CSHP
Rutgers Center for State Health Policy
Institute for Health, Health Care Policy and Aging Research

New Jersey Appleseed Forum on Reforming the Small Business Health Insurance Market: Potential State Initiatives

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Small Business Health Insurance in New Jersey: Issues and Options

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The author bears sole responsibility for errors committed and opinions expressed in this presentation

About Rutgers CSHP

History

Established in 1999 within Rutgers University Institute for Health, Health Care Policy and Aging Research

Mission

To inform, support, and stimulate sound and creative state health policy in New Jersey and around the nation

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About CSHP

Current Work

- Access to health services care and coverage
- Long-term care financing and delivery
- Racial/ethnic disparities in health care
- Pharmaceutical policy
- Performance measurement
- State health data

About CSHP

Center Funding

- Robert Wood Johnson Foundation
- Federal grants and contracts
  - CMS, AHRQ, HRSA
- NJ state agencies
  - Health and Senior Services; Human Services; Banking and Insurance
- Other public and private sources

Outline

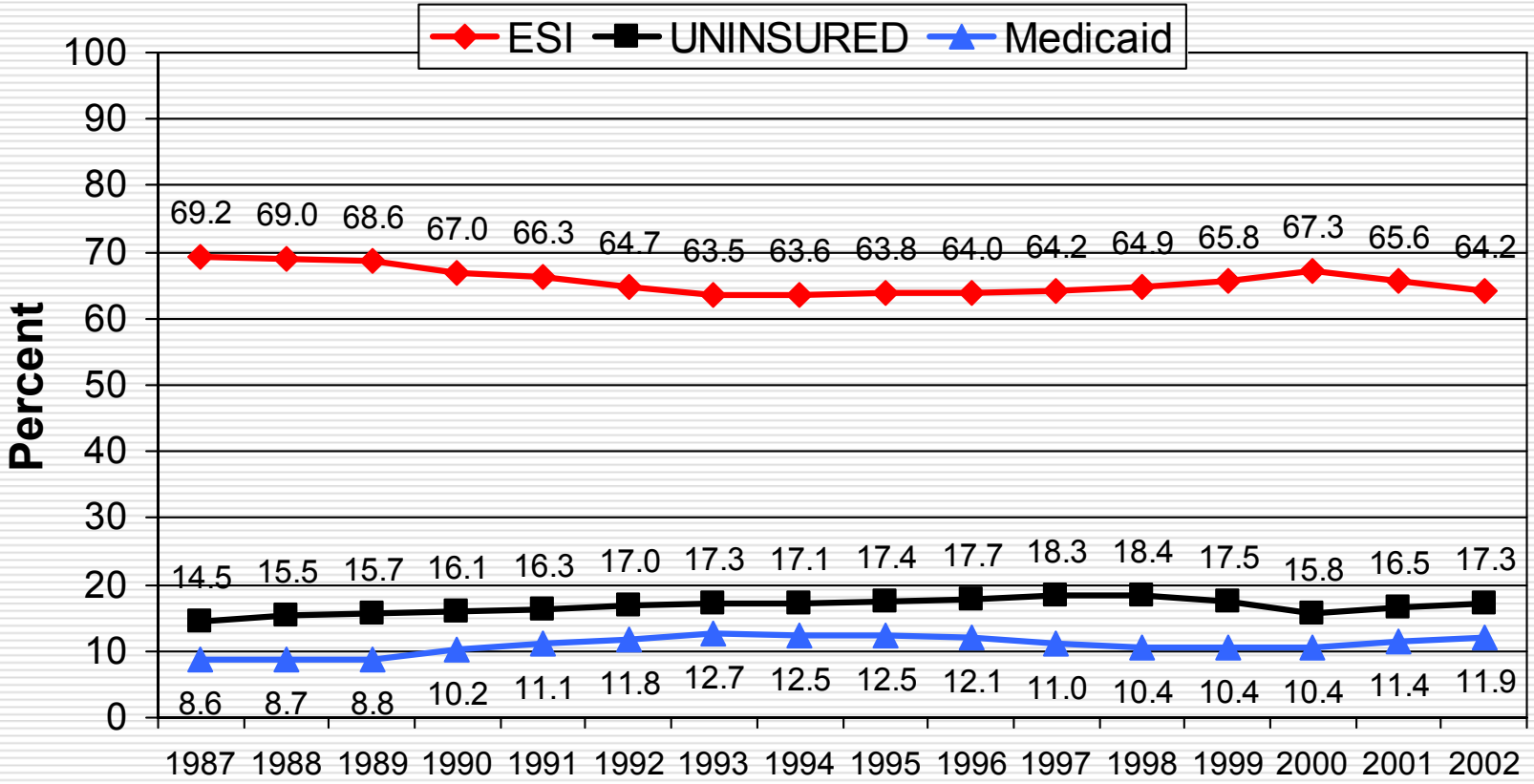
- Market Trends
- State Policy Context
- Options

Market Trends

- Among the highest premiums in the nation
- NJ tracks with national trends
- Yet, participation by small businesses and their employees in health insurance is strong

Long-Term Decline in Employer-Sponsored Insurance (ESI), Rise in Uninsured, 1987-2002

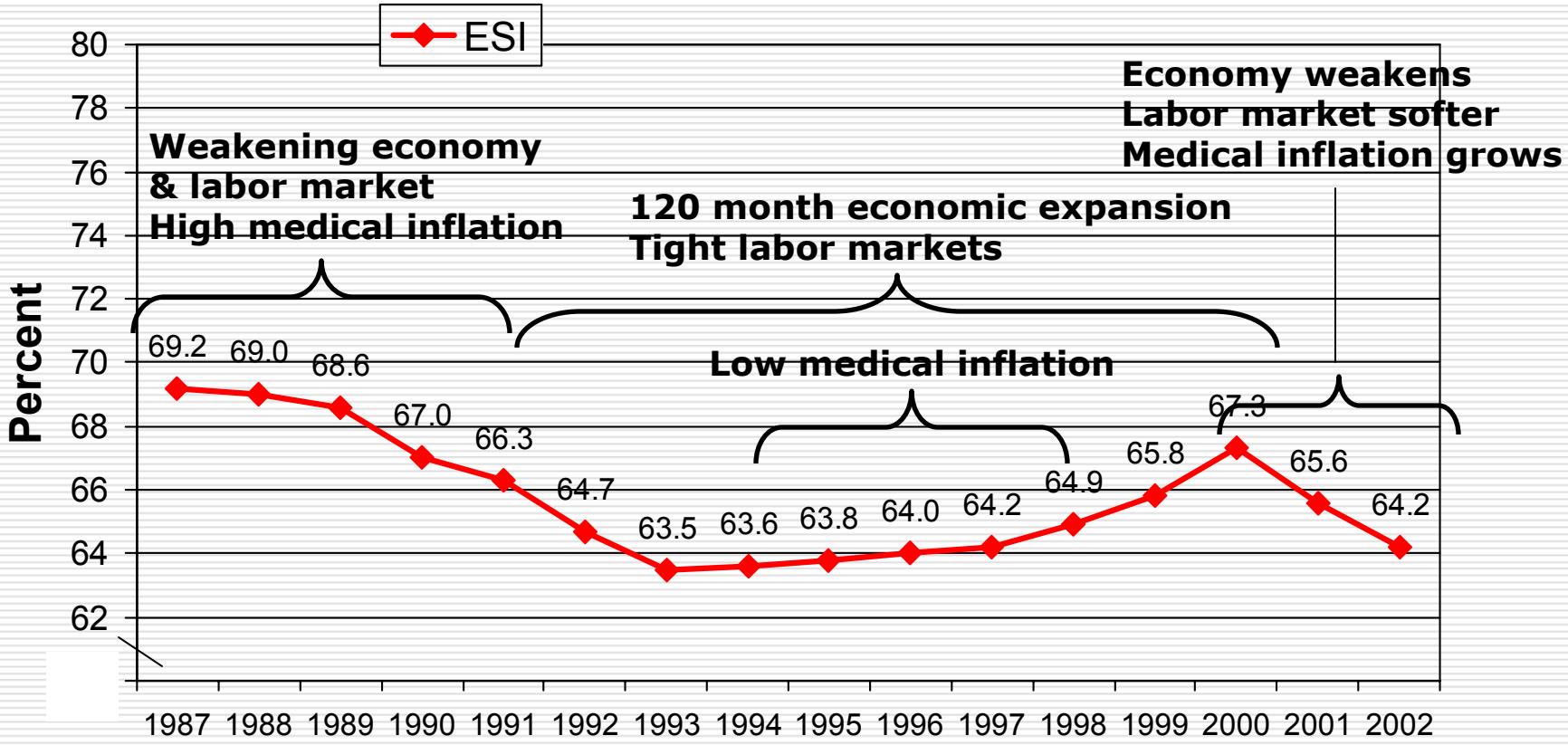
Non-elderly population, United States



Source: Employee Benefits Research Institute tabulations of the Current Population Survey

Closer Look at ESI, 1987-2002

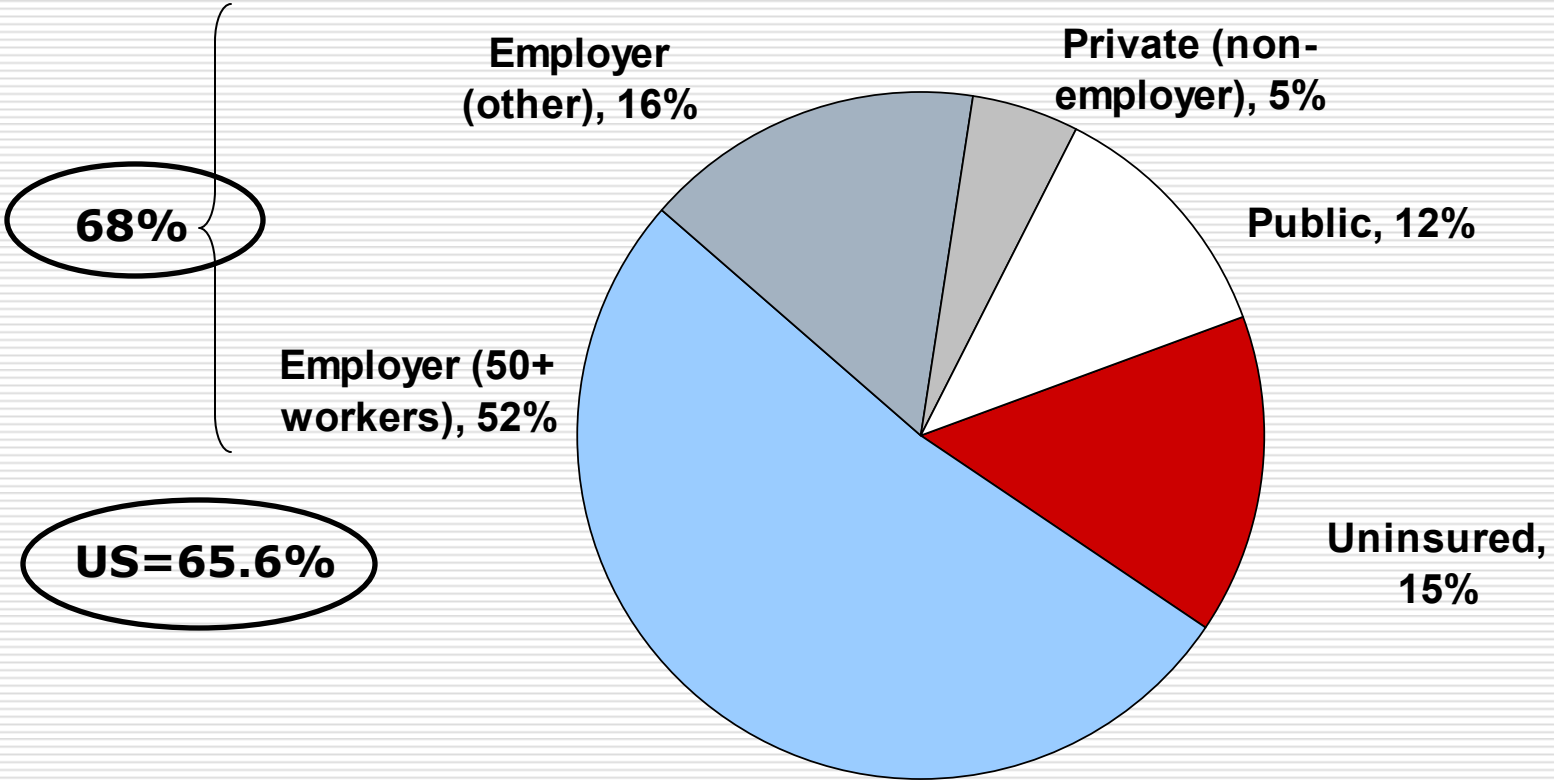
Non-elderly population, United States



Source: Employee Benefits Research Institute tabulations of the Current Population Survey

Most NJ Residents have ESI, 2001

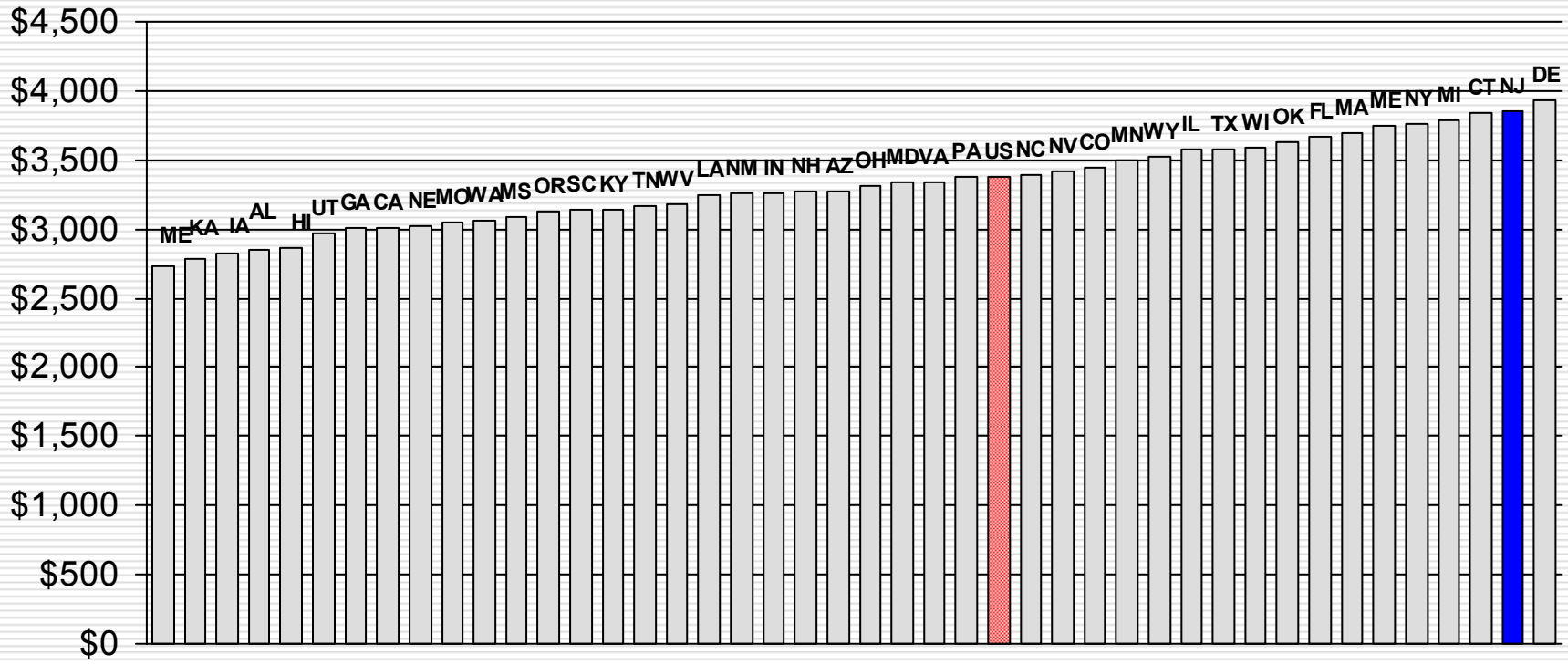
Non-elderly population



Source: *Rutgers Center for State Health Policy.* NJ Family Health Survey, 2001

NJ Small Firms have Very High Premiums, 2002

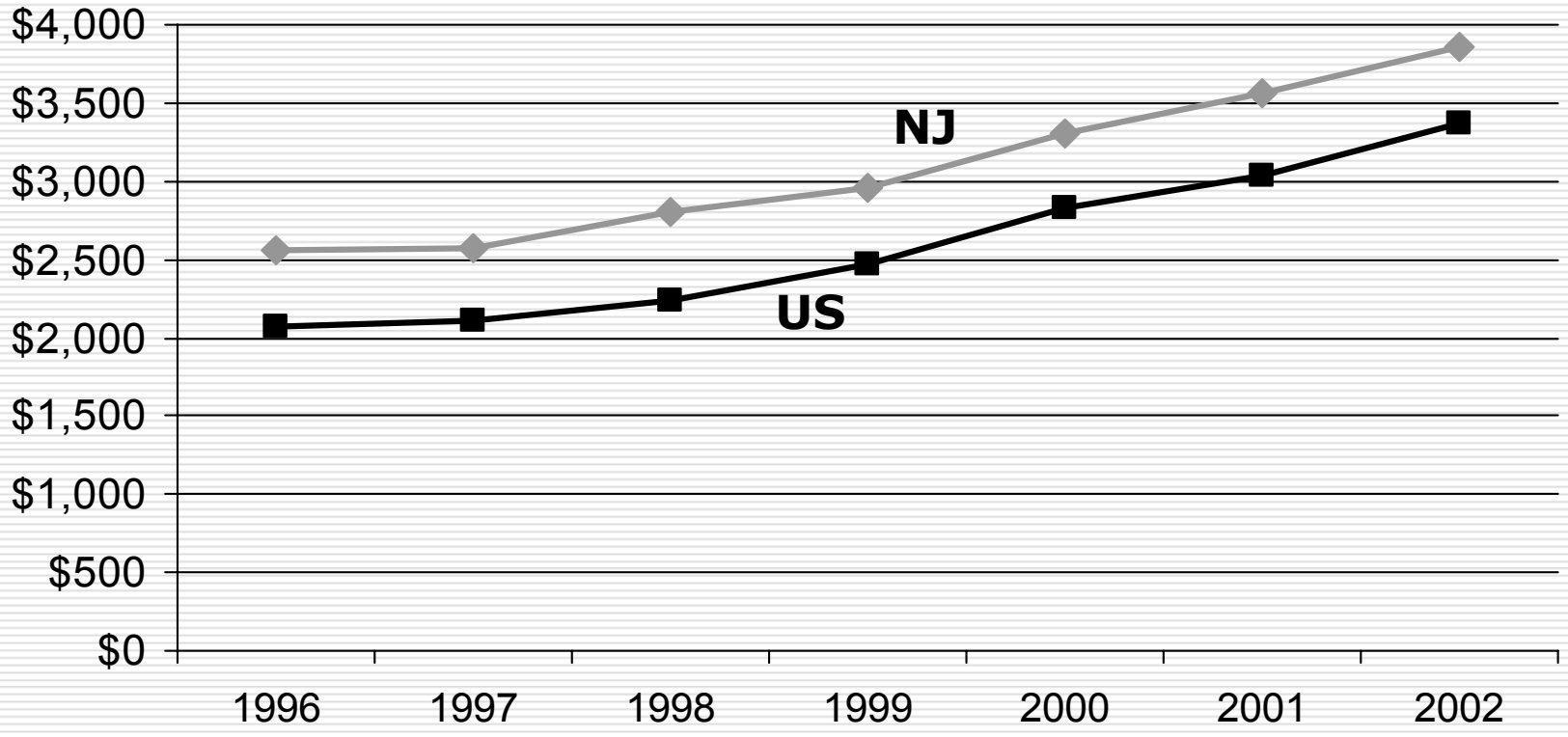
Single premium in firms with <50 workers



Source: Medical Expenditure Panel Survey - Insurance Component

NJ Small Firm Premiums Have Grown with US Trend

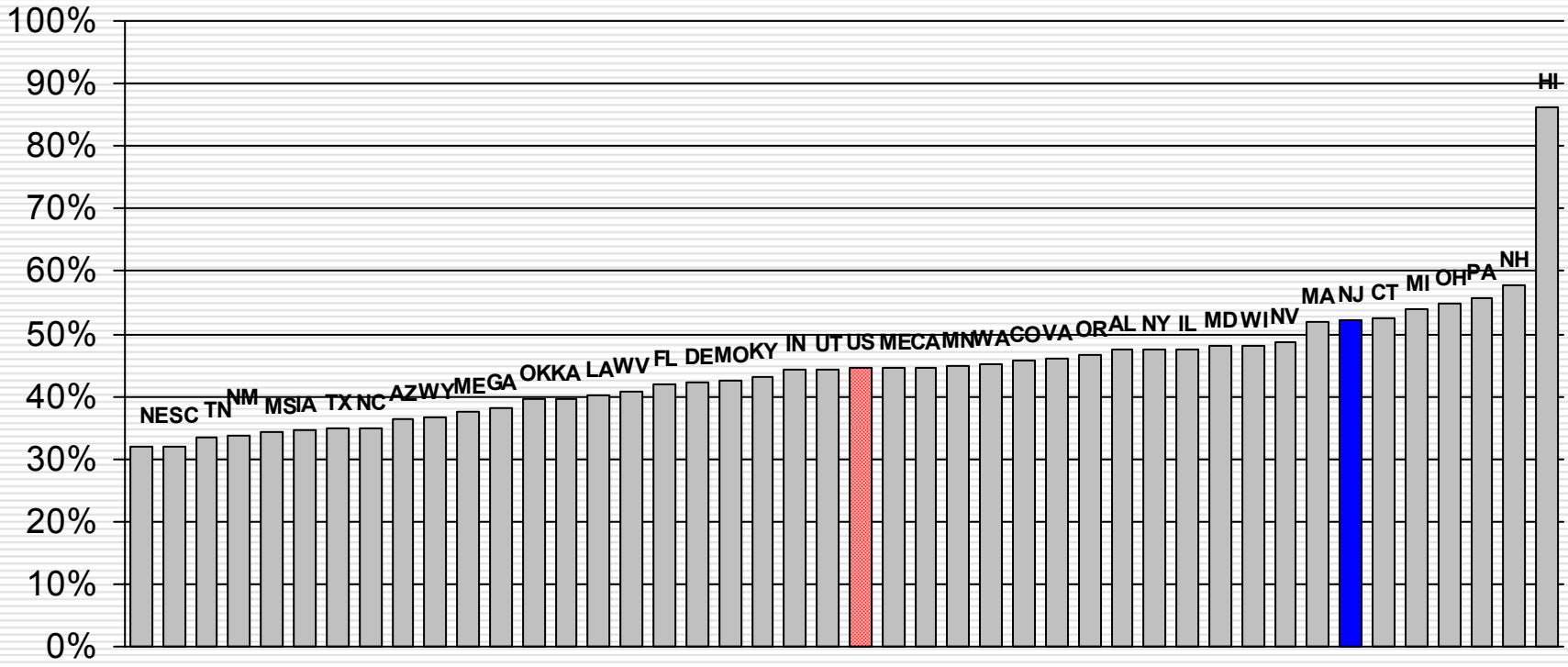
Single premium in firms with <50 workers



Source: Medical Expenditure Panel Survey - Insurance Component

NJ Small Firms have High ESI Offer Rate, 2002

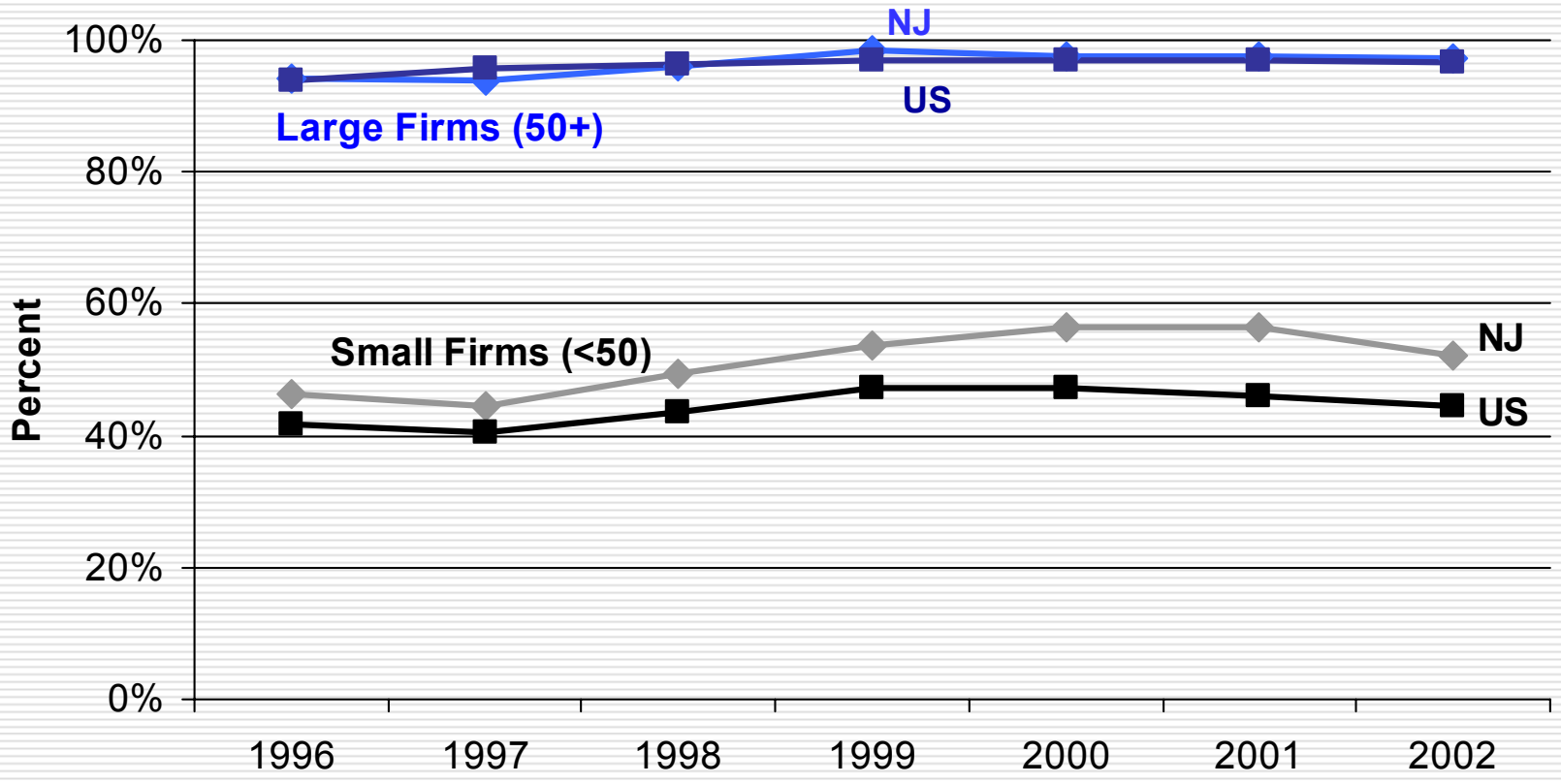
Single coverage in firms with <50 workers



Source: Medical Expenditure Panel Survey - Insurance Component

NJ ESI Offer Rate Tracks with US Trend

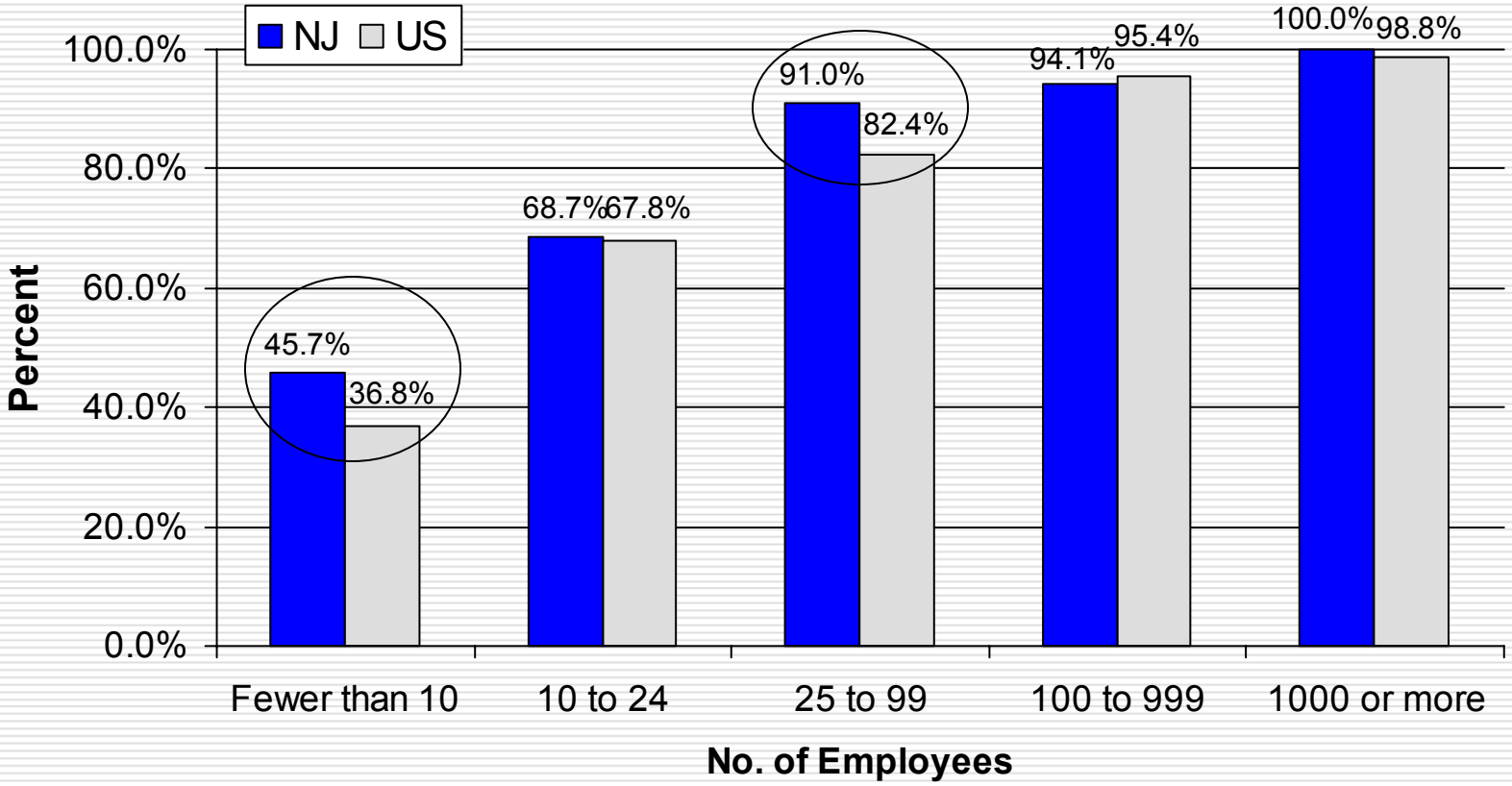
Small and large firms



Source: Medical Expenditure Panel Survey - Insurance Component

Small NJ Firms are More Likely to Offer Coverage than US Average, 2002

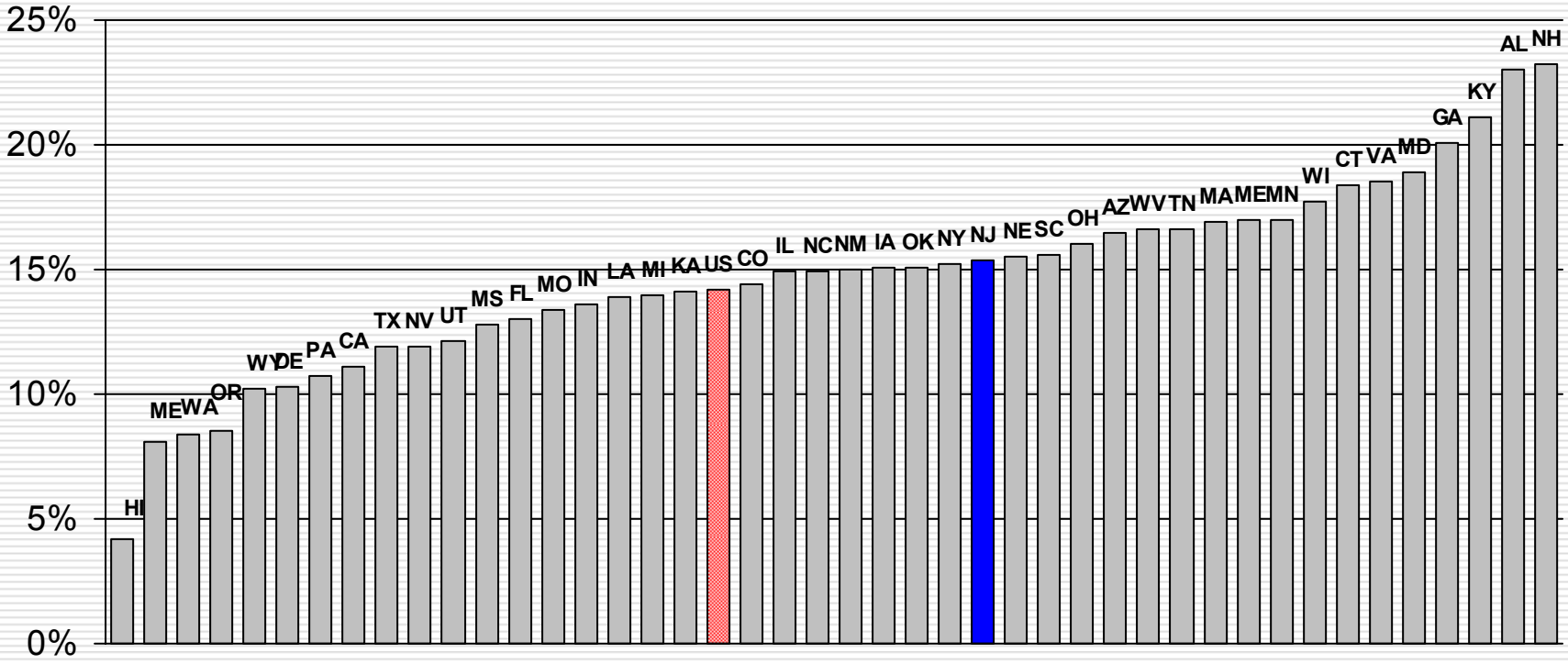
Single coverage



Source: Medical Expenditure Panel Survey – Insurance Component, 2002

Employee Premium Share in Small NJ Firms is Just Above US Average, 2002

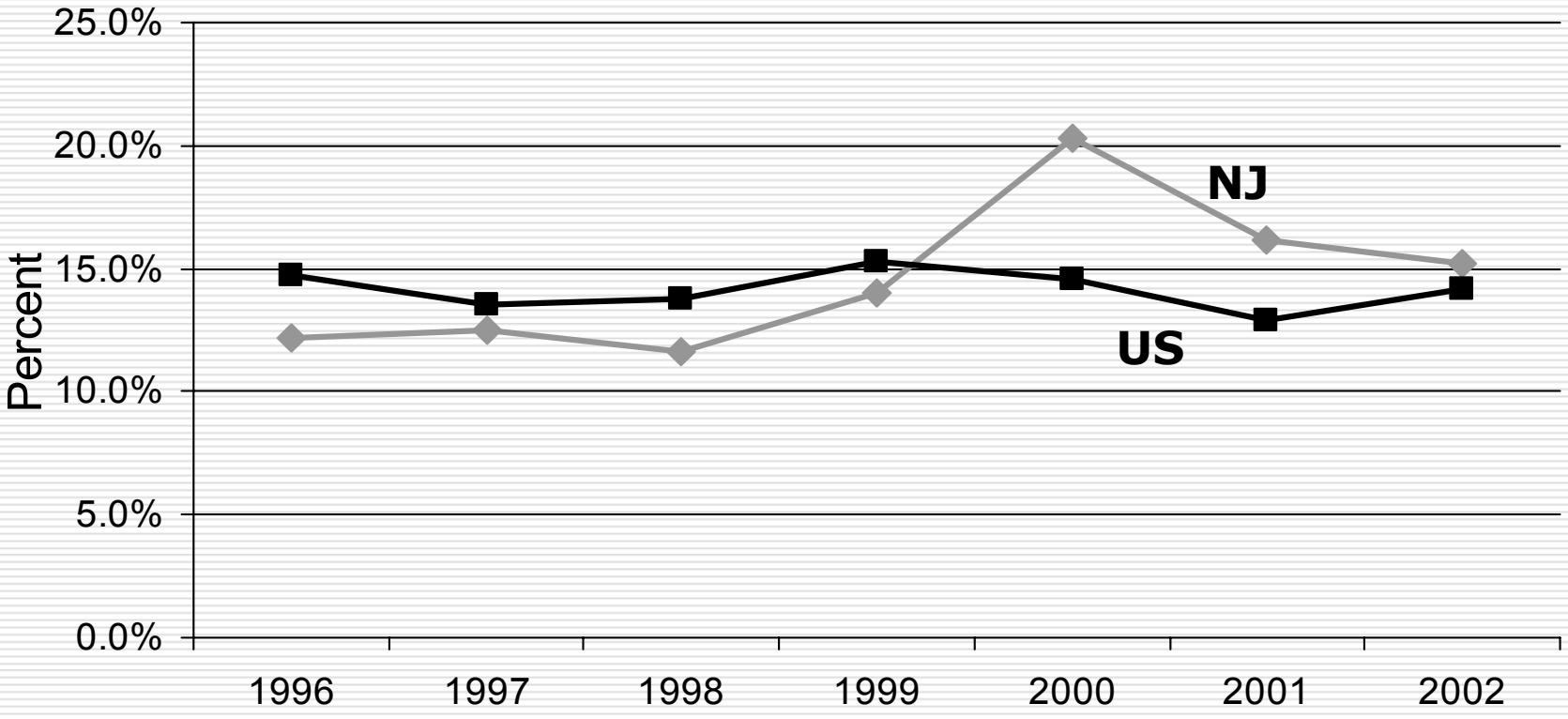
Single coverage in firms with <50 workers



Source: Medical Expenditure Panel Survey - Insurance Component

NJ Employee Premium Share in Small Firms May be Rising

Single coverage in firms with <50 workers



Source: Medical Expenditure Panel Survey - Insurance Component

Understanding the Trends

- **Rising health care costs and changing economy -> long-term ESI decline in US & NJ**
- **High underlying health care costs in NJ -> especially high ESI premiums**
- **Strong economy, tight labor markets, high wage structure in NJ -> strong ESI participation here**

Outline

- Market Trends
- **State Policy Context**
- Options

State Policy Context

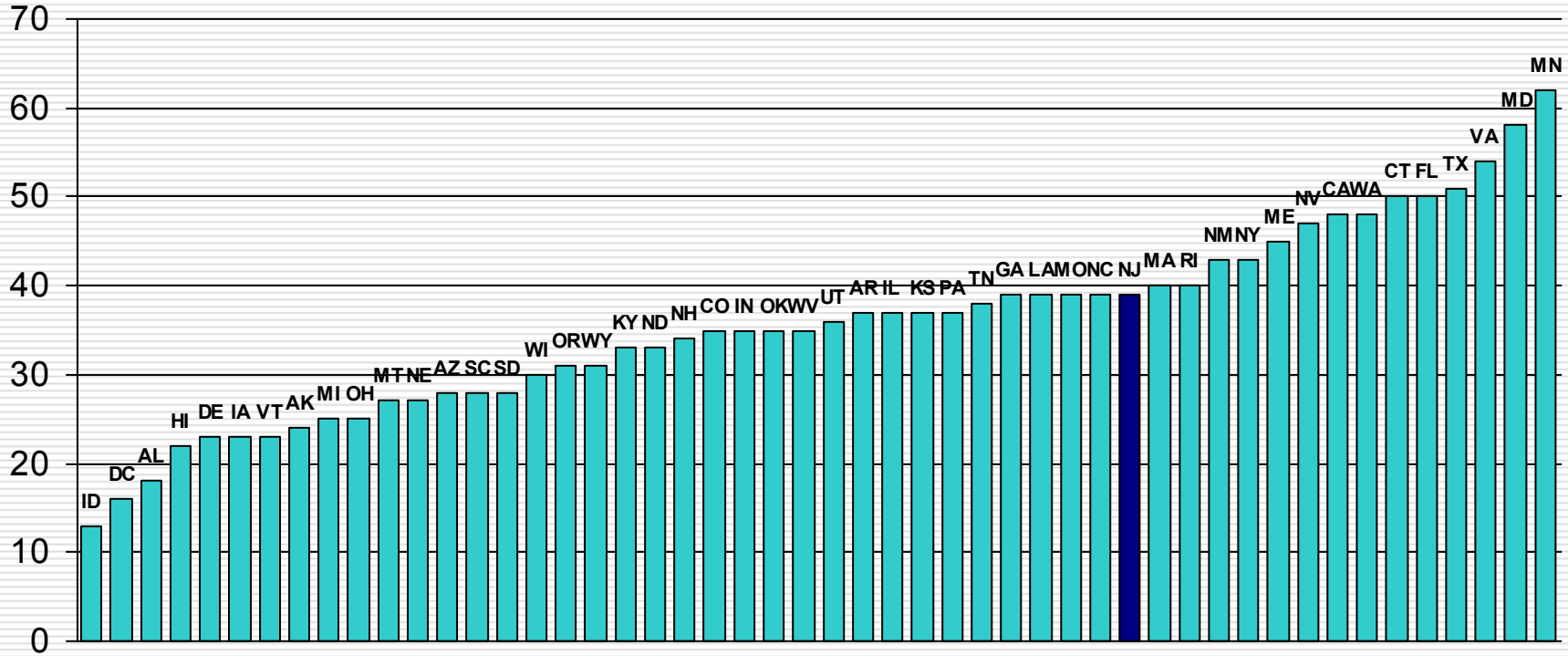
- Strong access and rating regulations for small groups
- Typical private coverage benefit mandates
- High level of public coverage
- Structural state budget deficit

New Jersey's Small Employer (2-50 employees) Market Regulations

- Guaranteed issue regardless of health status
- Guaranteed renewability
- Modified community rating
  - 2 to 1 maximum rate band defined by age, gender, & geography
- Limited pre-existing conditions limitations
- Portability
- Minimum loss ratio (i.e., medical expense payout)
- Standardized policies, but riders permitted
- Oversight by volunteer Board of stakeholders

Source: NJ Department of Banking and Insurance

Number of State Health Insurance Benefit, Provider, and Population Coverage Mandates



Source: Council for Affordable Health Insurance, 2004

Selected (Probably Expensive) **Mandates**

Mandates NJ Has

- In vitro fertilization – 15 states
- Bone marrow transplants – 10 states

Mandates NJ Does Not Have

- Hospice – 11 states
- Rehabilitation services – 7 states
- Morbid obesity treatment – 4 states
- Prescription drugs – 3 states
- Orthotics/prostetics – 4 states

Source: Council for Affordable Health Insurance, 2004

Public Coverage in NJ

- Child eligibility limit 350% FPL, highest in US
- Parents eligible up to 200% FPL, currently frozen
- Better than average Medicaid eligibility
- More contributions to charity care

Structural State Budget Deficit

- 20% to 25% shortfall, long-term
- Funding has been largely sustained for Medicaid and NJ FamilyCare
- Growing consensus that state employee benefits, including health plan contribute to the problem

Outline

- Market Trends
- State Policy Context
- **Options**

Selected Options for Expanding Small Group Coverage

Focus on options that are…

- **Incremental**
- **Relevant in NJ regulatory & market context**
- **Require …**
  - **little or no new state revenue**
  - **some new state revenue**
- **Discuss popular, new ideas** ✓

Options Not Requiring State $

- Pooled purchasing (e.g., association plans)
- Regulatory relief ✓
- Full-cost buy-in to state programs ✓
- Increase age for dependent eligibility ✓
- Permitting "groups of one"

Pooled Purchasing

The Idea

- **Combine purchasing power of many small businesses**
- **Gain efficiencies of larger groups**
- **Various designs…**
  - **Association plans**
  - **State-sponsored purchasing cooperatives**

Pooled Purchasing

Considerations

- **Purchasing pools in other states have increased health plan choice but done little/nothing to influence market or moderate costs**
- **Pools that waive existing market regulations can lead to risk segmentation and destabilize the "main" small group market**

Regulatory Relief

The Idea

- **State mandated coverage of specific benefits, provider types or populations are costly**
- **Rating and enrollment regulations raise costs for firms with low-risk workers**
- **Reduce mandated benefits overall or exempt some employers (e.g., very small or low-wage firms) from some/all mandates**
- **Relax rating and enrollment regulations**

Regulatory Relief

Considerations (mandate relief)

- **Lower premiums with thinner benefits, may increase coverage**
- **Market favors comprehensive plans; "bare bones" plans are unpopular**
- **Potential for "under-insurance", under-utilization & uncompensated care**
- **Consumer misunderstanding, extensive appeals**
- **Fairness across firms of different sizes, composition**

Regulatory Relief

Considerations (rating and access regulations)

- **Lower premiums for some firms, may increase coverage**
- **Less risk pooling; higher costs for firms with higher risk workers**

Full-Cost Buy-In

The Idea

- **Those without access to ESI and income just above thresholds for public coverage cannot afford coverage**
- **Public programs have low administrative cost and high bargaining power with providers**
- **Allow uninsured individuals or small groups to purchase through public programs, e.g., NJ FamilyCare or the State Employees Health Benefit Program**

Full-Cost Buy-In

Considerations

- **Public plan design problems**
  - Some state employee options haven't kept up with market
  - Medicaid has very broad benefits with little cost sharing
  - NJ FamilyCare plan design may be more appropriate
- **Medicaid/NJ FamilyCare carriers not set up to manage enrollment and collect premiums**

Full-Cost Buy-In

Considerations (continued)

- **Private coverage "crowd out" possible**
- **Lower provider payments**
- **Adverse risk selection possible**
- **Other states' FCBI programs have had low enrollment**
  - May be result of program design details

Increase Dependent Age

The Idea

- **Many young adults are uninsured (32% age 19-25) & they have comparatively low cost**
- **Require higher age of eligibility for dependent coverage (pending NJ bill A-3759)**
  - **From age 19 (or 23 for students) to age 30**
  - **Not eligible for other coverage**
  - **Employee pays full incremental cost**

Increase Dependent Age

Considerations

- **Could apply to many uninsured**
- **Impact greatest for healthiest uninsured**
- **May increase average risk in *non-group* market** (but in NJ, few young adults have non-group coverage)
- **Restrictions may be difficult to enforce** (e.g., other coverage eligibility, living with parents, etc.)
- **Administrative cost and hassle for employers** (enrollment, payroll deduction, turnover)

Groups of One

The Idea

- **Currently, only groups of 2-50 are eligible for small-employer coverage**
- **Non-group coverage is more expensive & subject to pure community rating (so younger individuals are at a disadvantage)**
- **Would permit self-employed with no employees in the small-group market**

Groups of One

Considerations

- Difficult to screen out non-employed
- High turn over, poor "labor-force attachment"
- Adverse risk selection into small-group market
- May increase average risk in non-group market

Options Requiring State $

- Permit medical underwriting, create a high risk pool
- Premium subsidies & tax credits
- Universal or targeted reinsurance 

Medical Underwriting & High Risk Pool (HRP)

The Idea

- High-cost cases drive premiums up
- Allow private plans to use health status to exclude pre-existing conditions, set premiums, or deny coverage
- Individuals/firms excluded from coverage are eligible for state-established HRP
- State subsidy of HRP

Medical Underwriting & High Risk Pool (HRP)

Considerations

- 30+ states
- Lower private premiums, lower average risk
- States subsidies of HRPs are very low, premiums are very high & enrollment low (except MN)
- Leaves sickest with least affordable coverage, many left uninsured

Premium Subsidies & Tax Credits

The Idea

- **Many of the smallest firm and others with low wage workers cannot afford coverage**
- **Target direct subsidies or tax credits to very small firms (e.g., <10) and/or low-wage workers**

Premium Subsidies & Tax Credits

Considerations

- **Improves affordability**
- **Costly, research shows that very large subsidies/credits would be needed**
- **Not "target efficient" (i.e., much of the subsidy would go to firms already offering coverage – nearly half of NJ firms <10 already offer)**
- **Major leverage for tax credits is at federal level**

Reinsurance

The Idea

- **Five percent of covered lives accounts for half of expenditures for privately insured**
- **Insurers may be reluctant to participate in market and may add a "risk premium" as hedge against risk**
- **State required or subsidized "reinsurance"** (a.k.a. "stop loss" coverage) **pays some of the costs of high cost cases**

Reinsurance

The Idea (continued)

- **Can target to smallest firms or to firms with low wage workers**
- **Broadens risk pooling for high-cost cases**
- **Subsidizes high-cost cases**

Reinsurance

Considerations

- **Lower premiums may increase coverage**
- **May encourage carrier participation & competition**
- **Design to maintain carrier case management incentives**
- **Should subsidies be targeted to low wage workers or firms or all covered workers/firms?**
- **Which markets** (small group, large group, non-group)**?**
- **Financing and cost** (premium tax, general revenue, target firms/population)

Discussion

Some Observations

- National forces drive ESI trends with poor prognosis over the long-run
- NJ ESI is expensive, but participation strong

Some Questions

- Can "excess" NJ ESI costs be reduced?
- How much can be gained from low-cost/no-cost policy options?
- Options with state costs can be expensive and complex, is there consensus to proceed?

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