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**A Decade After Regulatory Reform:
A Case Study of New Jersey's Individual
Health Coverage Program**

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A Decade After Regulatory Reform: A Case Study of New Jersey's Individual Health Coverage Program

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Executive Summary

New Jersey has been a national leader in the development of public policies designed to increase the accessibility and affordability of health insurance coverage. In the early 1990s, the prognosis for the sustainability of New Jersey's non-group, i.e., individual, market was bleak. Enrollment in the individual plans was dropping dramatically, while premiums were rising sharply. In addition, restrictive medical underwriting practices meant a limited choice of health coverage for people with pre-existing health conditions. In response to these factors, New Jersey adopted *The Health Care Reform Act of 1992*, sweeping reform legislation aimed at, among other things, restructuring the struggling non-group and small-group health insurance markets and increasing access to coverage. Over ten years later, while the enrollment decline has slowed, additional policy changes are being considered in an attempt to reinvigorate the individual market. Based on key informant interviews, this case study examines several of these options including: modified community rating (which appears, at this time, to be the most politically feasible); eliminating the standardized benefits and allowing flexibility in plan design; merging the individual and the small group markets; and creating a high risk pool. Legislative action is predicted on this issue in early-2005.

A Decade After Regulatory Reform: A Case Study of New Jersey's Individual Health Coverage Program

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Introduction

New Jersey's Individual Health Coverage Program (IHCP) was born out of the *The Health Care Reform Act of 1992* and represented the State's attempt to address access issues by restructuring the individual coverage market. These regulations were implemented in 1993, and at its peak in 1996, the IHCP boasted an enrollment of over 200,000. However, after that mid-90s surge, the IHCP experienced a steep enrollment decline, losing membership at a rate of approximately 3% per quarter until 2002. Since that time, the decline has slowed, and between 2003 and 2004, enrollment has remained basically unchanged.

Some of the key features of the IHCP include: guaranteed issue and renewal, pure community rating, standardization of benefit plans¹, a carrier loss assessment reimbursement mechanism, and the creation of the Individual Health Coverage Program Board, an independent regulatory body vested with oversight authority. While enrollment trend data indicate that the IHCP was successful in its early years (through the mid-1990s), the current decline suggests that additional regulatory intervention may once again be necessary stabilize the market. In addition, the steep membership decline has slowed over the recent quarters, and while many would be reluctant to characterize the market as being in a "death spiral" (a phrase that was frequently used to describe the market in 2000-2001), policy changes may be necessary to once again make the IHCP a robust, sustainable market.²

This case study was undertaken to identify the impact of the 1992 reforms on the IHCP and to assess the sustainability of the market under its current regulatory structure. Among policymakers and key stakeholders interviewed for this study in the summer/fall of 2003, the diagnosis of the problem is notably consistent; the cycle of increasing premiums and decreasing membership has left the market unattractive and unaffordable for young, healthy subscribers. While there may be agreement among policymakers and other stakeholders with respect to identifying the problems in the IHCP, there is considerable debate among these players with regard to the market's overall performance, the priority for policy options, and the general prognosis for the future of the non-group market.

Features of the IHC Market Reforms

The Loss Assessment Mechanism

In New Jersey, there has been a steep decline in the number of carriers providing coverage in the individual market: from a high of twenty-eight in the initial post-reform years to nine carriers in 2004. One factor thought to be closely linked to the initially large number of participating carriers and the subsequent exodus of many is the loss assessment mechanism, a major feature of New Jersey's 1992 reform legislation. The goal of the loss assessment was to encourage carriers to participate in the individual market by offering a mechanism by which losses (including non-medical losses) above a certain amount would be reimbursed. The regulators wanted to make the market more competitive and avoid the ongoing scenario in which one carrier (in New Jersey's case, Blue Cross Blue Shield) is being burdened with all of the risk and carrying the title of "payer of last resort." The "Play or Pay" feature requires that all carriers in New Jersey that sell health insurance are required to "play" in the individual market, either by actively selling individual coverage or by "paying" to cover the losses incurred by the other carriers that do participate (see Table 1 for enrollment data).

Prior to 1997, carriers were reimbursed for their first-dollar losses in the individual market, including non-medical losses. Therefore, more carriers, particularly those with smaller membership, took the chance of entering the market with low premiums because they thought a "safety net" mechanism existed through which they could recover all or part of their incurred losses. For a variety of reasons, including premium "low balling" to attract membership, a number of these carriers underestimated the medical risk they would encounter in the IHCP, and the reimbursements they were offered were insufficient to convince them to continue to participate in the individual market.³ In 1998, significant legislative change took place. The New Jersey Legislature moved forward and amended the carrier loss assessment mechanism. Beginning that year, the mechanism was changed to require carriers to incur a 115% loss, *excluding* non-medical losses, before they would be eligible for any reimbursement.⁴ With this change, many of the smaller carriers that were unable to withstand these losses abandoned the market.

The loss assessment mechanism differs from reinsurance in that its goal was to promote participation in the individual market and carrier competition, while re-insurance is the mechanism by which carriers are reimbursed for catastrophic medical claims payments.

Several experts consider the loss assessment mechanism an abject failure of the New Jersey reforms because it afforded carriers the opportunity sit on the sidelines rather than, as one expert stated, “to get in the game” and caused, to some degree, market instability with the early withdrawal of many of the smaller carriers.

**Table 1: Enrollment in New Jersey’s Individual Health Coverage Program 1997-2003
(Selected Carriers Only)**

	1997	1998	1999	2000	2001	2002	2003
Blue Cross & Blue Shield of NJ	86,890	81,738	73,244	61,587	51,682	46,684	44,048
HIP Health Plan of NJ*	11,169	9,717	-	-	-	-	-
Aetna**	8,869	11,407	15,115	18,581	17,555	14,293	11,531
Prudential Health* Care Plan, Inc.	8,111	7,911	4,369	-	-	-	-
Oxford***	7,900	8,600	8,672	7,764	8,200	10,485	13,189
AmeriHealth HMO	2,203	2,783	3,403	2,916	3,085	3,926	5,204
Cigna HealthCare of NJ, Inc.	4,512	4,054	6,075	5,850	2,751	1,484	995
Total Selected Carriers	129,654	126,210	110,878	96,698	83,273	76,872	74,967
Total Other Carriers	24,601	4,958	2,070	2,071	1,695	1,826	1,686
Total Market	154,255	131,168	112,948	98,769	84,968	78,698	76,653

* HIP Health Plan of NJ withdrew from the market in 1999 and Prudential Health Care Plan, Inc. withdrew in 2000.

** Total includes Aetna U.S. HealthCare & Aetna Life & Casualty enrollment.

***Total includes Oxford Health Plans of NJ & Oxford Health Insurance enrollment.

Source: NJ Department of Banking & Insurance fourth quarter administrative data.

Carrier Competition and Behavior

In New Jersey, while there are nine carriers who participate in this market, the membership is highly concentrated, as illustrated by the fact that in 2003 the top five carriers claimed nearly 98% of the market share (see Table 2 below). As one would predict, premiums among these carriers are generally competitive across the standard benefit plans. There are, however, a few companies in the current mix whose premiums are so prohibitively expensive (three, four or five times more expensive than those of the top four carriers), and their enrollment so small, that their participation in the market is more theoretical than practical.

Conventional wisdom points to these carriers staying in the market only to avoid further penalty under the previously mentioned loss assessment mechanism. In addition, if carriers withdraw from the individual market in New Jersey, they are barred from returning for five years, a provision that serves as a deterrent, particularly for those who believe that some modified reforms could make the market once again more attractive to small carriers in the future. Regardless, some interviewees argued that a carrier that charges \$16,000 a month for a family policy, (a case in point for a carrier in New Jersey with a very small market share) is de facto out of the market and should therefore not be protected by the current regulations. The state does not appear to be exerting any concerted effort to police these “outlier” carriers and rein in astronomical premium prices. An interesting point to mention is that despite portability of coverage in the IHCP, there are still a small number of very high- risk members who retain enrollment in these plans and refuse to change coverage. In addition, there are those who argue that while these anomalous premiums impact only a small number of people, such exorbitant pricing is an illustration of one of the failure of the reforms.

Table 2: Total Market Share in New Jersey’s Individual Health Coverage Program

	1997	1998	1999	2000	2001	2002	2003
Largest carrier	56.3%	62.3%	64.8%	62.4%	60.8%	59.3%	57.5%
Largest two carriers	63.6%	71.0%	78.2%	81.2%	81.5%	77.5%	74.7%
Largest five carriers	79.5%	91.0%	95.2%	97.9%	98.0%	97.7%	97.8%

Source: NJ Department of Banking & Insurance fourth quarter administrative data.

Community Rating and Guaranteed Issue and Renewal

The primary goal of the 1992 reforms was to increase access to non-group coverage, particularly for high-risk individuals. An obvious way to increase access is to make the coverage more affordable. One regulator described access and affordability as being analogous to two of the three legs of a stool. If one of the legs is off kilter or broken, then the stability of the entire stool is compromised.

After community rating reform was implemented, carriers could no longer employ medical underwriting models to calculate premiums. In the absence of such risk adjustment, a twenty-two year old man and a sixty-year-old woman would pay the identical premium for the same benefit plan. In this sense, the coverage became more *accessible* to the sixty year old woman, but less *affordable* for the twenty-two year old man. One interviewee commented, “the market is one big cost shift.” Not surprisingly, one regulator characterized community rating as a “subsidy” for the older, less healthy subscribers that is paid on the backs of younger, healthier subscribers in the form of increased premium costs.

In addition to using a community rating formula to set prices, guaranteed issue and renewal are other key features of the New Jersey’s IHCP market. This means that a member can never be denied coverage due to a medical condition or high utilization, provided he or she is able to afford the cost of the carrier’s premiums. Most insurance executives interviewed strongly oppose these guaranteed provisions. While acknowledging that these enrollment and renewal regulations have eliminated some access barriers, they also contend that the medical risk that is assumed by enrolling some of these members contributes to increased premiums for all IHCP members.

The Role of the Regulatory Board

The 1992 regulatory reforms also called for the creation of an oversight board. The Individual Health Coverage Program Board is comprised of nine members, including carriers, brokers, other regulators and consumers, and is served by an Executive Director. According to regulation, the IHCP Board is considered “in”, but not “of”, the New Jersey Department of Banking and Insurance. While there is consonance in their voice, the Department is vested with policy responsibilities, while the Board’s function is to evaluate regulations and review enforcement issues and litigation challenges.

The stakeholders, regulators, and other experts participating in this case study had mixed views with regard to the Board’s effectiveness and role in the individual coverage market. Many

felt the Board's perspectives were too influenced by the opinions of carriers (particularly those with the largest membership), while the carriers felt, despite its statutory autonomy, that the Board acts too much like an arm of the state's Department of Banking and Insurance and exerts little independent policy influence or judgment.

One interviewee suggested that while Board meetings present the proper venue to hold relevant policy discussions, there is a breakdown in terms of the ability to implement change. In addition, it was suggested that administrative changes in the Department (e.g., turnover in the Commissioner's office), negatively impacts the Board's functioning. Another consistent observation was that there is an absence of a strong consumer presence on Board. This would contribute to the perception that insurance carriers drive the Board's agenda.

Standardization of Plans

One of the key features of the 1992 IHCP reforms is the standardization of plan designs. The purpose of the standardized plans was to promote administrative simplification and facilitate consumer access to coverage. By limiting the number and range of plans that a carrier could offer (see Table 3 below describing the medical and hospital coverage for the indemnity plans and the HMO plan), it was thought that consumers could better comparison shop for benefits based on premiums and would not be overwhelmed by carriers offering a multitude of plan options.⁵

One interviewee also suggested that the standardized plans also prevent the problem of adverse risk selection in certain plans, i.e., with too large of a menu from which to choose, high-risk individuals would gravitate to the richest benefit options. Another interviewee commented that standard plans were well intended, but that the market had "gone beyond that" in terms of the lack of creativity.

Table 3: Characteristics of the Standard Health Benefits Plans

	Plan A/50	Plan B	Plan C	Plan D	HMO
Carrier/Covered Person Deductible	50%/50%	60%/40%	70%/30%	80%/20%	Carriers have the option to cover drugs at 59%
Deductible/Copayment Options	\$1,000/\$2,500	\$1,000/\$2,500	\$1,000/\$2,500	\$500/\$1,000	\$10/\$15/\$20/\$30
Hospital Copay	No	Yes-In addition to deductible	No	No	Yes

Source: New Jersey Individual Health Coverage Insurance Program Buyer's Guide found at <http://www.state.nj.us/dobi/reform.htm>

Basic and Essential Health Plan

In addition to the five plans described above, in January 2003 New Jersey implemented its Basic and Essential Health Plan designed to provide “bare bones” health coverage to members. While the premiums for this plan are more affordable than those for other more generous plans, the scope of coverage is understandably more narrow and geared toward inpatient confinements with a limited benefit for preventive outpatient services. The plan was designed to attract the younger, healthier subscribers and was thought to provide “gap coverage” for individuals who did not want to completely forgo health insurance, but also did not want to pay the higher premiums attached to a more comprehensive plan. The premiums vary by carrier and can be modified community rated or pure community rated. According to one expert, in 2003, rates for single Basic and Essential coverage ranged from a low of \$120 per month to a high of \$2,987 per month.

In addition, although the premiums are more affordable, the co-payments for covered services can be quite steep; e.g., a \$500 copayment per hospital stay and a \$100 copayment for an emergency room visit.⁶ Through the second quarter of 2004, take up in this plan has been quite modest, with a total enrollment of 1,387 lives.

Other Factors & Constituencies that Influence New Jersey's IHCP

Marketing Activity

The New Jersey carriers in this study confirmed that their companies spend few resources marketing this product, and rely, rather, on basic enrollment material to address inquiries. In addition, a recent survey of individual insurance market members, also conducted by Rutgers Center for State Health Policy, found that materials available on the New Jersey Department of Banking and Insurance's website, including rate sheets and a Buyer's Guide, were also considered valuable sources of information for subscribers and were used extensively in their purchase decisions.⁷

The Role of Brokers

In New Jersey, there is little broker activity in the non-group insurance market, with only two of the current carriers in the market engaging the services of brokers, or "producers" as they are known in the state. The producer or broker payment mechanism differs between the two carriers, with one paying commission based on a small percent of premium and the other paying a flat fee per member, per month. One interviewee concluded that there is little opportunity for brokers to enjoy large paydays selling in the individual market alone. This is the reason why individual coverage is generally just one of a number of products brokers will sell for a carrier or brokerage firm.

Legislature and Consumers

With regard to the New Jersey Legislature's role and their understanding of individual insurance coverage, several interviewees commented that given the host of policy issues that compete for their attention, legislators often do not get their hands around the complexities of the individual market. Out of necessity, legislators frequently make decisions based on information provided by active constituencies. The insurance industry is certainly one of those powerful and well-organized groups in New Jersey, with obvious and particular interest in legislation and regulations that have an impact on their business. New Jersey has a part-time "citizen" Legislature, so both the partisan and non-partisan staff assumes a large role in gathering information and interpreting regulations to inform the legislative debate. In addition, the New Jersey Legislature's very public and controversial attempt to deal with sky-rocketing medical malpractice and automobile insurance costs in the state have relegated non-group insurance reform to a less prominent place on the policy agenda.

While all the interviewees agreed that carriers have the access and resources required to influence policy, they also noted that there is an absence of a strong consumer voice in the individual market debate. One admitted that individual health coverage is just one of a myriad of issues in which she is involved, and therefore her ability to distill and understand the details is limited. Some suggest that the reason for this is that in addition to New Jersey rarely if ever being considered a consumer driven or activist state, there is no “one face” of members in New Jersey’s individual market as there is with some other issues that affect, for example, only the elderly, children or minorities.

One interviewee suggested that this dilemma could be resolved by having a funded consumer representative on the IHCP Board (modeled after the National Association of Insurance Commissioners) to mitigate some of the dominance of the insurance carriers. A funded Board position could allow for a consumer representative who has a greater understanding of the complexities of the issues and is more motivated to attend the meetings.

Potential Policy Options

In New Jersey, it seems clear that the political climate is conducive to only incremental policy reforms, and a wholesale rollback of the regulations seems quite unlikely. However, there is less agreement around which policy option offers the most promise. As previously noted, the apparent adverse selection spiral that characterized the market in the late 1990s and into the beginning of this decade seems to have slowed, with an estimated membership of 77,000 in the second quarter of 2004.⁸ Some have suggested that the steep decline was, at least in part, the result of a vibrant state economy that saw a rise in employer sponsored coverage. The argument follows that as the economy slowed, and other more affordable group coverage became less available, the mass exodus from the IHC abated. Despite the recent stabilization, most experts agree that this market is still in need of repair particularly when one considers that at its peak in 1996, the IHC boasted an enrollment of 200,000.

Modified community rating and flexibility in plan design appear to be two of the more popular and politically viable reform options, and alternatives that could offer the widest appeal to the largest group of stakeholders. However, there has been some additional discussion about creating a high-risk pool or some form of re-insurance mechanism to offset some of the costs carriers incur for catastrophic cases or, lastly, merging the individual and small group markets. Though opinions among those interviewed varied, in general, the latter two options meet with greater skepticism. Each policy option is briefly described below.

Modified Community Rating

As previously discussed, one of the key features of New Jersey's individual health coverage market is pure community rating; i.e., the absence of any risk adjustment in premium costs. Many argue that while community rating addresses the access issue for high cost individuals, the market, in its current design, is a magnet for adverse selection and raises the question of how long the young, healthy members will continue to be able to absorb the costs of insuring older and potentially less healthy members; the proverbial adverse selection spiral.

One policy option currently debated calls for a shift in the market from pure community rating to modified community rating where some characteristic, such as a person's age, gender or geography could be considered in setting premium rates. While several scenarios have been considered, some more seriously than others, the one possibility that appears to have the broadest appeal is a 2:1 age adjustment, similar to the design in New Jersey's small employer group market where there are defined rate bands based on age, sex and geographic location. In this scenario, the rate of the highest premium charged in the market can only be twice the amount of the lowest premium. Supporters argue that this approach would be incremental and would be the first step in addressing the risk selection dilemma and bringing some stability and perhaps even growth, back to the market.

It is significant to mention that some carrier representatives advocated taking an additional step and allowing medical underwriting to further mitigate some membership risk. As one expert observed, "Insurance companies have come to be claims payers, not insurance companies, because there is no medical underwriting."

While medical underwriting in a voluntary market would help control carrier costs, the policy change would likely jeopardize access to coverage as some individuals with existing medical conditions could be priced out of the market. Given the current unease in the political climate and the heretofore reluctance on the part of legislators to address this issue, it appears unlikely that a full-scale dismantling of community rating will take place.

Flexibility in Plan Design

A second policy option considers allowing some flexibility in the standard plan designs. Some regulators are generally supportive of the existing standardized plans (four indemnity, and HMO and bare bones plan), mostly because parallel benefit packages are easier for consumers to navigate and understand. In addition, providing a limited and comparable number of benefit plans is administratively more efficient for carriers. Several also commented that having standard plans also facilitates dispute resolution and complaint review.

However, there were a small number of interviewees who would agree that the current plan designs are restrictive for carriers. As mentioned above, a carrier representative asserted that insurance companies like to be creative and competitive in the design and marketing of their benefit plans. He commented that the standard plans had served their purpose of allowing consumers to better understand their benefit choices during the initial years following reform. However, since that time, the market had “gone beyond that,” and he expressed confidence that both the carriers and the consumers would benefit from an increased choice of plans.

Another stakeholder suggested that while plan modification is an option that warrants some discussion, adverse selection could be an unintended consequence since consumers who believe or know that they will need medical care may gravitate to the richer plans. None of the options under discussion can be considered without first accepting the premise that political and policy tradeoffs may be necessary in order to move forward successfully.

Creating High Risk Pools

Referred to by one interviewee as the “third rail” of health insurance reform, in New Jersey, many key stakeholders voiced strong reservations about a high-risk pool, particularly with respect to the funding that would be necessary to successfully implement and sustain this initiative. Although concern over the creation of a high-risk pool has been raised in many camps, it would be misleading to imply that there is consensus on the viability of this policy option. For example, one large carrier actively and openly lobbied the Legislature in support of creating a high-risk pool for New Jersey’s individual market.

This carrier, along with some other key constituencies including the New Jersey Association of Health Underwriters, estimated that it would take approximately \$75-\$100 million to adequately fund premium subsidies in this pool. In addition, they contended that a supplemental funding source (in addition to state dollars) would need to be identified in order for the risk pool to perform optimally.

One potential revenue source that has been discussed is money for which New Jersey might be eligible under the Health Coverage Tax Credit (HCTC) of the 2002 Trade Adjustment Assistance Reform Act. However, observers predict that New Jersey’s allocation would only range from anywhere between \$500,000 to \$2 million, making it more “seed money” for a high-risk pool rather than a viable source of supplemental funding. In addition, an initial funding application submitted by the New Jersey Department of Banking and Insurance under HCTC was denied in 2003 because New Jersey failed to meet the qualifications for funding a risk pool under this program.

As the high-risk pool debate continues (albeit less vocally recently), with nearly sixty percent of the individual market share, Horizon is certainly a force with which to be reckoned should they decide to push for this option. That having been said, given New Jersey's budget deficit, estimated at between \$4-\$5 billion, and the continued challenge of dealing with medical malpractice and automobile insurance reform, high-risk pools would seem to have formidable competition for a priority slot on the 2005 legislative agenda.

Small Group "Policing" & Merging the Markets

In New Jersey, where a small employer group is defined as 2-50 lives, both carriers and regulators agree that there is an increased effort to "police the border" between individual and small group policies to prevent "groups of one" from slipping through the eligibility cracks. In fact, it is becoming more common for carriers to review W-2 and other payroll records to verify applicants' eligibility for small group coverage, though nearly all interviewees agreed that migration into the Small Employer Health Benefit Program (SEHBP, a program that was also born out of the original reforms) occurs fairly regularly and violations can be difficult to identify. In light of this fact, there has been an increased policy discussion about the viability of merging the two markets. It is significant to note that this is not the first time that pooling the markets has been considered as a policy option. In a September 1996 report to the New Jersey Legislature, the Small Employer Health Benefits Program Board concluded that pooling the IHCP and small group markets was infeasible because it would increase small group premiums.⁹

Those who support this option believe that a market merger would result in a better risk pool and would address the cost barrier that currently exists for IHCP members. However, the majority of our study respondents felt that premiums would actually increase if the two markets were integrated because the small group segment, a robust and "healthy" market (illustrated by a third quarter 2003 enrollment of nearly 900,000) would be saddled with costs of high risk IHCP members. For that reason, most respondents did not advocate such a bold initiative. However, those who support the integration of the two markets suggest that de facto, the small group market already bears the costs of the smaller and unstable non-group market because carriers absorb financial losses in one product by increasing prices in their other lines of business. In addition, since the non-group market is less than one-tenth the size of the small group market, such a merger today might have fewer negative effects than once thought.

Conclusion

Cycles in IHCP enrollment appear to be correlated to the economic employment trends in the state. During the mid- to late-1990s when New Jersey enjoyed an economic boom and an increase in employer sponsored coverage, the individual market eroded as people had access to other forms of more affordable health insurance coverage. However, it appears that the non-group market has stabilized, due, at least in part, to the economic slow-down which swept through the nation over the past several years; fewer jobs translated into fewer opportunities to enroll in employer-sponsored coverage.¹⁰ If the recent economic upturn continues, as many predict, enrollment in the IHCP may respond accordingly and the market may once again face a dire risk selection scenario. The goal of new reforms would be to make the market more attractive to younger, healthier people who may not have access to employer sponsored coverage by making it more affordable.

It is impossible to predict which, if any, regulatory reforms policymakers and the New Jersey Legislature will favor. However, after completing the research for this case study, several concluding observations seem relevant. First, a complete dismantling of the current IHCP structure seems unlikely. Any reform will almost undoubtedly be incremental and will likely address one key feature of the current market design. Perhaps the first hint of the future can be seen in a recent bill submitted in the New Jersey Assembly. The “Health Insurance Affordability and Accessibility Reform Act” which would allow 2:1 modified community rating based on age, gender, and geography was introduced by Assemblyman Neil M. Cohen on October 7, 2004.¹¹ Assemblyman Cohen’s bill is the first recent attempt at legislative reform, albeit in a modest fashion. It is anticipated that this bill will be considered in early in 2005.

The second noteworthy point is that, regardless of which policy option is pursued, tradeoffs will be necessary for reform to move forward and be successful. For example, in order to strike a balance between access and affordability, costs may shift from one group to the other, and some constituency or stakeholder will no doubt object to the proposed solution. Consensus building will continue to be difficult during the debate, and all policymakers should be mindful of how decisions made today could impact the equilibrium of the entire insurance coverage market in New Jersey tomorrow.

The final observation is that while the debate among carriers, regulators, and other experts revolves around identifying the best mechanism to revive the IHCP almost all agree that some change is necessary to guarantee access to affordable coverage in the non-group market in New Jersey. The sustainability of this market and the desire to avoid periods marked by terms such as “death spirals” hinges on regulatory intervention.

Methods

In an effort to inform a multi-state study of insurance market reforms, the research team conducted a case study to learn more about New Jersey's health insurance landscape in 1992, as well as the impetus for the individual market reforms. Through key informant interviews, the authors looked at whether New Jersey's regulatory changes achieved their stated goals, discussed whether additional reforms are necessary to revive the state's faltering non-group market, and identified which policy options are most viable in the current fiscal and political climate. In the summer/fall 2003, seven state officials were interviewed, including regulatory and legislative service staff, four insurance carriers or brokers, and two consumer advocates. In addition, the research team reviewed current market administrative data and literature on the state of New Jersey's health insurance market. Findings from this research were shared with Nancy Kane and Nancy Turnbull, of the Harvard School of Public Health, to inform their paper, "Insuring the Healthy or Insuring the Sick: The Dilemma of Regulating the Individual Health Insurance Market". Their multi-state case study looking at the individual insurance market reform in seven states can be found at www.cmwf.org.

Endnotes

¹ Guaranteed coverage and renewal means that an eligible person is guaranteed health insurance coverage in the IHCP regardless of his/her health status. There is a 12 month waiting period for pre-existing conditions, though members will continue to receive coverage for conditions unrelated to their pre-existing condition. Community rating states that the same premiums will apply to all people who purchase the identical IHCP plan. There can be no premium differentiation based on age, sex, gender, occupation, geography, or health status. Additional details about these definitions can be found at <http://www.state.nj.us/dobi/bgihc98.htm#DESCRIP>

² Cantor JC, et al., *Facts & Findings*, “Non-Group Health Insurance in New Jersey,” New Brunswick, NJ: Rutgers Center for State Health Policy, July 2004 and Monheit AC, Cantor JC, Koller M and Fox KS. “Community Rating and Sustainable Individual Health Insurance Markets: Trends in the New Jersey Individual Health Coverage Program,” *Health Affairs*, July/August 2004.

³ Discussion follows Swartz K and Garnick D, “Unintended but Predictable Outcomes of Regulations: The Case of New Jersey’s Individual Health Coverage Program,” Unpublished Manuscript, January 12, 1998.

⁴ Monheit, Cantor, et al, July/August 2004.

⁵ Cantor et al. July 2004.

⁶ New Jersey Individual Health Coverage Insurance Program Buyer’s Guide found at <http://www.state.nj.us/dobi/reform.htm>.

⁷ Unpublished tabulations of the NJ Family Health Survey, IHCP Supplement, 2002, Rutgers Center for State Health Policy.

⁸ The second quarter 2004 enrollment number is relatively unchanged since second quarter 2003. In fact, the decline slowed to below 2% per quarter beginning in 2002 and decrease slipped even lower in 2003. Source: NJDOBI administrative data.

⁹ Monheit, Cantor, et al, July/August 2004. Also see New Jersey Small Employer Health Benefits Program Board, “The Effects on the Individual and Small Employer Health Coverage Markets of Permitting Individuals to Purchase Small Employer Health Benefits Plan: A Report to the New Jersey Legislature” (Unpublished report, September 25, 1996).

¹⁰ Monheit, Cantor, et al, July/August 2004.

¹¹ New Jersey Assembly Bill, No. 3359, introduced October 7, 2004. Copy can be found at <http://www.njleg.state.nj.us/>