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# Center for State Health Policy

*A Unit of the Institute for Health, Health Care Policy and Aging Research*

## Data for Planning a Temporary High Risk Health Insurance Pool in New Jersey

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## Executive Summary

The Patient Protection and Affordable Care Act (PPACA), signed by the President in March 2010, will lead to coverage of the majority of the uninsured across the nation beginning in 2014. Before these provisions go into effect, PPACA includes temporary measures to increase access to affordable coverage for many uninsured, including the creation of high-risk health insurance pools (HRPs) for individuals with pre-existing health conditions. States have the option of establishing a qualified HRP, and New Jersey has expressed intent to do so. The law makes \$5 billion available to fund HRPs through 2013, including a projected \$141 million available for HRP subsidies in New Jersey. Eligibility for enrollment in a new HRP will be limited to persons with pre-existing conditions who are lawfully resident and had been without creditable coverage for at least six months. The federal law also requires that HRPs cover a minimum 65% of insured expenses with no exclusions for pre-existing conditions, limits premiums to the “standard rate” charged to others, and provides rules for permissible premium variation by age and other factors. Subsidies will be available to fund expenses above the standard rate.

This analysis was conducted to provide information to the State of New Jersey for the development of its application to create a state-sponsored HRP. State officials requested that the Center for State Health Policy estimate the number of persons that would be eligible and the number that would enroll in a state HRP building on its existing Individual Health Coverage Program (IHCP). IHCP plan benefits would be enhanced to comply with PPACA rules for HRP coverage. The extent of claims within the HRP subject to federal reimbursement would depend on the “standard rate” applicable to HRP enrollees. Under one scenario, existing IHCP age-rated premiums would serve as the “standard rate”. In this scenario, HRP-eligible persons would pay premiums derived in the existing IHCP, adjusted to reflect the enhanced benefit package. However, it can be argued that the true “standard rate” should be lower than current IHCP premiums because prevailing practice in most states is to permit medical underwriting (i.e., setting premiums or denial of benefits or coverage based on health status). Thus, we estimate eligibility and enrollment based on medically underwritten-equivalent premiums that are 50% to 70% of current rates in the guaranteed issue IHCP.

Data from the New Jersey Family Health Survey, sponsored by the Center for State Health Policy, and the federal Current Population Survey are used to estimate the number of eligible and enrolled adults in New Jersey. Estimation procedures use coverage, health status, and income information from these surveys. Parameters not available in the surveys, including the number of otherwise qualified persons who are not legal residents and assumptions about purchasing behavior (i.e., take-up elasticities), are drawn from published studies. We impose an “affordability constraint”, assuming that no eligible person would pay more than 10% of income to purchase coverage.

This procedure yields a lower bound estimate of persons eligible for temporary high risk pool coverage in New Jersey of 164,160 and an upper bound estimate of 255,975. This estimate is sensitive to the definition of pre-existing conditions that is applied. A predicted take up rate of between 16.7% and 24.0% among eligible persons reflects the high cost of coverage, even with premiums based on a medically underwritten standard.

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## Introduction

New Jersey has a robust history of efforts to provide access to health insurance coverage for persons at risk of high health expenditures.<sup>i</sup> In 1992, New Jersey reformed its individual and small-group insurance market regulations to require all state-regulated carriers to enroll all individuals regardless of health status and to limit permissible variability in premiums based on age or other factors. In particular, pure community rating was imposed in the non-group market, called the Individual Health Coverage Program (IHCP). Under pure community rating, insurers were not permitted to take demographic factors, including age, into account when setting premiums. Earlier work by the Center for State Health Policy documented that the IHCP has enrolled disproportionately older and sicker persons, partly due to its guaranteed issue and community rating rules, leading to very high premiums.<sup>ii</sup> In 2008 New Jersey enacted legislation modifying its IHCP regulations.<sup>iii</sup> Today, coverage in the IHCP is made available to any individual regardless of health status, and premiums may vary by no more than 3.5 to 1 and may consider only the insured's age and geographic location.

The Patient Protection and Affordable Care Act (PPACA), signed by the President in March 2010, will eventually lead to coverage of the majority of the uninsured across the nation through a combination of Medicaid expansions, enrollment mandates, and public subsidies. Before these provisions go into effect in 2014, PPACA includes a number of provisions to increase access to affordable coverage for many uninsured persons. One of these early provisions is the creation of temporary high risk health insurance pools (HRPs) which will provide coverage for uninsured individuals with pre-existing health conditions at the same premiums that are available to others.<sup>iv</sup> The law, which makes \$5 billion available to fund HRPs through 2013, requires the Secretary of the Department of Health and Human Services (HHS) to implement this provision within 90 days of enactment (i.e., by September 23, 2010). On April 2, 2010, HHS Secretary Sebelius wrote to governors and state insurance commissioners soliciting interest in creating state-based HRPs,<sup>v</sup> to which New Jersey responded expressing preliminary intent to do so. HHS estimates that \$141 million will be available for HRP subsidies in New Jersey over 42 months.<sup>vi</sup>

Under PPACA, the temporary HRP will be required to:<sup>vii</sup>

- Provide coverage to all individuals without exclusion of pre-existing conditions.
- Guarantee a minimum actuarial value of 65% of covered costs (i.e., the insurer's share of claims payments must be at least 65% of covered costs while the insured's share in the form of deductibles and other cost sharing may not exceed 35% of covered costs). The law also limits participant out-of-pocket costs.
- Premiums may vary only by age, tobacco use, geographic area, and whether coverage is for an individual or family, and age rates may not vary by more than four-to-one.
- Participants may be charged no more than the prevailing "standard rate" without regard to "excess costs" arising from their health conditions. Federal subsidy funds would be used to fund these additional costs.

Eligibility for enrollment in the HRP is limited to persons with pre-existing conditions, lawfully resident in the US who had been without creditable coverage for at least six months.<sup>viii</sup>

This report provides estimates of the number of adults eligible for a federally-qualified HRP in New Jersey and the number of those eligible that is likely to enroll. This analysis was conducted at the request of Robert Schwaneberg, health policy advisor in the office of Governor Christopher Christie. Estimates of projected "excess claims" beyond the amount expected for those paying "standard rate" is another important planning parameter requested by the Governor's Office, but time and data constraints precluded inclusion of those estimates in this report. The following section briefly describes the design of a New Jersey HRP. Next, data sources and procedures for estimating the size of the HRP eligible population and number of persons likely to enroll are described along with the estimates of these parameters. A final section summarizes findings and limitations of these estimates.

## HRP Design

New Jersey officials requested that CSHP produce estimates of eligibility and enrollment of persons in a state HRP that permits eligible persons to enroll in the existing Individual Health Coverage Program (IHCP), with some enhancements to comply with federal HRP guidelines. Specifically, the standard 12-month waiting period for coverage of pre-existing conditions in the IHCP would be waived for HRP eligibles and benefits would be modified to comply with PPACA (e.g., eliminate the out-of-pocket maximum for prescription drug benefits). HRP eligible individuals would be permitted to enroll only in IHCP plans that are PPACA compliant. That is, plans not meeting the 65% actuarial value and other standards, including *Basic and Essential* plans, would not be available). The NJ Department of Banking and Insurance would work with IHCP carriers to calculate "excess claims" for which they would obtain federal HRP reimbursement.



The extent of “excess claims” subject to federal reimbursement would depend on the “standard rate” applicable to HRP enrollees. Under one scenario, existing IHCP age-rated premiums would serve as the “standard rate”. In this scenario, HRP-eligible persons would pay premiums derived in the existing IHCP, adjusted to reflect the enhanced benefit package, including waiver of the pre-existing condition waiting period. However, it can be argued that the true “standard rate” should be lower than current IHCP premiums because prevailing practice in most states is to permit medical underwriting (i.e., setting premiums or denial of benefits or coverage based on health status). Regulators in New Jersey estimate that a medically underwritten rate in New Jersey’s non-group market would be 50% to 70% of current premiums in the state’s guaranteed issue environment.

## **Estimation Procedures and Results**

Data from the 2009 New Jersey Family Health Survey (NJFHS), combined with information from the 2009 Current Population Survey (CPS) March Demographic Supplement, are used to derive the estimates in this report. Developed and sponsored by Rutgers CSHP, the NJFHS was designed to represent the state’s non-institutionalized population and collected data from 2,500 New Jersey households covering 7,336 individual household members. The survey asked questions about health insurance coverage, health status, socio-economic status, demographics and other topics. A description of NJFHS methods is provided in the Appendix to this report. The CPS is sponsored by the US Department of Labor and US Census Bureau and provides detailed data about health insurance coverage. While the CPS is commonly used for developing state health insurance estimates, it lacks some important information needed for this report. The NJFHS is used to support the core estimates in this report, and parameters from the NJFHS are applied to CPS coverage data to supplement these core estimates. Parameters not available in these data sets are drawn from published studies and applied in the estimation procedures as described below.

### ***Number of HRP Eligible Adults***

Federal rules limit eligibility for temporary HRP coverage to persons who had been uninsured for six months or more, have a pre-existing condition, and are legally resident in the U.S. Only adults (age 19 or older) are included in our estimates as other provisions of PPACA mandate that all health insurance plans cover children regardless whether they have pre-existing conditions. NJFHS questions about health status and duration of uninsurance provide direct measures of the number of persons meeting waiting period and pre-existing condition criteria. We adjust our eligibility estimates using data from the Pew Hispanic Center on the number of unauthorized immigrants in New Jersey.<sup>ix</sup> Based on this information, the following steps are used to generate the count of eligible individuals:

- 1.1 Identify adults (age 19+) in the NJFHS and the CPS for whom no source of coverage is reported.
- 1.2 Identify uninsured adults with a period of uninsurance of at least six months in the NJFHS, and apply the corresponding percentage to CPS estimates.
- 1.3 Identify adults with at least six months of uninsurance in the NJFHS reported with pre-existing health conditions and apply rates of pre-existing conditions to the CPS. Federal policy provides little guidance on what health conditions may be considered pre-existing for purposes of HRP eligibility; thus we use the NJFHS to create “narrow” and “broad” definitions of the number of eligible persons with pre-existing conditions. The narrow definition includes NJFHS participants who were reported to be in “poor” or “fair” general or mental health (based on questions that also included “good”, “very good” and “excellent” response categories). The broad definition includes 1) those reported in fair or poor health; plus 2) those reported to have had a health professional diagnosis of diabetes, asthma, or “any other type of serious or long-lasting medical condition;” or 3) any of a list of 15 serious health symptoms during the three months prior to the interview.<sup>x</sup>
- 1.4 Adjust the number of eligible persons to remove those not legally present in the US. According to a careful study by the Pew Hispanic Center, an estimated 550,000 unauthorized immigrants were resident in New Jersey in 2008. Of these, an estimated 84.7% are adults. Applying the estimated national uninsured rate among unauthorized persons from the Pew Center report (59%), 247,852 uninsured adults in New Jersey were unauthorized immigrants and ineligible for HRP enrollment. Applying proportions of uninsured persons who had been without coverage for at least six months from Step 1.1 (77.8%) and the range of estimates of those with pre-existing conditions from Step 1.3 (36.4% to 54.5%) yields a count of unauthorized immigrants who would otherwise be eligible for the HRP of 100,046 to 149,767.

Table 1 below summarizes these parameters and estimates. The NJFHS and CPS estimates differ for several reasons. First, NJFHS data are calibrated to the Census Bureau’s American Community Survey (ACS), which estimates a slightly smaller number of persons living in New Jersey households. Second, questions about insurance coverage in these surveys are structured differently, yielding somewhat different estimates.<sup>xi</sup> Other differences in survey design and field procedures may also affect these estimates. Nevertheless, using these two data sources provides a robust range of plausible estimates of the size of the HRP-eligible population. Differences between NJFHS and CPS estimates are small, but results are sensitive to assumptions about criteria for defining pre-existing conditions. These calculations yield a lower bound estimate of persons eligible for a temporary high risk pool in New Jersey of 164,160 (NJFHS data, narrow definition of pre-existing conditions) and an upper bound estimate of 255,975 (CPS data, broad definition of pre-existing conditions).

**Table 1: Estimates of Persons Eligible to Enroll in a Temporary High Risk Pool in New Jersey**

Parameter	NJFHS		CPS		Notes
	N	%	N	%	
<b>Population Counts</b>					
Number of adults (age 19 or older)	6,290,325		6,363,845		
Total uninsured adults	932,363	14.8	956,745	15.0	% of adults
Uninsured at least six months	725,641	77.8	744,617	77.8	% of uninsured
<b>Number Uninsured 6+ Months with Pre-Existing Condition</b>					
Narrow: Fair or poor general or mental health	264,206	36.4	271,115	36.4	% with pre-existing from NJFHS
Broad: Any health problem (see text)	395,402	54.5	405,742	54.5	
<b>Narrow Pre-Existing Condition Definition</b>					
6+ mo. uninsured & pre-x condition	264,206		271,115		From above
Less unauthorized immigrants	100,046		100,046		See text
Net number HRP eligible	<b>164,160</b>		171,069		
<b>Broad Pre-Existing Condition Definition</b>					
6+ mo. uninsured & pre-x condition	395,402		405,742		From above
Less unauthorized immigrants	149,767		149,767		See text
Net number HRP eligible	245,635		<b>255,975</b>		

Source: Rutgers Center for State Health Policy

Note: Lower and upper bound estimates are shown in bold

### ***Number of Persons Likely to Enroll***

Under the first policy scenario, persons enrolling in the HRP would pay the full premium based on experience in the existing New Jersey IHCP, adjusted for added benefits required under federal HRP policy. We assume that these required benefits would add approximately 10% to current premium levels.<sup>xii</sup> The research literature does not provide sufficient guidance to predict the number of uninsured HRP-eligible persons that is likely to enroll in the enhanced benefit at this premium level. By definition, these persons did not purchase coverage at prevailing IHCP rates (which would be 10% higher in the HRP). Even so, some eligible persons might be induced to purchase in the HRP because it would immediately cover services that are likely to be of great value to them. Nevertheless, because of the uncertainty about the likely response, we assume that no HRP-eligible persons would enroll under the new program under these circumstances.

As described above, if prevailing IHCP rates were adjusted to reflect common medical underwriting practices (banned in New Jersey), then premiums paid by HRP enrollees would be

between 70% and 50% of the IHCP rate. To estimate the number of persons likely to enroll at these rates we apply price responsiveness or “elasticity” (denoted " $\eta$ ") assumptions derived from econometric studies of non-group markets.<sup>xiii</sup> Specifically, reflecting the range of uncertainty in the published literature we apply elasticities of -0.4 and -0.6; that is, a 10% decline in price is expected lead to a 4% to 6% increase in enrollment. Applying these elasticity and premium parameters, HRP eligibility criteria, and observed take-up behavior in the existing IHCP market by persons with pre-existing conditions (using the same definitions described above), we calculate the number of HRP-eligible persons expected to purchase coverage (shown in the second and third columns of Table 2).<sup>xiv</sup>

We make one further adjustment to our estimates of total predicted HRP enrollment to account for the possibility that some consumers may not be able to afford coverage, regardless of their level of need. Simply applying elasticity assumptions does not account for affordability. Specifically, we calculate an “affordability threshold” below which it is assumed that consumers would not purchase coverage. For simplicity, we assume that annualized premiums in excess of 10% of family income can be deemed unaffordable. The net number of HRP-eligible persons we predict will purchase coverage *and* who can afford that coverage is shown in the right two columns of Table 2. The affordability threshold has a large impact on estimates of the number likely to enroll, even at premiums reduced to proxy medically underwriting. In sum, accounting for affordability, we estimate that take-up in the HRP would be between 16.7% (narrow pre-existing condition definition, -0.4 elasticity, premium at 70% of IHCP standard) and 24.0% (broad pre-existing condition definition, -0.6 elasticity, premium at 50% of IHCP standard).

**Table 2: Estimates of Persons Likely to Enroll in a Temporary High Risk Pool in New Jersey**

Pre-Existing Condition & Premium Definitions	Total Predicted Enrollment		Predicted Affordable Enrollment*	
	$\eta = -0.4$	$\eta = -0.6$	$\eta = -0.4$	$\eta = -0.6$
<b>Narrow Pre-Existing Condition Definition</b> (164,160 eligible persons)				
70% of Baseline	27,379	29,399	14,425	14,425
50% of Baseline	31,083	35,654	15,740	15,740
<b>Broad Pre-Existing Condition Definition</b> (255,975 eligible persons)				
70% of Baseline	96,845	109,943	36,094	39,241
50% of Baseline	103,986	126,111	41,954	61,594

Source: Rutgers Center for State Health Policy

\*Limited to persons for whom the premium is less than 10% of family income

## Conclusion

We estimate that a federally-qualified temporary HRP in New Jersey building on the existing non-group market would provide a new affordable coverage option for an estimated 14,425 to 61,594 long-term uninsured persons with pre-existing conditions. Our enrollment predictions depend on the acceptability to the federal government of New Jersey's plans to use a medically

underwritten proxy premium as the "standard rate". Like other states with guaranteed issue rules in their non-group insurance markets, New Jersey's efforts to provide access to coverage for persons with pre-existing conditions would put it at a significant disadvantage in meeting the intent of the PPACA HRP program if the federal government does not approve the use of medically underwritten premiums.

We estimate that a total of 164,160 to 255,975 adults would be eligible to enroll in the HRP, depending on the definition of qualifying pre-existing conditions and other modeling considerations. The predicted take up rate of between 16.7% and 24.0% among eligible persons reflects the high cost of coverage, even with medical underwriting. Many long-term uninsured persons with pre-existing conditions are low income, putting private coverage out of reach.

The estimates provided in this report reflect a series of assumptions and utilize survey data. There is therefore considerable uncertainty in these estimates. For instance, elasticity assumptions and take-up predictions are based on purchase behavior in the existing non-group market. Persons who have been uninsured six months or more and who have serious health conditions may not behave like the "average" person deciding whether or not to purchase non-group coverage. To the extent they do not, our predictions may be inaccurate. In addition, all survey data involve sampling and measurement errors which add additional uncertainty to our estimates. Further, we use data for 2009 (2008 for the CPS), which was a time of high unemployment and economic uncertainty. These circumstances may have affected our income and insurance behavior measures limiting the applicability of our findings to better economic times. To the extent possible, we provide ranges of plausible estimates in this report to account for underlying uncertainty.

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<sup>iii</sup> N.J. P.L. 2008, Ch. 38.

<sup>iv</sup> U.S. P.L. 111-148, §1101.

<sup>v</sup> Sebelius continues work to implement health reform, announces first steps to establish temporary high risk pool program. U.S. Department of Health & Human Services Web site. <http://www.hhs.gov/news/press/2010pres/04/20100402b.html>. Updated May 24, 2010. Accessed May 21, 2010.

<sup>vi</sup> Fact Sheet – Temporary High Risk Pool Program. U.S. Department of Health & Human Services Web site. [http://www.hhs.gov/ociio/initiative/hi\\_risk\\_pool\\_facts.html](http://www.hhs.gov/ociio/initiative/hi_risk_pool_facts.html). Accessed May 21, 2010.

<sup>vii</sup> U.S. P.L. 111-148, §1101(c).

<sup>viii</sup> U.S. P.L. 111-148, §1101(a) and (d).

<sup>ix</sup> Passel JS, Cohn D. *A Portrait of Unauthorized Immigrants in the United States*. Washington, DC: Pew Hispanic Center; 2009. <http://pewhispanic.org/files/reports/107.pdf>. Accessed May 21, 2010.

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- <sup>xii</sup> This assumption was derived in consultation with Neil Vance of the Department of Banking and Insurance.
- <sup>xiii</sup> Marquis MS, Buntin MB, Escarce JJ, Kapur K, Yegian JM. Subsidies and the demand for individual health insurance in California. *Health Serv Res*. 2004; 39(5): 1547-1570; and Congressional Budget Office. *The Price Sensitivity of Demand for Nongroup Health Insurance*. Washington DC: U.S. Government Printing Office; 2005.  
<http://www.cbo.gov/ftpdocs/66xx/doc6620/08-24-HealthInsurance.pdf>. Accessed May 20, 2010.
- <sup>xiv</sup> Take up equation available from the authors.

## **APPENDIX**

### **2009 New Jersey Family Health Survey**

#### **Summary of Methods**

The 2009 New Jersey Family Health Survey (NJFHS) was conducted between 11-3-08 and 11-5-09 by the Rutgers Center for State Health Policy (CSHP) and funded by the Robert Wood Johnson Foundation. The general goals of the survey were to provide precise population-based estimates of health care coverage, access, use, and other health topics important for policy formulation and evaluation in New Jersey over the next 3-5 years, to complement existing CSHP studies, and to provide trend data on important health care indicators.

Schulman, Ronca, & Bucuvalas, Inc. (Abt SRBI) conducted the survey fieldwork for the project under contract to Rutgers CSHP. The survey was a random-digit-dialed telephone survey of 2,100 families with landlines and 400 families with cell phones residing in the state of New Jersey covering 7,336 individuals. Low-income families (<200% FPL; n=570) and families with young adult unmarried children ages 19-30 (either living in the household or not; n=1151) were oversampled. The state was divided into 5 geographically contiguous areas containing socioeconomically similar counties and proportionate samples were drawn from each area in order to ensure representativeness for different areas of the state. The overall response rate was 45.4%; the landline response rate was 61.7% and the cell phone response rate was 26.0% (all using the AAPOR “response rate 3” formula).

The survey averaged 37.1 minutes in length (landline version 36.7 minutes, cell phone version 39.3 minutes), and landline respondents were paid \$15 for completing the survey while cell phone respondents were paid \$25. Addresses supplied by the respondents in order to receive the incentives were geo-coded for latitude and longitude via GPS software. Interviewing was conducted in both English and Spanish. The selected respondent in the family was the person who was most knowledgeable about the health and health care needs of the family. This person answered questions concerning all members of the household related by blood, marriage, domestic partnership, adoption, guardianship, or foster care, plus any other young adult children ages 19-30 not living in the household. The topics covered in the survey included health care coverage and young adult dependent coverage; health status; health care utilization (including detailed sections on emergency department utilization and patient-doctor relationship); access to care; attitudes about care-seeking and coverage; obesity (including food and physical activity behaviors and environment); care-giving and caregiver assistance; employment and earnings; and demographics.

The cell-phone sample was drawn from New Jersey families who only have a cell-phone (no landline available) or who have both a landline and a cell phone, but mainly use the cell-phone to receive calls and would be “very or somewhat unlikely” to answer the landline if it rang.

Sample weights were developed to adjust for differences in probability of selection of households and for possible biases arising from non-response or sample frame coverage gaps. For the landline respondents, base sampling weights to account for the 5 geographic strata were calculated as the population count of telephone numbers in the geographic divided by the total number of sample telephone numbers for the main sample and oversample released replicates for that stratum. As the cell phone sample is a state-wide equal probability sample, for these respondents the base weight equals the population count of telephone numbers in the cellular sampling frame divided by the total number of sample telephone numbers for the released replicates. Base sampling weights for respondents with both a landline and cell phone (which occurred in both the landline and cell phone samples) were multiplied by 0.50. All sampling weights were then divided by the count of telephone devices in the household (separately for cell phone only, landline only, and landline + cell phone households).

The base sampling weight was put through three iterations of sample “raking procedures” to assure that NJFHS population estimates reflect official estimates of population counts and demographics from the US Census Bureau. These population control totals non-telephone adjustment margin, ages of oldest and youngest adult in household, number of adults and children in household, total number of persons in household, own/rent home, telephone usage group, region of residence, household poverty level, presence of unmarried person in household ages 19-30, family/non-family household, highest education level among adults, race-ethnicity, education, marital status, gender and age) were drawn from the New Jersey 2005-2007 American Community Survey (ACS) PUMS. Non-telephone coverage was estimated by asking respondents about phone service interruptions in the past year. It has been shown that households with transient telephone coverage are much more similar to continuous non-telephone households than to continuous telephone households on both demographic variables and other variables such as health status and health insurance coverage. Telephone usage group population totals were developed from the 2008 National Health Interview Survey (NHIS) PUF for the Northeast Census Region (NCHS does not release state estimates). The 2009 percentage of cell-only households in the Northeast Census Region was estimated by applying the published NCHS percent increase in these households from July-December 2007 to July-December 2008 to the 2008 NHIS PUF estimate. Weights above the 97<sup>th</sup> and below the 3<sup>rd</sup> percentiles were trimmed to the 97<sup>th</sup> and 3<sup>rd</sup> percentiles, respectively, to reduce the increase in sampling variability arising from unequal weights.





  
The Rutgers University logo, featuring the word "RUTGERS" in a red, serif font. The letter "R" is stylized with a long, sweeping tail that extends downwards and to the left.

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