

NEW JERSEY SMALL EMPLOYER HEALTH BENEFITS PROGRAM FIELD RESEARCH REPORT

I. CONTEXT

Overview of Trends in New Jersey's Health Insurance Markets

In 2005, New Jersey's 8.7 million residents fell into one of several categories of health insurance coverage.¹ One-third of residents were insured by the state or federal government through Medicare, Medicaid, SCHIP, military, or the state or federal health benefits program. Another 26% of residents were insured through self-funded plans with large employers. An additional 13% were covered by fully insured large employers. Less than 1% was insured in the individual market. New Jersey's small employer group health insurance market (businesses of two to fifty employees) insured almost 11% of residents. Finally, 15% of residents remained uninsured.

New Jersey is one of the wealthiest states in the country with an average per capita income of nearly \$44,000 per year in 2005 compared to nearly \$34,500 for the U.S. as a whole.² Still, nearly 17% of state residents under age 65 were uninsured in 2005, a number that has been increasing over the last six years (Figure 1). Young adults in New Jersey have been most affected by increases in the uninsured rate. Health insurance coverage among those ages 19 to 34 has declined over the last several years compared to other age groups.

Similarly, the number of Medicaid and SCHIP beneficiaries in New Jersey has grown from 2000 to 2004, a sign that some New Jersey residents are struggling financially and have sought out coverage through the state's public programs (Figure 2). In fact, in 2007, over a million New Jersey residents were enrolled in Medicaid and NJ FamilyCare, nearly 12% of the state's population.³

Like other states, most New Jersey businesses are small and employ fewer than 50 workers (78% in NJ and 75% in the U.S. in 2005).⁴ However, most full-time employees work for large firms, leaving a little more than a quarter of New Jersey's full-time employees working for small firms (Figure 3). Most large firms in New Jersey offer health insurance coverage, while far fewer small firms offer coverage (Figure 4). Yet, since 2000, the percentage of large employers offering coverage has declined slightly from 98% in 2000 to 94% in 2005, while the percentage of small firms offering coverage has increased from 56% in 2000 to 62% in 2005. Furthermore, offer rates in New Jersey's small group market consistently exceed the U.S. average for small firms.

In fact, in 2005, most full-time employees worked at establishments that offered health insurance, though employees of small firms were less likely to be offered coverage than those of large firms (81% for full-time employees of small firms and 98% for full-time employees of large firms) (Figure 5). The percentage of full-time employees working for a large employer that offers health insurance coverage has been stable, 99% in 2000 and 98% in 2005, while the percentage of full-time employees working for a small employer that offers coverage increased from 76% in 2000 to 81% in 2005. In addition, a greater percentage of full-time employees of

small firms in New Jersey are offered coverage than in U.S. small firms on average, and in recent years offer rates increased more in New Jersey than in the U.S. small group market.

Health insurance premiums for New Jersey's small firms are much higher than those of large firms. In 2005, small firms paid almost \$500 more in total premiums per single enrollee than large firms (Figure 6) and about \$900 more per enrolled family (Figure 7). From 2000 to 2005, total premiums for single coverage increased approximately \$1,400 for both small and large firms. Premiums for family coverage increased more than \$4,000 from 2000 to 2005 for small firms and about \$3,800 for large firms.

The proportion of the premium paid by the employer has also remained relatively steady for all New Jersey firms from 2000 to 2005 (Figures 6 and 7). On average over the six-year period, smaller employers contributed a greater proportion of the premium for single coverage than large employers (86.3% for very small employers, 83.6% for small employers, and 82.7% for large employers). For family coverage, very small employers contributed the most toward premiums on average over the six-year period (83.7% for very small employers, 78.3% for small employers, and 79.4% for large employers) though this trend may be because some very small employers in New Jersey employ their spouse.

In short, New Jersey's private employers are managing to maintain offer rates and coverage despite high and rising health insurance premiums over the last several years. In fact, New Jersey's health insurance premiums are among the most expensive in the country, especially in the small group market where premiums are the fourth highest for single coverage and third highest for family coverage.⁵ Offer rates have remained steady and even grown in the small group market. Employers continue to contribute more than 80% of total premium costs per enrollee, on average. However, New Jersey's full-time employees continue to share the burden of increasing premiums as their out-of-pocket expenditures toward premium contributions also raise.

New Jersey's Health Insurance Regime

New Jersey's private health insurance market is regulated by the NJ Department of Banking and Insurance (DOBI). In particular, DOBI oversees the individual and small group health insurance markets as well as monitors HMO and other private coverage enrollment and premiums.

In 1992, New Jersey reformed its individual and small group health insurance markets. These changes were implemented in the individual health insurance market in 1993 and in the small group market in 1994. The reformed individual market is now called the Individual Health Coverage Program (IHCP) and the reformed small group market is called the Small Employer Health Benefits Program (SEHBP).

The IHCP covers individuals without access to group coverage, including sole proprietors and their families. Health insurance premiums in the IHCP are based on community rating and standardized plans are offered. Only recently has the IHCP begun offering plans with premiums based on modified community rating that vary by 3.5 to 1, based on age, gender, and geography,

but not health status. These are dubbed “Basic & Essential” plans (B&E) because the standard B&E plan includes only minimum benefits.

Unfortunately, the IHCP has been struggling to maintain enrollment and keep premiums affordable. In 2005, the average annual premium per enrollee in the IHCP was \$4,744, while in the SEHBP the average annual premium per enrollee was \$3,524⁶ and enrollees in the individual market usually purchase less rich policies with more cost sharing than those in the small group market. In addition, enrollment in the IHCP declined from 220,384 at the end of 1995 to 77,571 at the end of 2005.⁷

Enrollment increased somewhat in 2006, when the IHCP began to allow insurance carriers to add benefits to the B&E policies through coverage riders. This resulted in a richer benefit package, while premiums were still determined by modified community rating. Since then, enrollment in B&E policies has increased, as these policies are particularly attractive to young adults who benefit from lower premiums. In the third quarter of 2007, enrollment in the IHCP was 87,579, about 29% of which were enrollees in B&E plans.⁸ Outside of the B&E policies, enrollment in the IHCP has continued its decline.

The SEHBP covers small businesses with two to fifty employees and their families. Health insurance premiums are determined using modified community rating based on age, gender, and the location of the business. Rates may vary two-to-one across eligible subgroups. Standardized plans are offered, though there is great flexibility in how these standard plans are implemented. Carriers are allowed to alter standard plans by submitting riders that detail any reductions or additions in benefits relative to the standard plan. The result is that a wide variety of insurance products are offered in New Jersey’s SEHBP.

Since 1995, enrollment in the SEHBP has been steady at around 900,000.⁹ Average annual premiums per enrollee in the SEHBP were similar to New Jersey’s fully insured large group market in 2005, \$3,524 in the SEHBP and \$3,603 in the large group market.¹⁰ In fact, in 2005, the percentage of New Jersey’s full-time eligible employees that enrolled in coverage at small firms that offered coverage was slightly higher than the national average, 78.9% in New Jersey and 78.5% in the nation.¹¹

New Jersey policymakers consider the IHCP unstable because of declines in enrollment and increases in premiums. In addition, it is widely believed that sole proprietors are fleeing the IHCP by employing their spouse as a means of joining. As a result, the difficulties of the IHCP impact the SEHBP. The incentive for families to move from the IHCP to the SEHBP is magnified by differences in permitted rating variations by age. When policymakers consider solutions for the IHCP they often consider changes to the SEHBP because they were part of the same reform package. However, some in the insurance industry feel this is unfair to the SEHBP, which is currently a healthy and stable market.

Many ideas have been proposed to remedy the difficulties of the IHCP market including reinsurance, risk pools, and merging with the small group market. A reinsurance mechanism could control costs in the IHCP by allowing insurance carriers to share the risk of high cost enrollees with other carriers or the state government.¹² When claims costs attain a predetermined

amount, the reinsurance mechanism covers some or all of the claims until an upper threshold is reached, at which time the originating insurance carrier again assumes full risk for claims. High risk pools separate higher cost enrollees in the individual market from other enrollees, making premiums for healthy individuals much more affordable. Those in the high risk pool may still enroll in a comprehensive private market insurance product at about 125% to 200% more than the average individual market rate. The balance of the cost for insuring these high risk individuals is funded either by the state or through an assessment on health insurance carriers in the state. Reinsurance mechanisms or high risk pools that require state funding are not currently being considered because of New Jersey's current fiscal challenges. Reinsurance or high risk pools funded through assessments on New Jersey's insurance carriers may be possible. However, these assessments are often passed on to the insured population through higher premiums for coverage. As such, these options have garnered little interest among policymakers.

Some have championed the idea of merging the IHCP and SEHBP including Commissioner Steven Goldman of the New Jersey Department of Banking and Insurance. Those who oppose merging the markets are concerned that bringing individuals and sole proprietors into the small group market will increase premiums for all small groups. Insurers report that individuals and sole proprietors are more costly than groups because individuals can self-select into policies that match their medical needs and group contract provisions offer greater protection to insurers than individual policies.¹³ Commissioner Goldman would like to merge the markets and add a reinsurance mechanism to control premiums for older individuals in the IHCP, to prevent a negative impact on premiums for those in the SEHBP. Data estimates from the NJ DOBI indicate that merging the individual and small group markets, without a reinsurance mechanism, would increase premiums in the small group by less than 1% and would insure approximately an additional 100,000 people. According to DOBI and an independent study, bringing age rating into the individual market would increase enrollment and stabilize premiums by attracting more young enrollees.¹⁴ In addition, the lower risk profile of the small group market would further stabilize the IHCP.

Other stakeholders believe that sole proprietors bear similar risk to small groups of two spouses that are permitted to enroll in the small group market. They question the equity in allowing groups of two to benefit from reduced premiums in the small group market, while sole proprietors are subject to higher premiums in the IHCP. However, taking sole proprietors out of the IHCP would damage the IHCP risk pool and reforms to that market would be necessary to maintain access to coverage for those not offered coverage through an employer.

In March of this year, a new bill, introduced by a bipartisan group of state legislators led by Senator Joseph Vitale, would institute regulatory changes in the IHCP and SEHBP with the hope of stabilizing the IHCP and making both markets more affordable. There appears to be strong support among state policymakers for these reforms. The bill proposes modified community rating based on age with 3.5 to 1 rate bands for the IHCP market, in addition to the Basic & Essential plans already offered that allow for rating variation based on age, gender, and geography. The bill also requires that carriers participating in the SEHBP also participate in the IHCP. The number of standard plans required in the IHCP and SEHBP would be reduced from five to three. Also, carriers offering policies in the IHCP would be allowed to use riders to modify the standard plans with both additions and reductions in specified benefits.

In the large group fully insured market, premiums can be based on age, gender, location of the business, health status, medical claims experience, and other factors. However, the same premiums must be charged to all enrollees in the group without discrimination against individual members of the group that may be higher cost or higher risk than others. All fully insured health insurance plans in New Jersey are guaranteed issue and guaranteed renewable.

New Jersey does require certain mandated benefits in all fully insured health insurance plans including those sold in the SEHBP.¹⁵ These benefits are mandated through legislation. However, the legislature may refer proposed mandate bills to an advisory commission made up of seventeen members. This advisory commission reviews the bill and makes recommendations based on the social and financial impact of the mandate as well as the medical efficacy of the proposed health benefit. There are currently thirty-one mandated benefits in New Jersey including coverage for alcoholism treatment, mental illness, bone marrow transplants, congenital bleeding disorders, home health care, and nursing home care. Infertility and diabetes treatment are mandated for the large group market but not the SEHBP or IHCP. However, coverage for diabetes treatment is already included in SEHBP and IHCP standard plans. Regulators did not feel that New Jersey's benefit mandates affect health insurers' decision to do business in the SEHBP, perhaps because our mandates are not more onerous than in other states.

As with all fully insured health insurance plans in New Jersey, since 2006, the SEHBP allows for health insurance coverage of domestic partners in civil unions. Also, in 2006, New Jersey enacted a coverage expansion to include over-age adult dependents less than thirty years old with continuous coverage under a parent or guardian's policy from age eighteen. These expansions allowed for greater access to health insurance coverage, including the SEHBP.

II. REFORM

Political Origins

Prior to New Jersey's small employer health insurance reforms, the percent of uninsured residents had grown from 7.9 in 1987 to 13.3 in 1992.¹⁶ At that time, insurers could choose not to insure certain individuals or groups if they might be high risk or have known pre-existing conditions.¹⁷ Blue Cross Blue Shield of New Jersey was the insurer of last resort so they did offer coverage to all individuals and small groups. However, premiums charged could be very high and incorporate age, gender, geography, industry, and health rating. Even for individuals and small groups offered coverage, premiums could vary greatly making insurance coverage very expensive for older and sick residents. In fact, insurers could deny coverage for pre-existing conditions forever. This created 'job lock' as employees needed to remain with their current employer in order to hold on to coverage for a health condition. A few insurers would do post claim underwriting and terminate groups based on claims experience.

Legislators in the state Assembly and Senate supported reforming these markets in response to pressure from the public, business associations, most notably the New Jersey Business and Industry Association (NJBIA), and some health insurers that desired a fair chance to compete for

contracts offering reliable coverage. In particular, a coalition of business and retail merchant representatives called the HEAL Coalition (Help Establish Affordable Healthcare Laws) was formed to work with carriers to reform the markets and create greater accessibility and portability of coverage. Insurance brokers and agents were initially against the reform because they were concerned that too few plan options would be offered and that small groups would no longer seek or need their assistance in choosing a policy. However, as the reforms were worked out it became apparent that coverage riders would allow small groups many choices for coverage and that brokers could still play a role in assisting them with selecting the best coverage option for their group. In fact, the small group is easier for brokers to manage under the reform because they need not be concerned that individual employees will be denied coverage or premiums could vary greatly across enrollees.

Stakeholders in the SEHBP including regulators, insurers, and brokers report that the SEHBP is healthy. Enrollment is considered good and there are many coverage options with several different carriers. The loss ratios are high so the premiums are appropriate relative to claims. However, small businesses and their employees feel that premiums are expensive in the SEHBP. This is a reflection of medical inflation that has increased insurance costs for all group sizes. Some stakeholders feel that high premiums in this market keep enrollment below what could be achieved and that lack of enrollment growth in the SEHBP may indicate that the market is not meeting the needs of all small businesses.

When stakeholders were asked whether the SEHBP has become institutionalized and broadly supported or controversial, all responded that it is institutionalized. Some stakeholders have concerns about the market, but in general they feel that it is broadly supported.

Description of the Small Employer Health Benefits Program

The SEHBP is based on five standardized plans and an HMO. All insurance carriers in the SEHBP must offer the five standard benefit plans, A through E.¹⁸ Plan A is the most basic, covering only hospitalization. Plans B through E are comprehensive medical plans covering the same medical and hospital services but at different rates of coinsurance (the percentage of costs covered by the insurance plan). Plan B has a 60% coinsurance rate, plan C has a 70% coinsurance rate, plan D has an 80% coinsurance rate, and plan E has a 90% coinsurance rate. Carriers are allowed to be flexible in how they structure these plans. For example, they can offer PPO or POS plans as long as either the in-network or out-of-network coinsurance rate matches the rate of one of the standard plans. A standard HMO plan designed by the Board is also available. In March 2008, legislation was introduced that may reduce the number of standard plans offered in the SEHBP to three.

Insurers are also permitted to submit riders to these five standardized plans that either add to or take away from benefits of the standard plans. So, in practice, many plans are available to small businesses in this market. Policies sold in the SEHBP vary greatly by coverage, premium, and network of providers.

The SEHBP, like other small employer markets, is guaranteed issue. So, small employers and their employees can not be denied coverage or renewal. In order for a small employer to participate in the SEHBP, 75% of the business's full-time (25 hours per week or more) employees must be enrolled in group coverage, through that small employer, another group plan, or Medicare. Small employers in the SEHBP must also contribute a minimum of 10% of the total health insurance premium.

Premiums in the SEHBP are determined using modified community rating where rates can vary by 2 to 1 and can be based on age, gender, and the location of the business, but not health status of the employees. When the SEHBP reform was first implemented the plan was to start off rating the small group market using 3 to 1 rate bands and then move the market to 2 to 1 rate bands, and then pure community rating. However, soon after the legislation was passed, the Board did a study to assess the impact of moving this market to pure community rating and found that they should not. New legislation was later passed to freeze the rate bands for the SEHBP at 2 to 1.

Health insurance carriers may impose a six-month limitation on coverage of pre-existing conditions for small businesses with 2-5 employees for conditions that were diagnosed or treated within six months of enrollment in the SEHBP (except pregnancy).¹⁹ Enrollees can receive credit toward the pre-existing condition waiting period with prior health insurance coverage. Therefore, those insured for the six months prior to enrollment in the SEHBP plan would not be subject to the pre-existing condition exclusion. Carriers may not impose pre-existing condition exclusions on small businesses with 6-50 employees.²⁰

Implementation and Management

As described earlier, the New Jersey Department of Banking and Insurance oversees and regulates health insurance markets in the state including the SEHBP. A staff of three or four does the administrative work of managing the SEHBP as well as the IHCP. This staff reviews and approves insurers' requests for modifications to the standardized plans. Enrollment reporting, premium comparisons and the loss ratio requirement described below are also managed by the DOBI staff.

The SEHBP is run by a Board of Directors made up of eighteen members including insurance carriers, brokers, a physician, representatives of small businesses and others.²¹ Members of the Board of Directors are nominated by the SEHBP Executive Director and appointed by the Governor's office. The Board meets monthly and members serve without compensation. The Board is a state agency with rulemaking authority and its administrative costs are funded by assessments on health insurers, though costs are minimal. The Board and DOBI staff are responsible for implementing any legislative changes to New Jersey insurance regulation that impact the SEHBP.

Prior to the small group reform, DOBI had prior-approval authority for premiums charged to small employers. However, this process led to significant delays in bringing new plans to the market. In addition, when DOBI did not approve a rate, the insurer would sometimes initiate litigation. This process was costly and time consuming for both DOBI and insurers. Under the

SEHBP, neither DOBI nor the Board regulates premiums charged by insurers in the market, though carriers are required to file rates with DOBI prior to using them.

To insure that premiums charged to small group enrollees are not exorbitant, insurance carriers are required to have a minimum loss ratio of 75%, so that at least 75 cents of every premium dollar is paid out as claims for health services. If this minimum loss ratio is not met then carriers must pay that portion back to policyholders. In 2006, the overall loss ratio for the SEHBP was 81.8% after three insurers made premium refunds to policyholders.²² Overall loss ratios in New Jersey's small group market in 2005 were similar to the fully insured large group market, but lower than in the IHCP.²³ Legislation introduced in March 2008 would increase the minimum loss requirement to 80%.

Most regulators felt that the SEHBP was not difficult for the state to manage. However, insurance carriers did feel that it was at least somewhat administratively burdensome. The biggest management issue cited by stakeholders was the use of the standardized plans in the SEHBP. Insurers in the SEHBP must submit several forms in order to describe an insurance product that they would like to introduce. They submit a form to describe the new product as a standard plan and then rider forms describing the benefits they are adding and/or taking away. Instead, insurers would like to submit one set of paperwork that describes the plan as it is, as is done in other states. This administrative process means that insurers have to submit and maintain additional paperwork to operate in New Jersey's SEHBP and some argue that these costs are passed on to consumers in their premiums.

In addition, some feel that the standard plans in the SEHBP are obsolete and should be updated to include products commonly sold in today's health insurance markets. The process for changing standard plans in the SEHBP is somewhat cumbersome for the Board, DOBI, and insurers. Changes to the SEHBP market are difficult because the market was created through a lengthy rule-making process required by legislation. So, altering rules that are no longer ideal may require months to be implemented. Some have suggested that a reduced standard benefit package should be permitted so that carriers can offer lower cost options in the SEHBP. However, regulators fear that offering a less rich standard plan will reduce benefits below what is acceptable and enrollees may not realize that the benefits are limited until they try to file a claim.

New legislation introduced in March 2008 would continue the use of standard plans (though the number of standard plans would be reduced from five to three) and allow insurance carriers to use riders to modify those standard plans. In addition, to improve price transparency in this market, the legislation would require that the price for the standard plan be listed separately from the price adjustment(s) for riders to the standard plan. In this way, employers can compare the cost of different policies within and across carriers and better understand how the price was derived. Similarly, agents and brokers would be required to disclose their fees and commissions to employers.

Another concern raised about small group market regulations is that employers are permitted to offer an unlimited number of plans. This allows employees to choose plans to meet their health care needs, which may result in adverse selection. Carriers contend that adverse selection into richer plans is raising premiums in those plans and making them unstable. In addition,

enrollment in multiple plans is complex and costly for carriers to administer. A legislative bill introduced in March 2008 would still allow employers to offer multiple plans, but would require that the employer only offer policies from one insurance carrier. This may help insurance carriers to limit adverse selection across plans. Until recently, employees in the SEHBP could also switch plans as frequently as they wanted. However, after much discussion, the Board agreed to allow a plan change only once in twelve months at renewal. This change reduced the ability of enrollees to move into richer benefit plans when they need medical care, and to return to less rich plans when they are healthy.

Finally, over the past few years, the SEHBP Board has been considering the choice of fee schedule for out-of-network claims. The SEHBP currently requires insurers to reimburse out-of-network claims at 80% of Ingenix's Prevailing Healthcare Charges System (PHCS) commercial pricing data. However, insurers argue that these fees are inflated because they are based on whatever a physician chooses to bill major insurers for their services. Insurers contend that this fee schedule results in higher premiums for plans with out-of-network benefits and that changing this fee schedule would lower premiums for popular insurance products.

The alternative to the current fee schedule is the Medicare Resource Based Relative Value Scale (RBRVS) physician payment schedule and then reimburse at 150% to 200% of these rates. However, Medicare rates are routinely criticized by providers for being too low. Some products sold in New Jersey's large group market already use the RBRVS fee schedule and insurance carriers would like this fee schedule to apply to the small group as well.

Program Effectiveness

Most stakeholders and regulators consider the SEHBP a success. In 2005, almost two-thirds of small firm establishments offer health insurance and over 80% of full-time employees of small businesses are at firms that offer insurance (Figures 4 and 5). Enrollment in the SEHBP market grew from 1994 when the program was first implemented to 1999 and then leveled off and has remained stable since (Figure 8). Ten different insurance carriers participate in the SEHBP, and competition is considered adequate. Horizon BCBSNJ, Aetna, and United Healthcare/Oxford insure the greatest proportion of the small group market (Horizon 44%, Aetna 25%, and United Healthcare/Oxford 17% in the third quarter of 2007).²⁴

Stakeholders also agree that the SEHBP reform has achieved intended objectives for the market. The main objective of the reform was to guarantee accessibility to health insurance coverage for employees of small businesses, especially those with significant health problems. Guaranteed issue and guaranteed renewability (now required in all small employer markets as per federal Health Insurance Portability and Accountability Act legislation) ensure access to the market and portability of coverage. In addition, keeping the employer contribution requirement low, using modified community rating to keep premiums reasonable, and including family coverage resulted in more small businesses offering coverage through the SEHBP. Many more employees of small businesses in New Jersey have access to coverage than in the nation as a whole (Figures 4 and 5). The reform also sought to reduce coverage restrictions based on pre-existing conditions, which it did.

The greatest challenge to the SEHBP, as in other New Jersey markets, is that some may not be able to access coverage because of unaffordable premiums. The impact of medical inflation on premiums affects all New Jersey health insurance products, not just the SEHBP. However, average premiums in the SEHBP remain higher than the average for large groups (Figures 6 and 7). This trend is more acute in New Jersey than in the nation as a whole where premiums for single coverage among small firms was less than \$200 more than large firms and premiums for family coverage in small firms were actually less than in the large firms.²⁵

Stakeholders point to one factor in particular that contributed to the successful implementation of the SEHBP reform and that is the creation of a diverse Board of Directors. High level representatives of all the key stakeholders in the market were able to share their expertise and perspectives early on and have a say in how the legislation was implemented. As a consequence, these stakeholders supported the final market regulations. Since then, the Board's impact has diminished as it now makes fewer decisions about the market's structure, but is instead focused on enforcing SEHBP rules and maintaining gains in health insurance coverage accomplished through these initial reforms.

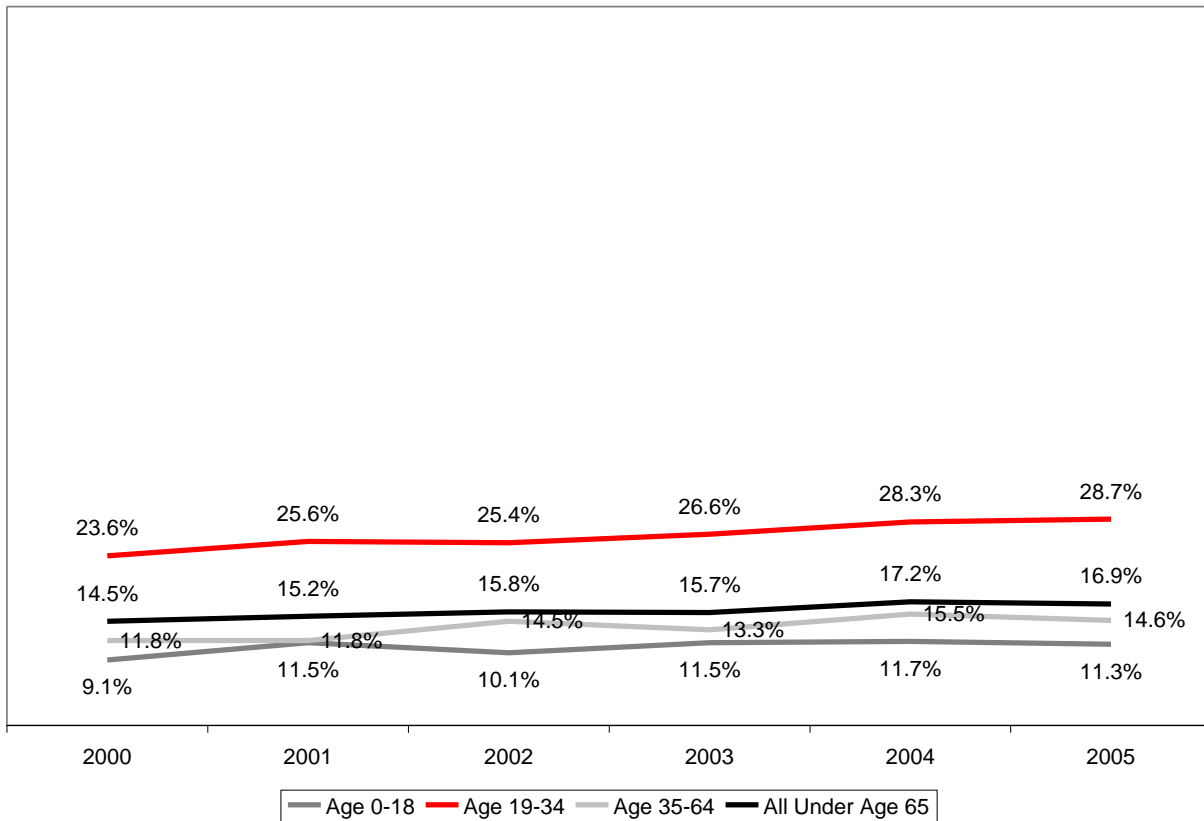
CASE STUDY STAKEHOLDER INTERVIEWS

NAME	TITLE AND ORGANIZATION*
Ellen DeRosa	Executive Director NJ Individual and Small Employer Health Benefits Program Boards
Ward Sanders	President NJ Association of Health Plans
Gale Simon	Assistant Commissioner NJ Department of Banking and Insurance – Life and Health
Christine Stearns	Vice President of Health and Legal Affairs NJ Business and Industry Association
Jim Stenger	Principal NAS Financial Services Small Employer Health Benefits Program Board Chairperson
Lilton (Tony) Taliaferro	Vice President AmeriHealth Small Employer Health Benefits Program Board Vice Chairperson
Neil Vance	Managing Actuary NJ Department of Banking and Insurance – Life and Health

* Opinions expressed by case study interviewees are their own and not the opinions of their organization or the Small Employer Health Benefits Program Board.

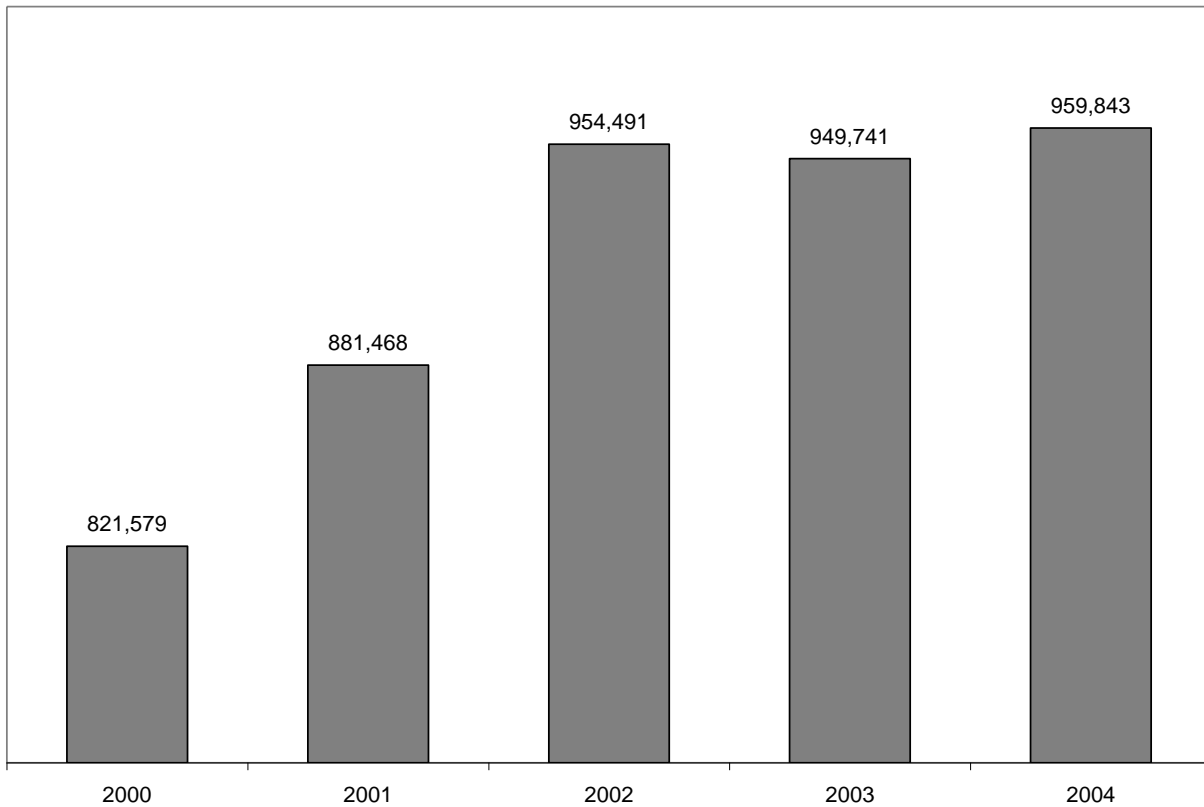
Note: Stakeholder interviews were conducted in February 2008.

Figure 1: New Jersey's Percent Uninsured by Age, 2000-2005



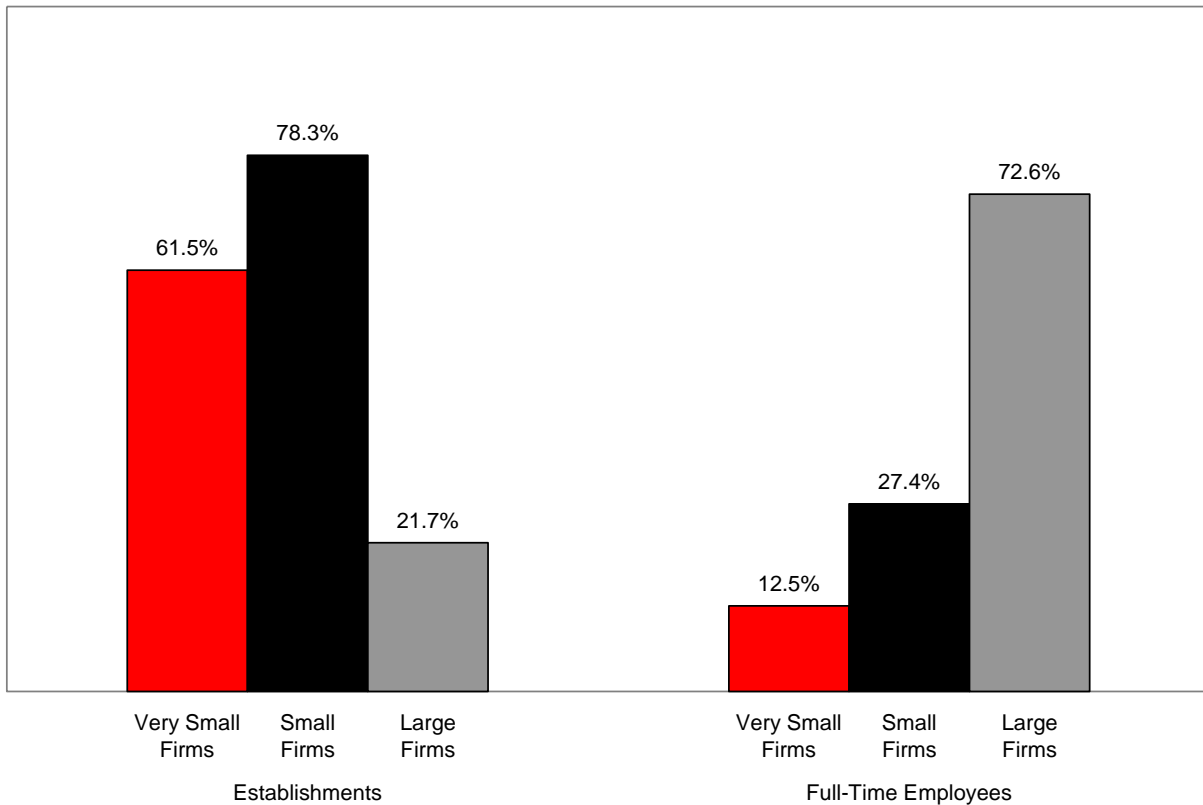
Source: Current Population Survey, Annual Demographic File, Bureau of the Census. Data analyzed by The Center for Health Statistics, NJ Department of Health and Senior Services. Accessed on 1/14/08 at <http://www.state.nj.us/health/chs/hic.shtml>.

Figure 2: New Jersey Medicaid and SCHIP Beneficiaries, 2000-2004



Source: U.S. Centers for Medicare and Medicaid Services, Center for Medicaid and State Operations, National MSIS State Summary Tables, Revised 6/22/2007. Accessed on 1/15/2008 at www.cms.hhs.gov/MedicaidDataSourcesGenInfo/02_MSISData.asp#TopOfPage.

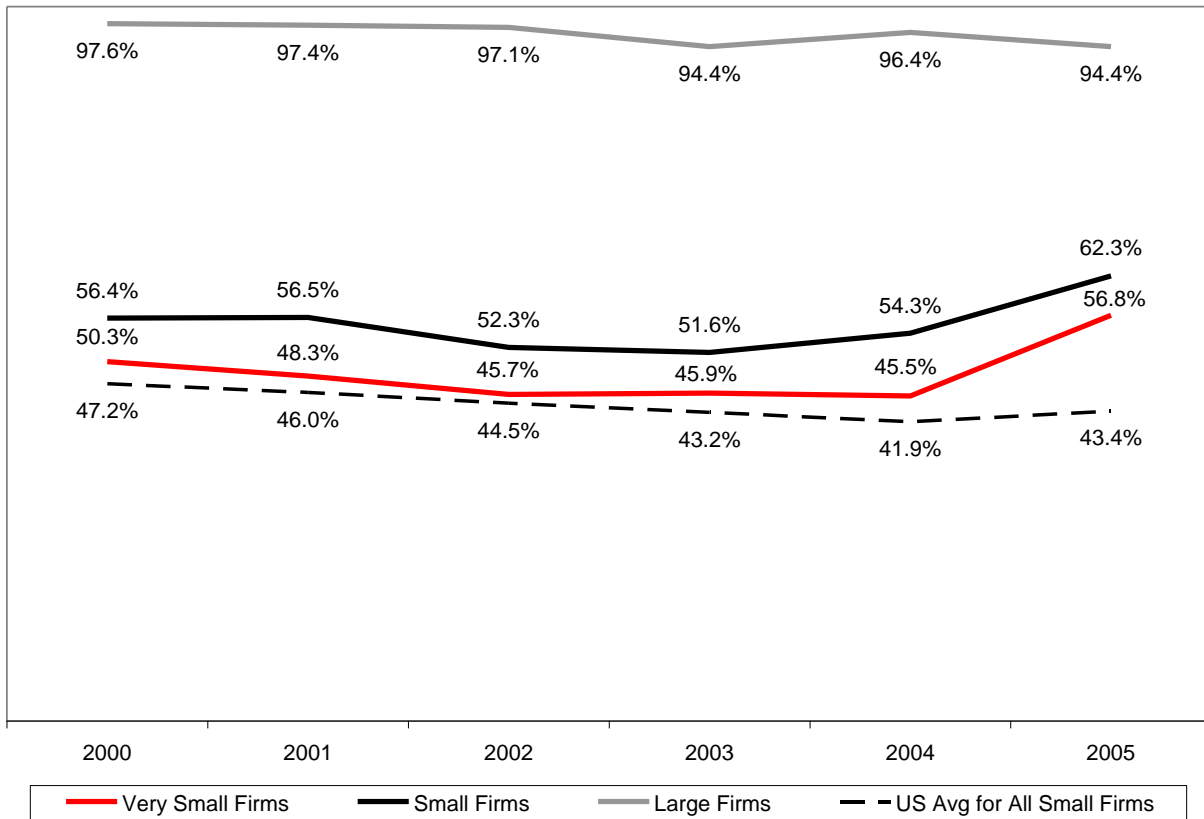
Figure 3: New Jersey Businesses and Full-Time Employees by Firm Size, 2005



Note: The designation of ‘Very Small Firms’ corresponds to the MEPS-IC category of 2-9 employees. ‘Small Firms’ corresponds to the MEPS-IC category of 2-49 employees. ‘Large Firms’ corresponds to the MEPS-IC category of 50+ employees. The MEPS-IC firm size categories do not exactly match NJ small group health insurance market sizes, which include firms with 2-50 employees.

Source: Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. Medical Expenditure Panel Survey – Insurance Component. Accessed on 1/17/2008 at http://www.meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=2.

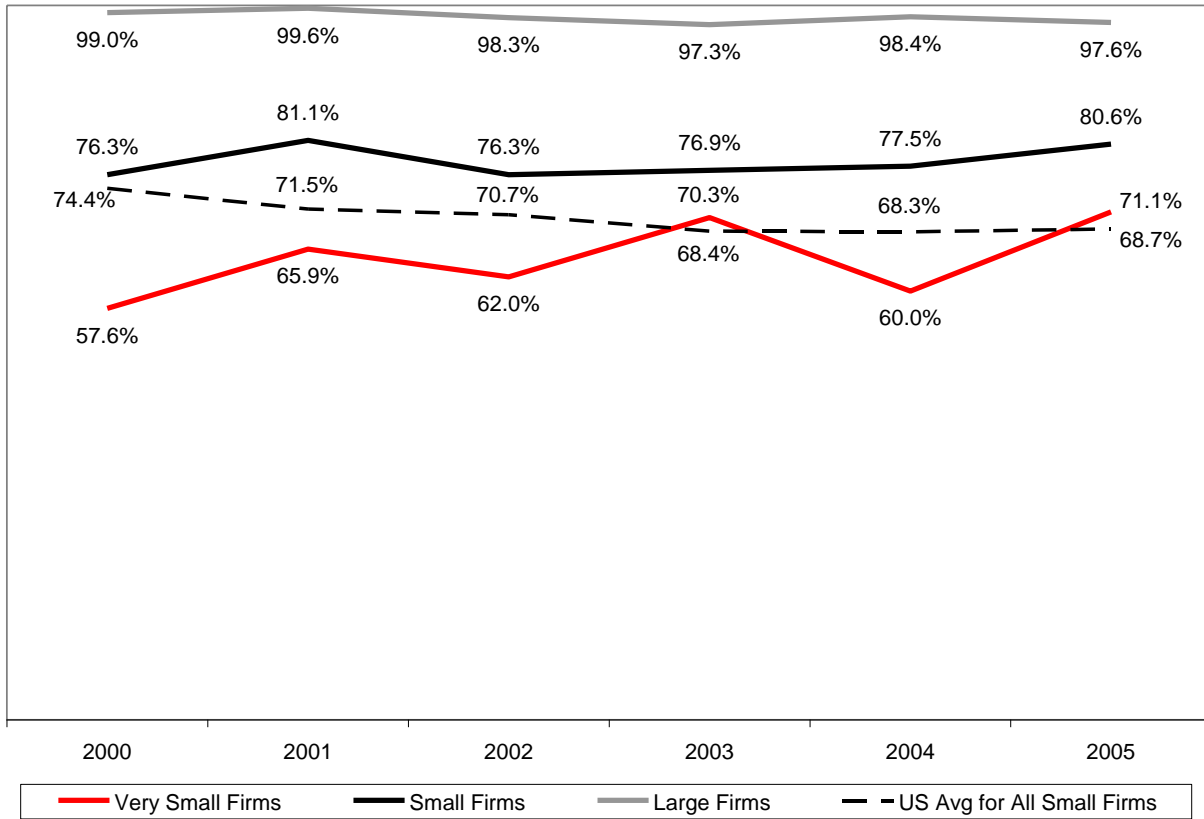
Figure 4: Percent of New Jersey Establishments that Offer Health Insurance, 2000-2005



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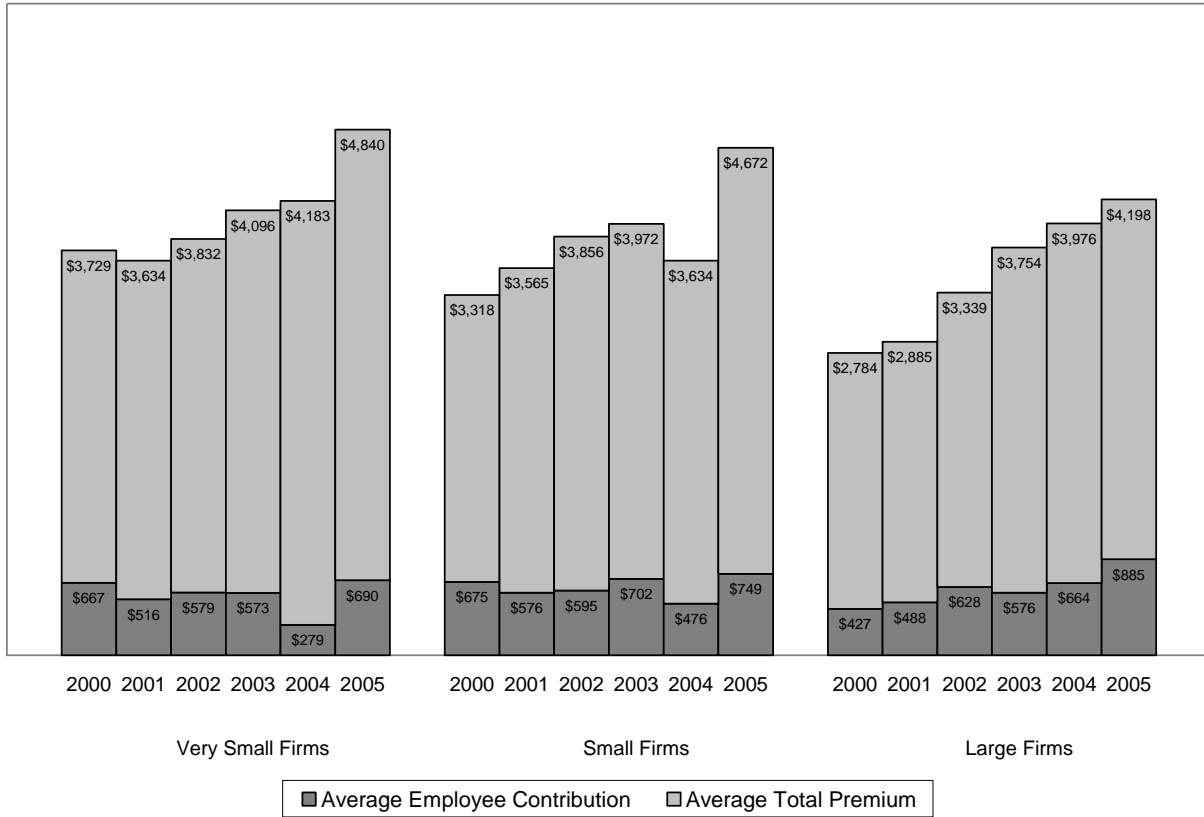
Figure 5: Percent of New Jersey Full-Time Employees at Establishments that Offer Health Insurance, 2000-2005



Note: The designation of ‘Very Small Firms’ corresponds to the MEPS-IC category of 2-9 employees. ‘Small Firms’ corresponds to the MEPS-IC category of 2-49 employees. ‘Large Firms’ corresponds to the MEPS-IC category of 50+ employees. The MEPS-IC firm size categories do not exactly match NJ small group health insurance market sizes, which include firms with 2-50 employees.

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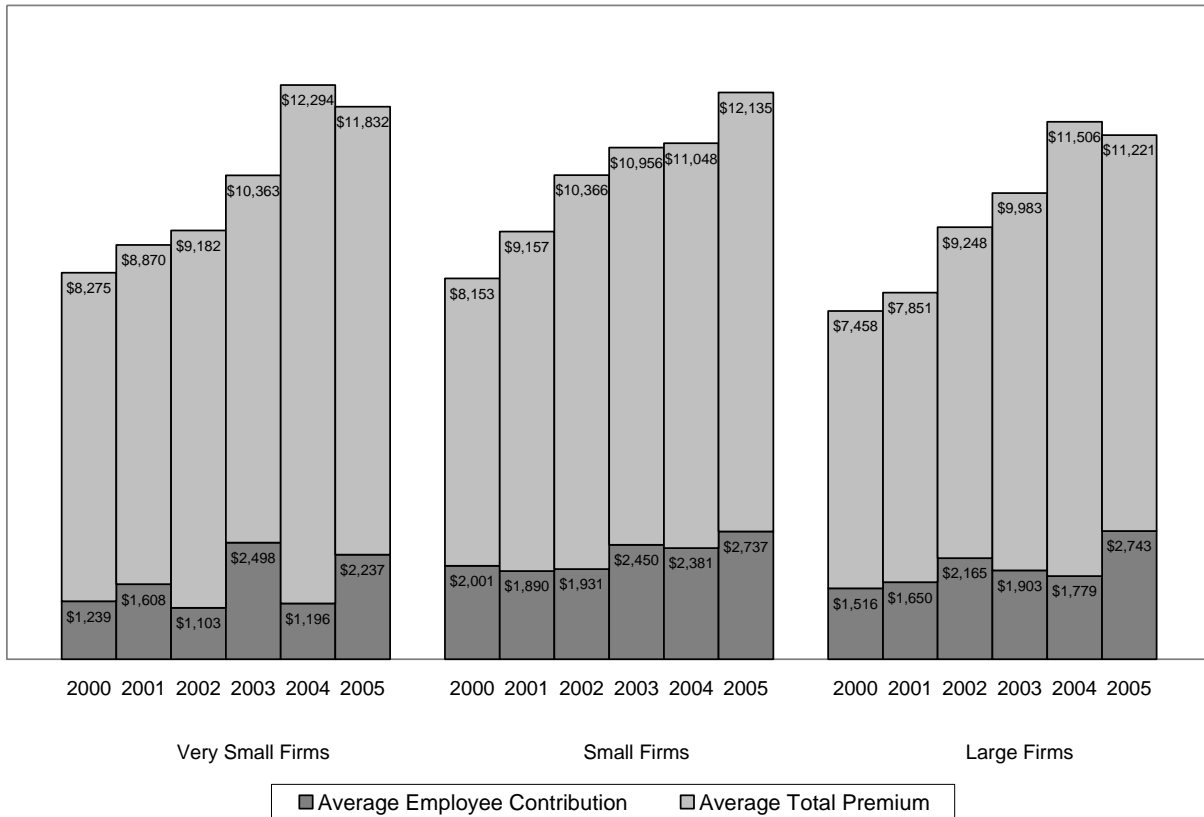
Figure 6: Average Total Premium and Employee Contribution for Single Coverage in New Jersey, 2000-2005



Note: The designation of ‘Very Small Firms’ corresponds to the MEPS-IC category of 2-9 employees. ‘Small Firms’ corresponds to the MEPS-IC category of 10-49 employees. ‘Large Firms’ corresponds to the MEPS-IC category of 50+ employees. The MEPS-IC firm size categories do not exactly match NJ small group health insurance market sizes, which include firms with 2-50 employees.

Source: Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. Medical Expenditure Panel Survey – Insurance Component. Accessed on 1/17/2008 at http://www.meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=2.

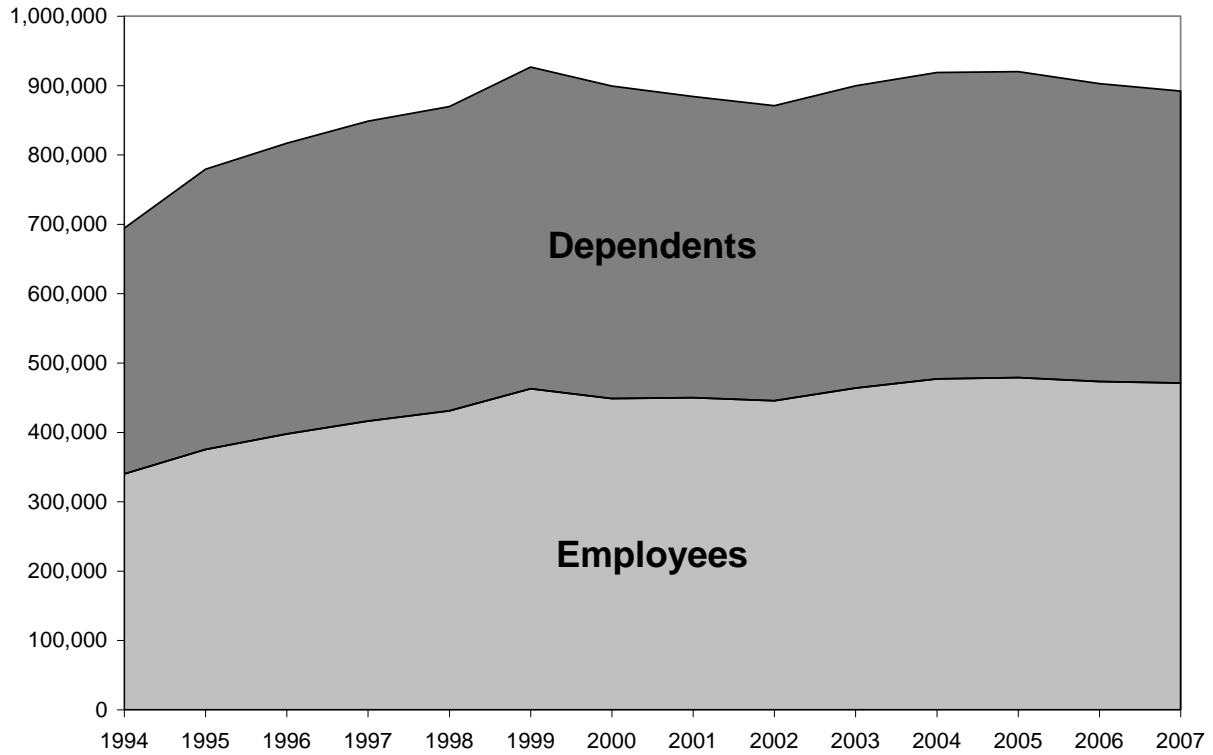
Figure 7: Average Total Premium and Employee Contribution for Family Coverage in New Jersey, 2000-2005



Note: The designation of ‘Very Small Firms’ corresponds to the MEPS-IC category of 2-9 employees. ‘Small Firms’ corresponds to the MEPS-IC category of 10-49 employees. ‘Large Firms’ corresponds to the MEPS-IC category of 50+ employees. The MEPS-IC firm size categories do not exactly match NJ small group health insurance market sizes, which include firms with 2-50 employees.

Source: Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. Medical Expenditure Panel Survey – Insurance Component. Accessed on 1/17/2008 at http://www.meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=2.

Figure 8: Historical Enrollment in New Jersey’s Small Employer Health Benefits Program, 1994-2007



Note: Note: Data for 1993-2006 are from the fourth quarter. Data for 2007 are from the third quarter.

Source: NJ Department of Banking and Insurance, Insurance Division. Historical Comparison of Enrollment Data 3rd Quarter – 2007. Accessed on 1/15/2008 at www.nj.gov/dobi/reform.htm.

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- ¹ NJ Department of Banking and Insurance, Life and Health. New Jersey Commercial Health Market – 2005 Preliminary Report.
- ² Bureau of Economic Analysis, US Department of Commerce, March 27, 2007. Data on Per Capita Personal Income prepared by the New Jersey Department of Labor and Workforce Development in July 2007. Accessed on 1/15/2008 at www.wnjin.net/OneStopCareerCenter/LaborMarketInformation/lmi10/pci.htm.
- ³ NJ Department of Human Services, Division of Medical Assistance and Health Services – December 2007 Enrollment Report. Accessed on 1/15/2008 at www.state.nj.us/humanservices/dmahs/enrollment_reports.html.
- ⁴ Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2005 Medical Expenditure Panel Survey – Insurance Component. Accessed on 1/17/2008 at http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2005/tiia1a.pdf.
- ⁵ Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2005 Medical Expenditure Panel Survey – Insurance Component. Accessed on 1/17/2008 at http://www.meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=2.
- ⁶ NJ Department of Banking and Insurance, Life and Health. New Jersey Commercial Health Market – 2005 Preliminary Report.
- ⁷ NJ Department of Banking and Insurance, Insurance Division. Historical Comparison of Enrollment Data 3rd Quarter – 2007. Accessed on 1/15/2008 at www.nj.gov/dobi/reform.htm.
- ⁸ NJ Department of Banking and Insurance, Insurance Division. Historical Comparison of Enrollment Data 3rd Quarter – 2007. Accessed on 1/15/2008 at www.nj.gov/dobi/reform.htm.
- ⁹ NJ Department of Banking and Insurance, Insurance Division. Historical Comparison of Enrollment Data 3rd Quarter – 2007. Accessed on 1/15/2008 at www.nj.gov/dobi/reform.htm.
- ¹⁰ NJ Department of Banking and Insurance, Life and Health. New Jersey Commercial Health Market – 2005 Preliminary Report.
- ¹¹ Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2005 Medical Expenditure Panel Survey – Insurance Component. Accessed on 1/17/2008 at http://www.meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=2.
- ¹² Belloff, D., Cantor, J.C., Koller, M.M., and Monheit, A.C. “Reinsurance Options for New Jersey’s Health Insurance Markets.” Rutgers Center for State Health Policy, January 2007, <http://www.cshp.rutgers.edu/Downloads/7140.pdf>.
- ¹³ A Report to the New Jersey State Legislature. “The Effects on the Individual and Small Employer Health Coverage Markets of Permitting Individuals to Purchase Small Employer Health Benefits Plans.” Written and presented by the New Jersey Small Employer Health Benefits Program Board in conjunction with the New Jersey Individual Health Coverage Program Board and the New Jersey Department of Banking and Insurance, September 25, 1996.
- ¹⁴ Monheit, A.C., Cantor, J.C., and Banerjee, P. “Assessing Policy Options for the Non-Group Health Insurance Market: Simulation of the Impact of Modified Community Rating in the New Jersey Individual Health Coverage Program.” Rutgers Center for State Health Policy, March 2005, Revised October 2006. <http://www.cshp.rutgers.edu/DOWNLOADS/6600.PDF>.
- ¹⁵ New Jersey Department of Banking and Insurance, “Questions and Answers on the Mandated Health Benefits Advisory Commission Act.” Accessed on 1/10/2008 at www.state.nj.us/dobi/mandatedhbac.htm.
- ¹⁶ U.S. Census Bureau, Current Population Survey, 1988 to 2006 Annual Social and Economic Supplements. Historical Health Insurance Table HI-4. Accessed on 1/23/2008 at <http://www.census.gov/hhes/www/hlthins/historic/hlthin05/hihist4.html>.
- ¹⁷ Cantor, J.C. “Health Care Unreform: The New Jersey Approach.” *Caring for the Uninsured and Underinsured*, JAMA, December 22/29, 1993-Vol. 270, No. 24, pp. 2968-2970.
- ¹⁸ New Jersey Department of Banking and Insurance, “Small Employer Health Benefits Premium Comparison Survey – 2006.” Accessed on 1/7/2008 at www.nj.gov/dobi.semrates.htm.
- ¹⁹ New Jersey Department of Banking and Insurance, “New Jersey Small Employer Health Benefits Plans General Information,” January 2005. Accessed on 1/22/2008 at <http://www.state.nj.us/dobi/sehguide.pdf>.
- ²⁰ The only exception to this is for late enrollees who were uninsured before enrolling in the SEHBP.
- ²¹ New Jersey Department of Banking and Insurance, “What Is New Jersey Health Insurance Reform?” Accessed on 1/7/2008 at www.nj.gov/dobi/ihc_seh.htm.

²² NJ Department of Banking and Insurance Memo from R. Neil Vance, FSA, Managing Actuary, Life & Health Actuarial and Avnee Parekh, ASA, Actuarial Analyst, Life & Health Actuarial to Ellen DeRosa, Executive Director, SHE/IHC Boards, dated February 15, 2008, re: SEH Loss Ratio and Refund Reports for 2006.

²³ In 2005, the loss ratio for the small group market was 81.4%, the loss ratio for the individual market was 85.1%, and the loss ratio in the large group market was 81.7%. NJ Department of Banking and Insurance, Life and Health. New Jersey Commercial Health Market – 2005 Preliminary Report. Complete data for 2006 were not available.

²⁴ NJ Department of Banking and Insurance, Insurance Division. Historical Comparison of Enrollment Data 3rd Quarter – 2007. Accessed on 1/15/2008 at www.nj.gov/dobi/reform.htm.

²⁵ Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2005 Medical Expenditure Panel Survey – Insurance Component. Accessed on 1/17/2008 at http://www.meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=2.