THE RIGHT Rx FOR NJ: NATIONAL HEALTH CARE REFORM
Preliminary Analysis of H.R. 3200

By Raymond J. Castro
SENIOR POLICY ANALYST

BACKGROUND

We all want and need good health. Unfortunately this goal is in jeopardy because of rapidly rising uninsurance rates and unrelenting increases in medical costs that are making health coverage unaffordable for a growing number of New Jerseyans, businesses, and government. As the number of uninsured people increases, health insurance premiums increase at an even faster rate because the uninsured’s uncompensated care is often shifted to others with insurance, which in turn causes families and businesses to drop their insurance because of its high cost. While there is disagreement on how to solve this problem, it is generally agreed that unless something is done soon to stop this spiral, it will only get worse.

That is why it is important for New Jerseyans to understand what is going on in Congress to reform health care. Unfortunately, the debate on this issue has often centered on the concerns raised by interest groups that have a political agenda or a major financial stake in the health industry which now represents about one sixth of the nation’s economy. What is lost in this debate is how health reform will affect typical working Americans.

The good news is that there is consensus in Congress on some important elements of reform such as changes in the private insurance marketplace. Some of those elements include a prohibition on denying insurance to people because they were ill, terminating insurance if the policyholder becomes too sick and capping lifetime benefits. However, while those changes are needed, limiting the bill only to them, as some have suggested, would create other problems. Because those changes would result in more sick people being covered by private insurance, they would probably increase the cost of insurance for everyone making it even less affordable and thereby increase the number of uninsured.

To prevent that from happening, the bill would need to mandate health coverage for everyone—much like states do with car insurance—to prevent people from applying for health coverage only when they are ill. However a mandate would not be successful if low and moderate-income families could not afford the required health coverage, so subsidies would be needed. Because such subsides would be costly, offsets are needed such as greater efficiencies in the health care system and more federal revenues. More choice and competition to hold down the increase in premiums would also be needed. In other words, the reforms are interlinked and must be comprehensive; there is no easy, piecemeal solution.

The “America’s Affordable Health Choices Act of 2009” (H.R.3200), which was introduced on July 14, 2009 in the U.S.
The bill would provide a public insurance option which many consider key to reform. The public option would be an insurance plan similar to Medicare that would be available through the Exchange. It would have to meet all the requirements that apply to private plans and be self-sustaining. It would set a benchmark for a basic insurance plan that families and small businesses with limited human resource capacity could use as a clear standard for comparing insurance policies both in and out of the Exchange. Because it would not have the same overhead as many private insurance companies, it would likely charge lower premiums. These lower premiums would likely have the effect of reducing the premiums that private insurers would charge in order to compete in the marketplace. The public option would provide another choice in an industry usually dominated by a small number of insurance companies in each state, and it would be a viable alternative source of insurance for vulnerable families.

The cost of the bill as introduced was estimated by the Congressional Budget Office (CBO) at about $1 trillion over ten years. The actual cost would probably be less as a result of amendments that were adopted before August 7, 2009 by three committees in the House. According to CBO, funding health reform would probably increase current federal expenditures for health care by ten percent. But that increase will be worth it as an investment in the nation’s future if it means that a serious illness will not bankrupt a family and a job loss will not mean the loss of health insurance as well.

More amendments are possible before the House leadership finalizes the bill for a full House vote scheduled in October. The
House bill must be combined with any bill that is passed by the Senate in a conference committee and voted on again before it can be sent to the President for his signature. An alternative legislative process called “reconciliation” is possible. This process requires only 50 rather than 60 votes to pass in the Senate, but it might limit the reforms that can be included in the bill.

As more information becomes available, New Jersey Policy Perspective plans to provide updates on the financial impact of these bills—on individuals, businesses and the public sector.

KEY FINDINGS

- National health reform is critical to New Jersey’s public health and its economy. It is more urgently needed in New Jersey than in most states because the number of uninsured people in this state has increased at a faster rate than the national average since 1999 (31 percent vs. 19 percent). This has happened in part because employer-based insurance in New Jersey has decreased by seven percentage points since 2000.

- Total health expenditures in New Jersey are increasing at twice the inflation rate which is taking a major toll on family, business and government finances. The cost of family premiums has risen four times faster than median worker wages since 2000. About a quarter of a typical middle class family’s income is spent on health care costs and forgone wages paid by employers for employees’ health care premiums.

- These high medical costs are one of the main reasons why a public insurance option is so important to New Jersey. It would likely reduce their growth by promoting more competition and choice, which is especially important in a state that already has one of the highest costs of living in the nation.

- The bill would cause the number of uninsured New Jerseyans to decrease by an estimated 1 million primarily because of an estimated $34 billion over ten years in federal health subsidies to low and middle class people and the inclusion of indigent adults without children in Medicaid. This is expected to increase to 94 percent the non-elderly population in New Jersey with insurance by 2019. New Jersey would benefit more than most states from the bill because it has the 9th highest number of uninsured people in the country.

- All of the mostly middle class 5.6 million people who receive employer-based insurance would benefit from the peace of mind knowing that if their premiums at work become unaffordable or they lose their job that affordable, quality insurance will be available. The bill should also reverse the alarming trend in New Jersey of employers shifting more of health insurance costs to workers or dropping health coverage entirely as it becomes more expensive to provide.

- Almost all groups in New Jersey would benefit from at least some provision in the legislation: many of the 1.2 million seniors and people with disabilities on Medicare would receive better drug prescription coverage; 1.5 million insured children would be guaranteed essential benefits like vision coverage; and most of the 250,000 uninsured children would have insurance.

- The bill would also likely reduce the cost of insurance for small employers which could save jobs, preserve wages and increase their competitiveness by making health insurance more affordable. The estimated $1.3 billion in federal tax credits in New Jersey would be an incentive for these businesses to continue providing health coverage to their employees.

- The vast majority of New Jerseyans would benefit—only those whose incomes exceed $350,000 a year (less than three percent of New Jersey tax filers) would see their federal taxes increase as a result of the legislation. The economy will benefit from the infusion of new federal funds and the cost savings from improved health outcomes will benefit everyone.

- The bill would help New Jersey state government which would receive more federal funds than most states because of the types of health services—some of which are now funded entirely with state funds—that would be funded at higher federal matching rates.

- To protect New Jerseyans, the congressional delegation needs to ensure that the key provisions identified in this report are maintained in the final legislation.
NATIONAL HEALTH REFORM IS NEEDED

The Uninsured

The number of people without insurance in New Jersey increased to 1.28 million in 2007-2008 from 974,000 in 1999-2000, a gain of about 300,000 people. This represents a 31 percent increase, which is 12 percentage points higher than the national increase of 19 percent. Although 15 percent of New Jersey residents did not have insurance in 2007-2008, and that was the national average, New Jersey had the ninth highest number of people without insurance because of its larger population.

One of the reasons for the higher growth rate in uninsured people in New Jersey is that employers here are dropping coverage for their employees faster than the national average. New Jersey’s share of adults and children covered by an employer-based policy dropped 7 percentage points from 76 percent in 2000-2001 to 69 percent in 2007-2008 compared to a 5 percentage point decrease in the national average from 68 percent in 2000-2001 to 62 percent in 2007-2008. This was the 14th highest decrease in the nation.

As large as the number of uninsured people is in New Jersey, it would be much larger without NJ FamilyCare which provides health coverage to children and their low-income parents. The state has made an extraordinary commitment to this program by making additional state funds available to obtain federal funds even in tough budget times, making it easier to apply for assistance through the Express Lane application, eliminating premiums for low-income children and expanding outreach. All of these efforts have resulted in a major increase in NJ FamilyCare enrollment.

Health Expenditures

Personal health care expenditures have been skyrocketing in New Jersey for some time, increasing by an annual average of about 6 percent between 1991 and 2004, more than twice the national inflation rate. By 2004 these expenditures were about $50 billion, making personal health care expenditures in New Jersey the ninth highest in the nation.

These increases are causing unsustainable increases in health premiums for businesses and families. Since 2000, premiums have increased at four times the increase in earnings for the typical worker in New Jersey—median wages have increased by only 20 percent while total annual family employment-based premium costs have increased by 79 percent.

It is even worse for families who must purchase private insurance either because they are self-employed or their employer does not offer insurance. The cost of a comprehensive family plan is typically about $16,000 with a $1,000 deductible, a price tag well beyond the reach of most New Jersey residents.

Struggling New Jerseyans

Out of control medical costs are a threat not only to the health of most New Jerseyans, but to their standard of living as well. Workers usually share in the cost of the premiums. In 2009, the total cost of premiums for employer-based health insurance averaged $13,595; the employees’ share averaged $3,494 which was more than double the $1,610 they paid in 2000; the employers share went up by 69 percent to $10,101 from $5,982 in 2000. Clearly the burden of rising health care costs is affecting both...
employees and employers, but it is gradually being shifted to the employees.\textsuperscript{12} In addition to the premiums, the typical working family spends about $1,952 on out of pocket expenses such as co-payments and deductibles.\textsuperscript{13}

These higher health care costs are reducing the wages that New Jerseyans would otherwise have received from employers who provide health coverage. The amount of money available for salaries and benefits is not infinite so when benefits cost more, it is likely that employers offer lower cost-of-living increases and bonuses. In fact, the American employer-based health insurance system started in the 1940’s when the federal government prevented businesses from increasing wages to avoid inflation. In order to attract quality employees, employers started to offer health benefits in lieu of higher salaries.

The health care burden is much greater for middle class families than for wealthy families. Wealthy people pay a smaller share of their income for health insurance and their income has increased at much faster rates than that of the middle class whose income has largely stagnated. From 2002 to 2007, the nation’s last economic expansion, two-thirds of the total income gains went to the top one percent of households.\textsuperscript{14} One study found that households nationally with an average income ($66,570 in 2006) spent about a quarter of their income on all health related expenses compared to about 9 percent for households with incomes starting at the top 5 percent of the income distribution ($174,014).\textsuperscript{15}

Without reform, the problem of escalating health care costs for middle class families and employers will only get worse. National health care costs are expected to increase by 71 percent over the next decade. At that rate New Jersey’s average premium for families in 2006 will double to $24,119 by 2019 (see below). This will be particularly burdensome to New Jersey’s families which have one of the highest costs of living and the highest median monthly housing costs in the nation—leaving less disposable income for rising health care costs compared to other states.\textsuperscript{16}

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**Health Care Premiums for Families in New Jersey are Projected to Double Within a Decade Compared to 2006**

![Graph](https://example.com/graph.png)

**SOURCE:** David Cutler, Health Care Premiums Run Amok, Center for American Progress, July 24, 2009
Specific groups in New Jersey are particularly vulnerable. Nearly a quarter of all adults without dependents in New Jersey have no health insurance. A major reason for this high rate is that—unlike about half of the states—New Jersey does not have a public program providing comprehensive health coverage for low-income adults without children (it only provides scaled back benefits for such adults on welfare mostly earning less than $140 a month).19

Young adults (age 20-30) are more likely to be unemployed or to start employment with employers who do not provide health insurance. About 40 percent of all uninsured non-elderly adults (below age 60) in New Jersey are young adults, 80 percent of these uninsured young adults have at least a high school degree and about half (53 percent) have at least some college.20

New Jersey’s 3.4 million minorities are more likely to be uninsured compared to whites, resulting in racial and ethnic disparities in health outcomes. Eleven percent of whites had no insurance compared to twice that for African Americans (21 percent) and almost four times that of Hispanics (40 percent) in 2006-2007 in New Jersey. Minorities are less likely to have insurance or to have a regular doctor or a usual place of care and therefore are more likely to go without treatment. In New Jersey this has meant that African-Americans, for example, are more than three times more likely to die at birth and twice as likely to die of diabetes as whites. African-Americans are also more likely to die of cancer and heart disease in New Jersey.23

Small businesses are disproportionately affected by the high cost of health insurance in the state. In 2007, 215,283 businesses—88 percent of all employers in New Jersey—employed between 1 and 25 people. These businesses employ about a fifth (753,100) of all people in the state.24 A survey in 2008 found small employers are paying 12 percent more than larger companies for insurance, which is one of the causes for the large drop in the number of small employers who are providing health coverage for their employees. The percentage of employers with 2-19 employees that provide health coverage dropped from 92 percent six years ago to 75 percent in 2007—for large companies the percent hardly changed.

This not only affects employees, it often means that employers cannot afford health coverage for themselves and their own families which might discourage potential entrepreneurs from starting a small business. Many might opt to take a job in a large company with health benefits to avoid the risk of catastrophic medical expenses. Contrary to popular perceptions, the United States has a much smaller small business sector—as a share of total employment—than other countries at a level of comparable economic development. Of 22 rich democracies, the United States has the second lowest rate of self-employed workers (just over 7 percent) and among the lowest rates of employment in small businesses that manufacture products (just over 11 percent). The nation’s undersized small business sector is consistent with the view that high health care costs discourage small business formation, since start-ups in other countries can tap into government-funded health care systems.26

WHO WILL BENEFIT?

Overall Impact

Without reform, the number of people without insurance in New Jersey is estimated to increase to 1.5 million in 2019 from 1.3 million in 2007-2008 (see Methodology, page 10). The House bill would reduce the number of people without insurance in New Jersey by about 1 million people by 2019, which would increase the percent of all non-elderly people in the state who have insurance to 94 percent (it was 82 percent in 2006-200728). Only unauthorized immigrants and those who choose not to be covered would not be covered. The bill increases the insurance rate primarily by providing affordable health coverage to uninsured working families and individuals up to four times the federal poverty level ($88,200 for a family of four) and by providing Medicaid for childless adults to 133 percent of the federal poverty level ($14,079 for a single adult).

From 2013 to 2019 the bill would result in $34 billion in additional federal expenditures in New Jersey through the Exchange subsidies and Medicaid and it would increase primary care rates in Medicaid to 100 percent of Medicare rates to improve access. The 5.6 million New Jerseys who are estimated to have employer-based health insurance would have the security of knowing that if they lose their jobs, they still would have access to affordable health coverage. And when workers move to another state or move to New Jersey from another state, they would still have insurance because it would be a national policy.
Most of the 662,000 people who have had no choice but to purchase their own health insurance at much higher rates will also benefit because they may be eligible for insurance subsidies through the Exchange; their premiums may grow at a slower rate because of greater competition; and they may be able to purchase less expensive coverage through a public option.

These fiscal estimates do not take into account the benefits that many other groups in New Jersey would receive such as senior citizens and people with disabilities in Medicare. In addition, these new federal funds could have a very positive impact on the state’s economy that could well exceed the federal expenditures.

**Middle Class Families**

Most middle class families would benefit from the bill whether they have health insurance or not. Almost a quarter of the non-elderly people without insurance are middle-class families. A June 2009 survey found that over half (56 percent) of middle income non-elderly adults reported that they or another family member in their household had to forgo needed health care or skimped on care because of cost.

Families without insurance would be eligible for subsidies on a sliding scale to better afford insurance as long as their income does not exceed $88,200 for a family of four. Families that already have employer-based insurance would be eligible for these subsidies if their premiums at work exceed 12 percent of their wages and they meet the income criteria for the subsidies. Families with incomes above $88,200 who do not have insurance would be able to purchase insurance through the Exchange, including the public option, at competitive rates. Covered families would have more stability and security in their insurance. Families with insurance would know they can obtain comprehensive, affordable insurance if they become uninsured due to loss of employment.

Middle class families with health insurance would benefit in other ways from the many reforms in the bill. No family with insurance would have to pay more than $10,000 a year on costs such as deductibles and co-payments. This is a major reform that would remove one of the greatest problems for individuals who become seriously ill. For example, in a cancer survey, 25 percent of the respondents with insurance and without said they used up all of their savings as a result of the costs they had to bear to treat the cancer. In 2007 about two-thirds of all bankruptcies were caused by a medical problem, up 50 percent from 2001. Most disturbing, over three-quarters of these bankruptcies were filed by individuals who had insurance.

Middle class families may also see a reduction in the future premiums they would otherwise have to pay. One study found that if everyone had insurance, premiums for families would have been reduced by an average of $1,017 nationally in 2008 because health care providers sometimes charge higher rates to individuals with insurance to make up their losses on individuals without it. This is sometimes referred to as a “hidden tax.” This estimate does not take into account the many other reforms in the bill that would reduce the acceleration of insurance costs, including placing an annual limit on increases in premiums (no more than 150 percent of medical inflation).

One of the most remarkable aspects of the bill is that most New Jerseyans would not pay for these federal benefits. One might argue that a slight increase in federal income taxes for a typical family would be well worth a lifetime guarantee of affordable, quality health coverage. But the only families that are likely to pay any additional taxes are those earning more than $350,000 a year—less than three percent of tax filers in New Jersey. Congress appears dead set against taxing middle class families to pay for health reform. Even a modest proposal to tax carbonated beverages was scrapped. Half of the bill’s cost over ten years would be covered by taxes on the wealthy; the rest would come from Medicare and Medicaid savings.

**Children**

Children would benefit from many of the changes recommended. NJ FamilyCare would be replaced by the health subsidies in the Exchange, which would increase eligibility to $88,200 from $77,175 for a family of four. Replacing NJ FamilyCare could start as soon as 2013 but would not occur until the federal government certifies that coverage would be comparable to that provided in 2011 by NJ FamilyCare and that there would be no interruption of coverage. The cost sharing requirements would be higher in the House bill compared to current policy in NJ FamilyCare but the freed-up funds the state would realize in NJ FamilyCare as a result of the federal government funding the entire subsidy would allow the state to maintain its cost sharing levels. It would be important for the state to take such
action because of the higher cost of living in New Jersey. All insurance plans would have to include pediatric benefits such as vision and hearing services. Infants who do not have coverage would be automatically enrolled in Medicaid.

**Adults**

Low and middle class childless adults and middle class parents would be helped by the bill. About one million uninsured non-elderly adults live in New Jersey. Nearly 19 percent of them have no insurance compared to about 12 percent of children and 1.5 percent of the elderly in 2007-2008. Childless adults are currently not eligible for any public insurance in New Jersey but would become eligible for full Medicaid coverage if their individual annual incomes were under $14,079. A childless adult with an income up to $43,330 would also be eligible for subsidized insurance in the Exchange. Although parents would be phased-out of FamilyCare, they would be transferred to the Exchange and eligibility for a family of four would be doubled to $88,200 from $44,100.

**Seniors and People with Disabilities**

For seniors and people with disabilities receiving Medicare, the bill would close the so-called “doughnut hole” in Part D prescription drug coverage, increase low income subsidies, improve access to primary care and eliminate cost sharing for preventive service. It also would make other changes such as it would eliminate overpayments to private plans with which Medicare has a contract and improve payment accuracy that should extend the financial solvency of Medicare for another five years. It would create a temporary reinsurance program for employers who provide health insurance coverage to retirees who are not eligible for Medicare (age 55-64). Many individuals who do not meet the federal definition of a disability but who have mental health, substance abuse and other needs would benefit from the expanded coverage in Medicaid for childless adults and from the subsidies in the Exchange. All insurance plans would be required to provide preventive, rehabilitative, mental health and substance abuse services.

The bill would establish a major voluntary insurance program for individuals with functional limitations who need to purchase community living assistance services and supports (called CLASS). This program should substantially reduce the need for institutionalization and public expenditures. It would be funded totally through voluntary payroll deductions by all workers.

**Racial and Ethnic Disparities**

The large racial and ethnic disparities in health care in New Jersey would be reduced or eliminated in the House bill. Because minorities in the state often are disproportionately lower income, they would benefit from the expansions in Medicaid and the subsidies available in the Exchange. The bill would also monitor health outcomes, which should help African-Americans and Hispanics whose health is often worse than the rest of the population. The bill would require outreach, would authorize a study on the feasibility of developing a Medicare payment system for language services and would develop standards for the collection of race and ethnicity data. Increasing reimbursement rates for primary care providers should also promote access to these services in urban areas where minorities more often live.

**Small Businesses**

This legislation would provide incentives for small businesses to maintain or start to offer health coverage for their employees. Without these reforms, New Jersey will never be able to cope with the insurance crisis that is unfolding. Since much job growth is in small business, the decrease in employer-based insurance and the escalating insurance costs means fewer people will have insurance in the future if costs are not curtailed.

This is not only a health care issue; it is an economic one as well. Historically, small businesses (fewer than 25 employees) have created most of the new jobs in the state. From 2003 to 2005, large firms (over 500 employees) had a net loss of 105,000 jobs while firms with 1 to 4 employees alone created about 90,000 new net jobs. In fact, in 2005 (the last year for which data are available) the only firms that created a net increase in jobs were in those with four or fewer employees.

Making it easier and less costly for small employers to insure their employees will make them more productive. Forty percent of small businesses nationally reported that health care costs have had a negative effect on other parts of their business such as less productivity and causing more turnover. A recent
study found that health reform could reduce health care costs for small businesses (under 100 employees) nationally by over a third over the next ten years which would free up costs for reinvestment, reduce job losses by up to 72 percent, and help to preserve wages.42

H.R. 3200 would benefit businesses with 25 or fewer employees by making available a credit of up to 50 percent on the cost of health converge for employees earning up to $40,000. Small employers would start to receive these credits in 2013, which would total about $1.3 billion in New Jersey by 2019 (see Methodology, page 10). And because insurance companies would not be allowed to charge higher premiums based on an employee’s health status, small businesses would not have to pay more for insurance simply because one or two employees had very high medical costs.

It is likely that employers with fewer than 10 employees would be eligible to purchase health coverage at reduced rates through the Exchange in 2013. This benefit would be expanded in 2014 to businesses with fewer than 20 employees. Many of the other changes in the bill that would benefit families would also benefit small businesses such as the market reforms that prevent financial ruin for their employees due to medical costs and the public option which would help to limit premium costs. Employees working in small businesses that do not provide insurance would be free to purchase affordable insurance through the Exchange on their own.

State and Local Government

State government would receive much needed increases in federal funds. New Jersey’s reimbursement rates for primary care providers in Medicaid are 37 percent of Medicare rates, the lowest in the nation.43 Those reimbursement rates to providers would increase to 80 percent of Medicare rates in 2010, 90 percent in 2011 and 100 percent in 2012. The cost of increasing those reimbursement rates would be paid entirely by the federal government in 2013 and 2014 and at a 90 percent federal matching rate thereafter (in other words the state would pay only ten percent of the additional cost after 2014). As a result of these reimbursement rate changes, New Jersey probably would receive more additional federal funds per primary care provider than almost any other state because New Jersey’s current reimbursement rates are now the lowest in the nation.

Children and their parents in NJ FamilyCare would be transferred to the Exchange as early as 2013. New Jersey now pays 35 percent of the costs for health coverage in NJ FamilyCare (federal matching funds pay the balance). When families are transferred to the Exchange, their coverage will be paid entirely by federal funds which will save the state its 35 percent match. The Exchange, however, will require higher co-payments and premiums than is currently the case in NJ FamilyCare. To maintain the current cost sharing for these families, the state might need to use freed-up state funds to offset future cost sharing in the Exchange.

For years, New Jersey has been trying to secure a federal waiver to make childless adults eligible for Medicaid up to 100 percent of the federal poverty level ($10,830 for a single adult) with a 50 percent federal matching rate, but the Bush administration never approved the waiver. The bill would make these individuals eligible up to 133 percent of the poverty level ($14,400 for a single adult). For the first two years it would be at a 100 percent federal matching rate; after that it would be reduced to 90 percent. These reforms would mean New Jersey will no longer pay the full medical cost for people eligible for General Assistance; those costs mostly would be paid by the federal government.

The state would save because it is likely that Charity Care for hospitals would be less necessary because the number of people without insurance would be reduced by about two-thirds. These savings and additional funds would allow the state to reinvest them to further improve health care and fill any gaps that might be created in federal health reform.

State and local governments could achieve some relief to soaring premiums for their own employees and retirees. Based on rates in 2007, these premiums are projected to increase next year by about 23 percent for state employees and 32 percent for local governments.44 Provisions in the bill to improve the efficiency of medical services through accountability, information technology, and focusing on outcomes and coordination of services and to reduce the costs of uncompensated care in the system could help slow the growth in these public expenditures. While these plans already have economies of scale because of their large insurance pool, even a small improvement in health care delivery statewide could create significant savings.
CONCLUSIONS AND RECOMMENDATIONS

Given the unrelenting increase in the number of people without insurance and the high cost of health coverage in New Jersey, health reform is a necessity not an option. Without it, the state’s public health and its economy are threatened.

H.R. 3200 addresses most of New Jersey’s major health coverage problems and would benefit more people in this state than in most states. Almost all groups—low and middle class working families, seniors and people with disabilities, children, childless adults and small businesses—in New Jersey would benefit either directly or indirectly by some provision in the bill. It would provide much needed relief to the state government by increasing the federal government’s share of funds for health services to low and moderate-income people. And it would do all this at no cost to most New Jersey taxpayers. All of this makes this legislation a win for New Jersey.

The federal legislative process has just started and changes will be made to the bill. It will be important for the New Jersey congressional delegation to protect those provisions in the House bill which will benefit the state. Amendments already have been adopted in the House to save money by increasing cost sharing for the subsidies; requiring the state to pay for a portion of the cost to expand eligibility in Medicaid; increasing the limits on health subsidies to individuals with employer-based insurance; restricting the public health insurance option; and limiting the amount the federal government would require insurance companies to spend on benefits instead of profits and administration. While these amendments are troublesome, they are manageable.

But further restrictions in the bill could tip the balance against New Jerseyans. To prevent this from happening, it is important for the New Jersey delegation to maintain the following provisions in the bill that directly benefit New Jersey:

■ Set an income limit at 400 percent of the federal poverty level ($88,200 eligibility for a family of four) for health insurance subsidies.
■ Limit cost sharing in the subsidies and in private insurance; insurance must be affordable.
■ Guarantee children receive the same or better benefits in the Exchange than they receive in NJ FamilyCare.
■ Promote choice and competition through a public health insurance option.
■ Guarantee Medicaid eligibility for childless adults and increase primary care provider rates with at least 90 percent federal matching funds.
■ Protect essential benefits in all plans for children and rehabilitation for people with disabilities.
■ Improve Medicare by eliminating the “doughnut hole” in prescription drugs.
■ Provide tax credits and the option to purchase insurance through the Exchange to small businesses.
■ Require everyone to have health insurance as long as it is affordable.
■ Require larger employers to either “pay or play” to increase employer-provided insurance.
■ Pay for the reform with a tax surcharge on the wealthy and use other revenues based on ability to pay.

Methodology

The analysis in the text is based on H.R. 3200 including the amendments that were made by the three committees as of August 7, 2009 that have jurisdiction over this legislation. It is expected that most of the amendments will be accepted. It also is possible that new amendments will be added.

The Congressional Budget Office released preliminary national estimates of the bill before it was amended. It has not issued new estimates resulting from the amendments and may not do so until the bill is finalized in the House. However the new amendments are not expected to have a major fiscal impact.

The estimates of total federal expenditures under the bill for the Exchange subsidies and Medicaid expansion in the report from 2013 to 2019 ($34 billion) and the number of people who become insured (one million) are based on New Jersey’s share of the total uninsured nationally in 2006-2008 using data from the U.S. Census Current Population Survey. That share is applied to the CBO national estimates for H.R. 3200 which were included in a July 17, 2009 letter to Rep. Charles B. Rangel.45

The small business tax credit estimate was calculated by applying New Jersey’s share of small employers nationally and adjusting that estimate downward to take into account that the average annual payroll is about 13 percent higher in New Jersey (the tax credit in the House is income sensitive). That share was applied to the CBO national estimate for the tax credit.
1 Congressional Budget Office, letter to Rep Dave Camp, July 26, 2009. The letter states CBO estimates “that the public plan’s premiums would, on average, be about 10 percent lower than that of a typical plan offered in the insurance exchanges.”

2 Committee on Ways and Means, Provisions that Benefit Small Businesses, July, 2009. The report states that, in 39 out of the 43 states the American Medical Association studied, two insurance companies dominated more than 50 percent of the small group insurance market.


5 NJPP analysis of US Census, Historical tables, Table H1A-4, http://www.census.gov/hhes/www/hlthins/historic/histt4.xls. Years are averaged to improve reliability of data.

6 Ibid.

7 Center for Budget and Policy Priorities, CPS State by State Tables for Overall Health Coverage, Poverty and Median Income, September 10, 2009, unpublished. Email.


10 FamiliesUSA, Costly Coverage: Premiums Outpace Paychecks in New Jersey, September 2009.


14 Avi Feller and Chad Stone, Top 1 Percent of Americans Reaped Two-thirds of Income Gains in Last Economic Expansion, Center for Budget and Policy Priorities, September 9, 2009.


18 Keaney Klein and Sonya Schwartz, State Efforts to Cover Low-Income Adults Without Children, State Health Policy, Monitor, September 2008.

19 Federal poverty eligibility estimates were prepared by NJPP based on the GA grant level ($140 a month for an employable adult) and 2009 federal poverty guidelines for a household of one ($10,830 annually). http://aspe.hhs.gov/poverty/09poverty.shtml


22 Ibid.

23 Ibid.

24 NJPP estimates based on data from U.S. Census Bureau, 2007 County Business Patterns. Data for businesses employing 20-49 persons were prorated because the bill only provides tax credits to businesses with 25 or fewer employees.


30 Diane Rowan, Catherine Hoffman, and Molly McGinn-Shapiro, Kaiser Family Foundation, Health Care and the Middle Class– More Costs and Less Coverage, July 2009. Middle class is defined in the report as having an income between 200 percent ($44,000 for a family of four in 2009) and 400 percent ($88,000) of the federal poverty level.

31 Ibid

32 Ibid.


34 FamiliesUSA, Hidden Health Tax: Americans Pay a Premium, 2009.

35 NJPP estimates based on New Jersey Division of Taxation, Statistics of Income 2006, for tax returns filed on April 15, 2007. There were an estimated 70,940 state tax filers with incomes above $350,000 out of 2,744,512 total tax filers, or 2.6 percent. While the bill applies the surtax to federal income tax, the results are expected to be similar.
Another more detailed methodology was used to verify the estimate for federal expenditures on specific programs in New Jersey such as General Assistance medical expenditures, expanding Medicaid eligibility to 133 percent of the federal poverty level for childless adults and increasing the reimbursement rate for primary care providers. The General Assistance medical assistance data were obtained from the Governor’s 2010 Budget. The primary care reimbursement data were obtained from state administrative records. Since the Exchange subsidies do not exist yet, the state’s share of the CBO estimates was used. The total of these separate estimates was consistent with the $34 billion estimate.