CSHP

Rutgers Center for State Health Policy

State of New Jersey

NJ State Planning Grant
Expert Panel Discussion

State Health Insurance Regulation Toward Inclusive and Sustainable Health Insurance Markets: A Dialogue between Policymakers and Researchers

Sponsored by the New Jersey Departments of: Human Services, Banking and Insurance, Health and Senior Services and Rutgers Center for State Health Policy

Trenton, New Jersey
April 10, 2003

The Expert Panel Discussion is funded through a grant provided by the Health Resources and Services Administration to the New Jersey Department of Human Services in collaboration with the New Jersey Departments of: Health and Senior Services, Banking and Insurance, Treasury, and the Office of the Governor of the State of New Jersey.

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Conference Purpose and Overview

New Jersey was among a number of states that implemented health insurance market reforms in the early 1990s to improve access to affordable health coverage. Accelerating health insurance costs and reemerging growth in the number of uninsured nationally have led many states to take stock of their health coverage policies. With a decade of experience, research has begun to emerge analyzing the effects and sustainability of state health insurance reforms like those in New Jersey.

Today, as many states reexamine their strategies, it is important that the emerging studies be brought to light and carefully evaluated. By convening this expert panel, we hope to stimulate a broad dialogue about the emerging body of research evidence among representatives from the policy, research, insurance carrier and consumer advocate communities. This conference is intended to provide a forum for discussion of the future of state regulation in the non-group and small-group health coverage markets and the policy changes that may be required to sustain healthy markets.

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Agenda

8:00–8:45A.M. **Continental Breakfast and Registration**

8:45–9:00A.M. **Remarks**
Joel C. Cantor, *Rutgers Center for State Health Policy*
Commissioner Holly Bakke, *New Jersey Department of Banking and Insurance*

9:00–10:15A.M. **Findings on Health Insurance Market Reform – Perspectives from Researchers**

Introductions and Panel Overview
Moderator: Alan C. Monheit, *University of Medicine & Dentistry of New Jersey and Rutgers Center for State Health Policy*

What Have We Learned from Research on the Small Group Market?
Presenter: Kosali Simon, *Cornell University*

What Have We Learned from Research on the Non-Group Market?
Presenter: Deborah Chollet, *Mathematica Policy Research, Inc.*

Q & A and Discussion

10:15–10:30A.M. ***Break***

10:30–11:45A.M. **Findings on Health Insurance Market Reform (Continued) – Responses to Findings on Market Reform**

Moderator: Alan C. Monheit

Panelists:

What does all this evidence say about the effects of reform?
Tom Buchmueller, *University of California, Irvine*

What should every policymaker know about the research?
Barbara Schone, *Agency for Health Care Research and Quality*

How can reform work better?
M. Susan Marquis, *RAND*

Q & A and Discussion

11:45A.M.–12:45P.M. ***Luncheon*** **(Delaware Room)**

12:45–2:00P.M. **Perspectives from the Field: How Can Access to Affordable Coverage be Sustained?**

Moderator: Wardell Sanders, *Individual Health Coverage Program and Small Employer Health Benefit Program Boards*

Panelists:

Commissioner *Steven Larsen, Maryland Insurance Administration*
Mark Scherzer, *New Yorkers for Accessible Health Care*
Sanford Herman, *Guardian Life Insurance Company*
Karen Pollitz, *Georgetown University*

Q & A and Discussion

2:00–2:15P.M. ***Break***

2:15–3:15P.M. **Reforming Insurance Market Reform: What are the Possibilities? What are the Alternatives?**

Moderator: Vicki A. Mangiaracina, *NJ Department of Banking and Insurance*

Panelists:

Len M. Nichols, *Center for Studying Health Systems Change*
Kathy Swartz, *Harvard School of Public Health*

Q & A and Discussion

3:15–3:30P.M. **Closing Remarks and Adjournment**

Joel C. Cantor

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State of New Jersey

2002 NJ State Planning Grant

Project Goals and Activities:
The New Jersey Department of Human Services (NJDHS) was awarded a 2002 State Planning Grant to study the problem of the medically uninsured. The two-part goal of this grant is to 1) optimize current innovative coverage initiatives and 2) describe remaining gaps in access to affordable coverage and explore potential policy approaches to address these gaps. This grant was awarded by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (USDHHS).

Project Direction and Leadership:
Matt D'Oria, Chief of Staff, Division of Medical Assistance and Health Services (DMAHS), NJDHS
Deborah Bradley Kilstein, Chief of Staff, NJDHS
Lorraine Thomas-Danzy, Special Assistant to the Deputy Commissioner, NJDHS

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Kathryn Plant, Director, DMAHS, NJDHS
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Rutgers Center for State Health Policy (CSHP) Project Leadership:
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Who We Are

Rutgers Center for State Health Policy is a policy research center dedicated to helping leaders and decision-makers examine complex state health policy issues and solutions. The Center, established in 1999, is an initiative within Rutgers Institute for Health, Health Care Policy, and Aging Research.

Leadership

Joel C. Cantor, Sc.D., *Director*
Susan C. Reinhard, R.N., Ph.D., *Co-Director*

CSHP Mission

Rutgers Center for State Health Policy informs, supports, and stimulates sound and creative state health policy in New Jersey and around the nation.

Strategies

To accomplish this mission, CSHP marshals the expert resources of a major public research university to:

- Identify and analyze emerging state health policy issues
- Conduct rigorous, impartial research on health policy issues
- Provide objective, practical, and timely evaluation of programs and policy choices
- Enhance the utility of state information resources by applying expertise in administrative data linkage, survey design, and statistical analysis
- Convene the health policy community in a neutral forum to promote an active exchange of ideas on critical issues
- Educate current and future health policy makers, researchers, and administrators
- Promote the practical application of scholarship in health policy
- Foster wide understanding of health policy choices

Our Current Research Focus

- Long-term care
- Access to health care
- Racial and ethnic health disparities
- Health care performance measurement
- Pharmaceutical policy
- State health data and information

Funding and Core Support

CSHP was established with a major grant from The Robert Wood Johnson Foundation. The Center is also supported by grants and contracts from public agencies, foundations, and the private sector.

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CSHP
Rutgers Center for State Health Policy

State of New Jersey

State Health Insurance Regulation
Toward Inclusive and Sustainable Health Insurance Markets:
A Dialogue between Policymakers and Researchers
April 10, 2003

Sponsored by the New Jersey Departments of: Human Services, Banking and Insurance, Health and Senior Services and Rutgers Center for State Health Policy

Panelist and Moderator Bios

Commissioner Holly Bakke, J.D.

Holly C. Bakke was nominated in February of 2002 and was sworn in as the Commissioner of the NJ Department of Banking and Insurance on March 13, 2002. From 1989 to February 2002, she served as Executive Director of the New Jersey Property-Liability Insurance Guaranty Association, the New Jersey Surplus Lines Insurance Guaranty Fund and the New Jersey Medical Malpractice Reinsurance Association. Prior to that, she served as Special Deputy Commissioner of Insurance Litigation Practices for the New Jersey Department of Insurance.

Commissioner Bakke is currently a member of the New Jersey State Bar Association, where she chaired the Alternative Dispute Resolution Committee and the Judicial Administration Committee. She has also served on several Supreme Court Committees dealing with criminal practice, civil litigation, and complimentary dispute resolution. A trained mediator, she has authored articles on alternative dispute resolution and family case and criminal management.

Ms. Bakke received her J.D., from Seton Hall Law School in 1982, was a Graduate Fellow at the Institute for Court Management of the National Center for State Courts in 1978, and earned her B.A. from Drew University in 1973.

Tom Buchmueller, Ph.D.

Tom Buchmueller is an Associate Professor of Health Care at the University of California, Irvine, Graduate School of Business. He earned his Ph.D. at the University of Wisconsin-Madison. His primary areas of research are health economics, particularly the economics of employer-provided health insurance, health insurance reform and managed competition.

Professor Buchmueller's research focuses on a number of economic and public policy issues related to health insurance. His work on the economics of employer-provided insurance investigates how the link between health insurance and the workplace affects the behavior of workers and firms. In other research, Professor Buchmueller has examined the health plan choice and switching behavior of consumers under "managed competition" and the effects of health insurance regulation and reform.

Professor Buchmueller has received grants from The Robert Wood Johnson Foundation, the Kaiser Family Foundation, the California Health Care Foundation, the California Policy Research Center, and the Aspen Institute. His publications include articles in the *Journal of Health Economics*, *Journal of Human Resources*, *Industrial and Labor Relations Review*, *Health Economics*, *Health Affairs and Inquiry.* He is a Faculty Associate of UCI's Research Unit in Health Policy and Research and a Faculty Research Fellow of the National Bureau of Economic Research.

Joel C. Cantor, Sc.D.

Joel C. Cantor is Director of the Rutgers Center for State Health Policy and Professor of Public Policy at the Edward J. Bloustein School of Planning and Public Policy at Rutgers, The State University of New Jersey. Prior to joining the Rutgers faculty in February 1999, Dr. Cantor served as Director of Research at the United Hospital Fund in New York City. Throughout his professional career Dr. Cantor has focused on issues of health care financing and delivery at the state level. His recent work includes studies of the effect of health care market competition on access to care, the organization and performance of the health care safety net for the uninsured, and the role of minority physicians in improving access to care of underserved populations. Dr. Cantor has published widely on health policy topics, and serves on the editorial board of the policy journal *Inquiry*. He received a Doctor of Science degree from Johns Hopkins University.

Deborah Chollet, Ph.D.

Deborah J. Chollet is a Senior Fellow with the Research Division of Mathematica Policy Research, Inc., in Washington, D.C. In this position, she is responsible for leading research projects related to health insurance coverage, markets, and financing. Dr. Chollet received her Ph.D. in economics from the Maxwell School of Citizenship and Public Affairs at Syracuse University and was previously a Vice President at Alpha Center in Washington, D.C. She has managed and conducted research on health insurance coverage and markets, the conversion of nonprofit hospitals to for-profit status, and Medicare supplemental insurance regulation, as well as provided technical assistance to state governments on related issues. She is a well-known and widely published researcher in her field.

Kimberley Fox, M.P.A.

Kimberley Fox is a Senior Policy Analyst at the Center for State Health Policy at Rutgers, where she is currently project director for a study of state pharmacy assistance programs. Her substantive areas of research expertise include health insurance coverage, access to care issues and health care performance measurement. Prior to coming to CSHP, Ms. Fox was a Senior Research Associate at Baruch College School of Public Affairs. She has extensive experience in health policy research and planning for at-risk populations having worked as Deputy Director of Planning at HIV CARE Services division of Medical and Health Research Association, Deputy Director of Policy Research at the Center on Addiction and Substance Abuse, and Senior Research Analyst at the United Hospital Fund of New York City. Ms. Fox received her Masters Degree in Public Administration from the Maxwell School of Public Citizenship in 1986.

Sanford Herman, F.S.A., M.A.A.A.

Sandy Herman is Vice President, Group Pricing & Standards at the Guardian Life Insurance Company and a member of the New Jersey Individual Health Coverage Program and Small Employer Health Coverage Program Boards. In his position at the Guardian, Mr. Herman has oversight and responsibility for the pricing and experience analysis of all group insurance products.

Prior to his current position, Mr. Herman directed the Pricing and Analysis of experience on the Guardian Portfolio of Group Medical products, with annual premiums in excess of $1.5 billion and was responsible for all activities related to the company's Managed Health Care product line. He also has considerable expertise in the area of health insurance reform. Mr. Herman assisted the Georgia Insurance Department to enact one of the first small group rate reforms in the nation. He served on the Actuarial Subcommittee of the Massachusetts Small Group Reform Reinsurance Pool and also participated in the New York State Actuarial Task Force to revise group conversion premium during mid 1980s.

Mr. Herman is a Fellow of the Society of Actuaries (F.S.A.) and a member of the American Academy of Actuaries (M.A.A.A.). He is a Phi Beta Kappa graduate of New York University with a major in Mathematics.

Margaret Koller, M.S.

Margaret Koller is a Senior Project Manager at Rutgers Center for State Health Policy where she oversees the outreach, communication and strategic planning/organizational development activities. Ms. Koller represents the Center's interests to both public and private health policy stakeholders. Before joining the Center in February 2001, she worked for Prudential Healthcare (PHC)/Aetna US HealthCare (AUSHC). During her five years at PHC/AUSHC, she helped launch SeniorCare, PHC's Medicare HMO, and later held the positions of SeniorCare Operations and SeniorCare Product Manager. Ms. Koller also managed the QI Credentialing Department and served on the business integration transition team after PHC was acquired by AUSHC. Prior to her tenure at PHC/AUSHC, she spent five years as a Congressional Aide in the district office of Congressman Bernard Dwyer. Ms. Koller was a fellow at the Eagleton Institute of Politics at Rutgers, The State University of New Jersey where she earned an M.S. in Public Policy.

Steven Larsen, J.D.

Steven B. Larsen was appointed Insurance Commissioner for the Maryland Insurance Administration in June 1997. The Maryland department has 270 employees and an annual budget of $21 million. Prior to this appointment, Commissioner Larsen had served as the chief legislative officer for the current Governor of Maryland Parris N. Glendening. In his career he has served as counsel and senior counsel for the USF&G Corporation, as legislative aid to Maryland's prior Governor William Donald Schaefer, and as counsel for the Economic Matters Committee of the House of Delegates in the Maryland General Assembly.

Commissioner Larsen has been active in the National Association of Insurance Commissioners (NAIC). He has served as chairman of the Health and Managed Care (B) Committee, vice-chairman of the Health Insurance (B) Task Force, chair of the Market Conduct and Consumer Affairs Committee, the Consumer Complaints Working Group, and the External Grievance Working Group. Commissioner Larsen has also served on NAIC Executive Committees and held leadership positions in the Northeastern Zone.

Commissioner Larsen also serves on the Board of American Accreditation Health Care Commission/URAC and serves as a Trustee of the Maryland Health Care Foundation. He is a frequent presenter at health care conferences and has testified on health care issues before Congress. He received a Bachelor's Degree in Business Administration from Gettysburg College; a Master's Degree in Politics and Public Policy from the Eagleton Institute of Politics, Rutgers University; and the Jurist Doctor degree from Rutgers-Camden School of Law.

Vicki A. Mangiaracina, J.D.

Vicki A. Mangiaracina was appointed to the position of Special Deputy Commissioner for Affordable and Available Health Care at the New Jersey Department of Banking and Insurance in March of 2002 by Commissioner Holly C. Bakke. In that position, she is the Department's point person on the issues of the affordability and accessibility of health care.

Ms. Mangiaracina first joined the Department in 1999 as Director of Regulatory Affairs, where she supervised and coordinated the work of the unit that produces the Department's regulations, bulletins and orders. In 2000, she became Special Deputy Commissioner where she worked on the design, development and implementation of policy Department-wide as well as on special projects. Prior to joining the Department, Ms. Mangiaracina was a Deputy Attorney General in the Division of Law, Department of Law and Public Safety for fifteen years. While at the Attorney General's office, Ms. Mangiaracina represented the Department of Banking and Insurance, the University of Medicine and Dentistry of New Jersey, several health-related Professional Boards and the Division of Motor Vehicles.

Ms. Mangiaracina received her J.D. from Albany Law School of Union University in 1980 and earned her A.B. from Mount Holyoke College.

Susan Marquis, Ph.D.

Susan Marquis is a Senior Economist at RAND, a public policy research institute. Previously, she was an economist at Research Triangle Institute, with responsibility for economic analysis of environmental policies. Dr. Marquis is one of he preeminent health economists in the nation. She has an extensive record of research on consumer demand for health insurance, health plan choice, and employer-sponsored health insurance. Dr. Marquis served as co-principal investigator for the RWJF Employer Health Insurance Survey. She also served as a senior investigator on the State of Washington State Planning Grant with Dr. Cantor, who was co-principal investigator. Dr. Marquis received her Ph.D. in Economics from the University of Michigan.

Alan C. Monheit, Ph.D.

Alan C. Monheit is Professor, School of Public Health, Health Systems and Policy Division, University of Medicine and Dentistry of New Jersey. He is also a Research Professor in the Institute for Health, Health Care Policy, and Aging Research and its Center for State Health Policy at Rutgers University. Dr. Monheit has held research positions at the Boston University Health Policy Institute and the Boston University School of Medicine. Most recently, Dr. Monheit was Director of the Division of Social and Economic Research in the Center for Cost and Financing Studies, Agency for Healthcare Research and Quality. His research interests include the relationship between employment and health insurance coverage, health insurance dynamics, the uninsured population, the distribution of health care expenditures and health insurance benefits, and children's access to health care. His published work has appeared a number of professional journals. Dr. Monheit has served as a member of the President's Health Reform Task Force and has been a technical advisor to the Robert Wood Johnson Foundation, the Kaiser Family Foundation, and the Health Insurance Association of America. In 1993, he received the first Administrator's Award for Health Services Research from the Agency for Health Care Policy and Research. He is an editor and contributor to the volume, "Informing American Health Care Policy: The Dynamics of Medical Expenditure and Insurance Surveys, 1997 - 1996". Dr. Monheit is also a Fellow of the Employee Benefit Research Institute and an elected member of the National Academy of Social Insurance.

Len M. Nichols, Ph.D.

Len M. Nichols, Ph.D. is Vice President of the Center for Studying Health System Change (HSC). Previously, he served as a Principal Research Associate at the Urban Institute. In his role as Vice President, Nichols helps to shape HSC's research agenda to provide timely and relevant information to policy makers about the nation's changing health system.

An economist, Dr. Nichols is a health policy expert who has written and published extensively on a variety of topics, including insurance market regulation, the effect of tax policy on health insurance purchase decisions and private insurance options for Medicare. Dr. Nichols also has testified before Congress several times and testified before the Bipartisan Medicare Reform Commission about competitive vs. administered prices.

Dr. Nichols is a member of the Competitive Pricing Advisory Committee, a group convened by the U.S. Department of Health and Human Services to guide attempts to begin competitive bidding for Medicare + Choice plans in select markets. He also served on the 2000 Technical Review Panel for the Medicare Trustees Reports, an independent body that reviewed government actuarial projections for Medicare.

Before joining the Urban Institute in 1994, Dr. Nichols was the senior adviser for health policy at the Office of Management and Budget, where he oversaw cost and revenue estimates for President Clinton's Health Security Act and its congressional successors. Previously, Dr. Nichols was a Visiting Public Health Service Fellow at what is now known as the Agency for Healthcare Research and Quality and an Associate Professor and Chair of the Department of Economics at Wellesley College. Nichols earned his Doctorate in Economics from the University of Illinois, Urbana-Champaign.

Karen Pollitz, M.P.P.

Karen Pollitz is a Project Director at the Georgetown University Institute for Health Care Research and Policy where she researches health insurance reform issues as they affect consumers and patients. Ms. Pollitz's work has focused on regulation of private health coverage by federal and state government, access to affordable health insurance, managed care consumer protections, and confidentiality of medical records. As an Adjunct Professor for the Graduate Public Policy Institute at Georgetown University, Ms. Pollitz teaches graduate level seminars on health insurance reform policy and process.

Before coming to Georgetown University, Ms. Pollitz served as Deputy Assistant Secretary for Health Legislation with the U.S. Department of Health and Human Services. There she was a legislative liaison on all federal health care issues including national health care reform, Medicare, Medicaid, and U.S. Public Health Service agencies and programs. Ms. Pollitz also served as Assistant Director of the American Academy of Family Physicians, Instructor at Marymount University School of Business, and Legislative Assistant for Senator John D. Rockefeller IV, Congressman Sander Levin, and the Subcommittee on Compensation and Employee Benefits.

Ms. Pollitz earned an M.P.P. from the Graduate School of Public Policy at the University of California, Berkeley and a B.A. with Honors from Oberlin College.

Wardell Sanders, J.D.

As Executive Director of the New Jersey Individual Health Coverage ("IHC") Program Board and the New Jersey Small Employer Health Benefits ("SEH") Program Board, Ward Sanders is the administrator for the State agencies charged by law with regulating the individual and small group health benefits markets. These two markets cover nearly one million New Jersey residents. Ward has spoken at numerous national and state conferences on New Jersey's health reforms, to consumer and business groups, and to insurance executives.

Prior to his appointment as Executive Director, Mr. Sanders served as the Assistant Director of the SEH Board. He began his State service as a Deputy Attorney General of the New Jersey Division of Law representing the New Jersey Department of Banking and Insurance, the SEH Board, and the IHC Board. He has been closely involved with New Jersey's health coverage reform programs since their inception in early 1993.

From 1984 to 1988, prior to earning his law degree, Mr. Sanders worked in Washington, D.C. for the International Center, a foreign policy research organization.

He is a 1991 graduate of the Villanova University School of Law, where he was an editor of the *Villanova Environmental Law Journal*, and was the class commencement speaker. He is also a 1984 graduate of Franklin & Marshall College in Lancaster, Pennsylvania, where he received his B.A. in Government.

Mark Scherzer, Esq.

Mark Scherzer is an attorney in private practice in New York City, concentrating in insurance policy and employee benefits litigation and counseling for people with AIDS, cancer and other serious or chronic illnesses. He is legislative counsel to New Yorkers for Accessible Health Coverage, a coalition of voluntary health organizations and consumer groups working for insurance reform at the state level. He has served as a cooperating attorney with Lambda Legal Defense & Education Fund and with Gay Men's Health Crisis and a mentor and trainer for the Cancer Advocacy Project of the Association of the Bar of the City of New York.

In 1992 and 1995, Mr. Scherzer was appointed to Technical Advisory Committees to the New York Insurance Department, assisting in implementing insurance reform laws. He has lectured widely and published nationally about access to health coverage and benefits.

Mr. Scherzer received his undergraduate degree from Haverford College, a Master of Arts degree in Anthropology from the University of Chicago, and his law degree from Yale Law School.

Barbara Schone, Ph.D.

Barbara Schone is a senior economist in the Center of Cost and Financing Studies at the Agency for Healthcare Research and Quality. Prior to joining the Agency for Healthcare Research and Quality, Dr. Schone taught in the Economics Department at Vanderbilt University. She received her Doctorate in Economics at the University of Virginia, where she was an Alfred P. Sloan Doctoral Dissertation Fellow. Dr. Schone also enjoys her role as an Adjunct Professor in the Public Policy Program at Georgetown University. She teaches the first health economics course, which is aimed at helping students develop their economic reasoning skills to analyze public policies that are related to the demand for health.

Dr. Schone's research focuses on the economics of health, with a particular interest in the link between employment and health insurance and the economics of the family. Currently, she is investigating the effects of small group insurance market reforms on insurance coverage and is conducting an analysis of the effect of health insurance on labor supply and job choice decisions of married women.

Dr. Schone's current research agenda also includes several projects that develop economic models of long term care, with specific focus on how families make caregiving decisions for frail elderly parents. Dr. Schone has recently been published in the *Journal of Human Resources*, *Demography*, *Inquiry*, and *Health Affairs*. In 1996 she received the New Investigator Award for Excellence in Research in Aging and Disability from the Gerontological Health Section of the American Public Health Association.

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Kosali Ilayperuma Simon is an assistant professor in the Department of Policy Analysis and Management. She received her B.A. in economics and German from Hamilton College and her M.A. and Ph.D. in economics from the University of Maryland at College Park. Her research and teaching interests focus on policy-oriented issues in health economics, labor economics, and public finance. Her past research has studied how state regulation of private health insurance affects the outcomes in insurance and labor markets. She will be teaching two undergraduate classes in Spring 2002: Economics of Health Policy and Applied Public Finance

Katherine Swartz, Ph.D.

Katherine Swartz is a Professor in the Department of Health Policy and Management at Harvard School of Public Health, Harvard University. Her current research interests focus on the population without health insurance and efforts to increase access to health care coverage, as well as health care financing and organization. Within this range of topics, she is currently examining whether regulations of insurance markets and subsidies of premiums can effectively increase access to health insurance. Recently, Professor Swartz has begun a project on the impact of the mapping of the human genome and its implications for health insurance; in particular, what types of genetic illnesses and conditions will no longer be insurable by private insurance companies, and the role that government may have in providing financing of genetic therapies and tests. Professor Swartz completed her undergraduate work at MIT, and earned an M.S. and also her Ph.D. at the University of Wisconsin, Madison.

What Have We Learned from Research on Small-Group Insurance Reforms?

Kosali Simon, Ph.D.

Road-map of Presentation

- Underlying rationale for Small Group Market Reform
- Policy instruments used
- Prevalence of reforms across states and over time
- Reasonable expectations
- Possible insurer, employer and employee reactions
- Summary of empirical findings

Reasons for Enacting Reforms

- High and volatile premiums in small-group market, compared to large-group market
- 'Excessive' underwriting
  - 'Red-lining', rejections and uncertain renewal prospects
  - Experience-rating of premiums
- Compromised job mobility into and within small firms
  - 'excessive' use of pre-existing conditions clauses

Policy Tools

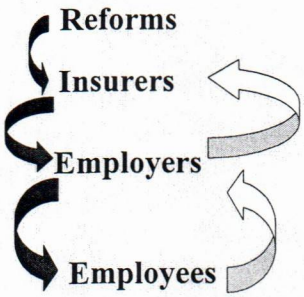
- Pricing laws
  - Rate bands, case characteristics, community rating.
- Issue laws
  - Guaranteed issue
    - Some products vs all products
  - Guaranteed Renewal
- Job-lock related laws
  - Pre-existing conditions exclusions
  - Portability

Variation in Reform Adoption Across States and Over Time

- {Maps}

What Could We Reasonably Expect from these Laws?

- Pricing:
  - Should expect reduced variance, but not a narrowing of the gap between small and large firm premiums
- Issuing:
  - Absent price restrictions on offers, this has no 'teeth'
- Job-lock:
  - Uncertain effects
- Effects expected to vary by risk status
  - After reform, the risk pool should include more of those who were previously denied health insurance



How will reforms affect the final outcomes of interest?

Final Outcomes of Interest

- Insurance coverage among small-firm workers
  - Type and terms of coverage (single vs family, etc)
  - Intermediate outcome: Offers vs take-up
- Premiums paid by small employers
  - Adjusting for plan characteristics
  - In theory, any price effect is borne by workers
  - Intermediate outcome: insurance market structure
- Job-lock (and other labor market outcomes) in small firms
- How does effect differ by group (risk status, demographic factors, firm size, etc) and by type of reform?

Kosali Simon
6 additional slides

Variation in Reform Adoption Across States and Over Time

Year # states	1992	1994	1996
No Reform	32	13	5
Some reforms	15	16	10
All reforms	3	21	35

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Timing and Nature of State Reforms: 1991-1996

State	All	Some			State	All	Some	
AK	94-96				MT	94-96		
AL					NC	91-96		
AR		92-96			ND	95-96	94-92	
AZ		94-96			NE	95-96	92-94	
CA	94-96				NH	96	94-95	
CO	96	95			NJ	95-96		
CT	92-96				NM	96	92-95	
DC					NV			
DE	94-96	92-93			NY	94-96		
FL	94-96	92-93			OH	93-96		
GA		92-96			OK	95-96	93-94	
IA	93-96	92			OR		92-96	
ID	94-96				PA			
IL		95-96			RI	93-96		
IN		93-96			SC	96	92-95	
KS	93-96	92			SD	96	92-95	
KY	96				TN	94-96		
LA	95-96	92-94			TX	95-96		
MA	92-96				UT		96	
MD	95-96				VA	94-96		
ME	94-96	91-93			VT	93-96		
MI					WA	94-96		
MN	94-96				WI		93-96	
MO	95-96	94			WV		92-96	
MS		96			WY	93-96		

6

Findings from the Literature Insurance Coverage

- The good news: no death spiral
  - At best, a neutral effect on overall coverage rates in small firms
  - At worst, a small decline in percent with health insurance through small employers
- By type of reform
  - The fewer types of reforms, the weaker the effect
- By population segments
  - Some variation in effect by risk status as predicted

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Offers of Insurance

- Employer health insurance purchasing/worker eligibility decisions appear to be unaffected

Premiums

- Key variable, but not many sources of data on premiums and plan characteristics
- Available evidence shows either no effect on level and variance, or small rise in level
  - Any rise that occurs may be passed on to workers

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Structure of Insurance Market

- Some evidence that issue reforms decrease market concentration
- Weak evidence that portability and pre-ex laws increased market concentration
- Reforms may spur managed care penetration
  - Consistent with idea of 'leveling the playing field'

12

Labor market outcomes

- No evidence of effects on labor market outcomes for general population
  - Hours of work, wages, small vs large firm employment opportunities
- Some evidence that rating reform increases small firm employment opportunities for those of worse health status at the expense of the population of older workers
- No evidence that job-lock is reduced by portability laws

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What Have We Learned from Research on the Individual Market?

Toward Inclusive and Sustainable Health Insurance Markets: A Dialogue Between Policymakers and Researchers

April 10, 2003
Trenton, New Jersey

Deborah Chollet
MATHEMATICA
Policy Research, Inc.

Overview

- Consumers
- Structure of supply
- The demand for individual coverage
- Adverse selection
- Insurer underwriting
- Impacts of regulation
- Observations about change

Who Buys Individual Coverage?

- In 2001, 16.4 million persons < age 65
- 5-7 percent of the nonelderly population
- 9 percent of the privately insured population

Who Buys Individual Coverage?

- Full-time, full-year wage and salary workers
- Adults under age 45, or children
- Most have income above 300% FPL

But, they are more likely than group-insured to be:

- Self-employed or employed in firms < 100
- Older: 1/3 of covered lives are age 45-64
- Lower-income: 43% are < 300% FPL

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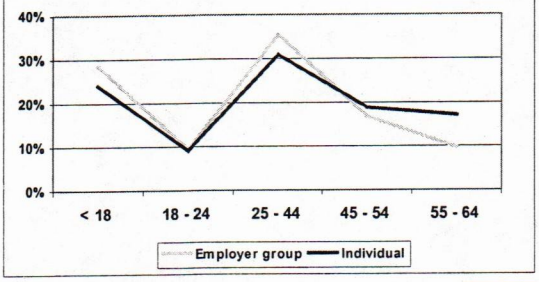
Frequency Distributions of the Group and Individually Insured Populations by Age
(Source: March 2000 Current Population Survey)



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The Supply Side

- Very concentrated: 3 insurers hold 50-100%
- BCBS dominates in most states
- Typically low HMO penetration
- Many insurers per premium volume
- Most insurers have very low premium volume

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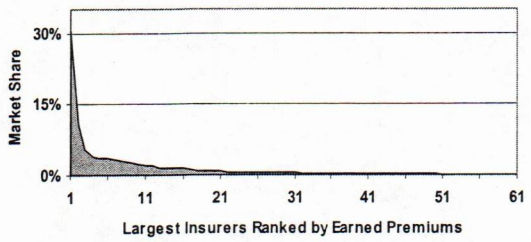
Individual Market Structure: New Jersey 1997 (n=195)



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Implications of Market Structure

- Most insurers are small and susceptible to adverse selection
- High share of premium allocated to marketing and administration
- Thus, where state regulation permits:
  - Incentive to underwrite aggressively
  - Incentive to reduce medical benefit

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Consumer Demand for Individual Coverage

- Residual market
- Sensitivity to price and income both estimated to be low
- Lack of observable sensitivity may be related to supply "cliffs":
  - Underwriting at new issue
  - Unintended cost of changing networks

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Adverse Selection

- Asymmetric information: the consumer knows what the insurer cannot
- Incentive to "wait" is strong: individual coverage is costly
- Forced pooling
  - Guaranteed issue/renewal
  - Rating constraints at issue and renewal
  - Limits on preex exclusions

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Does Adverse Selection Occur?

- No observed bias market-wide
  - Generally healthier than the general population
  - About as healthy as group-insured
- But:
  - Difficult to observe; underwriting deteriorates
  - Insurer-level experience may differ from the market

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Engineering Adverse Selection

- Price discrimination to maximize profit
- Subtle underwriting by product
  - "Substantially similar" products
  - "Basic and standard" alternatives
- Closed blocks of business, selective exit

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Insurer Underwriting

- Denial rates
  - Observed at 33 percent
  - Few states limit (7% max in WA)
- Exclusion riders
- Rate-ups

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Observed Rate of Underwriting: Individuals with Varied Health Problems

Underwriting (19 Insurers in 8 markets)	Percent of applications (n=60)
Denied	37%
Substandard coverage	28%
Rate-up	13%
Substandard coverage + rate-up	12%
Clean offer	10%

Source: Pollitz, Sorian, and Thomas 2001.

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Common Types of Regulation

- Guaranteed issue (all products, some products, some of the time)
- Exclusion riders
- Rate constraints (health, age, comprehensive)
- Preexisting condition exclusions
- High-risk pools
- Groups of one

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States with Access and Rate Regulation in the Individual Market

	High Risk Pool Only	Some or All Products Guaranteed Issue	No Products Guaranteed Issue
Rate Bands for Health Status, or Composite Bands	7	8	2
No rate Bands for Health Status	20	9	5

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Estimated Impacts on Markets

Regulation	Estimated Impact on Markets
Guaranteed issue, all products	+ market concentration
Rate bands on health	+ market concentration – commercial share
Comprehensive rate bands; rate bands on age	No impact
Shortened pre-ex exclusions	No impact
High risk pool	No impact

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Estimated Impacts on Coverage

Regulation	Estimated Impact on Coverage
Guaranteed issue, all products	Negative or none
No exclusion riders	No impact
Rate bands on health	Positive for some No impact otherwise
Rate bands on age	No impact
Comprehensive rate bands	Negative

Sources: Zuckerman and Rajan 1999; Chollet, Simon, and Kirk 2000; Chollet and Schone 2002.

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More Research Needed to Understand Impacts?

- Alternative measures of regulation
- Alternative measures of coverage
- Measures of price
- Longer time periods to capture more change
- Attention to longer-term impacts

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Concluding Remarks

- Idiosyncratic but essential market
- Economic efficiency: many small insurers or monopoly?
- Greater regulation and more uniformity for public subsidies?

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What Can We Learn from the Research on Small Group Health Insurance Reform?

Thomas C. Buchmueller
University of California, Irvine

Policy Goals and Potential Unintended Consequences

- A key objective was to increase coverage, especially among "high risk" groups.
- But, lowering costs for high risks may raise costs for low risks, causing them to drop coverage.

⇒ ***The Adverse Selection Death Spiral Hypothesis***

Academic Research on Small Group Reform

- Several recent studies examine effects on coverage
- Attempt to distinguish causal effects from secular trends and long-standing differences among states
- Similar data, but some differences in empirical methods
- Some differences in results
  - No effect on coverage vs. some decline from adverse selection

Methodological Issues

- To learn from this research, we need to understand several key methodological issues:
  - Defining the counterfactual
  - Defining the pre- and post-reform periods
  - Accounting for the targeted nature of the reforms
  - Testing for differential reform effects
- My talk will be organized around these issues

Some Notes on My Biases

- Project with John DiNardo started out as a broad study of small group reforms using national data.
- Expected to find evidence of adverse selection.
- Starting by looking at NY: strongest reforms mean the most likely chance of unintended consequences.
- Finding that NY's reforms did not reduce coverage made us believe that such effects were not likely elsewhere.
- As project progressed, we became more aware of the pitfalls of a national analysis.

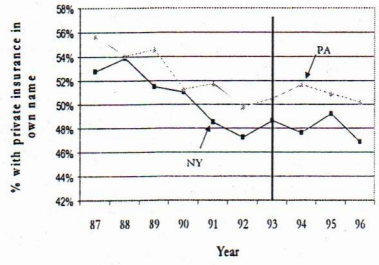
Big Question: What is the Counterfactual?

- Causal effects must be measured relative to what would have occurred in the absence of reforms.
  ⇒We need a "control group"
- Most obvious controls: non-reform states
  - best when states are neighbors and similar in other ways (NY vs. PA)
  - Challenge: only a few states didn't enact any reforms
    => ***Are AL, MI, PA, HI, DC representative of the rest?***

Most Common Method: Difference in Differences

- Compare trend pre/post for treatments and controls
- Need to define the two periods
- Most studies say little or nothing about how this is done or how sensitive the results are to this choice
- But this can have major effects on results
  Example: NY vs. PA

Figure 1. Private Insurance Coverage in NY and PA, 1987 to 1996



Pre/Post Trends in Coverage: NY vs. PA

- Pre = '87 to '93; Post = '94 to '96

	NY	PA
Change	-2.6 % pts.	-1.6% pts.

⇒ NY reforms caused coverage to fall by 1% pt.

B. Pre = '91 to '93; Post = '94 to '96

	NY	PA
Change	-0.2 % pts.	+0.2% pts.

⇒ No difference between the two states.

Accounting for the Targeted Nature of the Reforms

- Impact of reforms should be limited to small firms

  ⇒ Pooling large and small firms may obscure large effects

  ⇒ Large firms represent another possible control group

Accounting for the Targeted Nature of the Reforms

- Multiple control groups means alternative estimates
  - small firms, reform vs. non-reform
  - Within reform states: small vs. large
  - Use both across and within state contrasts: DDD
- No single "right" estimate
- Ideally, alternative controls should give similar results
- When they don't, results need to be interpreted cautiously

Accounting for the Differential Treatment Effects

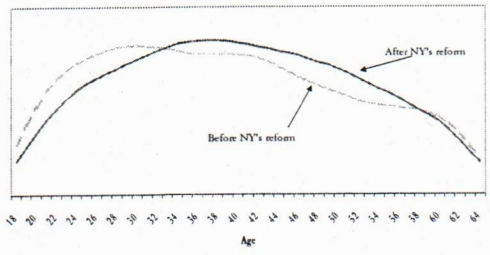
- Reforms should have affected high and low risks differently
- Differential effects are are
  - of direct interest
  - useful for distinguishing reform effects from other factors

  ⇒ ***Death spiral hypothesis predicts that coverage should have fallen most for low risks***

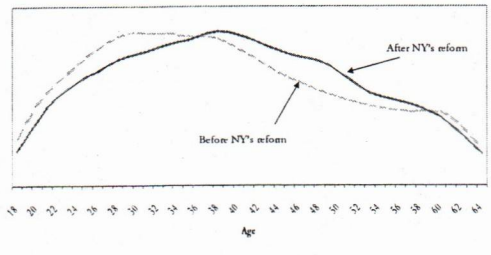
Testing for Differential Treatment Effects

- Need a risk proxy that insurers could use to set premiums before reforms but not after
- With community rating: age is a good proxy
  - clearly was used before; not after
  - readily measured in available data
- Tests using NY
  - coverage should have fallen for young relative to old
  - small group pool should get older

The Age Distribution of Adults insured in **New York's** Small Group Market, Before and After 1993



The Age Distribution of Adults insured in **Pennsylvania's** Small Group Market, Before and After 1993



Testing for Differential Treatment Effects in Other States

- Some studies use age and other demographics to conduct similar tests with national data
- Greater decline in coverage for young than old interpreted as adverse selection
- But in other reform states, these factors can still be used to set premiums

⇒ *Comparison of old and young provides no meaningful information about the effect of reforms*

Did Small Group Reforms Affect the Number of People with Insurance?

- Evidence from NY suggests no.
  - Policy was not the success hoped for, but not the disaster claimed.
- What about declines reported in other studies?
  - Adverse selection results driven by states other than NY where this outcome should have been much less likely.
  - Serious questions about what drives these results.
- **My conclusion: reforms did not affect the number of people with insurance.**

Why Was There no Measurable Effect on Coverage?

- Discriminatory underwriting practices were never a major cause of the "uninsured problem"
  - possible that small number of very high risk groups benefited
- Reforms in many states were actually pretty weak
- Reform effects were mainly on the level or type of coverage.
  - Again, evidence from NY is instructive.

What Happened in New York?

- Community rating dramatically altered pricing in small group and individual markets, raising rates for younger consumers
- Q: Why didn't younger consumers respond?
- A: They did. They switched to cheaper plans rather than dropping coverage altogether.

What Happened in New York?

- HMO penetration increased dramatically in NY's small group market after '93 reforms
- No similar effect in PA, CT, large firms
- Changes in risk pools suggests trend was driven by migration of younger consumers from indemnity to HMOs

⇒*Pattern points to a causal effect of the reforms*

Interpreting the New York Results

- Community rating led to adverse selection **within** the market, not **against** the market
  - certain plans lose enrollment
  - number insured unchanged
- Consistent with:
  - economic theory
  - qualitative evidence from NY
  - research on markets with community rating and indiv. choice
  - opposition of indemnity insurers

More Questions

- Research has focused mainly on coverage; less is known about other outcomes.
- How many very high risk groups? How did they fare?
- What type of small group regulations are best?
- What are the implications for the individual market?

The Literature on Small Group Market Reform: Methodological Considerations

Barbara Schone, Ph.D.

Goals Of Presentation

- To provide an overview of the methodological issues faced by researchers evaluating small group market reforms
- To discuss, in general terms, how methodological issues have been addressed
- To provide further suggestions for improving the literature on small group market reforms

Outline

- Role of research for policy
- Methodological approaches used in the first-generation and second-generation of small group reform studies
- Methodological issues to consider when interpreting existing studies of small group market reform
- What we should look for in the third generation of studies

The Nature of Small Group Market Reform Research

- Goal of Research: To answer a set of questions related to reform:
  - What was the impact of reform on fill in the blank?
    - Insurance status
    - Labor market outcomes
- We want the best answers to these questions so that the research can be used to inform policy

How Should Research Ideally Be Used by Policymakers?

- Policy should be influenced by a body of knowledge, not one particular study
- Policy should be influenced by good research

What is Good Research?

- Research that poses a clearly defined question and then attempts to answer it
- Studies that account for statistical and methodological considerations so that the answers obtained can be deemed reliable
- Outcomes that pass the "common-sense" test

How Does the Existing Literature on Small Group Reform Measure Up?

- There is a wide body of literature developing
- The literature has addressed well-defined (and important) questions --- most emphasis on insurance status
- The literature has evolved over time so that the latest studies use the best methodology

What Are the Take-Away Messages So Far?

- No evidence of adverse-selection death spirals in the small group market: markets did not collapse
- Relatively modest effects of reform overall
- Some indications that reform differentially affected individuals by riskiness

Features of the First Generation of Studies of Small Group Reform

- Based on case studies
- Analyses of individual states over time
- Analyses of a cross section of states at a point in time

Cautious in Interpreting the First Generation of Studies

- One should be confident that the estimated effects of reform are actually measuring reform
- Reasons to think that the estimated effects of reform might be contaminated by other factors

Studies of Individual States over Time

- Studies focus on the pre-reform and post-reform period
- Concern: unobservable trends in states over time will be reflected in the measure of reform
- Example: Decline in macroeconomic conditions

Studies of States at a Single Point in Time

- Compare outcomes across states after reform is enacted
- May be differences across states that are not controlled for explicitly – may bias the estimated effect of reform
- Example: Citizens in reform states may have greater demand for insurance

Second Generation Studies of Reform

- Aimed at addressing the inherent weaknesses in early studies
- Generally use a quasi-experimental (or natural experiment) approach
- Some account for theoretical considerations: reform should not affect all workers similarly

What Does It Mean to Use a Natural Experiment?

- Studies focus on reform and non-reform states over time (pre-reform and post-reform)
- Multiple control groups are defined relative to a treatment group
- Aimed to control for state-invariant time trends and time-invariant differences between states

How it Works

	Pre-Reform	Post-Reform
Reform States	I_1	I_2
Non-Reform States	I_3	I_4

- Estimate of reform is $(I_2 - I_1) - (I_4 - I_3)$
- Look at trends in coverage in reform states relative to trends in non-reform states
- Difference-in-difference (DD) estimate

What Does DD Accomplish?

- Controls for state-invariant time trends
  (e.g., changes in macroeconomic conditions)
- Controls for time-invariant state trends
  (e.g., differences in insurance demand across states)
- Doesn't account for different time trends across states
  If economic conditions improved in reform states over time relative to non-reform states, resulting change in insurance status will be attributed to reform

Difference-in-Difference-in Difference (DDD) Estimation

- Subtracts DD estimates for large firm observations from small firm observations:

$$[(I_2 - I_1) - (I_4 - I_3)]^{\text{small firm}} - [(I_2 - I_1) - (I_4 - I_3)]^{\text{large firm}}$$

- "Washes away" differential time trends across states that are common to large firm and small firm observations

Accounting for Differential Reform Effects

- Economic theory suggests that reform should benefit high risk persons relative to low risk persons
- Some second generation studies account for this and find evidence consistent with this hypothesis

Weaknesses that remain in the existing literature

- No effort to account for policy endogeneity, may bias estimated effects of reform
- Policy Timing and Data
  - Trade-off between having enough time to observe effects of reform versus timely evaluation of reform
  - Long-run versus short-run effects of reform
  - Timing of data --- Did insurers anticipate the effects of reform? If so, could bias findings away from finding an effect of reform

Other weaknesses

- Bundling of reform components/Multicollinearity
  - What are we really measuring?
  - What do we want to be measuring?
- Statistical Power of Some Studies
  - Identification of reform effects sometimes based on small number of observations
  - Economic versus Statistical Significance
- Estimated effects are average effects
  (differences may exist based on distribution of income, firm size, etc.)

Issues Related to the Second Generation Reform Studies

- DD and DDD require that time affect control groups and treatment groups similarly
- DD and DDD also require that control and treatment groups remain stable over time
- Are these conditions satisfied? Not clear

Why Might These Assumptions be Violated?

- General Equilibrium Effects
  Could insurers have adjusted to reform by changing the terms of insurance coverage in large firms?
- Stability of Groups
  Working in a small or large firm is a choice made by individuals; desire to work in a small firm may have changed; characteristics of work force may have changed

What Should We Expect from the Third Generation of Reform Studies?

- New statistical approaches enable researchers to relax some of the requirements of DD and DDD
- More emphasis on the validity of the conditions necessary for DD and DDD
- Focus on family-level analyses (how does reform affect workers who have the potential to obtain coverage from a family member)
- Studies that analyze reform's longer-run effects

Concluding Messages

- Methodological approach used to assess the effects of small group reform has improved
- A fairly consistent picture is emerging
- Still methodological concerns about existing studies but there are clear ways to proceed
- Much still to be learned but progress is good

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How Can Reform Work Better?

M. Susan Marquis

1

Background

- Regulations aim to limit risk segmentation and increase risk pooling
- The threat of adverse selection
  - Higher risks may drive up prices and drive low risks out
  - Individual insurers may suffer losses and be unwilling to supply insurance

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2

Is Adverse Selection A Problem?

- Mixed evidence on importance
  - Most quantitative studies show at most modest selection
  - Qualitative evidence points to more substantial problems
- Insurers have incentive to avoid the sick and enroll the healthy—cream skimming
  - Plan design
  - Network
  - Service
  - Marketing

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3

How To Reduce The Threat

- Risk adjustment
- High-risk pools
- Purchasing cooperatives

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4

Risk Adjustment

- Redistribute payments among insurers to match the *expected* (not actual) costs of the enrollees
- Types of risk-adjustment
  - Prospective risk adjustment (ex ante)
  - Risk sharing (ex post)

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5

Prospective Risk Adjustment

- Objective to adjust for "expected" risk
- Questionable whether existing risk adjustment technology is sufficient to solve the problem; it has failed market test
- Disadvantages:
  - Extensive data collection
  - Inappropriate incentives to invest in health improving activities
  - Incentive to distort information

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6

Risk Sharing

- Reimbursement for some of actual costs of enrolling high risks
- Reduces incentive to cream skim, but also to contain costs
- Forms of risk sharing
  - Threshold reinsurance
  - Proportional reinsurance
  - Risk sharing for high risks
  - Condition specific risk sharing

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7

Threshold Reinsurance

- Plan receives some share of actual cost for high cost cases
- Examples:
  - Healthy New York program
  - New Jersey's play or pay program
- Disadvantages:
  - Still gain from attracting healthy
  - Reimbursement for bad luck
  - Limits incentives for efficiency

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8

Proportional Risk Sharing

- Actual use as an adjuster
- Advantages:
  - Protects against underprovision of service
  - Reduces benefit from trying to attract healthy as well as limit disincentive to take sick
- Disadvantages:
  - Limits incentives for efficiency

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9

Risk-sharing for High Risks

- Plan reimbursed costs for a specified percent of high risk cases (designated ex ante)
- Advantages:
  - Focus on adjustment for predictable risk
- Disadvantages:
  - Plans with all risky patients still at risk
  - May not be useful for new applicants

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10

Condition-specific risk sharing

- New York's medical condition risk pool
- Advantages:
  - Can preserve incentives for efficiency by prospectively setting reimbursement amount
- Disadvantages:
  - Deciding the conditions
  - Patient privacy
  - Diagnosis inflation

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11

Risk -sharing and insurer incentives

- Dutch simulation of 3 methods: effects on predictable losses from bad risk selection
  - High-risk risk sharing: 50 %
  - Threshold risk sharing: 40 %
  - Proportional risk sharing: 20 %

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12

Risk Adjustment and Coverage Expansions

- Risk adjustment affects supply price of insurance; coverage depends on demand price
- Internal vs. external financing of risk adjustment will affect demand price
- Internal financing: risk still spread across purchasers in market
- External financing: spreads risk more widely and lowers premiums faced by purchasers
  - Healthy New York reinsurance scheme

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13

High Risk Pools

- High risk cases covered in a separate pool
  - 30 states have high risk pools
- How risks of pool are spread will affect demand
  - Premium assessments
  - General revenues
- Participation generally low
  - 5 to 25 % of target population

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14

Purchasing Cooperatives

- Expected advantages:
  - Lower demand price
  - Greater risk-pooling
- Price advantages have not been realized
- Cooperatives are not able to pool beyond market practice or they will experience adverse selection
- Administrative functions that can help markets work better:
  - Implement risk adjustment
  - Benefit standardization
  - Rules for plan participation
  - Education

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15

Conclusion

- Adverse selection is a potential problem with market reforms
- Risk adjustment or high-risk pools may reduce threat and incentives to cream skim
- Purchasing pools administratively can help make markets work better
- Gains in number of insured will likely require substantial subsidy
- Policy solutions to cover uninsured, protect high and low risks, and ensure a stable insurance market will likely require a mix of strategies

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RUTGERS CENTER FOR STATE HEALTH POLICY SEMINAR – APRIL 10, 2003

Prepared Remarks by Sanford B. Herman, FSA, MAAA – Vice President, Group Pricing & Standards – Guardian Life

Good afternoon – and thank you for inviting me to participate in this conference and in this particular panel discussion.

I spent a good deal of time thinking about how I should present my remarks on this subject. While I am an actuary by profession, I wanted to take a holistic approach and, therefore, found myself venturing into the fields of sociology, philosophy, psychology and history, as well as the classical principles of risk and insurance.

The nature of American society, and its stress on voluntary action by its citizenry, has, in many ways, resulted in a significant disconnect between the concepts of accessibility to and affordability of health care coverage. Anything related to universal coverage, on the other hand, has had the connotation of a mandate or forced action – something generally to be avoided.

The general precepts of group insurance revolve around the law of large numbers and the fact that if you get a broad cross-section of a working population you can achieve reasonable cost results. That all worked well back in the good old days of the 1950s and 1960s for the large employer market, where the offering of medical insurance benefits

was the overwhelming norm, and the employer subsidies were sufficiently generous to ensure virtually universal participation by their employees. Much of this situation was related to the prevalence of collective bargaining within such industries or, in some cases, the mere threat of potential unionization. Large industrial America, as we knew it back then, was the closest thing that America has had to universal health care coverage.

This somewhat ideal model never quite fit the small employer or individual market because of the very voluntary nature of American society. Small employers were not forced by either the government or the competitive marketplace (including labor unions) to make coverage available for their employees, and when they did, the level of subsidy was often not sufficient to assure the broadest possible employee participation. The individual insurance marketplace was, and continues to be, completely voluntary. As such, small employers and individuals could pick the time and place to enter the insurance market. Faced with these examples of potential anti-selection, insurance carriers desiring to offer affordable coverage felt the necessity to utilize various forms of underwriting. Freedom combined with relative affordability came with a price – that being the selection of risks – which, unfortunately was a barrier to accessibility for a certain segment of the population.

These somewhat optimal cost containing models – fairly universal coverage in the large employer market and underwritten coverage in the small employer and individual markets – worked for a while, but a deteriorating economy combined with hyperinflation in the 1970s caused employers and insurers to take actions to contain some of the

escalating costs. These included self-insurance mechanisms for larger groups that helped avoid costly state mandates, premium taxes and insurer risk charges, along with plan design changes within all of the markets. We also began to see the emergence and growth of the various forms of managed health care. In the smaller group marketplace, as well as in the individual markets, some insurers sought to utilize various new underwriting techniques to give themselves cost advantages. You may recall such terms as tier rating, durational rating, re-entry underwriting, along with just plain experience rating of small groups. It wasn't good enough to underwrite up-front and then fully pool the inforce risks. Some carriers had to continually "cleanse" their pool populations. These were the abuses that led to the initial small group rating reforms in the late 1980s and the more comprehensive small group and individual market reforms of the early to mid 1990s.

The major rationale for the small group and individual market reforms during the 1990s centered on accessibility – addressing the real and perceived abuses of the insurance industry. It was felt that, if only all citizens could have complete access to insurance coverage at the prevailing price level, this would make a great dent in the uninsured population that, around that time, numbered approximately 37 million. What the reformers failed to take into account, either intentionally or unintentionally, was that while the anecdotal stories made great newspaper headlines, these examples represented only a small fraction of the uninsured population, many of whom were within families having at least one worker. The bulk of the uninsured population was related to the overall price levels, and in actuality, the various forms of rate compression adopted by

state small group reform left many of these younger and healthier uninsureds even less willing and/or able to pay for coverage.

If anything, small group and individual market reforms, combined with the continued overall escalation in medical care costs, which impacted large employers and governmental entities as well, hastened the rise of managed care carriers and the decline of the indemnity insurers. The HMOs were able to put into place immediate fixes, in the form or utilization controls and deep provider discounts, that more than offset the incremental costs of the reform legislation. With the decline in indemnity insurance, we also saw a major reduction in the number of significant health insurance players. The cost of establishing local and national provider networks is quite prohibitive, and many of the former players merged, while others dropped out of the business either officially or on a de-facto basis. This development can be illustrated by what transpired in New Jersey in just a few years. As of 1995, shortly after the New Jersey SEH and IHC legislation and resulting programs were up and running, there were still 14 separate insurance entities in the small employer market having at least 2% of the small employer market. By 2001, that number had dropped to 8, and many of these names were new. It is not clear, at this time, whether the concentration of market-share will result in downward or upward pressure on bottom-line medical insurance premium costs.

Throughout the remainder of the decade following the state reform legislative activity, this nation enjoyed one of the longest and strongest economic growth periods, yet we barely made a dent in the level of uninsured people. Additionally, by the end of this

economic expansion, most of the HMOs had hit a brick wall relative to their ability to further reduce claim costs and, with the prolonged current period of economic difficulties, we now have millions more on the uninsured rolls.

So, with all this story of gloom & doom, what is my prescription? The answer is one that is difficult to swallow – we must come to grips with the fundamental conflicts and contradictions within American society's thought process and attitudes. We have an insatiable appetite for consuming medical care (and quite frankly a bunch of other things), but no desire to pay for what we want to consume. We tout freedom of choice and action, but will not accept a system that forces the consequences for making a wrong choice. We expect near miracles from our medical care system, but use our litigious nature to undermine the providers. Additionally, we don't want to pay directly for universal health care coverage, but are willing to pay for it back-door by accepting professional fees and hospital charges which are loaded for such things as uncompensated care and bad debt. Most importantly, we have a political system that does not permit elected officials to make the hard and unpopular decisions.

Since I am not currently in public office, nor do I ever intend to run for elective office, I have the luxury of putting forward one possible alternative, and it is quite simple – a nationally mandated benefit plan which would be funded by a combination of employer and employee contributions, along with an individual mandate containing subsidies varying by income level. For small employers, there would be some phase-in general revenue support as well to limit their out of pocket expenses. This program would be

best served by a competitive private marketplace, acting within the parameters of reasonable regulation, as opposed to the establishment of a massive governmental bureaucracy.

As part of such a comprehensive solution, we will need to enact national medical malpractice reform. I'm not necessarily advocating a specific cap on awards for economic and punitive damages, but rather an adjunct judicial system made up of expert tribunals which can look at such cases. Experts would make objective decisions as to the merit of malpractice claims, and where there was fault, make a reasonable evaluation regarding appropriate damage awards. Such a tribunal would also need to have the authority to deal with the professional licenses of blatant or repeat offenders. In this way, we could cut down on many of the unnecessary and costly procedures and tests done or ordered by the physician community, as well as strip away many of the unnecessary costs inherent within our present malpractice insurance system, where a disproportionate amount of dollars go to legal costs and fees, and not enough go to the injured patient. It would also be appropriate to put in certain controls on prescription drug prices. It's hard to understand why Americans have to subsidize the health care costs of the rest of the world. Finally, we would need to have at least some portion of the managed care elements in such a health care plan to keep costs down. This would probably not look quite like Canada, which has a degree of rationing, but would be a bit more tightly managed than the advocates of Patients Bill of Rights would have it. Such a system of managed care controls would, however, need to have adequate protections, such as timely external appeals. From a premium rating point of view, something akin to community

rating, with a program of risk adjustment allowances, would be appropriate under a system of universal coverage.

Many will argue that we can't afford this kind of a program, but quite frankly, we can't afford not to! Today we are already paying just about the entire cost for a lot worse results. I feel reasonably confident that the proposal I have outlined is the right way to go. Why? Well, the best thing in life is to make everyone happy with what you are doing or proposing. Absent that, the next best thing is to have everyone unhappy about something in an overall proposal. If everyone complains, then you have done a reasonably good job in coming up with a solution which widely distributes the pain. I believe that the proposal I have outlined succeeds in making just about everyone unhappy, so it must be the right way to go!

Once again, thanks for have me here this afternoon.

Can Access to Affordable Health Insurance be Sustained?

Karen Pollitz
Georgetown University
April 10, 2003

Individual Market Poses a Challenge

- Residual, small, voluntary, unsubsidized
- Expensive coverage
- Limited family incomes
- Adverse selection / risk selection
- 1 in 4 adults need individual coverage over a 3-year period; most face barriers

2

Comprehensive Market Reforms in New Jersey

- Guaranteed issue all products, all residents, all the time
- Standardized, comprehensive benefits
- Limits on pre-ex / credit for prior coverage
- Community rating

3

Approaches In Other States

- Portability
  (12 states; 10.5 with rate limits)
- Carrier of last resort
  (6 states; 3 with rate limits)
- High-risk pool only
  (23 states)
- Minimal
  (5 states)

4

Even Mild Health Problems May Pose Barrier to Access

Underwriting Actions Taken on 60 Applications By Persons With:

	"Clean Offers"	"Substandard Offers"	"Denials"
Hay Fever	3	52	5
Knee Injury Repaired 10 yrs	15	38	7
Asthma	3	49	9
Breast Cancer Treated 7 yrs	11	23	26
Depression	9	37	14
Hypertension/ overweight	2	25	33
HIV	0	0	60

5

'How Accessible is Individual Health Insurance for Consumers in Less Than Perfect Health?' Kaiser Family Foundation, June 2001.

Barriers to Access Over Time

- Age rating
- Stranded in policy
- Move / carrier exits market
- Post-claims underwriting
- Re-underwriting

6

Compared to People in Comprehensive Reform States, Likelihood of Encountering Health Insurance Barriers

	State Regulatory Approach:		
Barrier:	Portability	High-Risk Pool Only	Minimal
Denial	5.1	5.3	7.3
Family member denied	9.8	10.7	17.2
Exclusion	4.1	4.4	6.3
Rate Up	3.4	2.8	2.9
Any Barrier	4.3	4.2	6.8

7

Unpublished survey data, www.healthinsuranceinfo.net.

Strategies That Can Help

- Subsidize (vs. de-value) coverage
  - Medicaid expansion; other state programs
- Spread some risk over group market
  - Self-employed group of 1 (13-14 states)
  - Group conversion rights (5 states)
  - Reinsurance
  - Other cross subsidies
- Other regulation of medical underwriting
- Alternative to individual market?

8

CENTER for STUDYING HEALTH SYSTEM CHANGE

Providing Insights that Contribute to Better Health Policy

Reforming state insurance market reform: what's left to try?

Len M. Nichols

April 10, 2003

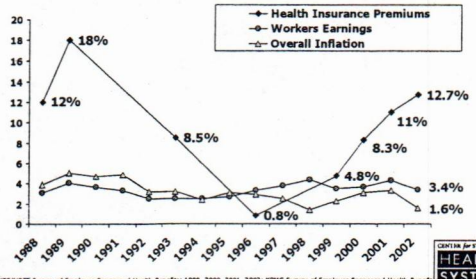
Trenton, NJ

for Rutgers and the NJ D of B&I

Goals of insurance market reform

- Make health insurance premiums more stable
- Make health insurance more affordable for the sick
- Make health insurance markets stable and sustainable in the long run

Increases in Health Insurance Premiums Compared to Other Indicators, 1988-2002



Source: KFF/HRET Survey of Employer-Sponsored Health Benefits: 1999, 2000, 2001, 2002; KPMG Survey of Employer-Sponsored Health Benefits

Note: Data on premium increases reflect the cost of health insurance premiums for a family of four.

Premium variance, by firm size, 1996-97

Firm size	percent of workers in firms where premiums changed			
	10%	-10 to +10%	10%+	avg.
All	8	78	14	1.9%
Fewer than 10	9	68	23	2.6
10-49 workers	7	75	18	2.2
50-499	7	77	16	2.0
500+	8	81	11	1.6

Source: Long and Marquis, *Health Affairs*, Nov./Dec. 1999.

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FACTS ABOUT SMALL FIRM PREMIUM INCREASES

- More likely to have large premium increases
- Variance among small groups greater than variance among large groups => return to selection/underwriting greater in small group market, greatest in individual market
- Transaction costs limit extent of underwriting

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Is there an "Optimal" set of insurance market reforms?

- Tradeoffs require value judgments
  - Healthy vs. sick
  - stability vs. coverage [$P = \alpha EXP_i + (1-\alpha)EXP_{GROUP}$]
- Evidence
  - Nongroup reforms reduced coverage
  - Small group reforms did not affect coverage
  - Risk pools?
- Enforcement?
- Best guess/second best…

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Best guess/second best insurance market reforms

- Limits on pre-existing condition exclusions and guaranteed renewal
- Guaranteed issue
  - Some products vs. all products
- Rating restrictions
  - Loose rate bands vs. pure community
- Small group NOT = nongroup
  - Tradeoffs more stark
- Second best may depend on other policies
  - GI in lieu of high risk pool
- My suggestions: small group = Limits + GR, GI + loose bands; nongroup = GR

Proposed "solutions" to enduring small group and individual market problems

- Exemption from benefit mandates
- Repeal small group reforms
- Association health plans
- Repeal ERISA
- Income-based subsidies (for non-group)
- Expand high risk pools
- Reinsurance
- Explicit subsidies for higher risk *and* low income

Fundamental problem: Cost

- Cost growth is driven by technology, and *enabled* by financing and delivery systems
- Health insurance is increasingly unaffordable: level exacerbates risk pooling difficulties
  - Absolute amount of cross-subsidies growing over time
  - "Quantitative change leads to qualitative change"
- Ready for Brave New World?
  - We may be able to afford nothing else…

What if we shared risk more broadly?

- Give up on making companies pursue social goals
- Basic idea: subsidize excess risk *and* low income
- Suppose no person or group had to pay more than what the community rate would be, but low risk persons and groups are not forced to pay the community rate, i.e., those who can and are willing are allowed to buy at actuarially fair rates?
- This could lead to more efficient pricing and more efficient subsidies as well

Forced Risk pooling ...

- Gets all prices wrong
  - Leads healthy to buy too little, if at all
  - Leads high risk to buy too much, if they can find it
- Excess risk subsidy approach gets low risk prices (majority) right

Excess risk subsidy...

- Is better than reinsurance because:
  - It's much easier to predict expense > average than being in top 1% or top 3%
  - Spreads risk much broader than insurance industry/premiums
    - Lower tax rates, less distortion
    - Decision on degree of subsidy = social/political choice, not technical artifact of accuracy of top 1% or top 3% predictions
  - Reinsurance and risk adjustment can never end strong incentives to select healthy enrollees

Why did we pass market reforms in the first place?

- We were NOT willing to pay for explicit subsides
- Policy makers used the levers they had
  - GI + CR = implicit taxes
- Implicit taxes were largely hidden, plus the nominal burden is on "insurance companies"

Are we willing to use explicit taxes and transfers now?

- Probably not
- On the other hand, is small group and individual market performance a whole lot better than pre-reform?
- Most proposed solutions would worsen risk segmentation
  - Do currently low risk fear this?
  - Does a critical mass fear this?

Practical Problems with excess risk subsidy

- Determining hypothetical community rate
- Creating mechanism for buying at no higher than HCR
- Providing subsidy without exacerbating moral hazard problem

General suggestions for insurance market reform and policy analysis research

- Distinguish between insurable and uninsurable risk
  - Move as much uninsurable out of commercial insurance as possible, into social policy
- Recognize underwriting as reality, use it to accomplish social goals
  - Leave it alone for healthy => lower average premiums
  - Use it to determine subsidy level and structure for higher risk

CENTER for STUDYING HEALTH SYSTEM CHANGE

Insurance Market Reform: When, How and Why?

Katherine Swartz, Ph.D.
Harvard School of Public Health

Trenton, New Jersey
April 10, 2003

Outline of Presentation

- When markets fail – circumstances under which state intervention should occur
- How states can create effective reforms
- Why reforms are good policy

When Markets Fail

- Market Power
- Asymmetric Information

Why Are People Uninsured?

- Affordability – especially if employers do not sponsor health insurance
- Form of competition in nongroup insurance markets

Competition in Nongroup Markets

- Asymmetric information causes carriers to fear adverse selection
- Competition is in terms of how best to avoid risk or to charge higher premiums for expected risk

Selection Mechanisms

- Medical underwriting
- Refusal to issue a policy
- Exclusion of coverage for pre-existing medical conditions
- Many policies with different covered benefits

What's Needed?

- Level the playing field of competition
- Compensate carriers for costs of extremely-high-cost persons
- Shift burden of costs of extremely-high-cost persons to broad population base

Lessons Learned

- Apply all regulations – not just one or two
- Involve private policymakers

Why?

- Keep people in the private sector
- Nongroup insurance is a "bridge" for people in short uninsured spells
- Product for people without access to employer-group coverage

Summary

- Regulatory reforms are good if they help the market be competitive
- Biggest problem is fear of adverse selection
- Need for spreading burden of costs of very-high-cost people to broader population base

New Jersey Individual Health Coverage Program Board

SINGLE	Plan A/50				Plan B		Plan C		Plan D		HMO Plans				Std Plan	Plan Type
	$1,000 Deduct	$2,500 Deduct	$5,000 Deduct	$10,000 Deduct	$1,000 Deduct	$2,500 Deduct	$1,000 Deduct	$2,500 Deduct	$500 Deduct	$1,000 Deduct	$10 Copay	$15 Copay	$20 Copay	$30 Copay	Rate Guar.	Basic and Essential
Aetna Life Insurance Company	625.00	514.00			735.00	636.00	835.00	718.00	2,131.00	1,561.00	-	-	-	-	12 mos	Ind/A-G-L
Aetna Health Inc.	-	-	-	-	-	-	-	-	-	-	649.50	532.00	442.10	387.70	12 mos	
AmeriHealth HMO, Inc.	-	-	-	-	-	-	-	-	-	-	814.00	580.00	438.00	354.00	none	HMO/A-G
Celtic Insurance Company	873.60	777.00	-	-	1,090.60	975.80	3,155.60	2,395.40	6,711.60	4,298.00	-	-	-	-	3 mos	Ind/A-G
CIGNA HealthCare	-	-	-	-	-	-	-	-	-	-	656.48	615.26	550.66	-	none	HMO-A
Fortis Insurance Company	1,034.00	853.00	-	-	1,870.00	1,564.00	2,580.00	2,193.00	8,127.00	3,719.00	-	-	-	-	3 mos	-
Fortis Insurance Company (PPO**)	-	-	-	-	-	-	-	-	6,499.00	2,975.00	-	-	-	-	3 mos	-
Guardian	664.00	555.00	-	-	755.00	634.00	912.00	748.00	2,079.00	1,387.00	-	-	-	-	none	Ind/A-G
Guardian PPO North (except Hunterdon)**	-	-	-	-	781.00	656.00	909.00	878.00	2,116.00	1,511.00	-	-	-	-	none	-
Guardian PPO South (except Salem)**	-	-	-	-	757.00	635.00	880.00	851.00	2,049.00	1,463.00	-	-	-	-	none	-
Health Net of NJ (formerly PHS)	-	-	-	-	-	-	-	-	-	-	524.28	512.74	498.06	-	none	HMO/A-G
Horizon Blue Cross Blue Shield of NJ	569.25	489.67	307.87	198.54	621.41	529.50	871.92	538.81	1,732.91	1,208.07	-	-	-	-	12 mos	Ind/CR
Horizon HealthCare of NJ HMO Blue	-	-	-	-	-	-	-	-	-	-	489.94	467.46	-	388.99	12 mos	-
National Health Insurance Company	596.00	489.00	-	-	704.00	591.00	940.00	770.00	2,158.00	1,304.00	-	-	-	-	none	-
Oxford Health Insurance Company	462.05	380.92	315.12	272.64	684.76	563.06	860.61	652.57	1,228.66	1,017.39	-	-	-	-	12 mos	EPO/CR
Oxford Health Insurance Company (PPO**)	-	-	-	-	-	-	409.82	332.67	-	456.17	-	-	-	-	12 mos	-
Oxford Health Plans	-	-	-	-	-	-		-	-		-	496.88	443.22	381.88	12 mos	-
Trustmark Insurance w/o optional ABMT	2,047.50	1,755.00	-	-	2,340.00	2,047.50	2,925.00	2,340.00	7,020.00	4,680.00	-	-	-	-	none	Ind/CR
Trustmark Insurance w/optional ABMT	2,149.88	1,842.75	-	-	2,457.00	2,149.88	3,071.25	2,457.00	7,371.00	4,914.00	-	-	-	-	none	-
United Health Care Insurance Company	641.94	506.26	-	-	823.41	675.86	848.00	712.32	1,801.15	1,073.57	-	-	-	-	none	-
United Health Care Plan	-	-	-	-	-	-	-	-	-	-	-	545.16	-	419.77	12 mos	HMO/CR

The above rates are monthly premiums. Each carrier listed has filed its rates with the IHC Board and certified that its rates conform with applicable laws and regulations.

These rates are in effect for new business and renewals which occur during the month shown at the bottom of this page. Contact the carriers or your agent for rates for subsequent months.

Listed under the "Plan Type Basic and Essential" heading is general information regarding the plan offered by each carrier that is making a basic and essential health care services plan available as of March 2003. The plans are not standard plans. "Ind" means the plan is issued as an indemnity plan, "HMO" means the plan is issued as a health maintenance organization plan and "EPO" means the plan is issued as an exclusive provider organization plan.

The letters that follow the plan type indicate the rating used for the plan. "A" means the carrier's rates are based on age. "G" means the carrier's rates are based on gender.

"L" means the carrier's rates are based on geographc location. "CR" means the rates are community rated. Contact the carriers for more information.

**The PPO plan rates shown are listed according to the out-of-network benefit level. Contact the carriers for details on the plan design for the available PPO products.

A PPO plan listed under Plan C, for example, means that the out-of-network coinsurance is based on Plan C (70%/30% coinsurance).

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This information may also be found on our web site at www.nj.gov/dobi/reform.htm

April 2003

04/03/200310:30 AM

New Jersey Individual Health Coverage Program Board

ADULT & CHILD	Plan A/50				Plan B		Plan C		Plan D		HMO Plans				Std Plan	Plan Type
	$1,000 Deduct	$2,500 Deduct	$5,000 Deduct	$10,000 Deduct	$1,000 Deduct	$2,500 Deduct	$1,000 Deduct	$2,500 Deduct	$500 Deduct	$1,000 Deduct	$10 Copay	$15 Copay	$20 Copay	$30 Copay	Rate Guar.	Basic and Essential
Aetna Life Insurance Company	1,080.00	885.00			1,262.00	1,076.00	1,422.00	1,221.00	3,719.00	2,695.00	-	-	-	-	12 mos	Ind/A-G-L
Aetna Health Inc.	-	-	-	-	-	-	-	-	-	-	1,170.30	958.60	796.60	698.70	12 mos	
AmeriHealth HMO, Inc.	-	-	-	-	-	-	-	-	-	-	1,482.00	1,056.00	797.00	644.00	none	HMO/A-G
Celtic Insurance Company	1,528.80	1,360.80	-	-	1,909.60	1,708.00	5,523.00	4,191.60	11,746.00	7,520.80	-	-	-	-	3 mos	Ind/A-G
CIGNA HealthCare	-	-	-	-	-	-	-	-	-	-	1,183.77	1,109.43	992.94	-	none	HMO-A
Fortis Insurance Company	1,561.00	1,303.00	-	-	2,580.00	2,161.00	3,733.00	3,175.00	11,657.00	5,402.00	-	-	-	-	3 mos	-
Fortis Insurance Company (PPO**)	-	-	-	-	-	-	-	-	9,325.00	4,325.00	-	-	-	-	3 mos	-
Guardian	1,183.00	988.00	-	-	1,346.00	1,129.00	1,624.00	1,336.00	3,689.00	2,470.00	-	-	-	-	none	Ind/A-G
Guardian PPO North (except Hunterdon)**	-	-	-	-	1,413.00	1,186.00	1,644.00	1,589.00	3,827.00	2,733.00	-	-	-	-	none	-
Guardian PPO South (except Salem)**	-	-	-	-	1,369.00	1,149.00	1,592.00	1,539.00	3,707.00	2,647.00	-	-	-	-	none	-
Health Net of NJ (formerly PHS)	-	-	-	-	-	-	-	-	-	-	891.37	871.76	846.80	-	none	HMO/A-G
Horizon Blue Cross Blue Shield of NJ	1,008.65	867.71	545.52	351.80	1,101.15	938.18	1,547.06	956.08	3,191.12	2,143.73	-	-	-	-	12 mos	Ind/CR
Horizon HealthCare of NJ HMO Blue	-	-	-	-	-	-	-	-	-	-	751.50	717.05	-	596.68	12 mos	-
National Health Insurance Company	1,036.00	851.00	-	-	1,224.00	1,028.00	1,636.00	1,336.00	3,749.00	2,266.00	-	-	-	-	none	-
Oxford Health Insurance Company	854.79	704.70	582.97	504.38	1,266.81	1,041.66	1,592.13	1,207.25	2,273.02	1,882.17	-	-	-	-	12 mos	EPO/CR
Oxford Health Insurance Company (PPO**)	-	-	-	-	-	-	758.17	615.44	-	843.91	-	-	-	-	12 mos	-
Oxford Health Plans	-	-	-	-	-	-	-	-	-	-	-	944.07	842.12	725.57	12 mos	-
Trustmark Insurance w/o optional ABMT	4,095.00	3,510.00	-	-	3,510.00	3,071.25	4,387.50	3,510.00	10,530.00	7,020.00	-	-	-	-	none	Ind/CR
Trustmark Insurance w/optional ABMT	4,299.75	3,685.50	-	-	3,685.50	3,224.81	4,606.88	3,685.50	11,056.50	7,371.00	-	-	-	-	none	-
United Health Care Ins. Co	1,258.20	992.27	-	-	1,613.88	1,324.69	1,662.08	1,396.15	3,530.25	2,104.20	-	-	-	-	none	-
United Health Care Plan	-	-	-	-	-	-	-	-	-	-	-	1,068.52		822.75	12 mos	HMO/CR

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Aetna Life Insurance Company	1,250.00	1,028.00			1,470.00	1,244.00	1,669.00	1,430.00	4,267.00	3,132.00	-	-	-	-	12 mos	Ind/A-G-L
Aetna Health Inc.	-	-	-	-	-	-		-	-		1,299.00	1,064.00	884.20	775.50	12 mos	
AmeriHealth HMO, Inc.	-	-	-	-	-	-	-	-	-	-	1,628.00	1,160.00	876.00	708.00	none	HMO/A-G
Celtic Insurance Company	2,037.00	1,811.60	-	-	2,542.40	2,275.00	7,354.20	5,580.40	15,639.40	10,012.80	-	-	-	-	3 mos	Ind/A-G
CIGNA HealthCare	-	-	-	-	-	-	-	-	-	-	1,265.50	1,186.03	1,061.50	-	none	HMO-A
Fortis Insurance Company	2,070.00	1,706.00	-	-	3,738.00	3,127.00	5,160.00	4,386.00	16,254.00	7,440.00	-	-	-	-	3 mos	-
Fortis Insurance Company (PPO**)	-	-	-	-	-	-	-	-	13,000.00	5,949.00	-	-	-	-	3 mos	-
Guardian	1,325.00	1,107.00	-	-	1,507.00	1,264.00	1,819.00	1,496.00	4,130.00	2,766.00	-	-	-	-	none	Ind/A-G
Guardian PPO North (except Hunterdon)**	-	-	-	-	1,584.00	1,329.00	1,843.00	1,781.00	4,291.00	3,064.00	-	-	-	-	none	-
Guardian PPO South (except Salem)**	-	-	-	-	1,535.00	1,288.00	1,785.00	1,725.00	4,156.00	2,968.00	-	-	-	-	none	-
Health Net of NJ (formerly PHS)	-	-	-	-	-	-	-	-	-	-	943.61	922.85	896.43	-	none	HMO/A-G
Horizon Blue Cross Blue Shield of NJ	1,369.99	1,178.58	740.96	477.84	1,495.68	1,274.32	2,079.08	1,284.91	4,288.47	2,880.96	-	-	-	-	12 mos	Ind/CR
Horizon HealthCare of NJ HMO Blue	-	-	-	-	-	-	-	-	-	-	1,047.77	999.77		831.93	12 mos	-
National Health Insurance Company	1,213.00	996.00	-	-	1,433.00	1,203.00	1,915.00	1,565.00	4,389.00	2,654.00	-	-	-	-	none	-
Oxford Health Insurance Company	924.10	761.84	630.24	545.28	1,369.52	1,126.12	1,721.22	1,305.14	2,457.32	2,034.78	-	-	-	-	12 mos	EPO/CR
Oxford Health Insurance Company (PPO**)	-	-	-	-	-	-	819.64	665.34	-	912.34	-	-	-	-	12 mos	-
Oxford Health Plans	-	-	-	-	-	-	-	-	-	-	-	993.76	886.44	763.76	12 mos	-
Trustmark Insurance w/o optional ABMT	6,142.50	5,265.00	-	-	4,680.00	4,095.00	5,850.00	4,680.00	14,040.00	9,360.00	-	-	-	-	none	Ind/CR
Trustmark Insurance w/optional ABMT	6,449.63	5,528.25	-	-	4,914.00	4,299.75	6,142.50	4,914.00	14,742.00	9,828.00	-	-	-	-	none	-
United Health Care Ins. Co	1,283.88	1,012.52	-	-	1,646.82	1,351.72	1,696.00	1,424.64	3,602.30	2,147.14	-	-	-	-	none	-
United Health Care Plan	-	-	-	-	-	-	-	-	-	-	-	1,090.33	-	839.55	12 mos	HMO/CR

These rates are in effect for new business and renewals which occur during the month shown at the bottom of this page. Contact the carriers or your agent for rates for subsequent months.

Listed under the "Plan Type Basic and Essential" heading is general information regarding the plan offered by each carrier that is making a basic and essential health care services plan available as of March 2003. The plans are not standard plans. "Ind" means the plan is issued as an indemnity plan, "HMO" means the plan is issued as a health maintenance organization plan and "EPO" means the plan is issued as an exclusive provider organization plan.

The letters that follow the plan type indicate the rating used for the plan. "A" means the carrier's rates are based on age. "G" means the carrier's rates are based on gender.

"L" means the carrier's rates are based on geographc location. "CR" means the rates are community rated. Contact the carriers for more information.

**The PPO plan rates shown are listed according to the out-of-network benefit level. Contact the carriers for details on the plan design for the available PPO products.

A PPO plan listed under Plan C, for example, means that the out-of-network coinsurance is based on Plan C (70%/30% coinsurance).

For a free Buyer's Guide, call 1-800-838-0935

This information may also be found on our web site at www.nj.gov/dobi/reform.htm

New Jersey Individual Health Coverage Program Board

FAMILY	Plan A/50				Plan B		Plan C		Plan D		HMO Plans				Rate Guar.	Plan Type Basic and Essential
	$1,000 Deduct	$2,500 Deduct	$5,000 Deduct	$10,000 Deduct	$1,000 Deduct	$2,500 Deduct	$1,000 Deduct	$2,500 Deduct	$500 Deduct	$1,000 Deduct	$10 Copay	$15 Copay	$20 Copay	$30 Copay		
Aetna Life Insurance Company	1,705.00	1,399.00			1,997.00	1,684.00	2,256.00	1,933.00	5,855.00	4,266.00		-	-	-	12 mos	Ind/A-G-L
Aetna Health Inc.	-	-	-	-	-	-	-	-	-	-	1,941.40	1,590.20	1,321.50	1,159.00	12 mos	
AmeriHealth HMO, Inc.	-	-	-	-	-	-	-	-	-	-	2,296.00	1,636.00	1,235.00	998.00	none	HMO/A-G
Celtic Insurance Company	2,045.40	1,818.60	-	-	2,552.20	2,284.80	7,386.40	5,604.20	15,705.20	10,056.20	-	-	-	-	3 mos	Ind/A-G
CIGNA HealthCare	-	-	-	-	-	-	-	-	-	-	1,827.12	1,712.39	1,532.59	-	none	HMO-A
Fortis Insurance Company	2,180.00	1,849.00	-	-	3,980.00	3,338.00	5,671.00	4,823.00	17,356.00	7,992.00	-	-	-	-	3 mos	-
Fortis Insurance Company (PPO**)			-	-					13,884.00	6,394.00						-
Guardian	1,758.00	1,469.00	-	-	2,000.00	1,678.00	2,413.00	1,988.00	5,473.00	3,671.00				-	none	Ind/A-G
Guardian PPO North (except Hunterdon)**	-	-	-	-	2,113.00	1,773.00	2,458.00	2,375.00	5,722.00	4,086.00	-	-	-	-	none	-
Guardian PPO South (except Salem)**	-	-	-	-	2,046.00	1,717.00	2,381.00	2,300.00	5,542.00	3,958.00	-	-	-	-	none	-
Health Net of NJ (formerly PHS)	-	-	-	-	-	-	-	-	-	-	1,258.46	1,230.77	1,195.53		none	HMO/A-G
Horizon Blue Cross Blue Shield of NJ	1,438.56	1,237.50	778.03	501.75	1,570.45	1,338.03	2,183.00	1,349.07	4,502.97	3,024.99	-	-	-	-	12 mos	Ind/CR
Horizon HealthCare of NJ HMO Blue	-	-	-	-	-	-	-	-	-	-	1,483.73	1,415.75	-	1,178.09	12 mos	-
National Health Insurance Company	1,570.00	1,290.00	-	-	1,855.00	1,556.00	2,480.00	2,026.00	5,683.00	3,436.00	-	-	-	-	none	-
Oxford Health Insurance Company	1,316.84	1,085.62	898.09	777.02	1,951.57	1,604.72	2,452.74	1,859.82	3,501.68	2,899.56	-	-	-	-	12 mos	EPO/CR
Oxford Health Insurance Company (PPO**)	-	-	-	-	-	-	1,167.99	948.11	-	1,300.08	-	-	-	-	12 mos	-
Oxford Health Plans	-	-	-	-	-	-	-	-	-	-	-	1,490.64	1,329.66	1,145.64	12 mos	-
Trustmark Insurance w/o optional ABMT	8,190.00	7,020.00	-	-	5,850.00	5,118.75	7,312.50	5,850.00	17,550.00	11,700.00	-	-	-	-	none	Ind/CR
Trustmark Insurance w/optional ABMT	8,599.50	7,371.00	-	-	6,142.50	5,374.69	7,678.13	6,142.50	18,427.50	12,285.00	-	-	-	-	none	-
United Health Care Ins. Co	1,900.14	1,498.53	-	-	2,437.29	2,000.55	2,510.08	2,108.47	5,331.40	3,177.77	-	-	-	-	none	-
United Health Care Plan	-	-	-	-	-	-	-	-	-	-	-	1,613.69	-	1,242.53	12 mos	HMO/CR

These rates are in effect for new business and renewals which occur during the month shown at the bottom of this page. Contact the carriers or your agent for rates for subsequent months.

Listed under the "Plan Type Basic and Essential" heading is general information regarding the plan offered by each carrier that is making a basic and essential health care services plan available as of March 2003. The plans are not standard plans. "Ind" means the plan is issued as an indemnity plan, "HMO" means the plan is issued as a health maintenance organization plan and "EPO" means the plan is issued as an exclusive provider organization plan. The letters that follow the plan type indicate the rating used for the plan. "A" means the carrier's rates are based on age. "G" means the carrier's rates are based on gender. "L" means the carrier's rates are based on geographc location. "CR" means the rates are community rated. Contact the carriers for more information.

**The PPO plan rates shown are listed according to the out-of-network benefit level. Contact the carriers for details on the plan design for the available PPO products. A PPO plan listed under Plan C, for example, means that the out-of-network coinsurance is based on Plan C (70%/30% coinsurance).

For a free Buyer's Guide, call 1-800-838-0935

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New Jersey Individual Health Coverage Program

High Deductible Plan Options

Available through: Horizon Blue Cross Blue Shield of NJ

	Plan C				Plan D				Rate
	$1500[1] Deductible	$1700[2,3] Deduct	$2250[1] Deductible	$2500[2,3] Deduct	$1500[1] Deductible	$1700[2,3] Deduct	$2250[1] Deductible	$2500[2,3] Deduct	Guarantee
Single Coverage	629.04	610.79	602.48	585.56	868.66	845.15	822.72	801.12	12 mos

	Plan C				Plan D				Rate
Other Than Single Coverage	$3000[1] Deductible	$3350[2,4] Deduct	$4500[1] Deductible	$5050[2,4] Deduct	$3000[1] Deductible	$3350[2,4] Deduct	$4500[1] Deductible	$5050[2,4] Deduct	Guarantee
Adult & Child Coverage	986.61	951.75	902.31	864.68	1,362.65	1,319.43	1,232.18	1,184.23	12 mos
Husband & Wife Coverage	1,325.98	1,279.04	1,212.67	1,162.11	1,831.24	1,773.19	1,655.88	1591.48	12 mos
Family Coverage	1,392.21	1,343.07	1,273.22	1,220.15	1,922.85	1,861.89	1,738.71	1671.05	12 mos

The above rates are monthly rates and are in effect for new business and renewals which occur during the month shown at the bottom of this page.

Contact the carriers or your agent for rates for subsequent months.

Each carrier listed has filed its rates with the IHC Board and certified that its rates conform with applicable laws and regulations.

Deductibles (and out-of-pocket maximums) are subject to change each calendar year to reflect the IRS inflation-adjusted indexed amount.

[1] These deductibles are still available, however they no longer qualify as High Deductible Plans that may be used in conjunction with an MSA.

[2] These deductibles are valid through December 31, 2003 as High Deductible Plans that may be purchased in conjunction with an MSA.

[3] The out-of-pocket maximum for this plan is $3,350

[4] The out-of-pocket maximum for these plans is $6,150

(The deductible and out-of-pocket maximum amounts shown above update the information found on page 21 of the IHC Buyer's Guide).

For a free Buyer's Guide, call 1-800-838-0935

This information may also be found on our web site at http://www.NJDOBI.org

April 2003

Revised 04/03/2003

Carrier List

Carrier Name	Street Address	City, State, Zip	Phone Number
Aetna Life Ins. Co.	1 Farr View	Cranbury, NJ 08512	800-234-8454 x3120
Aetna Health Inc.	1 Farr View	Cranbury, NJ 08512	800-234-8454 x3120
AmeriHealth HMO, Inc.	8000 Midlantic Drive	Mt. Laurel, NJ 08054	800-454-7651
Celtic Life Ins. Co.	233 So Wacker Drive	Chicago, Illinois 60606	800-545-6441
CIGNA HealthCare of NJ, Inc.	900 Cottage Grove Road	Hartford, CT 06152	800-462-6633
Fortis Ins. Co.	501 West Michigan, PO Box 3050	Milwaukee, WI 53201-3050	800-800-1212 x3980
Guardian Life Ins. Co. of America	3900 Burgess Place	Bethlehem, PA 18017	888-243-6586
Health Net of NJ (formerly PHS)	3501State Highway 66	Neptune, NJ 07754	800-669-3611
Horizon Blue Cross Blue Shield of NJ	Three Penn Plaza East - PP09T	Newark, NJ 07105-2200	800-682-7694
Horizon Healthcare of NJ	Three Penn Plaza East - PP09T	Newark, NJ 07105-2200	800-682-7694
National Health Ins. Co.	1901 N. Highway 360	Grand Prairie, TX 75050	800-237-1900 x500
Oxford Health Ins.	PO Box 7081	Bridgeport, CT 06601-7081	800-216-0778 Opt 3
Oxford Health Plans of NJ, Inc.	PO Box 7081	Bridgeport, CT 06601-7081	800-216-0778 Opt 3
Trustmark Ins. Co.	400 Field Drive	Lake Forest, Illinois 60045	800-366-6663
United HealthCare Insurance Company	Att: Individual Enrollment / 2 Penn Plaza, 7th Fl	New York, NY 10121	866-223-5802
UnitedHealthcare of New Jersey, Inc. (HMO)	Att: Individual Enrollment / One Park Place	Albany, NY 12205	866-223-5802

2003 Small Employer Health Benefits Premium Comparison Survey

INTRODUCTION

To assist small employers in shopping for health insurance coverage, the New Jersey Department of Banking and Insurance ("Department") has published this annual premium comparison survey for 2003.

ABOUT THIS PREMIUM SURVEY

Each carrier shown on the attached pages has responded to the survey with the rates it would charge a sample small employer for group coverage for one month. The premiums for each plan are effective January 1, 2003 and are listed for comparison purposes only. Premiums are subject to change throughout the year and may vary among small employers, but only according to the age, gender, and family status of the employees in the group, and the location of the business in New Jersey. As a result, the charts will not provide an employer with an accurate premium for its group, but merely demonstrate the relative pricing among carriers in the market for the sample group. A carrier that provides the lowest rate for the sample group for a particular benefit will not necessarily provide the lowest rate for a group whose employees have different age, gender, or family status characteristics than the sample group.

The sample premiums have been compiled for businesses located in Bergen, Camden, and Middlesex counties. Carriers' relative pricing positions may shift, depending on the location of your business. No premium information is available for businesses located in the other counties. The monthly premiums listed on the attached sheets are based on a small employer with six employees and their dependents, as described below:

- Single female employee age 27; single male employee age 37; female employee age 47, with two children; male employee and spouse, both age 57; male employee age 27, with spouse age 24, and two children; and, female employee age 47, with spouse age 50, and two children.

PLAN OPTIONS

All insurance carriers (other than HMOs) are required to offer five standardized contracts labeled A through E. Plan A is the most basic plan, covering primarily hospitalization. Plans B through E are comprehensive medical plans and cover the same medical and hospital charges, but differ in how much the covered person pays toward these charges. Plan B has 60% coinsurance, Plan C has 70% coinsurance, Plan D has 80% coinsurance, and Plan E has 90% coinsurance.

HMOs are required to offer a standard HMO contract. For a full description of the standard plans, please refer to the New Jersey Small Employer Health Benefits Plans Buyer's Guide.

While all carriers are required to offer the standard health benefits plans, carriers are allowed to be flexible in the structure of these plans, especially for plans with network and non-network benefits such as PPO and POS plans. For such plans, the network and non-network benefits in the same standard plan may be very different. For example, in a Plan D PPO, either the network or the non-network coinsurance percentage must be 80%. Thus, some of the benefit designs that could be identified as Plan D PPO include:

Network Coinsurance*	Non-Network Coinsurance
100%	**80%**
90%	**80%**
80%	70%
80%	60%

*The network coverage may or may not include copayments for specific services.

UNDERSTANDING RATES

The Department and the Small Employer Health Benefits Program ("SEH") Board do not set or approve rates. Carriers are required to file rates with the Department prior to using those rates. The law permits carriers to consider only three factors (other than plan of benefits, issue date, and family status) in determining the rates for a small employer group:

- the age of the employees
- the gender of the employees, and
- the location of the business in New Jersey

Carriers may not consider the health status or past claims experience of a group in determining premiums. The law requires carriers to limit variation in cost to a two to one ratio. Thus, rates for the highest cost group (based on age, gender, and geography) may not be more than two times the rate for the lowest cost group of the same size.

Carriers may base rates on the characteristics of all the employees in the company or of the employees that are actually enrolling in the plan.

RATE CHANGES

Generally, at renewal, if an employer's rate changes, it is for one or more of the following reasons:

- a change in the age/gender composition of the group
- a change in the location of the business
- a change in the factors that the carrier uses to reflect age, gender, and location
- a change in the carrier's rate for the plan of benefits
- a change in plan of benefits offered by the employer

SHOPPING FOR COVERAGE IN THE SMALL EMPLOYER MARKET

Carriers in the small employer market are required to issue coverage to eligible small employers who meet the participation and employer contribution requirements. An eligible small employer has from 2 to 50 employees who work at least 25 hours per week.

Carriers will require small employers to meet a 75% minimum participation requirement, which means generally that 75% or more of the full-time employees must participate in the employer's plan in order for the employer to be eligible for coverage. Credit for participation is given for employees that do not take coverage but are covered under some other type of insurance coverage.

A small employer is required to pay at least 10% of the overall premium for the entire group. However, the employer may elect to contribute more.

To obtain a price quote from a carrier, contact the carrier or an authorized insurance producer. Carriers and authorized producers are required to provide a price quote to a small employer within 10 working days of receiving a request for a quote and the information that is necessary to provide the quote.

In addition to cost, an employer may want to consider the financial strength of the carrier; its reputation for service; and for HMO, POS, and PPO plans, the carrier's network of providers in making a decision about coverage.

The attached list of carriers have made the filings necessary to offer small group coverage. Purchasing coverage from these carriers helps protect against insurance scams.

For more information about small employer health benefits plans, call 800-263-5912 to request a free copy of the New Jersey Small Employer Health Benefits Plans Buyer's Guide. The Guide outlines the key features of reforms in the law, the variety of standardized plans available, and answers commonly asked questions. The Guide and other information is available online on the Department of Banking and Insurance web site at: www.nj.gov/dobi/reform.htm. You may also contact an insurance agent or carrier for information.

2003 Small Employer Health Benefits Program - List of Carriers

Effective January 1, 2003		
	Carrier	**Phone #**
1	Aetna Health Inc.	1-800-338-8742
2	Aetna Life Insurance Company	1-800-852-0629
3	AmeriHealth HMO, Inc.	1-800-454-7651
4	AmeriHealth Insurance Company of New Jersey	1-800-454-7651
5	CIGNA Healthcare of New Jersey, Inc.	1-800-462-6633, press 3, then ext. 37856
6	Guardian Life Insurance Company of America	1-800-356-5808
7	Health Net	1-800-669-3611
8	Horizon Healthcare of New Jersey, Inc.	1-800-784-6222
9	Horizon Healthcare Services, Inc. (Horizon BCBS of NJ)	1-800-784-6222
10	Metropolitan Life Insurance Company	1-800-237-4878
11	New England Life Insurance Company	1-800-237-4878
12	Nippon Life Insurance Company of America	1-800-438-8480
13	Oxford Health Insurance, Inc.	1-800-449-8880
14	Oxford Health Plans of New Jersey, Inc.	1-800-449-8880
15	Trustmark Insurance Company	1-800-492-2234
16	United HealthCare Insurance Company, Inc.	1-973-244-8049
17	United HealthCare of New Jersey, Inc.	1-973-244-8049
18	University Health Plans, Inc.	1-888-TRY-UHP1
19	WellChoice HMO of NJ	1-888-476-8069
20	WellChoice Insurance of NJ	1-888-476-8069

Additional information may be found on our web site:
http://www.NJDOBI.org

Indemnity Carriers
Bergen County

New Jersey Small Employer Health Benefits Program
Premium Rate Comparison Survey

2003

CARRIERS	Plan A	Plan B				Plan C					Plan D				Plan E		Rate
	$250	Copay	$250	$500	$1,000	Copay	$250	$500	$1,000	$2,500	Copay	$250	$500	$1,000	Copay	$150	Guarantee
Aetna Life Insurance Company	$4,165	n/a	$7,201	$6,697	$6,135	$10	$5,110 (1)	$5,076 (1)	$5,042 (1)	n/a	$10	$5,186 (1)	$5,108 (1)	$5,072 (1)	n/a	$8,659	12 months
AmeriHealth Insurance Company of New Jersey	$3,209	n/a	$6,041	$5,722	$5,228	$30	n/a	n/a	$3,754 (2)	$3,537 (2)	$20	$4,740 (2)	$4,626 (2)	$4,275 (2)	n/a	$7,612	12 months
Guardian Life Insurance Company of America	$5,989	n/a	$6,846 (2)	$6,530(2)	$6,475 (2)	$10	$8,313 (2)	$7,939 (2)	$7,892 (2)	n/a	$10	$9,415 (2)	$9,006 (2)	$8,863 (2)	$10	$8,864 (2)	None
Horizon Blue Cross Blue Shield of New Jersey	$2,737	n/a	$3,516 (2)	$3,351 (2)	$2,952 (2)	n/a	$3,466 (1)	$3,271 (1)	$2,962 (1)	n/a	$10	$4,193 (1)	$3,701 (1)	$3,394 (1)	n/a	$6,572	1 month
New England Life Insurance Company	$34,010	n/a	$55,717	$48,276	$41,816	$10	$42,236 (2)	$37,094 (2)	$31,220 (2)	n/a	$10	$31,483 (2)	$34,180 (2)	$29,128 (2)	$10	$44,328 (2)	None
Nippon Life Insurance Company of America	$3,808	n/a	$3,885	$3,722	$3,478	n/a	$4,267	$4,060	$3,737	n/a	n/a	$4,611	$4,374	$4,013	n/a	$5,201	12 months
Oxford Health Insurance	$3,606	n/a	$5,367	$5,006	$4,347	$20	$3,988 (1)	$3,666 (1)	$3,570 (1)	n/a	$20	$4,142 (1)	$3,771 (1)	$3,609 (1)	$10	$5,262 (1)	12 months
Trustmark Insurance Company	$5,766	n/a	$6,001 (2)	$5,233 (2)	$4,519 (2)	n/a	$7,238 (2)	$6,675 (2)	$5,565 (2)	n/a	n/a	$8,181 (2)	$7,365 (2)	$6,826 (2)	n/a	$9,441	None
United HealthCare Insurance Company	$3,278	n/a	$6,224	$5,172	$4,456	Varies*	$4,067 (2)	$3,801 (2)	$3,779 (2)	n/a	n/a	$3,149 (2)	$2,681 (2)	$2,359 (2)	n/a	$9,259	30 days
WellChoice Insurance of NJ	$3,038	n/a	$5,996	$5,567	$4,829	$30	$4,827 (2)	$4,639 (2)	$4,413 (2)	$4,161 (2)	n/a	$7,298	$6,714	$5,735	n/a	$8,170	12 months

Note: Rates shown are monthly premiums for the sample group described on the attached page.

Note: Plans A-E may be issued as indemnity, PPO, or POS plans. POS and PPO plans may have different copayment and coinsurance options. Consult the carriers for the available options.

(1) Rates shown are for a POS Plan.

(2) Rates shown are for a PPO Plan.

* $250 deductibe plan has $10 copay; $500 deductible plan has $15 copay; $1,000 deductible plan has $20 copay

New Jersey Small Employer Health Benefits Program
Premium Rate Comparison Survey

CARRIERS	HMO Plans					HMO/POS Plan C $250					HMO/POS Plan D $250					Rate
	$5	$10	$15	$20	$30	$5	$10	$15	$20	$30	$5	$10	$15	$20	$30	Guarantee
Aetna Health	$3,663	$3,455	$3,266	$3,128	$3,010	n/a	$3,752	$3,593	$3,483	$3,340	n/a	$3,932	$3,785	$3,683	n/a	12 months
AmeriHealth HMO	$4,193	$3,824	$3,672	$3,499	$3,308	$4,569	$4,167	$4,002	$3,813	$3,606	$4,658	$4,249	$4,080	$3,887	n/a	12 months
CIGNA Healthcare of NJ	$3,323	$3,242	$3,188	$3,148	$2,946	$4,425	$4,377	n/a	$4,268	$4,097	$4,562	$4,501	n/a	$4,364	$4,264	12 months
Health Net	$4,395	$4,255	$4,112	$3,958	n/a	$4,474	$4,212	$3,984	$3,769	n/a	$4,555	$4,293	$4,065	$3,850	n/a	None
Horizon Healthcare of NJ	$3,706	$3,565	$3,402	$3,196	$3,094	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	1 month
Oxford Health Plans	$4,636	$4,354	$4,041	$3,729	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	12 months
United HealthCare of New Jersey	$3,290	$3,185	$2,952	$2,795	$2,568	$5,427	$5,615	$5,405	n/a	$4,716	$5,633	$5,945	$5,391	n/a	n/a	30 days
University Health Plans	$4,007	$3,794	$3,560	$3,308	$3,026	n/a	$4,128	$3,794	$3,659	$3,523	$4,548	$4,283	n/a	n/a	n/a	12 months
WellChoice HMO of NJ	$4,225	$4,060	$3,873	$3,636	$3,315	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	12 months

Note: Rates shown are monthly premiums for the sample group described on the attached page.

New Jersey Small Employer Health Benefits Program
Premium Rate Comparison Survey

CARRIERS	Plan A	Plan B				Plan C					Plan D				Plan E		Rate
	$250	Copay	$250	$500	$1,000	Copay	$250	$500	$1,000	$2,500	Copay	$250	$500	$1,000	Copay	$150	Guarantee
Aetna Life Insurance Company	$3,743	n/a	$6,472	$6,019	$5,514	$10	$4,592 (1)	$4,562 (1)	$4,532 (1)	n/a	$10	$4,661 (1)	$4,591 (1)	$4,558 (1)	n/a	$7,782	12 months
AmeriHealth Insurance Company of New Jersey	$2,852	n/a	$5,369	$5,085	$4,697	$30	n/a	n/a	$3,624 (2)	$3,415 (2)	$20	$4,575 (2)	$4,466 (2)	$4,127 (2)	n/a	$6,766	12 months
Guardian Life Insurance Company of America	$3,782	n/a	$4,314 (2)	$4,114 (2)	$4,081 (2)	$10	$5,222 (2)	$4,987 (2)	$4,959 (2)	n/a	$10	$5,907 (2)	$5,650 (2)	$5,554 (2)	$10	$5,568 (2)	None
Horizon Blue Cross Blue Shield of New Jersey	$2,596	n/a	$3,335 (2)	$3,179 (2)	$2,800 (2)	n/a	$3,287 (1)	$3,102 (1)	$2,809 (1)	n/a	$10	$3,977 (1)	$3,510 (1)	$3,219 (1)	n/a	$6,233	1 month
New England Life Insurance Company	$34,010	n/a	$55,717	$48,276	$41,816	$10	$42,873 (2)	$37,684 (2)	$31,722 (2)	n/a	$10	$39,139 (2)	$34,607 (2)	$29,506 (2)	$10	$45,056 (2)	None
Nippon Life Insurance Company of America	$4,436	n/a	$4,525	$4,335	$4,052	n/a	$4,970	$4,729	$4,353	n/a	n/a	$5,371	$5,095	$4,675	n/a	$6,058	12 months
Oxford Health Insurance	$3,341	n/a	$4,973	$4,638	$4,027	$20	$3,694 (1)	$3,397 (1)	$3,307 (1)	n/a	$20	$3,837 (1)	$3,493 (1)	$3,344 (1)	$10	$4,875 (1)	12 months
Trustmark Insurance Company	$5,088	n/a	$5,292 (2)	$4,615 (2)	$3,986 (2)	n/a	$6,381 (2)	$5,885 (2)	$4,908 (2)	n/a	n/a	$7,212 (2)	$6,493 (2)	$6,018 (2)	n/a	$8,322	None
United HealthCare Insurance Company	$3,278	n/a	$6,224	$5,172	$4,456	Varies*	$4,067 (2)	$3,801 (2)	$3,779 (2)	n/a	n/a	$3,149 (2)	$2,681 (2)	$2,359 (2)	n/a	$9,259	30 days
WellChoice Insurance of NJ	$2,979	n/a	$5,879	$5,458	$4,735	$30	$4,637 (2)	$4,457 (2)	$4,240 (2)	$3,998 (2)	n/a	$7,155	$6,583	$5,622	n/a	$8,009	12 months

Note: Rates shown are monthly premiums for the sample group described on the attached page.

Note: Plans A-E may be issued as indemnity, PPO, or POS plans. POS and PPO plans may have different copayment and coinsurance options. Consult the carriers for the available options.

(1) Rates shown are for a POS Plan.

(2) Rates shown are for a PPO Plan.

* $250 deductibe plan has $10 copay; $500 deductible plan has $15 copay; $1,000 deductible plan has $20 copay

HMO Carriers
Camden County

New Jersey Small Employer Health Benefits Program
Premium Rate Comparison Survey

2003

CARRIERS	HMO Plans					HMO/POS Plan C $250					HMO/POS Plan D $250					Rate Guarantee
	$5	$10	$15	$20	$30	$5	$10	$15	$20	$30	$5	$10	$15	$20	$30	
Aetna Health	$3,663	$3,455	$3,266	$3,128	$3,010	n/a	$3,752	$3,593	$3,483	$3,340	n/a	$3,932	$3,785	$3,683	n/a	12 months
AmeriHealth HMO	$4,193	$3,824	$3,672	$3,499	$3,308	$4,499	$4,104	$3,940	$3,754	$3,549	$4,587	$4,184	$4,018	$3,828	n/a	12 months
CIGNA Healthcare of NJ	$3,572	$3,485	$3,427	$3,384	$3,167	$4,757	$4,706	n/a	$4,588	$4,405	$4,904	$4,839	n/a	$4,691	$4,584	12 months
Health Net	$4,285	$4,149	$4,009	$3,859	n/a	$4,362	$4,106	$3,885	$3,675	n/a	$4,441	$4,185	$3,964	$3,754	n/a	None
Horizon Healthcare of NJ	$3,515	$3,381	$3,226	$3,032	$2,935	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	1 month
Oxford Health Plans	$4,295	$4,034	$3,744	$3,455	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	12 months
United HealthCare of New Jersey	$3,290	$3,185	$2,952	$2,795	$2,568	$5,427	$5,615	$5,405	n/a	$4,716	$5,633	$5,945	$5,391	n/a	n/a	30 days
University Health Plans	$4,007	$3,794	$3,560	$3,308	$3,026	n/a	$4,128	$3,794	$3,659	$3,523	$4,548	$4,283	n/a	n/a	n/a	12 months
WellChoice HMO of NJ	$4,060	$3,900	$3,721	$3,494	$3,185	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	12 months

Note: Rates shown are monthly premiums for the sample group described on the attached page.

Indemnity Carriers
Middlesex County

New Jersey Small Employer Health Benefits Program
Premium Rate Comparison Survey

2003

	Plan A	Plan B				Plan C					Plan D				Plan E		Rate
CARRIERS	$250	Copay	$250	$500	$1,000	Copay	$250	$500	$1,000	$2,500	Copay	$250	$500	$1,000	Copay	$150	Guarantee
Aetna Life Insurance Company	$4,059	n/a	$7,019	$6,528	$5,980	$10	$4,980 (1)	$4,948 (1)	$4,915 (1)	n/a	$10	$5,055 (1)	$4,979 (1)	$4,944 (1)	n/a	$8,440	12 months
AmeriHealth Insurance Company of New Jersey	$3,082	n/a	$5,802	$5,495	$5,021	$30	n/a	n/a	$3,652 (2)	$3,441 (2)	$20	$4,611 (2)	$4,500 (2)	$4,159 (2)	n/a	$7,310	12 months
Guardian Life Insurance Company of America	$4,598	n/a	$5,257 (2)	$5,014 (2)	$4,972 (2)	$10	$6,383 (2)	$6,096 (2)	$6,060 (2)	n/a	$10	$7,229 (2)	$6,915 (2)	$6,805 (2)	$10	$6,806 (2)	None
Horizon Blue Cross Blue Shield of New Jersey	$2,737	n/a	$3,516 (2)	$3,351 (2)	$2,952 (2)	n/a	$3,466 (1)	$3,271 (1)	$2,962 (1)	n/a	$10	$4,193 (1)	$3,701 (1)	$3,394 (1)	n/a	$6,572	1 month
New England Life Insurance Company	$34,010	n/a	$55,717	$48,276	$41,816	$10	$42,690 (2)	$37,500 (2)	$31,586 (2)	n/a	$10	$39,139 (2)	$34,607 (2)	$29,395 (2)	$10	$44,830 (2)	None
Nippon Life Insurance Company of America	$3,808	n/a	$3,885	$3,722	$3,478	n/a	$4,267	$4,060	$3,737	n/a	n/a	$4,611	$4,374	$4,013	n/a	$5,201	12 months
Oxford Health Insurance	$3,467	n/a	$5,161	$4,814	$4,180	$20	$3,834 (1)	$3,525 (1)	$3,433 (1)	n/a	$20	$3,983 (1)	$3,626 (1)	$3,470 (1)	$10	$5,059 (1)	12 months
Trustmark Insurance Company	$5,633	n/a	$5,863 (2)	$5,112 (2)	$4,415 (2)	n/a	$7,070 (2)	$6,521 (2)	$5,437 (2)	n/a	n/a	$9,92 (2)	$7,194 (2)	$6,668 (2)	n/a	$9,223	None
United HealthCare Insurance Company	$3,278	n/a	$6,224	$5,172	$4,456	Varies*	$4,067 (2)	$3,801 (2)	$3,779 (2)	n/a	n/a	$3,149 (2)	$2,681 (2)	$2,359 (2)	n/a	$9,259	30 days
WellChoice Insurance of NJ	$2,979	n/a	$5,879	$5,458	$4,735	$30	$4,732 (2)	$4,548 (2)	$4,326 (2)	$4,079 (2)	n/a	$7,155	$6,583	$5,622	n/a	$8,009	12 months

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HMO Carriers
Middlesex County

New Jersey Small Employer Health Benefits Program
Premium Rate Comparison Survey

2003

CARRIERS	HMO Plans					HMO/POS Plan C $250					HMO/POS Plan D $250					Rate
	$5	$10	$15	$20	$30	$5	$10	$15	$20	$30	$5	$10	$15	$20	$30	Guarant
Aetna Health	$3,663	$3,455	$3,266	$3,128	$3,010	n/a	$3,752	$3,593	$3,483	$3,340	n/a	$3,932	$3,785	$3,683	n/a	12 month
AmeriHealth HMO	$4,193	$3,824	$3,672	$3,499	$3,308	$4,499	$4,104	$3,940	$3,754	$3,549	$4,587	$4,184	$4,018	$3,828	n/a	12 month
CIGNA Healthcare of NJ	$3,323	$3,242	$3,188	$3,148	$2,946	$4,425	$4,377	n/a	$4,268	$4,097	$4,562	$4,501	n/a	$4,364	$4,264	12 month
Health Net	$4,395	$4,255	$4,112	$3,958	n/a	$4,474	$4,212	$3,984	$3,769	n/a	$4,555	$4,293	$4,065	$3,850	n/a	None
Horizon Healthcare of NJ	$3,706	$3,565	$3,402	$3,196	$3,094	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	1 month
Oxford Health Plans	$4,458	$4,187	$3,886	$3,586	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	12 month
United HealthCare of New Jersey	$3,290	$3,185	$2,952	$2,795	$2,568	$5,427	$5,615	$5,405	n/a	$4,716	$5,633	$5,945	$5,391	n/a	n/a	30 days
University Health Plans	$4,007	$3,794	$3,560	$3,308	$3,026	n/a	$4,128	$3,794	$3,659	$3,523	$4,548	$4,283	n/a	n/a	n/a	12 month
WellChoice HMO of NJ	$4,142	$3,980	$3,797	$3,565	$3,250	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	12 month

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