

A STEP BACKWARD:

How Federal Rules Would Deny Health Insurance to New Jersey Children

By Raymond J. Castro

SENIOR POLICY ANALYST

BACKGROUND

We all want what is best for our children, especially good health. Increasingly, however, the goal of health for our kids—and for children across the country—is threatened by the steeply rising cost of health insurance. Too often, health insurance is unaffordable for employers and for working families alike. Nationally, since 2001, insurance premiums have increased by 75 percent while wages have risen by only 19 percent.¹ A rising unemployment rate and the increasing likelihood of a national recession are fueling more anxiety among even insured low-income families. They live with the fear that they might be one paycheck away from losing health coverage. It is estimated that every one percent increase in the unemployment rate results in an increase of 1.1 million uninsured persons.²

It is no wonder, then, that the federally created State Children's Health Insurance Program (SCHIP), which is called FamilyCare in New Jersey, has proven to be a crucial support for millions of working families. Started in 1998, SCHIP is widely recognized as one of the most effective public programs in the nation for providing health coverage to children in working families. Public opinion polls at the national and state level have consistently shown tremendous support for expanding eligibility in SCHIP, which provides free or low-cost health in-

urance for children in qualifying families.³ Numerous studies have also shown that children with health coverage are significantly healthier than children without health coverage and even do better in school.⁴ (The term "FamilyCare" is used in this report to describe SCHIP. It should be noted that the state Department of Human Services often uses the term to include both SCHIP and Medicaid to avoid stigmatizing Medicaid children.)

Despite the overwhelming importance of health coverage, approximately one of every 10 children in New Jersey is uninsured. To their credit, Gov. Jon Corzine and the Legislature have been trying to address this problem. Now, however, the Bush administration has issued new rules, through a directive to states the impact of which could actually be to *reduce* the number of insured children at certain income levels. This report analyzes the President's policy, which, if enacted, could prevent New Jersey from carrying out current plans to make affordable, quality health insurance available for all children.

The Bush Administration argues that states have gone too far in covering children under SCHIP. The White House made it clear last year that it wants to change eligibility rules in many states so that some families that qualify for coverage today would lose that coverage because their income is too high. The change would be especially painful in New Jersey, where the cost of

living is among the highest in the country. As the analysis that follows shows, the effects would drastically reduce health coverage for one of the most vulnerable segments of society: New Jersey's children.

SUMMARY OF KEY FINDINGS

- The Bush administration's new policy is probably the most serious threat to FamilyCare since it was established 10 years ago. Many children in New Jersey would potentially suffer irreparable harm if the directive is implemented.
- Requirements of the new policy appear aimed at making the program as difficult as possible to administer, and at discouraging participation.
- The income limit of 2.5 times the poverty level in the new SCHIP policy could result in 35,000 fewer currently uninsured children in New Jersey receiving the health coverage they need.
- The fiscal impact of the directive is equally onerous. New Jersey could lose over \$200 million in federal SCHIP and Medicaid funds at a time when the state is trying to address the largest structural state budget deficit in its history.
- The impact on the state's economy would be even greater because the loss of federal funds would reduce economic activity and cost thousands of jobs.
- Every congressional district in New Jersey, from low-income urban and rural areas to affluent suburbs, is at risk of losing millions in federal money and state matching funds. It's clear what the consequences would be: uninsured children who miss more school because they are sick, or attend school and perform poorly; parents who are not as productive at work because they have to stay home to take care of their uninsured child or worry all day while they are at work; and hospitals that will have no choice but to treat these children in the emergency room at much greater public expense.
- Ironically, children in New Jersey's most affluent congressional districts would be most at risk of not being insured under the directive. This finding is supported by a Child Health Insurance Misery Index developed by NJPP for this report.

BEHIND THE FEDERAL POLICIES

The administration's policy would make it as difficult as possible for states to enroll children of families whose income is above a certain level for insurance under SCHIP, even though New Jersey and other states allow them in the program now. The stated rationale for this policy has shifted over time. In the administration's view, the intent of SCHIP legislation was to serve low-income children, with income limits strictly defined. The Bush administration would allow in SCHIP only children whose family income is no more than 2.5 times the federal poverty level—about \$44,000 for a family of three (the average household size of SCHIP enrollees)—unless states can meet certain requirements that many consider impossible to satisfy. New Jersey currently allows kids to be in FamilyCare if their family income is no more than 3.5 times the federal poverty level—about \$61,600 for a family of three.

The administration is trying to achieve its policy through legislative and administrative means. President Bush vetoed two bipartisan bills to renew SCHIP that actually supported the administration's stated goal of reaching more low-income children, but would have accomplished it without making other children ineligible. Recently, the President also included a legislative proposal in his Fiscal Year 2009 federal budget to limit eligibility in SCHIP.

However, the Bush administration is not waiting for legislation to implement its policy on SCHIP.

Preempting Congress

While the Senate was in the process of amending its own bill on SCHIP, the federal government's Center for Medicaid and Medicare Services (CMS) effectively preempted Congress. CMS issued a directive on August 17, 2007, that would result in reducing or preventing expansion of SCHIP eligibility levels in 23 states. States that set their eligibility level at more than 2.5 times the federal poverty level would be required to stop enrolling uninsured children above the limit until the state can assure that it meets a number of requirements. They include enrolling "at least 95 percent of the children in the State below 200 percent of the FPL [about \$35,000 for a family of three] who are eligible for either SCHIP or Medicaid...."²⁵

There is widespread agreement that the highest priority should be given to enrolling the lowest-income children. But the directive—unlike the SCHIP reauthorization bills in Congress—does not further this goal and does not provide the states with any new tools to reach more low-income children. The standards in the directive are also unrealistic, such as requiring a 95 percent participation rate of low-income children in Medicaid and SCHIP.

Also, in the unlikely event that a state reaches this level of participation, it must meet other equally unrealistic requirements before being allowed to enroll higher income kids. The state must guarantee, for example, that the number of children insured in the private market does not decrease by more than two percentage points over five years. This is impossible, since the states do not control private employers' decisions on health coverage. A state also must require a 12-month waiting period after becoming uninsured before a child could enroll in SCHIP if the family income is above 2.5 times the poverty level. And, states could not charge families substantially less than what private insurance costs.

With Congress and the administration at a standoff on this issue, the current SCHIP law has been extended until March 2009, the deadline for enacting another extension or reauthorization bill. It appears that the administration is asking that its legislation be adopted before then. The administration's CMS directive will take effect in August 2008, if Congress cannot get the President to sign a bill that at least places a one-year moratorium on the directive, and if lawsuits filed by many states to block it are unsuccessful.

Recently, the bipartisan federal Government Accountability Office (GAO) and the Congressional Research Service (CRS) concluded that CMS erred by implementing the August 2007 directive without sending it to Congress for review, and that the methodology for estimating the states' 95 percent participation requirement was not valid. While this would appear to further support the states' case that the directive is illegal, the Bush administration has said it will carry out the directive anyway. In fact, it has already denied requests from some states to increase their SCHIP eligibility levels based on the requirements in the directive.

In an apparent attempt to respond to the concerns raised by the CRS and GAO, CMS sent another letter to state officials on May 7, 2008 providing more information on issues states raised about the August 17 directive. This letter, however, retained the basic policy and requirements of the directive. It did allow states to count children with private health insurance coverage in addition to children enrolled in Medicaid and SCHIP in determining compliance with the 95 percent coverage requirement, but according to Georgetown University, even with that change, no state currently meets the standard. The letter also says CMS will work with states individually on complying with the 95 percent coverage and 12-month waiting period requirements. But this raises more questions than it answers since the letter does not provide clear criteria to be used by CMS to evaluate alternatives proposed by states.

EFFECTS ON NEW JERSEY

This issue is of particular importance to New Jersey because FamilyCare has the highest SCHIP income eligibility level in the nation. In 1999, New Jersey amended its SCHIP to raise eligibility to 3.5 times the federal poverty level.⁶ Most families in the program fall well below that limit. The federal government in 1999 approved this income limit; only last year did the Bush administration make it an issue.⁷

A major reason for New Jersey adopting such a high income-eligibility level is the state's high cost of living, something not taken into account by federal poverty guidelines which are the same for all 48 contiguous states. As a recent study by the Brookings Institution concluded, "The percentage, number, and distribution of families that are considered poor under the federal poverty guidelines would change dramatically in many central cities if regional differences in the cost of living were recognized."⁸ For example, the study found, the eligibility level would increase by 78.8 percent in Newark; that would be the second highest increase among 98 central cities examined, behind only New York City.

There has been strong, bipartisan opposition in New Jersey to Bush administration efforts to reduce SCHIP income eligibility. Governor Corzine has been active in Washington and in the National Governors' Association. And New Jersey is one of

nine states to sue the federal government to stop the CMS directive from taking effect. Both US Senators and 10 of New Jersey's 13 House members have supported the SCHIP bills that passed Congress. This includes three of the state's six Republicans in the House, despite their national party leadership's opposition to the legislation. In the state Legislature, Democratic and Republican leaders have urged the congressional delegation to protect FamilyCare from cutbacks.

New Jersey's current policy to make affordable, quality health coverage available to all uninsured children should result in the state enrolling 64,000 more children in FamilyCare within the next five years. But under the CMS directive lowering income eligibility to no more than 2.5 times the federal poverty level, that number would be 29,000.

In the process, New Jersey would lose \$128 million in federal SCHIP funds and about \$87 million in federal Medicaid funds under the directive, for a total loss of \$215 million. Because of what economists call the "multiplier effect" of federal funds on state jobs and commerce, this would result in a loss of \$486 million in business activity and 3,600 jobs.

The number of children with family incomes between 2.5 and 3.5 times the federal poverty level who will be in FamilyCare by August 2008—when the directive is to take effect—is projected to be 11,000. The directive allows these children to remain in FamilyCare after that date, but if they leave the program for any reason they cannot return unless their family income drops to the eligible level. At the current FamilyCare attrition rate, enrollment of these children will decrease about 84 percent within two years and almost all of these children would be out of the program within five years.

Closing FamilyCare to new enrollees in this income group would mean that the number of New Jersey children without health insurance in families making 2.5 to 3.5 times the federal poverty level would increase by a third, to 45,000. Although the Bush administration contends that cutting higher income children from SCHIP would result in more lower-income children enrolling, the rate of enrolling children in Medicaid—which serves the poorest children—would actually be lower. Indeed, enrolling higher income children actually has resulted in more

low-income children applying and enrolling in Medicaid in New Jersey, probably because a more inclusive eligibility policy reduces confusion as to who is eligible. Also, the directive—unlike the SCHIP reauthorization bills—does not provide states with any tools to reach more low-income children.

Obstacles to Enrolling Children in Need

There is no challenge to the Bush administration's belief that a greater number of low-income kids lacking health insurance should be enrolled in SCHIP and Medicaid. The problem is that the administration's approach to achieving that goal would result in other children being denied health coverage. Such a zero-sum outcome is neither necessary nor desirable.

A major objection to the President's policy is that SCHIP today is doing what it was created to do: providing more children with insurance that leads to them receiving care they need to be healthy and get a good start in life. The laudable intent was to make health insurance for children more affordable. If there is a flaw with SCHIP, it's that income eligibility limits are based on the federal poverty level, which is tied to general inflation, rather than the cost of health insurance. Since 1997, the SCHIP income eligibility level has risen by only 24 percent, while the cost of insurance premiums for families has gone up 102 percent.⁹

Another problem is that a fixed income-eligibility level that does not vary by state according to the cost-of-living is rigid and counterproductive. It is often argued that states should have flexibility to set income eligibility levels to take into account such differences, rather than require a "one-size-fits-all" approach.

While the administration has said that the states have the ability to meet all the requirements in the directive, it has neither explained how compliance would be determined nor officially informed the states whether they are in compliance now. The administration also has announced it will apply the directive's new standards to Medicaid as well as SCHIP, further limiting states' ability to expand eligibility for uninsured children.

It Could Get Worse...
Impact of the Bush Legislative Proposal

Five months after the CMS directive was sent to the states, the President in his Fiscal Year 2009 budget proposed legislation that essentially extends the directive to include children between twice and 2.5 times the poverty level. While the budget includes an additional \$19.7 billion through Fiscal Year 2013 for SCHIP, the administration stated it is enough only “to meet the anticipated State need in covering low-income, uninsured children.”¹⁰ It might not be sufficient to fund current SCHIP programs.¹¹ The budget also includes funds for outreach, but that would not help if the states lack funding to serve the additional children they enroll. The legislation has not been introduced yet, and it will be difficult for the President to get it passed by Congress, which wants to allow states to expand eligibility in SCHIP.

DETAILED FINDINGS

Uninsured Children in New Jersey

In 2004-2006, about 255,000 children in New Jersey lacked health insurance.¹² About 192,000 of them, or 75 percent, were income-eligible for SCHIP (131,000 children) or Medicaid (61,000).¹³ However, half of the children who are financially eligible for FamilyCare would be ineligible for other reasons, such as not meeting citizenship requirements, or living in families that are reluctant to apply.

Given these factors, this report estimates the maximum number of children who could be added to FamilyCare and Medicaid to be 64,000 and 30,000, respectively—assuming no increase in the number of children without insurance during the five years covered by this report’s projections. This would reduce the percentage of New Jersey children without insurance from 11 percent to seven percent.

Of the 255,000 children without insurance, 25 percent (63,000 kids) were in families with income more than 3.5 times the federal poverty level, according to data from the US Census

Current Population Survey. These kids are not eligible for FamilyCare under New Jersey rules. Some 13 percent of the uninsured (34,000) were at 2.5 to 3.5 times the federal poverty level. They are eligible today for FamilyCare, but would not be under Bush administration’s directive. The rest of the uninsured break down this way: 15 percent (38,000 kids) between twice and 2.5 the federal poverty level; 23 percent (59,000) between the poverty level and twice the poverty level; 24 percent (61,000) below the poverty level.

It is projected that 16,000 new children with family income 2.5 to 3.5 times the federal poverty level would enroll in FamilyCare over the next five years under current New Jersey eligibility rules. But under the CMS directive the number of such children in FamilyCare would actually *decrease* by 11,000 due to two factors: new federal rules that would bar the state from adding kids in this income group and the normal attrition in FamilyCare.

Among those with family incomes from twice to 2.5 times the federal poverty level, it is projected that 19,000 new children would enroll in FamilyCare over five years under the current rules, and 11,000 under the CMS directive, which provides no incentives or funding to be used for increasing enrollment rates above historical levels.

Importance of Attrition Rates

One of the main reasons for such a large, negative impact under the Bush administration policy is the high attrition rate in FamilyCare. It has been estimated that every two years about 84 percent of children enrolled in FamilyCare leave.¹⁴ Normally, these children are more than replaced by other uninsured children or the same children returning because they become uninsured again. But that would not be allowed under the CMS directive. Based on the normal attrition rate, within five years all or most of the 11,000 children between 2.5 and 3.5 times the poverty level who are projected to be enrolled in FamilyCare as of August 2008 will have left the program, and none would replace them because the CMS directive bars participation from that income group.¹⁵

Children cycle on and off SCHIP for various reasons. A parent might find a job that offers private health insurance, for example, then transfer to one without coverage. Also, families are

sometimes terminated from FamilyCare because they do not meet such program requirements as paying their premiums on time or providing necessary documentation. Children also often go back and forth between Medicaid and FamilyCare as their parents' wages vary.

This is a major problem because many children who leave FamilyCare quickly become uninsured. For example, recent research found that 26 percent of all uninsured children in New Jersey received Medicaid or FamilyCare the previous year.¹⁶ This is consistent with one of the largest studies on SCHIP, mandated by Congress, which examined the experiences of children leaving SCHIP. Six months after they left, the study found, 25 percent had no health insurance and may have been eligible to return to SCHIP.¹⁷

Loss of Federal Funds for New Jersey

As a result of these changes in projected enrollment, New Jersey would lose about \$128 million in federal SCHIP funds over five years. Instead of receiving an additional \$240 million from Washington under the state's current eligibility rules, New Jersey would receive only \$112 million. Because federal funds have a "multiplier effect" once they are spent in a state, New Jersey could also expect to lose about \$290 million in economic activity and 2,000 jobs. These estimates are based on an input-output economic model developed by the U.S. Department of Commerce.¹⁸

Impact on the Poorest Children

The Bush administration has said it wants to make many children above certain income limits ineligible for SCHIP so states can concentrate more on serving lower-income children. Since the poorest children are in Medicaid, it would then be expected that the directive would increase enrollment of children in that program at a faster rate than under current rules. But available evidence does not support such a conclusion.

In recent years, when there were substantial increases in the FamilyCare caseload, Medicaid enrollment roughly paralleled those increases. For example, between December 2005 and December 2007, there was a consistent net increase in child enrollment in Medicaid when there was a two-month consecutive increase in SCHIP (this occurred on eight occasions representing a total of 16 months).

Furthermore, the increase in enrollment during that two-year period was about the same (23,371 children in SCHIP and 24,658 in Medicaid). It is therefore estimated that the number of additional children enrolled in Medicaid would be equal to the number of children added in SCHIP under current New Jersey rules. This results in the enrollment of all 30,000 uninsured children likely to participate in Medicaid by the 25th month.

It is also unclear that the CMS directive would result in any increase in the rate of children enrolling in Medicaid. First, there is no evidence that reducing eligibility in SCHIP would increase enrollment in Medicaid. Recently in New Jersey, for example, when there was a major reduction in SCHIP enrollment, Medicaid enrollment decreased too.¹⁹

Second, while the term "FamilyCare" is used in this report to describe only SCHIP, the state Department of Human Services uses it to include both SCHIP and Medicaid to avoid stigmatizing those in Medicaid because of its association with the lowest-income children. It will be difficult for the state to encourage families to enroll their uninsured children in FamilyCare while at the same time having to tell them that many children who were eligible before are no longer eligible. This could be particularly confusing for families with language barriers.

Third, the Bush administration directive also does not remove a major disincentive to enroll children in Medicaid—the higher state match compared to SCHIP. New Jersey must pay 50 percent of all costs for a child enrolled in Medicaid compared to 35 percent in SCHIP. Per-child costs are also higher in Medicaid. This problem would have been fixed with performance bonuses in the SCHIP reauthorization bill that the President vetoed, but such bonuses are not included in the directive.

All these factors lead to an estimate that Medicaid enrollment under the CMS directive would increase at the historical monthly rate of .2 percent. At that rate, the state would not reach all 30,000 children likely to enroll in Medicaid until the 33rd month, eight months *after* this would happen under current rules. So, even the poorest children are hurt under the directive. This would result in a comparative loss of about \$87 million in federal Medicaid funds over the five-year period, \$200 million in business activity in the state and 1,500 jobs.

Impact by Congressional District

It is likely that each member of New Jersey’s congressional delegation will have to decide soon how to vote on legislation to place a moratorium on the CMS directive. To better inform that decision, and to make constituents aware of how the directive would affect their communities, this report breaks down by congressional district the impact of the directive.

Compared to districts in most other states, all of New Jersey’s have more children in SCHIP whose families are above the income limits the CMS directive would set. And in all New Jersey districts, housing classified as “lower-cost” is more expensive than the national average. This suggests that an income limit of 2.5 times the federal poverty level would be too low in every New Jersey district to cover many people who clearly need the help FamilyCare provides. The fiscal impact will almost double within congressional districts because they are also at risk of losing state matching funds, for a total loss of \$370 million in SCHIP and Medicaid funds. In addition, local officials must cope with the health and other consequences of the growing number of uninsured children in their communities.

Within New Jersey, the more affluent, white and suburban congressional districts on average would see the highest proportion of children denied health coverage and of federal funds lost under the Bush proposals. Such districts today have the highest proportion of children in FamilyCare above the income limit that the administration would impose. They also have more costly housing, which puts such families in greater economic need. These factors together result in relatively affluent, suburban districts ranking highest in the Child Health Insurance Misery Index explained below. However, in terms of actual numbers, rather than percentages, the more urban, diverse and less affluent congressional districts would see more children frozen out of SCHIP.

The CMS directive would have a major impact on children in each of New Jersey’s 13 congressional districts. The share of additional children who would be denied FamilyCare under the CMS directive as compared to current eligibility rules ranges from 42 percent in the 10th District (Essex, Hudson and Union) to 74 percent in the 5th (Warren, Bergen, Sussex, Passaic). Other districts that rank high in percentage of children denied FamilyCare are the 11th (Morris, Essex, Passaic, Somerset, Sus-

Percentage Drop in FamilyCare Enrollment under CMS Directive

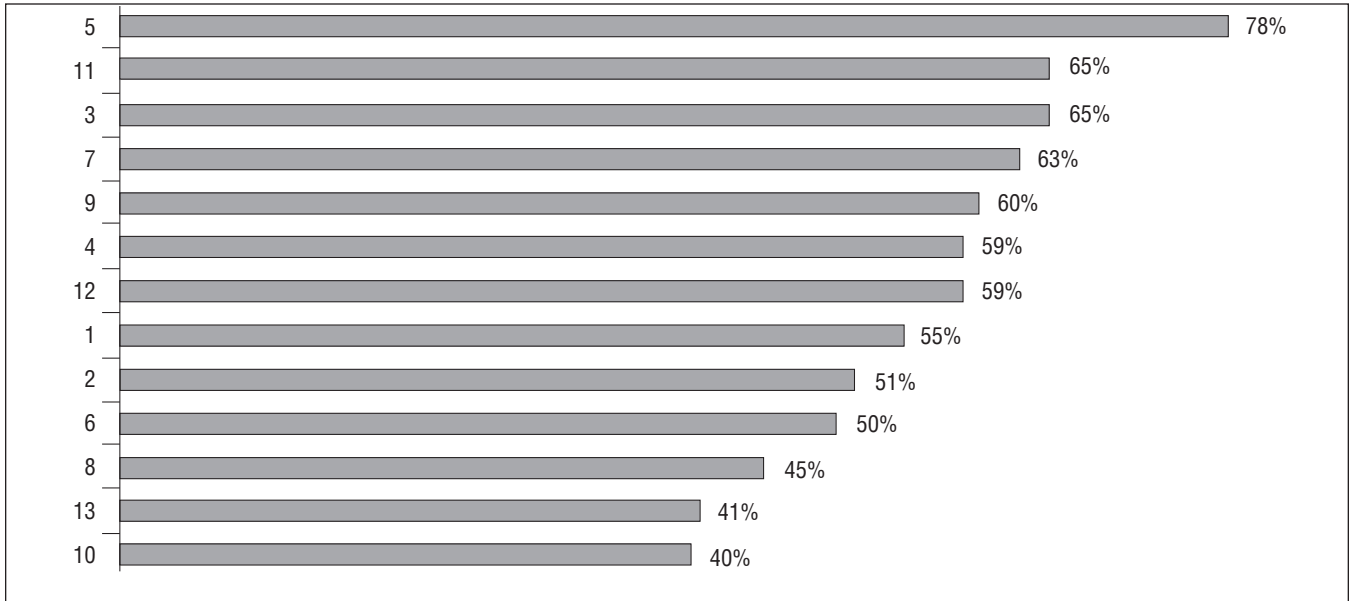
District	Current Enrollment Above 2.5 times FPL	Additional Children Enrolled at Fifth Year: Current Rules	Additional Children Enrolled at Fifth Year: Bush Policy	Children Not Enrolled at Fifth Year: Bush Policy	Reduction in All Additional Children Enrolled
5	16%	2,976	779	2,197	74%
11	12%	2,406	877	1,529	64%
3	12%	4,336	1,595	2,742	63%
7	11%	3,491	1,300	2,190	63%
9	11%	5,606	2,265	3,341	60%
4	10%	5,154	2,132	3,021	59%
12	10%	3,877	1,605	2,271	59%
1	9%	5,114	2,247	2,866	56%
2	8%	5,414	2,608	2,806	52%
6	8%	4,713	2,317	2,396	51%
8	7%	6,823	3,631	3,192	47%
13	6%	7,693	4,359	3,334	43%
10	6%	5,760	3,345	2,414	42%
TOTAL	9%	64,166	29,061	35,105	55%

SOURCE: NJPP analysis of administrative data.

sex), 3rd (Burlington, Camden, Ocean) and 7th (Hunterdon, Middlesex, Somerset, Union). See the table that follows for the percentage ranking of all districts. Based on an analysis of the median income, race and population in those districts, they tend to be more affluent and suburban than other districts in New Jersey, with higher percentages of white residents.

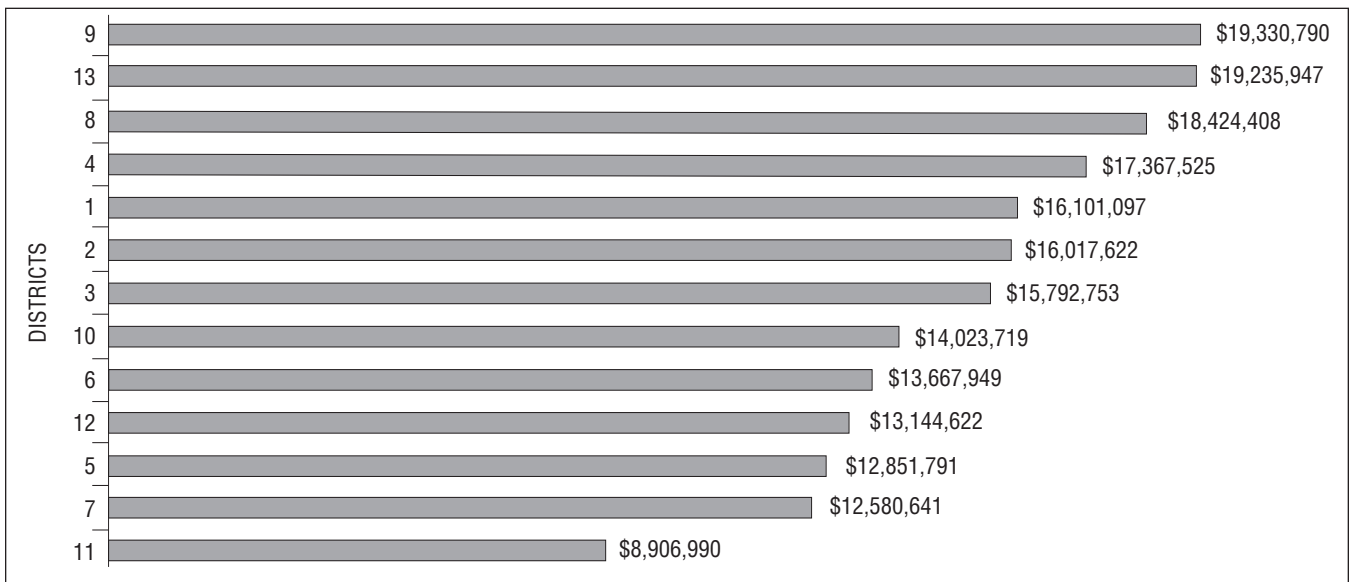
The main reason some districts have a higher rate of denied children than others is that average family income is higher. Those districts have a greater percentage of children with family incomes exceeding 2.5 times the federal poverty level in FamilyCare, as shown in the second column in the table above. Since the Bush administration directive mainly touches

Percentage Loss in Federal and State Funding in FamilyCare Under CMS Directive by Congressional District Over Five Years



SOURCE: NJPP analysis of SCHIP administrative data.

Dollar Federal and State Funding Loss in SCHIP Under CMS Directive by Congressional District Over Five Years



SOURCE: NJPP analysis of SCHIP administrative data.

children in that income bracket, those districts are disproportionately affected.

In terms of actual numbers, those who would be denied FamilyCare under the directive ranges from 1,529 in the 11th District to 3,341 in the 9th (Bergen, Hudson, Passaic). The other districts that rank highest in number children who would be de-

nied FamilyCare are, the 13th (Essex, Hudson, Middlesex, Union), 8th (Essex, Passaic) and 4th (Burlington, Mercer, Monmouth, Ocean).

The dollar impact of the directive on the congressional districts is compounded because in addition to the loss of \$128 million in federal SCHIP funds, they could also lose \$69 million in state

**Lower Cost Housing by Congressional Districts
Compared to National Average**

District	Median Household Income	Median Rent*	Percent Above National Average	Lower Value Quartile – Owner Housing	Percent Above National Average	Total Weighted Increase
11	\$92,765	\$1,016	60%	\$362,400	252%	131%
7	\$87,020	\$1,084	70%	\$338,400	229%	129%
9	\$61,399	\$965	52%	\$320,600	212%	111%
5	\$84,443	\$947	49%	\$323,300	214%	110%
8	\$57,255	\$872	37%	\$330,800	221%	105%
12	\$84,020	\$933	47%	\$297,600	189%	99%
6	\$66,188	\$946	49%	\$271,000	163%	91%
13	\$47,048	\$829	30%	\$277,500	170%	82%
4	\$61,418	\$917	44%	\$209,000	103%	66%
3	\$65,503	\$894	41%	\$203,000	97%	62%
10	\$42,717	\$767	21%	\$229,000	123%	58%
2	\$53,169	\$707	11%	\$161,400	57%	28%
1	\$56,305	\$708	11%	\$143,600	40%	22%

*Median rent selected for low-income households because they comprise a disproportionate share of renters.
SOURCE: NJPP analysis of US Census American Community Survey for 2006

matching funds, for a total loss of \$197 million. The proportion of additional funds lost ranges from 40 percent in the 10th to 78 percent in the 5th. The other highest-ranking districts in this category are the 11th, 3rd and 7th. The more affluent, white and suburban districts lose the highest share of funds.

The total potential funding loss ranges from about \$9 million in District 11, to \$19 million in the 9th. The other highest ranking districts in funding losses are the 13th, 8th and 4th, as shown on the previous page, bottom table.

These losses are in addition to reduced economic activity and jobs, as well as state and federal Medicaid funds as discussed earlier.

The breakdown by congressional district also yields important information about the income limits set by the CMS directive. For example, “low-cost” housing in New Jersey costs more than such housing almost anywhere else. Many children whose family income would be too high for FamilyCare under the directive are in fact not well-to-do when the amount their

Child Health Insurance Misery Index

District	Reduction in Total Additional Children Enrolled	Total Weighted Increase in Housing Costs	Child Health Insurance Misery Index (Total)
11	64%	131%	195
7	63%	129%	192
5	74%	110%	184
9	60%	111%	170
12	59%	99%	158
8	47%	105%	152
6	51%	91%	142
13	43%	82%	125
3	63%	62%	125
4	59%	66%	125
10	42%	58%	100
2	52%	28%	80
1	56%	22%	78

SOURCE: NJPP analysis of US Census American Community Survey for 2006. Index is computed by adding the first two columns.

families must spend on housing is considered. Districts with the most expensive low-cost housing are the 11th, 7th, 9th and 5th as shown above.

Child Health Insurance Misery Index

Children in districts who would be most affected by the directive can be determined by adding the weighted percentage of low-income housing costs that are above the national average in each district with the proportion of children who would be denied FamilyCare. Children above the income limit in the directive would fare the worst in those districts that scored highest in this Child Health Insurance Misery Index. Not only would a higher percentage of children be denied health coverage, but those families would also have a greater economic need for affordable health insurance because of the higher housing costs they must bear. These children have the highest probability of remaining uninsured under the CMS directive and experiencing economic hardship.

Children in all 13 districts would be expected to fare poorly compared to the national average because of New Jersey’s higher housing costs and larger percentage of children on SCHIP who have incomes exceeding 2.5 times the federal poverty level. Those districts scoring highest on the Index are the 11th, 7th, 5th and 9th as shown in the preceding table. The children who are most at risk of lacking insurance are in more affluent, white suburban districts.

CONCLUSION

The CMS directive is probably the most serious threat to FamilyCare since it was established 10 years ago.

The income limit of 2.5 times the poverty level could result in 35,000 fewer children who lack health insurance receiving the coverage they need. The directive fails to remove the real barriers to serving the poorest children. In addition, it denies FamilyCare to higher income children whose eligibility in New Jersey has helped bring in additional lower income children. The result is that it will take longer for New Jersey to reach children in the poorest families through Medicaid. Georgetown University found that no state currently meets the requirement of health coverage for 95 percent of all low-income children, which must be met if a state wants to serve kids above 2.5 times the poverty level. To make matters worse, even if a state could meet that requirement, those children would be singled out for a 12-month waiting period—which will also reduce the number of children eligible for the program. Requiring that FamilyCare premiums approximate what is charged in the private sector would result in even more children leaving FamilyCare because their parents cannot afford it, just as they cannot afford an ever-increasing share of the cost of insurance that employers require them to pay.

The fiscal impact of the directive is equally onerous. New Jersey could lose over \$200 million in federal SCHIP and Medicaid funds at a time when it is trying to address a serious structural budget deficit. The impact on the state’s economy would be greater still because of the multiplier effect of federal funds that would result in the loss of millions of dollars in economic activity and thousands of jobs a time of rising unemployment.

No part of the state would escape the impact of this policy. In fact, it is at the local level where it would be felt the most. Every congressional district is not only at risk of losing millions of

federal funds, but state matching funds as well. Most importantly, it is at the local level that parents and the community will have to address the consequences of denying health coverage to uninsured children. We already know that those consequences will be serious and long lasting.

Ironically, it will be in the highest-income congressional districts of the state where children would become most at risk of not being insured under the directive. Increasingly in New Jersey, the lack of health insurance is becoming a problem at all income levels. Employers regardless of size are either dropping their insurance coverage or increasing the costs passed on to employees. Self-employed parents who make a moderate wage are finding it harder to pay the mortgage in addition to health coverage that for a family now averages about \$16,000 a year for comprehensive coverage with a \$1,000 deductible.²⁰ Thousands of children from families in this predicament are precisely the ones the Bush administration would bar from FamilyCare.

The directive affects more than FamilyCare. It undermines New Jersey's policy of making affordable, comprehensive, quality health coverage accessible for all children. Without a partnership with the federal government, the state will not have the resources to achieve this goal.

RECOMMENDATIONS

Important steps need to be taken at the federal and state levels to solve this problem and guarantee access to health coverage so a new generation of children gets a better chance to grow up to become healthy, productive adults.

- Congress should place a moratorium on the CMS directive until March 2009, which is consistent with the extension of SCHIP that was enacted. This should be done immediately to avoid the possibility that New Jersey will have to slow or stop enrollment of higher income children in FamilyCare soon in order to try to meet the CMS directive requirements in time for the August 2008 deadline.
- Congress should continue to include adequate funding for SCHIP in pending legislation, as well as performance bonuses, funding for outreach and the means to encourage states to reach more low-income children.

- Congress should continue to allow states to expand or maintain eligibility levels higher than 2.5 times the poverty level.
- With full federal funding for SCHIP uncertain, New Jersey should maintain its commitment to reach as many uninsured children as possible, regardless of income, so all working families have equal access to affordable, quality health coverage for their children. This commitment is one reason New Jersey has gotten as much federal SCHIP funding as it has in the past. Failure to maximize federal funds now could reduce New Jersey's SCHIP allocation in the future because most of the money will likely be meted out based on prior expenditures.
- Regardless of the final SCHIP policy, the state on its own should attract more low-income children by working with and supporting minority community organizations to improve outreach; making more information available about FamilyCare in targeted media outlets; and improving retention of children already enrolled.

APPENDIX 1 Methodology

The study uses data from the US Census Bureau's Current Population Survey's Annual Social and Economic Supplement, the American Community Survey (ACS) and administrative records.

To determine the statewide impact on New Jersey of changes in SCHIP rules, NJPP started with a "baseline," the projected spending over five years under current law, with expected federal and state funding increases included. The next step was to compare this with spending under the Bush administration's CMS directive that would lower eligibility to 2.5 times the federal poverty level.

To arrive at the baseline, it was estimated that New Jersey will enroll all children who are likely to participate in FamilyCare in five years. This is consistent with Governor Corzine's policy of enrolling as many children as possible. It would require an increase in the average enrollment rate for children above twice the poverty level which, at various times in the past, the state has achieved.²¹

For children between poverty and twice the poverty level, it was estimated that there would be no change in the state's current average rate of enrollment under the baseline. Because there are fewer uninsured children to enroll in this income category, within three years the state will achieve full enrollment at the current enrollment rate.

The baseline rate of enrollment is lower than what would occur under the last SCHIP bill that passed Congress. It authorized about \$36 billion in additional federal funds and performance bonuses to states to encourage faster enrollment of kids in Medicaid. If these additional funds were added to the baseline, the results would show an even greater comparative loss in federal funds to the state and comparative decrease in the enrollment rate of poor children in Medicaid under the CMS directive.

Under SCHIP, states receive an amount of money that usually varies each year, but they also can be eligible for money that was allocated to other states but not spent by them. In fact, New Jersey now receives more from SCHIP funds not spent by other states than it does in its own allocation. Since it is not known how much other states will spend in the future, it is impossible to say how much would be available to New Jersey.

The national funding needed, however, would certainly be higher than the amount included in the President's budget. According to the Center on Budget and Policy Priorities, that amount might not be enough to even maintain current enrollment in the states.

Estimating the Impact on Children

Georgetown University Health Policy Institute has concluded that no state currently meets the 95 percent coverage rate required by CMS.²² Even Medicare, which provides health insurance coverage to the elderly, does not have a participation rate that high.²³ Data from the Institute indicates that it might be especially difficult for New Jersey to meet this rate. It estimated New Jersey's current rate at 85.9 percent, which is about the national average.

A study conducted by Rutgers University shows why such a high rate of coverage might not be possible in New Jersey. It found that only about half of all children financially eligible for FamilyCare would likely participate in the program when tak-

ing into account such factors as immigration status; the three-month waiting period required for enrollment in FamilyCare; and the New Jersey Family Health Survey, which measured consumer views.²⁴ Except for the waiting period, these barriers would also apply to children eligible for Medicaid.

Even if the state could achieve this standard, it would still have to meet another requirement in the directive: certifying that employers are not decreasing their insurance for certain children by two percentage points. Complex and costly reporting requirements would also have to be met, which might be just as difficult to achieve.

If a child lost health insurance, the Bush administration would require a 12-month waiting period before the child could be enrolled in FamilyCare or any other state's SCHIP. The harshness of this change is shown by the New Jersey Legislature's recent decision to reduce the state-mandated waiting period from six to three months, because the longer waiting period was found to discourage participation in the program.

The administration has said that children currently enrolled in FamilyCare who have family incomes above the eligibility cutoffs would be allowed to stay enrolled.²⁵ But if they ever leave the program, they could not return unless their family income decreased enough to meet the new eligibility standard. Uninsured children in families whose incomes were above the cutoff level would also be barred from enrolling. That means enrollment of children at those income levels would decrease each month at a rate of about 7.7 percent, the estimated current rate at which children leave FamilyCare now.²⁶

The administration claims that if states do not serve higher income children, it will free up resources to serve more lower-income children. There is no empirical evidence, however, to support this hypothesis. As explained above, it is even possible that the rate of enrollment could decrease under the directive. So, this report projects that the enrollment rate under the CMS directive for children in FamilyCare below 2.5 times the poverty level and for children in Medicaid to remain the same as the historical rate in those programs.

Estimating the Fiscal Impact

Once the impact on children is determined, estimating the fiscal impact is relatively straightforward. The number of children

who would be denied New Jersey's FamilyCare is multiplied by the average monthly SCHIP federal and state cost of health coverage for a child in FamilyCare. It is conservatively estimated that spending will increase by about six percent annually.²⁷

It was also assumed that New Jersey would not replace lost federal funds with state funds in order to continue to expand enrollment in FamilyCare. If the state decided to replace some or all of these federal funds, the number of children who would be denied FamilyCare under the directive would be reduced or eliminated. However, the amount of projected federal funds lost and the effects on the state's economy would remain unchanged.

Congressional Districts

The impact in each New Jersey Congressional district was estimated and ranked using the same methodology that was used for the state.²⁸ To provide an example of how the cost of living in these districts is higher than the national average, which is not taken into account in the directive's income limit, the differences in the cost of housing were calculated. To determine housing costs, median rent and the average value of the least costly homes in a district that are owned by occupants were weighted for the distribution of these housing arrangements (about 37 percent own their own home and 63 percent rent).²⁹

Lastly, the districts were ranked by a Child Health Insurance Misery Index developed for this study to determine how at risk a child would be for being uninsured under the CMS directive. This index is calculated by adding the percentage of children who would be denied FamilyCare under the directive and the extent to which housing costs in a district exceeded the national average.

APPENDIX 2

New Jersey Congressional Districts

1 Rep. Rob Andrews (D)

BURLINGTON COUNTY: Maple Shade, Palmyra, Riverton; CAMDEN COUNTY: Audubon, Audubon Park, Barrington, Bellmawr, Berlin Borough & Twp., Brooklawn, Camden, Chesilhurst, Clementon, Collingswood, Gibbsboro, Gloucester City & Twp., Haddon Heights, Haddonfield, Hi-Nella, Laurel Springs, Lawnside, Lindenwood, Magnolia, Mt. Ephraim, Oaklyn, Pennsauken, Pine Hill,

Pine Valley, Runnemede, Somerdale, Stratford, Tavistock, Voorhees, Winslow, Woodlynne; GLOUCESTER COUNTY: Deptford, East Greenwich, Glassboro, Greenwich, Logan, Monroe, National Park, Paulsboro, Washington Twp., Wenonah, West Deptford, Westville, Woodbury, Woodbury Heights

2 Rep. Frank A. LoBiondo (R)

All of ATLANTIC COUNTY, CAPE MAY COUNTY, CUMBERLAND COUNTY, SALEM COUNTY; BURLINGTON COUNTY: Washington; CAMDEN COUNTY: Waterford; GLOUCESTER COUNTY: Clayton, Elk, Franklin, Harrison, Mantua (part), Newfield, Pitman, South Harrison, Swedesboro, Woolwich

3 Rep. Jim Saxton (R)

BURLINGTON COUNTY: Bass River, Beverly, Burlington Twp. (part), Cinnaminson, Delanco, Delran, Easthampton, Edgewater Park, Evesham, Hainesport, Lumberton, Medford, Medford Lakes, Moorestown, Mount Holly, Mount Laurel, New Hanover, North Hanover, Pemberton Borough & Twp., Riverside, Shamong (part), Southampton, Tabernacle, Westhampton, Willingboro, Woodland, Wrightstown; CAMDEN COUNTY: Cherry Hill; OCEAN COUNTY: Barnegat, Barnegat Light, Beach Haven, Beachwood, Berkeley Twp., Dover, Eagleswood, Harvey Cedars, Island Heights, Lacey, Lavallette, Little Egg Harbor, Long Beach, Ocean Twp., Ocean Gate, Pine Beach, Seaside Heights, Seaside Park, Ship Bottom, South Toms River, Stafford, Surf City, Tuckerton

4 Rep. Christopher H. Smith (R)

BURLINGTON COUNTY: Bordentown City & Twp., Burlington City & Twp. (part), Chesterfield, Easthampton, Fieldsboro, Florence, Mansfield, Springfield; MERCER COUNTY: East Windsor, Hamilton, Hightstown, Trenton (part), Washington Twp.; MONMOUTH COUNTY: Allentown, Brielle, Colts Neck, Farmingdale, Freehold Borough, Freehold Twp. (part), Howell, Manasquan, Millstone, Roosevelt, Sea Girt, Spring Lake, Spring Lake Heights, Upper Freehold, Wall; OCEAN COUNTY: Bay Head, Brick, Jackson, Lakehurst, Lakewood, Manchester, Mantoloking, Plumsted, Point Pleasant, Point Pleasant Beach

5 Rep. Scott Garrett (R)

WARREN COUNTY: All; BERGEN COUNTY: Allendale, Alpine, Bergenfield, Closter, Cresskill, Demarest, Dumont, Emerson, Franklin Lakes, Glen Rock, Harrington Park, Haworth, Hillsdale, Ho-Ho-Kus, Mahwah, Midland Park, Montvale, New Milford (part), Northvale, Norwood, Oakland, Old Tappan, Oradell, Paramus, Park Ridge, Ramsey, Ridgewood, River Edge, River Vale, Rochelle Park,

Rockleigh, Saddle River, Tenafly, Upper Saddle River, Waldwick, Washington Twp., Westwood, Woodcliff Lake, Wyckoff; PASSAIC COUNTY: Bloomingdale (part), Ringwood, Wanaque, West Milford; SUSSEX COUNTY: Andover Borough and Twp., Branchville, Frankford, Franklin, Fredon, Green, Hamburg, Hampton, Hardyston, Lafayette, Montague, Newton, Ogdensburg, Sandyston, Sparta (part), Stillwater, Sussex, Vernon, Walpack, Wantage

6 Rep. Frank Pallone, Jr. (D)

MIDDLESEX COUNTY: Dunellen, Edison (part), Highland Park, Metuchen, Middlesex, New Brunswick, Old Bridge (part), Piscataway, Sayreville, South Amboy; MONMOUTH COUNTY: Aberdean, Allenhurst, Asbury Park, Atlantic Highlands, Avon, Belmar, Bradley Beach, Deal, Hazlet, Highlands, Interlaken, Keansburg, Keyport, Loch Arbour, Long Branch, Manalapan (part), Marlboro (part), Matawan, Middletown (part), Monmouth Beach, Neptune City, Neptune Twp., Ocean Twp., Red Bank, Sea Bright, South Belmar, Union Beach, West Long Branch; SOMERSET COUNTY: Franklin (part); UNION COUNTY: Plainfield

7 Rep. Michael Ferguson (R)

HUNTERDON COUNTY: Alexandria, Bethlehem, Bloomsbury, Califon, Clinton, Clinton Twp., Flemington, Glen Gardner, Hampton, High Bridge, Holland, Lebanon, Lebanon Twp., Milford, Raritan, Readington, Tewksbury, Union; MIDDLESEX COUNTY: Edison (part), South Plainfield, Woodbridge (part); SOMERSET COUNTY: Bedminster, Bernardsville, Bound Brook, Branchburg, Bridgewater (part), Far Hills, Green Brook, Hillsborough, Manville, Millstone, Montgomery, North Plainfield, Peapack and Gladstone, Rocky Hill, South Bound Brook, Warren Twp., Watching; UNION COUNTY: Berkeley Heights, Clark, Cranford, Fanwood, Garwood, Kenilworth, Linden (part), Mountainside, New Providence, Roselle Park, Scotch Plains, Springfield, Summit, Union Twp., (part), Westfield, Winfield

8 Rep. William J. Pascrell, Jr. (D)

ESSEX COUNTY: Belleville, Bloomfield, Cedar Grove, Glen Ridge, Livingston (part), Montclair (part), Nutley, South Orange (part), Verona, West Orange (part); PASSAIC COUNTY: Clifton, Haledon, Little Falls, North Haledon, Passaic, Paterson, Pompton Lakes, Prospect Park, Totowa, Wayne, West Paterson

9 Rep. Steven R. Rothman (D)

BERGEN COUNTY: Bogota, Carlstadt, Cliffside Park, East Rutherford, Edgewater, Elmwood Park, Englewood, Englewood Cliffs, Fair

Lawn, Fairview, Fort Lee, Garfield, Hackensack, Hasbrouck Heights, Leonia, Little Ferry, Lodi, Lyndhurst, Maywood, Moonachie, New Milford (part), North Arlington, Palisades Park, Ridgefield, Ridgefield Park, River Edge, Rutherford, Saddle Brook, South Hackensack, Teaneck, Teterboro, Wallington, Wood-Ridge; HUDSON COUNTY: Jersey City (part), Kearny (part), North Bergen (part), Secaucus; PASSAIC COUNTY: Hawthorne

10 Rep. Donald M. Payne (D)

ESSEX COUNTY: East Orange, Irvington, Maplewood, Millburn (part), Montclair (part), Newark (part), Orange, South Orange (part), West Orange (part); HUDSON COUNTY: Bayonne (part), Jersey City (part); UNION COUNTY: Elizabeth (part), Hillside, Linden (part), Rahway, Roselle, Union Twp. (part)

11 Rep. Rodney P. Frelinghuysen (R)

MORRIS COUNTY: All; ESSEX COUNTY: Caldwell, Essex Fells, Fairfield, Livingston (part), Millburn (part), North Caldwell, Roseland, West Caldwell; PASSAIC COUNTY: Bloomingdale (part); SOMERSET COUNTY: Bernards, Bridgewater (part), Raritan, Somerville; SUSSEX COUNTY: Byram, Hopatcong, Sparta (part), Stanhope

12 Rep. Rush Holt (D)

HUNTERDON COUNTY: Delaware, East Amwell, Franklin, Frenchtown, Kingwood, Lambertville, Stockton, West Amwell; MERCER COUNTY: Ewing, Hopewell Borough and Twp., Lawrence, Pennington, Princeton Borough and Twp., Trenton (part), West Windsor; MIDDLESEX COUNTY: Cranbury, East Brunswick, Helmetta, Jamesburg, Milltown, Monroe, North Brunswick, Old Bridge (part), Plainsboro, South Brunswick, South River, Spotswood; MONMOUTH COUNTY: Eatontown, Englishtown, Fair Haven, Freehold Twp. (part), Holmdel, Little Silver, Manalapan (part), Marlboro (part), Middletown (part), Oceanport, Rumson, Shrewsbury Borough and Twp., Tinton Falls; SOMERSET COUNTY: Franklin (part)

13 Rep. Albio Sires (D)

ESSEX COUNTY: Newark (part); HUDSON COUNTY: Bayonne (part), East Newark, Guttenberg, Harrison, Hoboken, Jersey City (part), Kearny (part), North Bergen (part), Union City, Weehawken, West New York; MIDDLESEX COUNTY: Carteret, Perth Amboy, Woodbridge (part); UNION COUNTY: Elizabeth (part), Linden (part)

ENDNOTES

- ¹ Paul Jacobs, *Wages and Benefits: A Long Term View*, Kaiser Family Foundation, February 2008.
- ² Stan Dorn, Bowen Garrett, John Holahan and Aimee Williams, *Medicaid, SCHIP and Economic Downturn: Policy Challenges and Policy Responses*, Kaiser Commission, April 2008.
- ³ Cindy Mann, "Covering Uninsured Kids: Missed Opportunities for Moving Forward, testimony before the Subcommittee on Health," House Committee on Energy and Commerce, January 29, 2009.
- ⁴ Children's Defense Fund, *Top 10 Facts about Children's Health Coverage in the U.S.*, February, 2007.
- ⁵ Dennis Smith, CMS Directive on SCHIP, August 17, 2007, p. 2.
- ⁶ Anne Milgram, *Complaint, State of New Jersey v. United States Department of Health and Human Services*, October 1, 2007.
- ⁷ Ibid.
- ⁸ Leah Curran, Harold Wolman, Edward Hill and Kimberly Furdell, *Poverty, Programs, and Prices: How Adjusting for Costs of Living Would Affect Federal Benefit Eligibility*, March 2008, p. 1.
- ⁹ Cindy Mann, "Covering Uninsured Kids: "Missed Opportunities for Moving Forward," testimony before the Subcommittee on Health, House Committee on Energy and Commerce, January 29, 2009, p. 12-13.
- ¹⁰ CMS, Summary of President's FY 2009 Budget, p. 67.
- ¹¹ Edwin Park, *President's Budget May Provide States with Inadequate Funding to Maintain Current SCHIP Programs*, Center on Budget and Policy Priorities, February 7, 2008.
- ¹² Current Population Survey's Annual Social and Economic Supplement
- ¹³ Ibid.
- ¹⁴ Cindy Mann, "Covering Uninsured Children: The Impact of the August 17 CHIP Directive," Testimony before the Subcommittee on Health Care, Senate Committee on Finance, April 9, 2008, p. 5.
- ¹⁵ The monthly enrollment rate was interpolated at 7.7 percent, which was used to project the five-year trend.
- ¹⁶ Benjamin D. Sommers, "Why Millions of Children Eligible for Medicaid and SCHIP are Uninsured: Poor Retention Versus Poor Take-Up," *Health Affairs*, July 26, 2007.
- ¹⁷ Judith Wooldridge, Genevieve Kenney, Christopher Trenholm, Executive Summary, *Congressionally Mandated Evaluation of the State Children's Health Insurance Program*, October 26, 2005, p. x.
- ¹⁸ Based on methodology in FamiliesUSA, *Good Medicine for State Economies*, 2004 update.
- ¹⁹ From May to September 2007, child enrollment decreased by 15,257 in SCHIP and 5,514 in Medicaid based on DHS enrollment data.
- ²⁰ Joseph Vitale and David Knowlton, *Health Care Coverage for All, A Blueprint for New Jersey*, Phase 2 section, March 17, 2008.
- ²¹ It would require a monthly enrollment rate of 1.2 percent for children between twice and 2.5 times the poverty level and 1.6 percent for children between 2.5 and 3.5 times the poverty level to reach all children by the fifth year in FamilyCare.
- ²² Cindy Mann and Michael Odeh, *Moving Backward: Status Report on the Impact of the August 17 SCHIP Directive to Impose New Limits on States' Ability to Cover Uninsured Children*, Georgetown University Health Policy Institute, December 2007, p. 2.
- ²³ Ibid.
- ²⁴ Methodology was included in a November 2, 2004 memo to the Division of Medical Assistance and Health Services and updated by Rutgers University staff in an email to the author.
- ²⁵ Dennis Smith, CMS Directive on SCHIP, August 17, 2007, p. 2.
- ²⁶ NJPP analysis of data included in Cindy Mann, "Covering Uninsured Children: The Impact of the August 17 CHIP Directive," Testimony before the Subcommittee on Health Care, Senate Committee on Finance, April 9, 2008, p. 5.
- ²⁷ National Health Expenditures (NHE) projected to increase by 6.7 percent through 2017. However that estimate includes costs for the elderly and persons with disabilities which inflate it so a lower estimate was used only for families with children and applied monthly. See NHE at <http://www.cms.hhs.gov/NationalHealthExpendData/Downloads/proj2007.pdf><http://www.cms.hhs.gov/NationalHealthExpendData/Downloads/proj2007.pdf>
- ²⁸ Rankings of districts in each table may vary depending on margin of error of the sampling of ACS and CPS data.
- ²⁹ While the full Cost-of Living Index (COLI) would have been preferable for this measure, it is not available by congressional district or by state. Furthermore, the largest component of the COLI is housing, therefore, it was considered the best single measure of living expenses. Least costly home ownership refers to those homes that fall within the lowest quarter in price in a district as reported by the 2006 American Community Survey.

ACKNOWLEDGEMENTS

This publication was made possible through funding from the Annie E. Casey Foundation, Open Society Institute and The Fund for New Jersey. The author thanks Matt Broaddus, Judy Solomon and Donna Cohen Ross of the Center on Budget and Policy Priorities and Jocelyn Guyer of the Center for Children and Georgetown University Health Policy Institute for their invaluable comments on this report.

New Jersey Policy Perspective

137 W. Hanover St. Trenton, NJ 08618
Phone 609-393-1145 E-mail njpp@njpp.org

Jon Shure President
Mary E. Forsberg Research Director
Raymond C. Castro Senior Policy Analyst
Sarah Stecker Policy Analysts
Anastasia R. Mann

New Jersey Policy Perspective is a nonprofit, nonpartisan organization established in 1997 to conduct research and analysis on state issues. NJPP is a member of the Economic Analysis Research Network and the State Fiscal Analysis Initiative.