NEW JERSEY POLICY PERSPECTIVE

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Estimated Impact of Health Reform Bills Passed by the House and Senate on New Jersey

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The following report identifies the major provisions in the health reform bills passed by the House and Senate. It estimates and explains the impact of each provision in these bills on New Jersey and includes recommendations by the NJ Consumer Voices for Coverage coalition (see members page 4) in terms of which bill is best for the state. It also includes a breakout of the fiscal impact and the number of New Jerseyans who would likely benefit from these bills by county and congressional district (page 15). Recently President Barack Obama released his proposal for health reform. Because it lacked detail, his proposal was not included in the attached report however an addendum was added (page 5) which shows how the main features of this proposal would affect New Jersey.

For many years, New Jersey has been plagued by double digit uninsurance rates, out-of-control medical costs, and some of the highest health insurance premiums in the nation. These developments have had the following effects: employers have shifted more of the costs of health coverage to employees or have dropped coverage altogether; state and local governments have curtailed essential services to pay for rising health care costs of public employees and retirees; and many hospitals have been bankrupted by the growing number of uninsured patients or patients who cannot pay for their care.

Both the House and the Senate bills would make major inroads to address these problems in New Jersey.

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They would create security and stability for many working middle class families who might be just one pay check away from losing their health coverage or can no longer afford the insurance they have. Both bills would make insurance companies more accountable. They could no longer deny insurance due to a pre-existing condition like heart disease or diabetes or drop coverage because the patient became too sick or place a lifetime limit on benefits. Insurance companies' profits and administration would be capped so more of the premiums these companies collect would have to be spent on patient care. Out-of-pocket expenses for preventive services and the practice of charging higher premiums for women would be eliminated.

Most New Jerseyans with insurance also would likely benefit from the cost containment measures in these bills which will slow the unrelenting growth in health care costs. Since 2000, average annual insurance premiums that employees must pay for have doubled whereas median wages have hardly changed. Medicare beneficiaries are also increasingly paying for out-of-pocket health expenses that are eroding their quality of living. Health reform will make the health delivery system more efficient and focused on health outcomes rather than volume. The individual insurance mandate will also bring premiums down for insured families because more healthy individuals will be added to the insurance pool. Because the cost containment measures in the bills are estimated by the Congressional Budget Office to result in a major reduction in the federal deficit, they also benefit middle class taxpayers.

These bills also invest in a healthier America by providing subsidies to low and moderate families to maintain the health coverage they have or to obtain more affordable quality health coverage if they are not insured. Between an estimated $23 billion to $29 billion in federal funds would be spent in New Jersey over a decade under these bills to lower the cost of premiums and cost sharing. Families up to four times the poverty level ($88,200 for a family of 4) would be eligible for subsidies or tax credits to reduce the cost of the premiums. As a result of this assistance, between 867,000 and 1 million of the 1.5 million persons who are projected to be uninsured by 2019 in New Jersey would have insurance. This would cause the state's current insurance rate of 85% to increase to between 92% and 94%. All counties and congressional districts would benefit from these bills in terms of people insured and federal funds spent which would have a positive effect on their economies.

Although New Jersey already has in place some of the insurance market reforms in these bills, like the prohibition on denying insurance due to a preexisting condition, those state reforms do not apply to the many employers who have self-insured plans because federal law prohibits states from regulating businesses that are self-insured. Thus, New Jersey's insurance requirements only apply to about 2.1 million of the 4.4 million residents who have commercial plans. Under both bills, however, many New Jerseyans employed in firms that are self-insured would also be covered under these reforms. Some of the other insurance reforms in the bills, like the annual limit on cost sharing and prohibiting caps on lifetime benefits, are not required at all in New Jersey. Mandatory insurance benefits would also increase in New Jersey such as prescription drugs and vision care for children in most plans.

In addition to the typical working families that already have insurance, most other groups in New Jersey would also benefit from these bills including:

- Seniors on Medicare all of whom would have their prescription drug coverage expanded by either partially or fully closing the current gap in coverage (also called the “donut hole”). Medicare would become more financially solvent and effective as a result of improvements and efficiencies in the program.

- Adults without children would be eligible for subsidies if their income is less than $43,300 for an individual (New Jersey does not provide any assistance to this group to help them afford comprehensive health coverage).

- More uninsured middle class children would be eligible for premium subsidies compared to NJ FamilyCare; lower income children would receive more benefits than they receive in NJ FamilyCare now because they would become eligible for Medicaid; and all insured children would be guaranteed critical pediatric services.

- Many people with disabilities would benefit from the expansion in premium subsidies, the mental health and substance abuse coverage that would be required in all new and existing plans, Medicaid and Medicare improvements, and the programs that would help avoid institutionalization.

- Most of the state’s 215,000 small employers would benefit from the tax credit they would receive for providing health coverage to their employees and from the opportunity to obtain health insurance through the Exchange at more competitive rates and reduced administrative costs.

While the benefits are many, challenges remain to resolve some important differences in these bills. Health reform will not work unless insurance is affordable. Because of the premium subsidies that are provided, the House bill is more affordable for adults below 250% of the poverty level but the Senate bill is more affordable for households above that limit. There is much more help with deductibles and co-payments in the House bill.

Most moderate and middle income children do better in the Senate bill because it would extend NJ FamilyCare for at least another two years with its lower premiums and cost sharing compared to what would be required in the Exchange. On the other hand, lower income children would do better in the House bill because it has a higher income level for Medicaid (150% of the poverty level) than in the Senate bill (133%). For the same reason, low income adults (parents and childless adults) also do better in the House bill.

The revenues that are needed to pay for the subsidies in the bills are more progressive in the House bill and would affect fewer people. The House bill relies mostly on a millionaire’s tax that would affect fewer than 2% of New Jerseyans. The revenues in the Senate bill include an excise tax on higher cost insurance policies. While that tax generates a major amount of revenues and affects high income families, it also would affect the health plans of many middle income families in New Jersey.

The bills are similar but where there are differences the following are the key provisions in each bill that NJ Consumer Voices for Coverage recommends:

House Bill

- Funding for Medicaid and premium subsidies
- Number of people insured
- Premiums subsidies for families below 250% of the poverty level
- Cost sharing subsidies for all income groups below 400% of poverty level
- Extension of Medicaid stimulus funds
- Increase in Medicaid rates for primary care
- Allow undocumented immigrants to pay for the full cost of insurance in the Exchange
- Individual and employer insurance mandates
- National Health Insurance Exchange
- Public insurance option
- Anti-trust exemption for insurance companies
- Prevent excessive increase in premiums if wellness goals are not achieved
- Insurance market reforms
- Guaranteed rehabilitative and habilitative services
- Completely close Medicare prescription gap
- Millionaire's tax

Senate Bill

- Funding to extend NJ FamilyCare for two years
- Subsidies for families above 250% of the poverty level
- Funding for tax credits to small businesses that provide health coverage
- Independent board to recommend ways to reduce cost of Medicare without cutting benefits
- Additional insurance benefits not guaranteed in House
- Assist states with individuals with chronic conditions
- Premium subsidy eligibility level for employees with access to employer-based insurance
- New options for home and community-based services
- Funding for reinsurance program
- Increase the Medicare Part A tax for the wealthy
- New fees on pharmaceutical firms and insurance companies
- Require that all members of Congress and their staff obtain their insurance through the Exchange

Consumer Voices for Coverage *is a joint initiative of Community Catalyst and the Robert Wood Johnson Foundation (RWJF) focused on ensuring consumer concerns are represented in both state and national health care reform.*

The NJ Consumer Voices for Coverage Leadership Team is represented by the following organizations: *AARP New Jersey, Camden Churches Organized for People, Communication Workers of America, Health Professionals and Allied Employees, Hispanic Directors Association of NJ, NJ Appleseed Public Interest Law Center, NJ Catholic Conference, NJ Citizen Action Education Fund, NJ Health Care Quality Institute, NJ Public Interest Research Group, NJ Policy Perspective, NJ State Conference of the National Association for the Advancement of Colored People, PICO New Jersey, and the Women's Fund of NJ.*

ADDENDUM

President Barack Obama's Health Reform Proposal and New Jersey

The President's Proposal is basically a compromise between the House and Senate bills although some new and important features were added. While details are not yet available regarding the Proposal, based on preliminary estimates of its cost, it appears that the impact would fall within the range of these bills. Thus, the amount of federal funds that would likely be spent in New Jersey would be between $23 billion and $29 billion over ten years and the number of persons insured would be between 867,000 and 1 million. This would greatly reduce the uninsured in New Jersey and improve the state's economy.

The President's Proposal would benefit New Jerseyans by:

1. Going beyond both bills and prohibiting excessive and unjustified increases in insurance premiums. New Jersey already has some of the highest insurance premiums in the nation. This is one of the fastest rising components of budgets in both the private and public sectors. In addition to working families, State and local governments (including school districts), small businesses and non-profit agencies simply can no longer afford annual increases that are often in the double digits.

2. Making health insurance more affordable. Compared to the Senate bill, it would increase tax credits to make insurance premiums more affordable for families with incomes below $44,000 and above $66,000. Compared to the House bill, families with incomes between $55,000 and $66,000 would also pay less for premiums. Cost sharing would be reduced for families with incomes below $55,000 compared to the Senate bill.

3. Eliminating the prescription drug "donut hole" in Medicare. This would expand coverage to about 600,000 seniors and people with disabilities in New Jersey, which would also prevent more costly hospitalization.

4. Protecting more people with insurance. There are 4.4 million people in New Jersey with commercial insurance but often the coverage is inadequate. Under the President's Proposal, plans that are "grandfathered" in the Senate bill would have to provide some of the insurance

market reforms and benefits that would be required for all other plans, like no limits on lifetime limits and denial of insurance due to preexisting conditions.

5. Making the excise tax on higher cost insurance plans fairer. The Senate bill's excise tax would have affected the plans of about 100,000 moderate income families in New Jersey. The Proposal would greatly reduce that number by increasing the threshold amount of insurance policies from $23,000 to $27,500 and delaying implementation from 2013 to 2018 for all of these plans.

6. Increasing federal support to states. The recent cuts in NJ FamilyCare in the FY 2010 budget proposed by Gov. Chris Christie demonstrates the state's fiscal plight and need for additional federal support from Washington for medical assistance. The Proposal would reimburse New Jersey with all federal funds for all new eligible people in the first four years compared to the current federal matching rate of 50%.

While all of these measures are a major step in the right direction, NJ CVC is concerned that other important reforms were not included in the President's Proposal. These include a public insurance option, a clear employer mandate, and a national insurance exchange. NJ CVC looks forward to working with the NJ Congressional Delegation to assure that the final legislation benefits all New Jerseyans.

Estimated Impact of Health Reform Bills Passed by the House and Senate on New Jersey[1]

Provision	House Bill	Senate Bill	NJ Estimated Impact	NJ Consumer Voices for Coverage Recommendation
Funding for Medicaid and Exchange subsidies over 10 years	$1.027 trillion	$821 billion	$29 billion (House)[2] $23 billion (Senate)[3] This federal funding, along with tax credits to small businesses, will not only result in insuring more New Jerseyans, it will create many jobs and stimulate the state's economy.	Support higher funding for subsidies in House bill because more people will be insured.
Net federal cost	$894 billion	$871 billion	The agreement between the President and Congress to limit net expenditures to $900 billion over ten years is a challenge because it makes it more difficult to meet the full need for health coverage.	Support the higher amount in the House bill.
Reduction in federal deficit over 10 years	$104 billion	$132 billion	While it is important to reduce the federal deficit, the first priority should be to ensure that sufficient funds are spent to help families afford health insurance.	Support the House bill which spends more funds to help low and middle income families afford health insurance.
People insured by 2019	36 million	31 million	The House bil1would increase New Jersey's insurance rate to 94% by insuring 1 million persons out of 1.5 million uninsured individuals projected by 2019. The Senate bill would increase New Jersey's insurance rate to 92% by insuring 867,000 persons.[4]	Support the House bill.
Eligibility for premium and cost sharing credits	Provides premium subsidies up to four times the poverty level for families and non-elderly adults without kids ($88,000 for a family of four; $43,300 for an individual).	Same except tax credits are used instead of subsidies.	Both bills would have a major positive impact on New Jerseyans. New Jersey does not cover any childless adults in either Medicaid or NJ FamilyCare. Parents are covered	Support the national eligibility levels in both bills with a provision to increase the levels for high cost-of-living states. Support subsidies in House bill instead of tax credits in

	. Employees with access to job-based insurance are not eligible for the subsidies unless their premiums exceed 12% of their salary.	 Same except 9.8%.	only up to twice the poverty level ($44,000 for a family of four) in NJ FamilyCare. Also children are only covered up to 3.5 times the poverty level ($77,200 for a family of four). The Senate bill would allow many more families into the Exchange with access to lower premiums which is important in a high cost-of-living state.	the Senate bill because they are easier to use. Support Senate bill.
Premium credits	Families and individuals under 2.5 times the poverty level would pay less than in the Senate bill but more above that level. The maximum a family of three with an annual income of $28,000 would pay in premiums annually would be $840 (3% of income) and with an income of $64,000 about $7,000 (11% of income).	Families and individuals under 2.5 times the poverty level would pay more than in the House bill but less above that level. Also the Senate bill provides funding to extend CHIP (NJ FamilyCare) for two years which would protect children from the higher premiums and cost sharing in the Exchange. The maximum a family of three with an annual income of $28,000 would pay in premiums annually would be $1,300 (4.6% of income) and with an income of $64,000 about $6,300 (9.8% of income).	Because of New Jersey's high cost of living, the subsidies/credits are not sufficient in either bill. Even the House bill has higher premiums than in NJ FamilyCare for families between 150% and 200% of the poverty level.[5]	Support the subsidies in the House bill for families below 250% of the poverty level and the Senate bill above that level with a requirement that the subsidies be increased for high cost-of-living states. Support extending CHIP for children not eligible for Medicaid as in the Senate bill but also include parents eligible for CHIP.
Cost sharing credits	Cost sharing (deductibles and co-payments) credits are equal to 97% of average benefits in the plan starting with family incomes at 133% of the poverty level and 70% of coverage at four times the poverty level.	Cost sharing credits are available for families between 100-150% of the poverty level resulting in coverage for 90% of the average benefits in the plan. For families between 150-200% of the poverty level, 80% of the plan would be covered. Families above 200% of the poverty level are not eligible for cost sharing credits.	Like premiums, cost sharing is a major concern in New Jersey because of its high cost-of-living. Other studies have shown that even the cost sharing in the House bill is significantly higher than in CHIP for children.	Support the House bill because it provides more cost sharing credits, but support extending CHIP as in the Senate bill to shield children from higher cost sharing in the Exchange.
Medicaid	Expands eligibility up to 150% of the poverty level for all non-elderly adults and children.	Expands eligibility to 133% of the poverty level for all non-elderly adults and children based on modified income.	Both bills would have a major positive impact in New Jersey. Currently parents and children above age 6 are eligible for Medicaid only up to 100% of the poverty level and no childless adults are eligible.	Support the greater Medicaid expansion in the House bill because there is no cost sharing in Medicaid and it provides more comprehensive benefits compared to private plans in the Exchange.

	Increase reimbursement rates to primary care providers to 100% of Medicare rates.	No provision for increasing primary reimbursement rates.	New Jersey primary care rates are currently the lowest in the nation[6] and would be tripled in the House bill resulting in an additional $500 million annually in federal funds.[7] A recent study concluded that the current shortage of primary care physicians would increase to about 1,000 by 2020 in part because of the state's low Medicaid rate.[8]	Support the increase in primary care rates in the House bill which would improve access.
	Funds both initiatives above with 100% federal funds in 2013 and 2014 and with 91% in later years	Provides 100% federal funding from 2014 to 2016 which will be gradually reduced through 2019 depending on a state's current eligibility for adults in Medicaid.	For the newly eligible, the federal matching rate in Medicaid would initially increase to 100 percent then it is eventually reduced to 91% in the House bill and reduced to 82% in the Senate bill by 2019. Medicaid is currently matched with federal funds at a 50% rate so this reflects a major increase in federal funding.	Support House bill because it reduces the regular state matching funds more for newly eligible people compared to the Senate bill.
Medicaid stimulus funds	Extends additional Medicaid funds that became available in the American Recovery and Reinvestment Act from the end of 2010 to June 30, 2011 (6 months).	No provision	New Jersey received about $2 billion over two years in Medicaid stimulus funds to help address the state's budget shortfall due to the recession. These funds expire at the end of 2010 even though the state's budget shortfall is expected to be similar or worse in that fiscal year which ends on July 1, 2011. New Jersey would receive about $587 million in extended funding in the House bill.[9] These funds are critically needed to avoid cutbacks in Medicaid.	Support the House bill.
CHIP (called NJ FamilyCare in New Jersey)	All children in CHIP below 150% of the poverty level would be transferred to Medicaid at the current CHIP federal matching rate (65% in New Jersey) in 2014 at which point CHIP is repealed. Children above that level would be transferred to the Exchange in 2014 at 100% federal cost. Parents in CHIP below 150% of	Extends funding in CHIP until 2015 and requires that states maintain eligibility rules for children until 2019. Beginning in 2015, states would receive a 23 percentage point increase in their federal matching rate. Parents in CHIP would either be covered by Medicaid (up to 133% of the poverty level at a 65% federal	As of December 2009 there were about 151,000 children enrolled in NJ FamilyCare.[10] New Jersey has the second highest eligibility level in CHIP (350% of the poverty level) in the nation and one of the highest for parents (200% of the poverty level). Many recent improvements have been made in the program to increase	Support the Senate's extension of CHIP for children and also add parents to protect them from higher cost sharing in the Exchange and maintain New Jersey's progress in enrolling more families.

	the poverty level would be transferred to Medicaid at a 65% matching rate and between 150 and 200% would be transferred to the Exchange with full federal funding. States are required to maintain CHIP eligibility rules until 2014.	matching rate) or the Exchange.	enrollment. Premiums and cost sharing in NJ FamilyCare are lower than in the House or Senate bill. New Jersey has established a goal of enrolling all 224,000 uninsured children in NJ FamilyCare by 2013.[11] Both bills would result in major state savings in CHIP, which could be used to offset other state costs that would result from reform.	
Health Insurance Exchange	Creates a National Health Exchange for families, individuals and small businesses with the option for states to administer if they can demonstrate their capacity to do so.	Creates state-based Exchanges for families and individuals and separate Exchanges for small businesses. These exchanges can be administered by government entities or non-profit organizations.	The state-based Exchanges in the Senate would likely result in delayed implementation, inefficiency and inconsistencies among the states. Many states also do not have the staff and could not afford to run an Exchange. There is also concern that states that do not support health reform may refuse to implement the Exchanges.	Support the National Health Exchange in the House bill because it would probably take less time to implement it and would be more effective in fostering competition among insurance plans.
	Firms with 25 or fewer employees are permitted to buy in the Exchange (including the public option) in 2013, firms with fifty or fewer employees in 2014, and firms with at least one hundred employees can purchase insurance in 2015 at the federal government's discretion.	Beginning in 2013, small businesses with fewer than 100 employees could purchase insurance through the small business Exchange.	Allowing small businesses to purchase insurance in the Exchanges, along with the tax credits, could result in reduced administrative and premium costs. Studies have shown that these changes should result in stabilizing or increasing the number of persons employed by small businesses.[12] Establishing two separate exchanges could be confusing, duplicative and result in less purchasing power.	Support the House bill because it allows for a public option that would also be available to small businesses and establishes a single national Exchange.
	No provision	Requires that all members of Congress and staff obtain their insurance through the Exchange.		Support Senate bill.
Prevention	Establish a national strategy to improve the nation' health and provide grants for the delivery of prevention and wellness services.	Similar	While there are a number of prevention programs in New Jersey,[13] they do not include any of those required in these bills. These preventive services could reduce state Medicaid costs and reduce the need for costly hospitalization.	Support both bills.

	Cover only proven prevention services in Medicare and Medicaid. Increase federal matching funds for states that remove cost sharing for preventive services. Increase Medicare payments for some preventive services at 100% of actual cost.	Same except no increase in Medicaid matching funds.		Support House bill.
	Provide Medicare beneficiaries access to a comprehensive health risk assessment and a prevention plan. Provide incentives to Medicaid and Medicare beneficiaries to modify their unhealthy behavior.	No provision.		Support House bill.
	Require qualified health plans to provide certain preventive services without any cost sharing.	No provision.		Support House bill.
Small business tax credits	Provides a credit up to 50% of premium costs for employees to employers with less than 25 employees and average wages less than $40,000. Total cost over ten years: $25 billion.	For years 2010-2013, provides a tax credit up to 35% of employer's contribution for employers with less than 25 employees and annual wages less than $50,000. For 2014 and after, a 50% tax credit is available for small businesses that purchase coverage through the small business Exchange. Total cost over ten years: $27 billion.	There are about 215,000 small establishments in the state with 1 to 25 employees,[14] many of which would be eligible for this tax credit. The combination of the tax credits and the lower premiums that are expected for small businesses that are participating in the Exchange could greatly benefit small employers (see "Health Insurance Exchange").	Support the higher funding level for tax credits in the Senate bill.
Individual Mandate	Requires individuals to have "acceptable health coverage." For those who do not comply there is a penalty of 2.5% of their adjusted income. There are exceptions for those who do not owe federal taxes and for financial hardship.	Non-complying families will be penalized by the greater of a flat fee starting at $95 in 2014 and increasing to $750 by 2016, or .5% of taxable income in 2014 rising to 2% by 2016. Many exceptions such as individuals below 100% of the poverty level; if the lowest cost plan option exceeds 8% of income; undocumented immigrants; and if there is financial hardship.	An individual mandate is needed to discourage individuals from seeking health insurance only when they are ill which increases the cost for everyone with insurance. However high penalties are not appropriate if health insurance is unaffordable, otherwise they will become an unacceptable financial burden on New Jerseyans. There is a state mandate for children to have coverage but there is no sanction if they do not comply.	Support the higher House penalties only if there are sufficient subsidies available to reduce premiums and cost sharing to adequate levels, otherwise lower those penalties and add more exceptions as in the Senate bill.
Employer	Requires large employers to offer	For large employers that do not offer	Employer-based health insurance has	Support the House bill but if that is

mandate	coverage to their employees or pay up to a 8% payroll tax depending on their size.	coverage, pay a fee of $750 per full time employee if there is one employee who is receiving a premium tax credit in the Exchange. For large employers who do offer coverage, pay the lesser of $3,000 for each employee receiving the credit or $750 for each full-time employee.	decreased by about 7 percentage points since 2000 in New Jersey.[15] The Senate bill would result in fewer employers providing coverage, be difficult to administer, and create an incentive not to hire full-time workers or to convert full-time workers to part-time to avoid the penalty. The House bill penalties would help to reverse the trend in New Jersey of employers not providing health coverage.[16]	not possible at least apply the employer penalty in the Senate bill to part-time workers.
Medicare prescription drugs	Reduces the coverage gap for prescription drugs (Part D) by $500 in 2010 and eliminates the gap by 2019. Provides a 50% discount on brand name prescriptions filled in the coverage gap.	Same but does not eliminate the gap.	About 600,000 elderly and disabled persons covered by Medicare Part D in New Jersey[17] would have their prescription drug coverage expanded under both bills.	Support eliminating the coverage gap in the House bill and the other Medicare improvements in these bills.
Insurance Market Reforms	Stops insurance companies from denying insurance based on pre-existing conditions; charging different rates based on gender, health status, family history or occupation; and limiting lifetime benefits. Allows premium variation based on age (limited to ratio of 2 to 1), premium rating area and family enrollment.	Similar except allows premiums to vary based on an age ratio of 3 to 1 and for smoking based on a ratio of 1.5 to 1.	The denial of insurance based on pre-existing conditions, charging different rates based on gender, health status, family history or occupation is prohibited in New Jersey but only for firms that are not self-insured. The bills apply to many of the firms that are self-insured as well. Since the state rules only apply to less than half of the commercial market in New Jersey (and only a quarter of all residents),[18] these bills would increase the number of employees covered by these reforms. Also the age ratio is 3.5 to 1 in New Jersey therefore older persons would pay less in their premiums under both bills.[19] New Jersey does not allow premiums to vary based on smoking which research has shown is more punitive than rehabilitative.	Support the House bill because it offers more protections and would not allow major increases in premiums that would likely impact more low-income people.

	Requires at least 85% of premiums collected by insurance companies must be used for consumer services (in other words, limits any profits and administrative costs to 15% of premiums).	Same except the percent is 85% for large group plans and 80% for individual and small group plans.	New Jersey only requires 80% so both bills would result in more of the premium dollars going back to the consumers in services.[20]	Support House bill.
	Health plans must cover 70% of the actuarial value of the covered benefits.	Same except 60%.	No minimums are required in New Jersey so this could result in less cost sharing.	Support House bill.
	Limits annual cost sharing (not premiums) to $5,000/individual and $10,000/family.	Similar except limits are $5,950 for individuals and $11,900 for families.	No such requirement so these limits could have a major impact in limiting out-of-pocket costs that are the biggest cause of bankruptcies for families and individuals.	Support House bill.
	No provision.	Allows insurers to increase the 20% limit on raising premiums for individuals who do not reach wellness goals (like being overweigh or having high cholesterol) to 50%.	The requirement could result in sever hardship for low-income families, minorities and older persons who are more likely to suffer from health conditions targeted by wellness programs for reasons beyond their control (like cannot afford proper diet to reduce weight or hereditary condition).	Support House bill.
Containing costs	Restructure Medicare Advantage Plans to avoid over charging Medicare; reduce market updates in Medicare payment rates for providers; reduce Medicare and Medicaid charity care payments to hospitals since there will be less need; test payment incentive models to create patient-centered medical homes; reduce payments for preventable hospital readmissions; require the federal government to negotiate drug prices directly with pharmaceutical companies concerning Medicare Part D drugs; increase the Medicaid drug rebate percentage; reduce fraud, waste and	Restructure Medicare Advantage Plans to avoid over charging Medicare; reduce market updates in Medicare payment rates for specified providers; freeze the threshold for income related Part B premiums and reduce the premium subsidy for higher income persons; establish an independent board that will submit recommendations to reduce per capita rate of growth in Medicare without cutting benefits if that growth exceeds a certain rate; create accountable care organizations; test different payment methods to reduce costs and improve quality; reduce payments to hospitals that have	Out-of-control medical costs are one of the major reasons why so many families are becoming uninsured. For the last 20 years health costs in New Jersey have increased by an average of 6% which is twice the inflation rate.[21] This rate cannot be sustained by either the public or private sector.	Most of the cost containment provisions in both bills should be accepted with the savings used to make the final bill more affordable and Medicare more financially solvent as long as traditional Medicare benefits are not reduced.

	abuse in public programs.	excessive preventable readmissions; increase the Medicaid drug rebate percentage; reduce Medicaid charity care payments to hospitals; and reduce fraud, waste and abuse in public programs.		
Guaranteed Benefits	-Hospitalization -Outpatient hospital and outpatient clinic services, including emergency services -Professional services of physicians and other health professionals -Such services , equipment, and supplies incident to the services of a physician's or a health professional's delivery of care -Prescription drugs -Rehabilitative and habilitative -Mental health and substance use disorder services, including behavioral health treatment -Preventive services -Maternity care -Well-baby and well –child care and oral health, vision, and hearing services, equipment, and supplies for children under 21 years of age -Durable medical equipment, prosthetics, orthotics and related supplies	-Hospitalization -Ambulatory services -Maternity and newborn care -Pediatric services such as dental and vision care -Mental health and substance use disorder services, including behavioral health treatment (also requires parity between mental health/ substance abuse services with physical health) -Prescription drugs -Emergency services -Rehabilitative and habilitative -Laboratory services -Preventive and wellness services and chronic disease management	Both bills would result in a major expansion of mandatory benefits compared to state law. For example, New Jersey does not require basic benefits like hospitalization, outpatient hospital services, prescription drugs, substance abuse treatment and vision services for children. There could also be a major expansion of benefits for people with disabilities depending on how "mental health", "rehabilitative and habilitative services" are defined. New Jersey also requires benefits that may not be included in the final federal benefits, but both bills would allow the state to continue to require them.[22]	Support all benefits specified in both bills.
Community living assistance	A community living assistance services and supports (CLASS) program would be established that provides a cash benefit to enable individuals with functional limitations to purchase non-medical services and supports. The program will be self-funded through voluntary payroll deductions.	Same	This program could have a significant impact in avoiding institutionalization and improving the quality of life for many New Jerseyans with disabilities.	Support both bills.

Assist States with individuals with chronic conditions	Expands the role of the Medicaid and CHIP Payment Access Commission to include all individuals and requires a report to congress on nursing facility payment policies. Requires reports on implementation of health care reform related to Medicaid and CHIP including effect of implementation on access.	Creates a new Medicaid state plan option to permit Medicaid enrollees with at least two chronic conditions to designate a provider as a health home. Provides states taking up the option with 90% FMAP for two years.	This new option for New Jersey would provide additional funding for two years to support people with disabilities in getting a medical home.	Support Senate bill to support people with disabilities including those with persistent mental health conditions
Medicaid Long Term Care	No provision	Establishes the Community First Choice Option in Medicaid to provide community-based supports and services to individuals with disabilities who require an institutional level of care. Provides states with enhanced federal matching rate of six percentage points for reimbursable expenses. Provides states with new options for offering home and community based services through a Medicaid state plan rather than a waiver for individuals up to 300% of the SSI level. Extends the Medicaid Money Follows the person Rebalancing Demonstration project through 2016. Creates the State Balancing Incentive Program to provide enhanced federal matching payments to eligible states to increase the proportion of non-institutionally based long term care services. An enhanced FMAP will be provided to selected states.	These provisions provide the State with significant changes to assist people with disabilities to live in the community. The Community First Choice Option as well as the new option for home and community-based services would change the institutional bias of Medicaid and allow New Jersey to support people with disabilities and seniors in their homes and the community. New Jersey would receive increased federal Medicaid funding for long term care services due to the Senate bill.	Support the Senate bill.
Workforce	Develop a national workforce strategy; increase Graduate Medical Education training positions with priority for primary care and general	Similar	Recent studies estimated that there would be a shortage of about 1,000 primary care physicians, 1,800 specialists, and 40,000 nurses in New	Support both bills.

	surgery; provide scholarships loans; provide more education, training and grants to increase supply of nurses.		Jersey by 2020.[23]	
Treatment of Immigrants	Most legal immigrants are eligible for premiums in the Exchange and for Medicaid. Legal immigrants who arrived within five year are also eligible for premiums although they remain ineligible for Medicaid (however states have the option to cover children and pregnant women as New Jersey does). Undocumented immigrants continue to not be eligible for Medicaid or CHIP. They will also not be eligible for subsidies in the Exchange but they can purchase insurance in the Exchange at full cost. Citizenship status must be verified	Same except undocumented immigrants may not purchase coverage through the Exchange.	Immigrants have always been a vital part of New Jersey and contribute to its economy and diversity. Given that about a third of all uninsured people in New Jersey are immigrants,[24] making most of them eligible for subsidies would have a major impact in reducing the uninsurance rate. It would also likely reduce state charity costs at hospitals. Unauthorized immigrants can purchase health coverage in the NJ FamilyCare Advantage program if their income is above four times the poverty level but not below it (they also are ineligible for CHIP or Medicaid).[25]	Support House bill.
Major revenues over ten years	Savings resulting from making Medicare and Medicaid more efficient. A 5.4% surtax on couples with incomes above $1 million and individuals above $500,000.	Savings resulting from making Medicare and Medicaid more efficient. Imposes an excise tax of 40% on the value of health plans that exceed $23,000 for families and $8,500 for individuals starting in 2013. These threshold amounts would increase by 20%, 10%, and 5% higher in the first three years for 17 states with the highest premiums. Increases the hospital insurance (Medicare Part A) tax rate from 1.45% to 2.35% for individuals earning over $200,000 and $250,000 for married couples. Requires new fees on pharmaceutical and medical device manufacturers, and insurance companies.	The "millionaires" tax in the House bill would affect less than 2% of households in New Jersey.[26] The excise tax, on the other hand, would affect middle class families in addition to higher income households. At least a fifth of households nationally earning between $50,000 and $75,000 have insurance polices that are targeted in the Senate bill which would affect about 100,000 households in New Jersey within six years.[27] On the other hand, New Jersey would be one of the 17 states that would have higher threshold amounts for the value of health plans during the first three years which would reduce the impact somewhat.	Support the "millionaire" and other taxes in both bills but oppose the excise tax. If the excise tax must remain, it should be amended to raise the threshold amounts for insurance plans and delay the implementation for plans that have been collectively bargained to give time for unions to renegotiate their contracts.

Impact of Health Reform Bills Passed by Senate and House on New Jersey By County*

County	County Population 2008	Age 65+ 2008	People with a Disability 2008	Insured 2008	Uninsured 2008	Uninsured Without Reform 2019	Reduction in Uninsured 2019 House Bill	Reduction in Uninsured 2019 Senate Bill	New Federal Funds to New Jersey 2010 - 2019 House Bill	New Federal Funds to New Jersey 2010 - 2019 Senate Bill
Atlantic	268,330	37,789	34,053	238,890	29,440	34,331	22,887	19,708	$657,350,387	$566,044,875
Bergen	884,858	125,080	71,335	782,913	101,945	118,881	79,254	68,246	$2,276,265,515	$1,960,093,816
Burlington	428,006	56,579	45,580	389,977	38,029	44,347	29,565	25,458	$849,131,037	$731,187,326
Camden	509,498	62,019	64,531	449,107	60,391	70,424	46,950	40,428	$1,348,438,545	$1,161,141,367
Cape May	92,669	18,895	11,244	84,205	8,464	9,870	6,580	5,666	$188,985,125	$162,735,222
Cumberland	146,093	18,113	19,325	124,551	21,542	25,121	16,747	14,421	$481,002,566	$414,191,643
Essex	754,586	85,322	75,538	627,067	127,519	148,704	99,136	85,367	$2,847,299,292	$2,451,811,398
Gloucester	286,174	32,541	32,345	260,047	26,127	30,467	20,311	17,490	$583,364,721	$502,335,767
Hudson	590,483	61,960	57,198	475,193	115,290	134,443	89,629	77,180	$2,574,237,806	$2,216,677,963
Hunterdon	126,587	14,549	9,679	119,356	7,231	8,432	5,621	4,841	$161,451,122	$139,025,673
Mercer	358,508	42,907	39,281	319,654	38,854	45,309	30,206	26,011	$867,550,864	$747,048,651
Middlesex	778,518	89,719	65,420	685,530	92,988	108,436	72,291	62,250	$2,076,270,619	$1,787,878,072
Monmouth	635,185	82,085	56,132	572,869	62,316	72,669	48,446	41,717	$1,391,424,523	$1,198,156,623
Morris	483,352	60,718	36,101	448,608	34,744	40,516	27,011	23,259	$775,777,236	$668,022,317
Ocean	562,744	113,521	73,731	508,169	54,575	63,642	42,428	36,535	$1,218,580,681	$1,049,320,671
Passaic	486,117	57,472	48,254	394,590	91,527	106,732	71,155	61,272	$2,043,643,399	$1,759,782,751
Salem	65,261	8,777	8,427	57,547	7,714	8,996	5,997	5,164	$172,250,272	$148,324,829
Somerset	321,726	37,955	21,472	298,718	23,008	26,830	17,887	15,402	$513,725,522	$442,369,404
Sussex	149,927	15,296	14,205	135,313	14,614	17,042	11,361	9,783	$326,310,486	$280,986,186
Union	519,805	63,604	48,515	427,738	92,067	107,362	71,575	61,633	$2,055,706,280	$1,770,170,105
Warren	108,852	13,696	9,077	98,623	10,229	11,928	7,952	6,848	$228,390,534	$196,667,247

Impact of Health Reform Bills Passed by Senate and House on New Jersey By Congressional District*

District	U.S. Representative	District Population 2008	Age 65+ 2008	People with a Disability 2008	Insured 2008	Uninsured 2008	Uninsured Without Reform 2019	Reduction in Uninsured 2019 House Bill	Reduction in Uninsured 2019 Senate Bill	New Federal Funds to New Jersey 2010 - 2019 House Bill	New Federal Funds to New Jersey 2010 - 2019 Senate Bill
1	Andrews	668,908	79,076	82,206	587,709	81,199	94,689	63,126	54,358	$1,813,050,911	$1,561,219,399
2	LoBiondo	666,668	93,149	84,136	592,586	74,082	86,389	57,593	49,593	$1,654,127,250	$1,424,370,124
3	Adler	665,991	113,340	80,853	605,639	60,352	70,378	46,919	40,402	$1,347,557,763	$1,160,382,926
4	Smith	704,383	105,372	74,074	635,341	69,042	80,512	53,675	46,220	$1,541,597,809	$1,327,470,944
5	Garrett	662,856	81,951	51,953	607,664	55,192	64,361	42,908	36,948	$1,232,347,682	$1,061,175,445
6	Pallone, Jr.	646,612	72,919	59,027	548,751	97,861	114,119	76,080	65,512	$2,185,085,458	$1,881,578,605
7	Lance	673,465	85,396	52,729	624,589	48,876	56,996	37,998	32,720	$1,091,326,867	$939,742,323
8	Pascrell, Jr.	640,559	77,656	62,180	528,507	112,052	130,667	87,112	75,012	$2,501,937,114	$2,154,419,787
9	Rothman	636,008	89,996	56,917	540,572	95,436	111,291	74,194	63,889	$2,130,936,529	$1,834,950,925
10	Payne	620,912	63,528	65,911	495,948	124,964	145,724	97,150	83,656	$2,790,239,954	$2,402,677,562
11	Frelinghuysen	654,976	85,191	48,152	611,103	43,873	51,162	34,108	29,371	$979,620,766	$843,552,122
12	Holt	681,860	90,381	61,497	635,853	46,007	53,650	35,767	30,799	$1,027,259,570	$884,573,929
13	Sires	634,081	63,324	61,441	484,403	149,678	174,544	116,363	100,200	$3,342,068,860	$2,877,857,816

*All 2008 data are from the American Community Survey (ACS). Data for 2019 are New Jersey Policy Perspective's projections based on New Jersey's share of the total uninsured nationally averaged for 2006-2008 using the Current Population Survey data applied towards the Congressional Budget Office estimates of the bills. The health reform bills will benefit many of the people in all categories shown (see report for specific benefits). "New Federal Funds" refer only to Medicaid and premium/cost sharing subsidies provided in the Exchange in the bills. The ACS definition of "disability" appears weighted towards physical disabilities therefore it probably undercounts mental illness.

ENDNOTES

[1] For more detail on what is included in the Senate and House bills, see the Kaiser Family Foundation side-by-side comparison at http://www.kff.org/healthreform/sidebyside.cfm

[2] New Jersey's average share of the uninsured nationally between 2007 and 2008 was multiplied times the Congressional Budget Office cost estimate of the House bill in a November 6, 2009 letter to Congressman John Dingell.

[3] New Jersey's average share of the uninsured nationally between 2007 and 2008 was multiplied times the Congressional Budget Office (CBO) cost estimate of the Senate bill in a November 18, 2009 letter to Senator Harry Reid.

[4] Same New Jersey share above except applied to the national number of uninsured people in the above CBO letters.

[5] Judith Solomon, *Subsidies in Senate Health Bill Would Be Inadequate for Many Low- and Moderate-Income Households, Need Improvement in Conference*, Center on Budget and Policy Priorities, January 8, 2010 for subsidies in the House bill (http://www.cbpp.org/cms/index.cfm?fa=view&id=3045) and the premium amounts in NJ FamilyCare posted at the NJ Division of Medical Assistance and Health Services website: http://www.njfamilycare.org/pages/whatItCosts.html

[6] Kaiser Family Foundation, *Medicaid-to-Medicare Fee Index*, 2008. New Jersey's primary care reimbursement rate is 37% of the Medicare rate.

[7] NJ Department of Human Services, January 2010.

[8] New Jersey Council of Teaching Hospitals, New Jersey Physician Workforce Task Force Report, *Too Many? Too Few?*, 2010, http://www.njcth.org/getmedia/b97e687f-e668-48c4-83e6-3665a2514385/2009_workforce_task_force_report.aspx

[9] Testimony of John Guhl, Division Director, NJ Division of Medical Assistance and Health Services, before the Senate Health, Human Services and Senior Citizens Committee, State House, January 4, 2010.

[10] NJ Division of Medical Assistance and Health Services website: http://www.state.nj.us/humanservices/dmahs/news/reports/enrollment_2009_12.pdf

[11] NJ Division of Medical Assistance and Health Services website: http://www.state.nj.us/humanservices/dmahs/news/reports/NJFC_Enrollment_Goals.pdf , also includes children in Medicaid.

[12] Small Business Majority, *The Economic Impact of Healthcare Reform on Small Businesses*, June 11, 2009. http://www.smallbusinessmajority.org/pdfs/SBM-economic_impact_061009.pdf

[13] New Jersey Prevention Network, Program and Services, http://www.njpn.org/programs-and-services

[14] NJPP estimates based on data from U.S. Census Bureau, *2007 County Business Patterns*, http://www.census.gov/econ/cbp/index.html

[15] Elise Gould, *Employer-sponsored health insurance erosion continues*, Economic Policy Institute, September 10, 2009, *http://www.epi.org/publications/entry/health_picture_20090910/* 26.

[16] Congressional Budget Office estimates of the House bill in an November 6, 2009 letter to Congressman John Dingell.

[17] Medicare Annual Statistical Supplement, 2008, http://www.socialsecurity.gov/policy/docs/statcomps/supplement/2008/8b.html#table8.b14

[18] NJ Department of Banking and Insurance, http://www.state.nj.us/dobi/lifehealthactuarial/2006comhealth_source.pdf

[19] PL 2008; c.38.

[20] Ibid.

[21] Office of the Actuary, *CMS, 2004 State Estimates–State Estimates by State of Residence–All Payers–Personal Health Care*, September, 2007.

[22] The benefits in the bills were compared to the mandatory benefits listed at the NJ Department of Banking and Insurance website: http://www.state.nj.us/dobi/division_insurance/mhbac/mandatedhbac.htm
New Jersey Council of Teaching Hospitals, New Jersey Physician Workforce Task Force Report, *Too Many? Too Few?*, 2010, http://www.njcth.org/getmedia/b97e687f-e668-48c4-83e6-3665a2514385/2009_workforce_task_force_report.aspx , and Nursing Home Initiative, *The Nursing Shortage and New Jersey*, May 5, 2009, http://www.njni.org/factsheet/nursing-shortage-and-new-jersey [23]

[24] NJPP analysis of Current Population Survey data averaged for 2007 and 2008.

[25] PL 2008;c.38

[26] NJPP analysis of state tax data for 2006.

[27] NJPP analysis of 2006-2008 American Community Survey 3-Year Estimates for New Jersey data and Congress' Joint Commission on Taxation as reported by AFL-CIO in an email dated January 6, 2010 for national data.