expected to continue to rise until January 2014 when the program will no longer be needed because most insurance plans will have to accept all individuals with preexisting conditions.

### **MANDATE REDUCES INSURANCE COSTS**

Under provisions of the ACA, those who do not have health insurance beginning in 2014 will face penalties levied by the Internal Revenue Service. The penalty will be based either on a flat amount (\$95 per adult and \$47.50 per child) or a percent of income (one percent of income above the level at which they must file for taxes which is \$18,700). By 2016, the penalty will increase to \$695 per uninsured adult and \$347.50 per uninsured child or 2.5 percent of income above the tax-filing threshold.

While nearly everyone is subject to the requirement to have insurance, not everyone is subject to the penalty. Families will be exempt from the penalty under certain conditions, including: their income is below the federal tax filing threshold; they would have to spend more than eight percent of their income on insurance provided by their employer or purchased in the individual market; they experience a short gap in coverage; or they have “suffered a hardship with respect to the capability to obtain coverage.” Interestingly, in Massachusetts’s health reform, the insurance mandate has been its least controversial provision.<sup>14</sup>

One of the ACA’s most popular requirements is that insurance companies will no longer be able to deny insurance to people with a pre-existing health problem. Insuring everyone no matter what their physical condition, spreads the risk to everyone and lowers the cost of insurance. Without this requirement, many uninsured would wait until they are seriously ill before

they obtain health coverage. Doing so increases the cost of insurance—for themselves and for those who already have insurance.

A recent Urban Institute study found that “the number of uninsured would be cut by more than half with the [ACA] mandate but by only about 20 percent without the mandate.”<sup>15</sup> It also found that dropping the mandate would result in a major cost shift in uncompensated care to the rest of society because fewer people would be insured.

### **MORE CHILDREN WILL BENEFIT TOO**

Since NJ FamilyCare began in 1998, child enrollment has increased every year except in 2002, when the enrollment of parents was closed – a clear indication that children are more likely to get coverage when their parents are eligible for coverage, too. Currently there are about 657,000 children enrolled in NJ FamilyCare. Another 209,000 uninsured children are eligible based on their family income but are not participating.<sup>16</sup> Also, two years ago, New Jersey negotiated with Horizon Blue Cross Blue Shield to provide private insurance for children whose families’ incomes were too high to benefit from NJ FamilyCare. To date, only about 600 children<sup>17</sup> are enrolled in this program, called NJ FamilyCare Advantage, most likely because the families cannot afford the full cost of the insurance (\$144 a month for one child, \$288 for two children, and \$432 for three or more children).

Reaching all eligible uninsured children continues to be a significant challenge in New Jersey. It is especially difficult reaching legal immigrants who may have language or other barriers. The state’s goal is to enroll all uninsured children in working families in NJ FamilyCare or NJ FamilyCare Advantage by January 2013.<sup>18</sup> Without more assistance from the federal government, however, it is unlikely that New Jersey will reach that goal.

One of the hurdles has been that there are no state funds for outreach — simply finding ways to let working families know that insurance is available to them. To address the outreach issue, the ACA provides \$140 million in funding for all states to improve enrollment efforts in Medicaid and CHIP, up from \$100 million, through 2015. These additional funds will be used to provide outreach when states themselves have not

appropriated funds or to supplement existing state outreach funds.

### **POSSIBLE THREATS TO INSURING FAMILIES**

One threat to enrolling more children and parents in NJ FamilyCare is the effort that is being made by Republican governors to have Congress repeal the requirement in the ACA that states shall maintain eligibility levels in Medicaid and CHIP. That requirement is needed because terminating thousands of families in those programs completely contradicts the main goal of the ACA, which is to reduce the number of uninsured. It will also make it that much more difficult for states to assist the increased number of uninsured who will need to apply for assistance in 2014. Governors already have flexibility to reduce services or reimbursement rates to providers to save state funds without terminating health coverage altogether.

Proposals are also being considered in Congress to block grant Medicaid or place a cap on federal Medicaid expenditures with the intent of saving federal funds and shifting Medicaid costs to the states. Governor Christie recently also has announced his plan to save \$300 million in state funds by submitting a “global waiver” to the federal government that would grant the state much more flexibility to administer Medicaid and possibly reduce eligibility. All of these efforts could reverse the progress that has made nationally and in New Jersey to insure low-income working families.

The ACA will expand health coverage for children by providing tax credits for premiums to families with incomes up to 400 percent of the poverty level. This will ensure up to 6,000 more children who currently are not eligible for NJ FamilyCare because their family income now exceeds 350 percent of the poverty level, which is the eligibility cap for NJ FamilyCare.<sup>19</sup> Since many of their parents will be eligible too, entire families who are uninsured will be eligible for help under the ACA who were not eligible under NJ FamilyCare.

Based on a New Jersey Policy Perspective study of NJ FamilyCare<sup>20</sup>, insuring more parents should result in more of their children obtaining health coverage in NJ FamilyCare too. The last time that there was a cutback in eligibility in NJ FamilyCare was in 2002 when enrollment of parents was closed. NJPP found there was almost an immediate slowdown in the enrollment rate for kids that resulted in 45,000 fewer children participating in the program over a four-year period.

Under the ACA, full funding for CHIP is guaranteed through 2015 and the program itself is authorized to continue through 2019, two years beyond its current expiration date. Starting in 2015, the federal matching rate in CHIP for New Jersey will increase from 65 percent to 88 percent, which is expected to increase federal funding by about \$175 million annually assuming continued federal funding for CHIP and based on current spending.<sup>21</sup> If the state runs out of federal CHIP funding, the ACA will still guarantee that tax credits will be available to families to help them pay their children’s insurance premiums.

New categories of children will also become eligible for health coverage. For example, Medicaid will be continued for children up to age 26 who have “aged out” of the foster care system.

The insurance mandate in ACA will also result in more children obtaining insurance. Current state law (P.L. 2008, c.38) requires that all children be insured, but there is no penalty for failure to do so. Most parents are probably not even aware of the requirement since it has not been advertised.

### **NEW INSURANCE MARKET REFORMS WILL BENEFIT MOST FAMILIES**

About 1.4 million children<sup>22</sup> and 1.5 million parents<sup>23</sup> are insured through employer-based insurance plans in New Jersey. The ACA will provide better health coverage for many of them because of new consumer protections that eventually will be required of most plans.

Currently most uninsured individuals are priced out of the private insurance market, which is most likely the reason just 98,000 individuals in New Jersey purchase insurance through the private market.<sup>24</sup> Also the number of people buying standard comprehensive plans in the private market is falling largely due to rising costs of the coverage and declining benefits. The mar-

ket reforms in the ACA will require better, more comprehensive insurance than what many of these people currently receive, while containing the cost.

The ACA is already having an impact on many people with insurance. Starting September 23, 2010, the ACA began requiring the following insurance protections that will have an especially positive impact on families and will gradually apply to most insurance policies. Those requirements include:

- A prohibition on limitation periods for preexisting conditions for individuals under age 19 in 2010 and for all ages by 2014.
- A restriction on annual limits in coverage.
- A prohibition on limits for lifetime benefits.
- Requirements for preventive services for children without cost sharing using the “gold standard” services recommended by the American Academy of Pediatrics.
- Elimination of prior authorization for emergency services and higher cost sharing for using a service from a non-participating provider.
- Insurers won’t be allowed to arbitrarily cancel policies.
- Children will be allowed to stay on parents’ health plans until age 26.
- Large group market plans must spend at least 85 percent of premiums collected on actual health services. Plans in the individual and small group market must spend at least 80 percent.

Other reforms that have a direct impact on families will take place starting in January 2014. Among those:

- Insurers will no longer be allowed to charge higher premiums based on health status or because of their gender.
- Insurance plans must cover “essential benefits” in all new individual, small business and exchange plans, including hospitalization, mental health treatment, rehabilitation, prescription drugs, maternity and newborn care, wellness services, and pediatric services, including oral and vision care.

### **CUTTING EDGE HEALTH INFORMATION TECHNOLOGY**

In an effort to improve the child enrollment rate in NJ FamilyCare, the New Jersey Health Care Act of 2008 directed the

Commissioner of Human Services to establish a Work Group to advise her about ways to reach more uninsured children. The Work Group, which consisted of various state departments, advocacy groups and Rutgers University, issued a comprehensive report to the Legislature in May 2009. One of the most important findings of the Work Group was “an overarching need for information technology investments and improvements at both state and county levels.”<sup>25</sup>

For example, a person could apply for NJ FamilyCare on the internet but staff at the County Welfare Agency would have to retype the information and enter it in the computer after it was received. Applicants also had no way to monitor their applications to know where it was in the process or even if it had been received. Because of this inefficiency, applicants would have to call the County Welfare Agency to obtain that information, diverting valuable staff time from processing the applications. Not only was this process inefficient and ineffective, it also resulted in delays in obtaining critically needed health coverage. Some improvements have been made by the state since the report was released, but more work needs to be done.

The ACA provides an opportunity to address this problem in a comprehensive and systemic manner that will make it easier for families to apply for assistance with better information technology. By 2014, the ACA requires the state to set up a single website with a single application so consumers will be able to find out whether they and their family members are eligible for premium tax credits, Medicaid, or the Children’s Health Insurance Program (CHIP), and then easily enroll in coverage. Rather than require people to submit all new documentation when they apply for coverage, states will also be required as much as possible to use existing federal and state sources of income and other information. The system will need to be set up to help people who do not have access to a computer or are not computer literate.

Federal funding under the ACA will be available to develop and maintain the consumer-centric, seamless information technology that is needed. These funds are not subject to the federal appropriations process and will be an entitlement to the states. States should soon become eligible for federal matching funds equal to 90 percent of all costs for Medicaid information technology and 75 percent for operational costs. These funds will help alleviate some of the up-front expenditures that will

need to take place in order to update systems. While long-term savings in administrative costs can be achieved as a result of upgrading information systems, the upfront investment is a major deterrent to making those changes.

Even without the ACA, states need those funds because most of their eligibility and Medicaid management information systems are antiquated, including New Jersey's. New Jersey has already made excellent progress in planning for these changes and expects to claim the new federal funds that will become available to reduce the need for additional state costs. Many of the state's upgrades in the information technology are expected well before 2014.

Some states see these funds as an opportunity to create a one-application process that will include programs in addition to subsidized health coverage, such as for food stamps, childcare and Temporary Assistance to Needy Families.<sup>26</sup> Using various databases makes it possible to automatically fill out much of the application for the family. This approach promises to revolutionize the way low and moderate-income families will apply for assistance in the future.

### **MORE HELP FROM COMMUNITY HEALTH CENTERS**

The ACA allocates \$11 billion nationally for Federally Qualified Community Health Centers. This will have a major impact because it will increase the scope and quality of health services provided by these centers, which are one of the most important primary care resources for low-income families and individuals in the state. That should also reduce future charity care costs at hospitals because fewer uninsured people will need to go to emergency rooms.

Located in low-income areas, they are often the only source of primary care available to residents. Twenty centers operate in New Jersey and they serve over 400,000 individuals, 37 percent of whom are children. Although most of their funding is from federal programs, the state also provides about \$40 million, demonstrating the value of the services they provide.<sup>27</sup>

A major goal of these centers is to serve the uninsured, who often have nowhere else to turn. About 46 percent of all individuals served in New Jersey are uninsured. The centers will con-

tinue to be important because some individuals will remain uninsured by 2019 even when ACA is fully implemented

Forty-one percent of the individuals served by the centers are children and parents who are enrolled in Medicaid. The centers also provide care to many who remain underserved, because of their racial and ethnic backgrounds and their financial circumstances. About 48 percent of all people currently served by the centers are African-American and about 52 percent identify themselves as Hispanic or Latino.<sup>28</sup>

### **CONCLUSION AND RECOMMENDATIONS**

The ACA will have a major impact in terms of providing affordable quality insurance for most uninsured families with children in New Jersey and expand consumer protections for many families that have insurance. It almost doubles the number of uninsured parents who will receive assistance to help afford health coverage and makes it more likely that all children will be insured in New Jersey. It will do this by improving and increasing funding for NJ FamilyCare; providing premium tax credits up to four times the poverty level; improving information technology; and establishing an exchange that will make insurance more accessible and affordable.

It will also require essential benefits in new insurance policies in the individual and the small group market and in the exchange, and improves upon the insurance mandate in NJ FamilyCare. Another important feature is that it will increase funding for community health centers, which is one of the main sources of primary care in the state for parents and children in low-income communities.

However, many of these expected positive outcomes for families are contingent on actions the state will need to take to implement health reform in a way that benefits New Jerseyans. In order to achieve the full promise of this legislation, the following is recommended:

1. The Governor, State Legislature and the New Jersey Congressional Delegation should vigorously oppose efforts in Congress to undermine the ACA or Medicaid.
2. The state should restore all cutbacks this year in NJ FamilyCare that affect eligibility for parents and not enact further

cutbacks to better prepare for full implementation of the ACA and maximize federal funds.

3. The needs of families should be paramount in creating the exchange. For example, it will be important for the exchange to use some of the same insurers that NJ FamilyCare contracts with so that parents can be covered by the same insurer as their children. Individuals whose incomes increase and become ineligible for Medicaid should be able to buy that coverage to maintain continuity.
4. The state should expedite its plan to upgrade the necessary information technology needed to improve the application process in NJ FamilyCare. It should take into account the need to eventually integrate this system with the seamless application process that is required for the exchange. Applicants should be able to apply for other federal or state programs in one single application.
5. The state should work with community health centers to improve health outcomes, coordinate care and improve health access as part of a comprehensive plan for families.
6. The state should maintain its commitment to cover all children and update on its website its monthly progress in enrolling all eligible children in NJ FamilyCare and the NJ FamilyCare Advantage program as required by state law.

## ENDNOTES

- <sup>1</sup> Kaiser Family Foundation, *Kaiser State Health Facts*, 2008-2009, <http://www.statehealthfacts.org/comparetable.jsp?ind=125&cat=3>
- <sup>2</sup> Ibid, <http://www.statehealthfacts.org/comparetable.jsp?ind=140&cat=3>
- <sup>3</sup> Ibid, <http://www.statehealthfacts.org/comparetable.jsp?ind=140&cat=3>
- <sup>4</sup> Ibid, <http://www.statehealthfacts.org/comparetable.jsp?ind=644&cat=3>
- <sup>5</sup> Ibid, <http://www.statehealthfacts.org/comparetable.jsp?typ=1&ind=127&cat=3&sub=39>
- <sup>6</sup> Ibid, <http://www.statehealthfacts.org/comparetable.jsp?typ=1&ind=644&cat=3&sub=39>
- <sup>7</sup> Ibid.
- <sup>8</sup> Ibid, <http://www.statehealthfacts.org/comparetable.jsp?ind=140&cat=3>
- <sup>9</sup> Kaiser Family Foundation, *Kaiser State Health Facts*, 2008-2009,, <http://www.statehealthfacts.org/comparebar.jsp?ind=134&cat=3>
- <sup>10</sup> NJ Department administrative data and Governor's FY 2010 Budget
- <sup>11</sup> Guaman v Velez, February 7, 2010
- <sup>12</sup> Kaiser Family Foundation, *Kaiser State Health Facts*, Medicaid-to Medicare fee index, 2008, <http://www.statehealthfacts.org/comparetable.jsp?ind=196&cat=4>
- <sup>13</sup> Verbal information from Department of Banking and Insurance
- <sup>14</sup> Verbal report from Massachusetts's advocates
- <sup>15</sup> Matthew Buettgens, Bowen Garrett, and John Holahan, *Why the Individual Mandate Matters*, Urban Institute, December 2010, p. 1, <http://www.urban.org/publications/412280.html>
- <sup>16</sup> Calculated from US Census Current Population Survey database, 2008-2009. Some of these children will be income eligible for NJ FamilyCare but will not meet other requirements such as they are unauthorized immigrants.
- <sup>17</sup> NJ Division of Medical Assistance and Health Services
- <sup>18</sup> NJ Department of Human Services website for enrollment goal as of November 2009 <http://www.state.nj.us/humanservices/dmahs/news/reports/index.html>
- <sup>19</sup> Based on NJPP calculations using US Census Current Population Survey electronic data for 2008-2009
- <sup>20</sup> Raymond Castro, *Falling Short: Time to Keep the FamilyCare Promise*, New Jersey Policy Perspective, May 2007, <http://www.njpp.org/reports/falling-short-time-to-keep-the-familycare-promise>
- <sup>21</sup> Based on NJPP calculations using Kaiser Family Foundation, *Kaiser State Health Facts* data for New Jersey's projected CHIP FY 2009 allotment, <http://www.statehealthfacts.org/comparetable.jsp?ind=660&cat=4>
- <sup>22</sup> Kaiser Family Foundation, *Kaiser State Health Facts*, 2008-2009, <http://www.statehealthfacts.org/comparetable.jsp?typ=1&ind=127&cat=3&sub=39>
- <sup>23</sup> Kaiser Family Foundation, *Kaiser State Health Facts*, 2008-2009, <http://www.statehealthfacts.org/comparetable.jsp?ind=130&cat=3>
- <sup>24</sup> NJ Department of Banking and Insurance, *Source of Coverage*, Third quarter, 2010, [http://www.state.nj.us/dobi/division\\_insurance/ihcseh/enroll/3q10/historical.pdf](http://www.state.nj.us/dobi/division_insurance/ihcseh/enroll/3q10/historical.pdf)
- <sup>25</sup> Outreach, Enrollment and Retention Working Group in Response to the New Jersey Health Care Reform Act of 2008, *NJ Family-Care Outreach, Enrollment and Retention Report*, May 2009.
- <sup>26</sup> See Wisconsin's website at <https://access.Wisconsin.gov/>
- <sup>27</sup> New Jersey Primary Care Association, *Federally Qualified Health Centers*, <http://www.njpca.org>
- <sup>28</sup> Ibid.



## ACKNOWLEDGEMENTS

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