



Private Insurance Coverage: A Case Study of the Small Group Market in New Jersey

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About the Report

The paper is intended to provide national policymakers with insight about the administrative structure, effects, and implementation challenges of small group market reforms in New Jersey. It also provides lessons about program reform administration and implementation for New York State policymakers.

About the Rockefeller Institute and the New York State Health Policy Research Center

The Nelson A. Rockefeller Institute of Government is the public policy research arm of the State University of New York. The New York State Health Policy Research Center (HPRC), a program of the Rockefeller Institute, provides relevant, nonpartisan research and analysis of state health policy issues for New York State and national policymakers. With funding support from the New York State Health Foundation and other foundations, HPRC uses its in-house health policy experts, as well as national experts, to build on the Rockefeller Institute's strength in analyzing the role of state and local governments in financing, administering, and regulating state health care systems.

About the Rutgers Center for State Health Policy

The Rutgers Center for State Health Policy is an initiative of the Institute for Health, Health Care Policy, and Aging Research (IHHPAR), established to create a formal capacity within Rutgers, the State University of New Jersey, for policy analysis, research, training, facilitation, and consultation on state health policy. Made possible by a grant from The Robert Wood Johnson Foundation with additional support from Rutgers University, the Center was conceived in response to recent transformations in the health care/health policy arena that resulted in the devolution of significant policy responsibilities to state governments. The Center combines Rutgers University's traditional academic strengths in public health, health services research, and social science with applied research and policy analysis initiatives. It serves as the focal point within the University for research and related activities relevant to state health policy.

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Executive Summary

Overview

In 1992, New Jersey enacted health reforms to the small group and individual market to improve accessibility, flexibility, and portability of health insurance coverage for these markets. After being implemented in 1993 and 1994, these reforms achieved their objectives through guaranteed issue and renewability, low employer contribution requirements, modified community rating in the small group market, and limits on coverage restrictions for pre-existing conditions. However, the reformed small group and individual markets, known as the Small Employer Health Benefits Program (SEHBP) and the Individual Health Care Program (IHCP), have become less affordable, with some of the highest premiums in the country. Many lessons, outlined below, have been learned from implementation of these reforms. As a result, state policymakers and stakeholders in New Jersey are working to implement administrative changes that are intended to improve affordability in this market, including reforms that were passed as this study went to print.

Administration

Since being implemented in 1994, the SEHBP has been run by a board of directors made up of eighteen members including insurance carriers, brokers, a physician, representatives of small businesses, and others.¹ The board and Department of Banking and Insurance (DOBI) are responsible for implementing any legislative changes to New Jersey insurance regulation that impact SEHBP. A small staff at DOBI reviews and approves insurers' requests for modifications to the standardized plans. Enrollment reporting, premium comparisons, and loss ratio requirement also are managed by DOBI staff.

Eligibility

To qualify for coverage in the SEHBP market, small businesses must have at least two, but not more than fifty employees who work 25 or more hours per week. In addition, 75 percent of these "full-time" employees must enroll in some kind of group coverage. Standard plans are available; however, riders are frequently used to amend the plan design. Premiums are set using a modified community rating with 2 to 1 rate bands based on the age and gender of employees and the business location. Employers are required to contribute a minimum of only ten percent toward the cost of the premium.

Effects of Reforms on Private Insurance Coverage

SEHBP enrollment has been stable at approximately 900,000 (see [Figure 6](#)). Offer rates for small firms are high in New Jersey compared to the U.S. and other states, and more full-time employees are offered coverage. SEHBP insurance products are commercially viable because state regulation allows carriers in the market to offer products similar to what is offered in the large group market by using riders to add and change standard plan benefits. The low employer premium contribution requirement makes offering SEHBP coverage a financially attractive option, as employees can be made responsible for most of the premium. Still, the average employer contribution for small firms in New Jersey is about 80 percent. On the downside, premiums for New Jersey's small firms are the fourth highest in the U.S. for

¹ New Jersey Department of Banking and Insurance, "What Is New Jersey Health Insurance Reform?" Accessed 1/7/2008 at www.nj.gov/dobi/division_insurance/ihcseh/ihc_seh.htm.

single coverage and third highest for family coverage.² In addition, total premiums for small firms are \$500 more than large firms for single coverage, and \$900 more for family coverage. New Jersey was among ten states in 2005 that had small-group premiums at least 10 percent higher than premiums in large firms³. Therefore, coverage in SEHBP currently is or may become unaffordable for many small businesses in New Jersey.

Lessons

The creation of a diverse board of directors was an important factor contributing to the successful implementation of the SEHBP reform – High level representatives of all the key stakeholders in the market were able to share their expertise and perspectives early on and positively influence implementation of the legislation. As a result, these stakeholders supported the final market regulations.

The process for changing the program is cumbersome – Changes to the SEHBP market are difficult because the market was created through a lengthy rule-making process required by legislation. Changing the legal constructs of the program could allow policymakers to be more responsive to program needs.

Less regulation of premiums appears to have improved administration – Prior to the small group reforms in 1992, DOBI had prior-approval authority for premiums charged to small employers. This process led to significant delays in bringing new plans to the market. This process was costly and time consuming for both DOBI and insurers and has since been reformed.

Constant re-evaluation of the need for reforms is important to help stabilize and stem increases in premiums – Some stakeholders in the New Jersey health insurance industry feel that administrative changes in the SEHBP including reductions in regulatory requirements associated with introducing a new plan to the market, reducing the number of plans that small groups can offer to employees, or changing the fee schedule for out of network claims might help control costs and reduce or stabilize premiums. Conversely, these options may adversely affect access to care and affordability of services so the SEHBP board of directors has not yet acted on them. Legislation introduced in March 2008 would modify some SEHBP administrative rules, including reducing the number of standard plans and increasing price transparency by listing the premium for the standard plan separately from the adjustment for riders and broker/agent commissions.

Standardization of administration may help lower premium costs – The biggest management issue cited during the research was the paperwork associated with SEHBP standardized plans. Insurers would prefer streamlined paperwork and believe this would reduce administrative costs and subsequently reduce premium costs.

Affordability may be as important for access to insurance as regulatory protections – New Jersey has the fourth highest small group premiums in the country. Although SEHBP enrollment has been steady, it has

² 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

www.meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=2.

³ In 2005, New Jersey had the eighth highest ratio of small firm premiums for single coverage to large firm premiums. New York ranked third. 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 www.meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=2.

leveled, and there are concerns that affordability may be keeping some small employers from offering coverage.

Price transparency may improve market functioning – New legislation introduced in March 2008 and recently passed is expected to improve price transparency in New Jersey by requiring brokers to disclose their fees and commissions and allowing standard plans to be listed separately from the price adjustment(s) for standard plan riders. It is expected that this reform will allow employers to compare the cost of different policies within and across carriers and better understand how prices are derived.

Limiting the number of plans that employers can offer may stem adverse selection; altering rules related to plan switching may help stabilize premiums – Currently, employers are permitted to offer an unlimited number of plans; although this allows employees more choice, it may result in adverse selection. Enrollment in multiple plans is complex and costly for carriers to administer. Carriers also contend that adverse selection into richer plans is raising premiums in those plans. Until recently, employees in SEHBP could also switch plans as frequently as they wanted. The board recently agreed to allow a plan change only once a year, at the time of 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.

Changing the fee schedule for out-of-network plans might lower premiums – Over the past few years, the SEHBP board has been considering the appropriate fee schedule to reimburse out-of-network claims. SEHBP currently requires insurers to reimburse out-of-network claims at 80 percent 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 services. Insurers contend that this fee schedule results in higher premiums for plans with out-of-network benefits and that changing it would lower premiums for popular insurance products.

I. Introduction

In 1992, New Jersey enacted health insurance market reforms for the individual and small group markets to improve accessibility to health insurance coverage and services in the state. This legislation created the Individual Health Coverage Program (IHCP), which was implemented in 1993, and the Small Employer Health Benefits Program (SEHBP), which was implemented in 1994. New Jersey's IHCP insures individuals and sole proprietors and their families. SEHBP insures owners and employees of small businesses and their families.

This paper reviews the small group and individual health insurance markets in New Jersey, including sources of insurance coverage, the regulatory regime, employer offer rates, market structure and enrollment, and the reforms that were implemented in the early 1990s. The paper pays particular attention to the management and implementation challenges to reforming the small group market, discusses recent market reforms, and suggests what can be learned from New Jersey's experience for other states that are considering insurance market reforms.

II. Trends in New Jersey's Health Insurance Markets

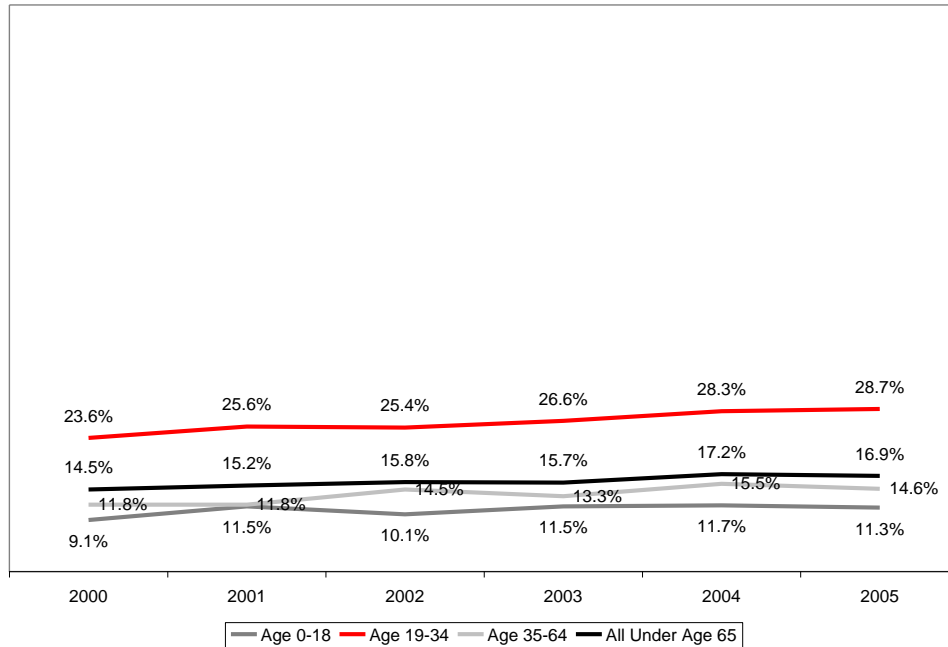
In 2005, New Jersey's 8.7 million residents fell into one of several categories of health insurance coverage.⁴ One-third of residents were insured by the state or federal government through Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), military, or the state or federal health benefits program. Another 26 percent of residents were insured through self-funded plans with large employers that are exempt from state regulation. An additional 13 percent were covered by fully insured, state regulated plans sponsored by large employers. Less than 1 percent was insured in the individual market. New Jersey's small employer group health insurance market (businesses of two to fifty employees) insured almost 11 percent of residents. Finally, 15 percent 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.⁵ Still, nearly 17 percent of state residents under age 65 were uninsured in 2005, a number that has been increasing over the last six years, especially for young adults aged 19 to 34 ([Figure 1](#)).

⁴ NJ Department of Banking and Insurance, Life and Health. "New Jersey Commercial Health Market – 2005 Preliminary Report."

⁵ 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.

Figure 1: New Jersey's Percent of 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.

Most large firms in New Jersey offer health insurance coverage, while far fewer small firms offer coverage ([Figure 2](#)). Yet, since 2000, the percentage of large employers offering coverage has declined slightly, from 98 percent in 2000 to 94 percent in 2005, while the percentage of small firms offering coverage has increased from 56 percent in 2000 to 62 percent in 2005. Additionally, offer rates in New Jersey's small group market consistently exceed the U.S. and New York average for small firms.

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 percent for full-time employees of small firms and 98 percent for full-time employees of large firms) ([Figure 3](#)). The percentage of full-time employees working for a large employer that offers health insurance coverage has been stable, 99 percent in 2000 and 98 percent in 2005, while the percentage of full-time employees working for a small employer that offers coverage increased from 76 percent in 2000 to 81 percent 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 New York small firms over the last few years. In recent years offer rates increased more in New Jersey than in the U.S. small group market.

Figure 2: Percent of Establishments That Offer Health Insurance, 2000-2005

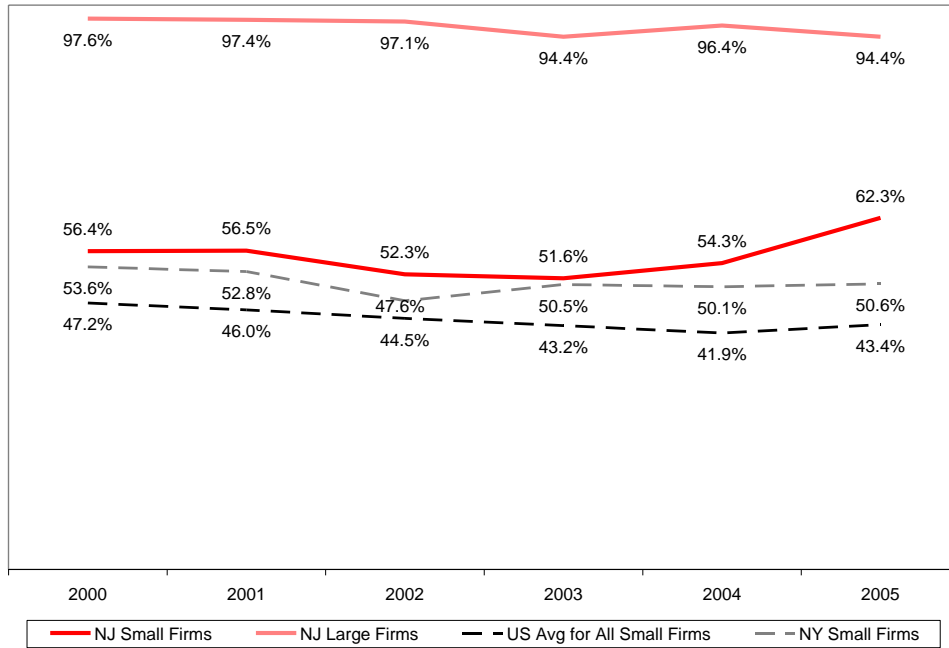
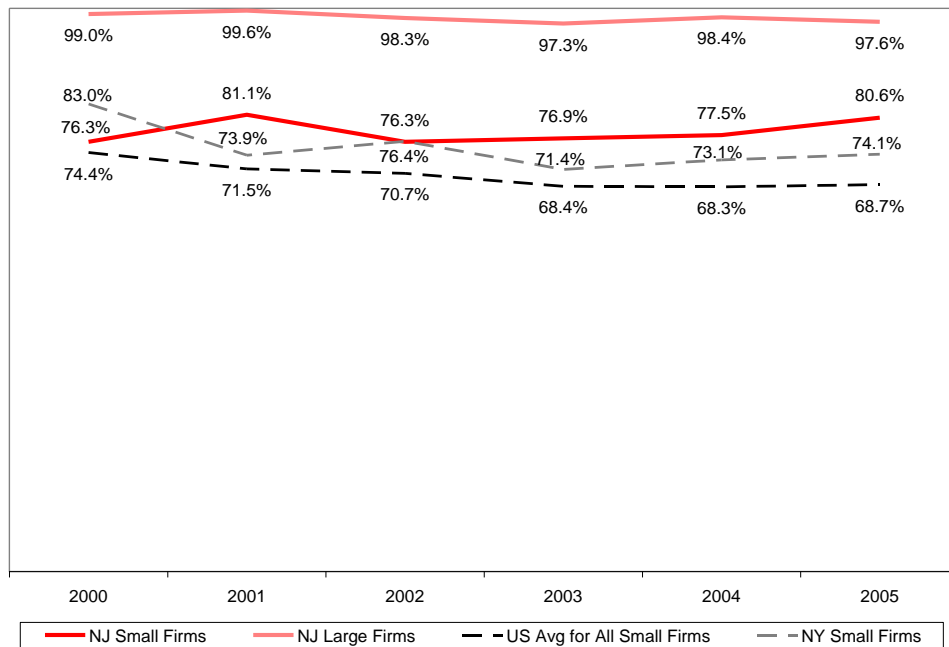


Figure 3: Percent of Full-Time Employees at Establishments That Offer Health Insurance, 2000-2005



Note: "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."

Health insurance premiums for New Jersey's small firms are higher than those of large firms. In 2005, small firms paid almost \$500 more in total premiums per single enrollee than large firms ([Figure 4](#)) and about \$900 more per enrolled family ([Figure 5](#)). New Jersey was among ten states in 2005 that had small group premiums at least 10 percent higher than premiums in large firms.⁶ From 2000 to 2005, total premiums for single coverage increased approximately \$1,400 for both small and large firms in New Jersey. 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 remained relatively steady for all New Jersey firms from 2000 to 2005 ([Figure 4](#) and [Figure 5](#)). On average over the six-year period, small employers contributed a greater proportion of the premium for single coverage than large employers (83.6 percent for small employers, and 82.7 percent for large employers). For family coverage, large employers contributed the most toward premiums on average over the six-year period (78.3 percent for small employers, and 79.4 percent for large employers).

In short, New Jersey's private employers are managing to maintain comparatively high offer rates 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.⁷ Offer rates have remained steady and even grown in the small group market. Employers continue to contribute about 80 percent 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 rise.

⁶ Agency for Healthcare Research and Quality. "2005 Medical Expenditure Panel Survey."

⁷ Ibid.

Figure 4: Average Total Premium and Employee Contribution for Single Coverage in New Jersey, 2000-2005

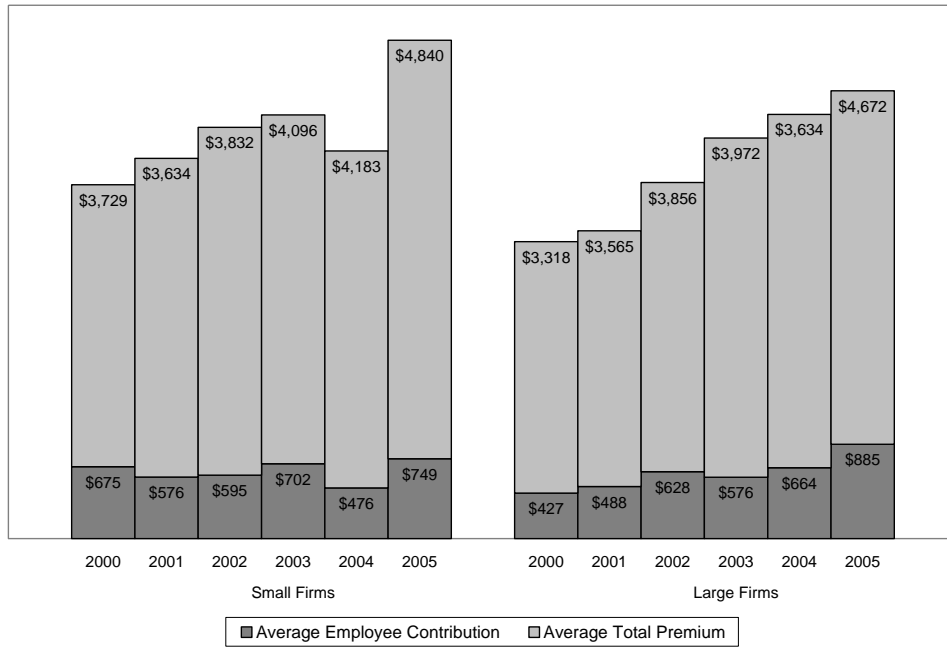
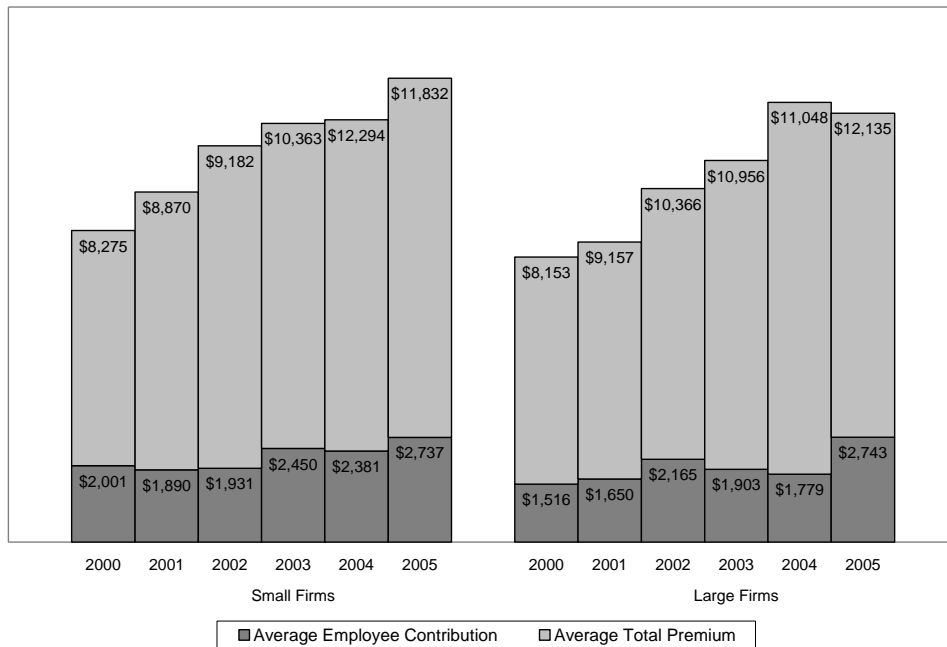


Figure 5: Average Total Premium and Employee Contribution for Family Coverage in New Jersey, 2000-2005



Note: "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."

III. New Jersey's Health Insurance Market Structure

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 Health Maintenance Organization (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).

Individuals and Sole Proprietors

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 nine benefits. In addition, in March 2008, legislation was introduced that would allow modified community rating in the IHCP with rate bands of 3.5 to 1 based on age.⁸

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 \$3,524⁹ 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 during a ten year stretch from 220,384 at the end of 1995 to 77,571 at the end of 2005.¹⁰ The decline in IHCP enrollment has been attributed to several possible causes, including the end of a short-lived subsidy program and problems with a carrier loss assessment mechanism.¹¹

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 percent of which were enrollees in B&E plans.¹² Outside of the B&E policies, enrollment in the IHCP has continued its decline.

⁸ New Jersey State Legislature. Bill S1557 and A2624 passed both Houses in June 2008. Accessed on 6/30/2008 at www.nileg.state.nj.us/bills/BillView.asp.

⁹ NJ Department of Banking and Insurance, Life and Health. "New Jersey Commercial Health Market – 2005 Preliminary Report."

¹⁰ 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.

¹¹ Monheit, A.C., J.C. Cantor, M. Koller, and K.S. Fox. "Community Rating and Sustainable Individual Health Insurance Markets in New Jersey." *Health Affairs* 23 (July/August 2004): 167-175.

¹² NJ Department of Banking and Insurance, Insurance Division. "Historical Comparison of Enrollment Data 3rd Quarter – 2007."

Small Businesses

The SEHBP, like small employer markets in other states, is guaranteed issue. So, small employers and their employees cannot be denied coverage or renewal. In order for a small employer to participate in the SEHBP, 75 percent 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 are only required to contribute a minimum of 10 percent 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 the 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, finally, to 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.

The SEHBP has been based on five standardized plans and an HMO. All insurance carriers in the SEHBP must offer the standard benefit plans, A through E.¹³ 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 percent coinsurance rate, plan C 70 percent, plan D 80 percent, and plan E 90 percent. Carriers are allowed to be flexible in how they structure these plans. For example, they can offer Preferred Provider Organization (PPO) or Point of Services (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 will reduce the number of standard plans offered in the SEHBP to three.¹⁴

Insurers are also permitted to submit riders to these 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 so that small groups can find a policy to meet their needs.

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).¹⁵ 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.¹⁶

¹³ New Jersey Department of Banking and Insurance, "Small Employer Health Benefits Premium Comparison Survey – 2006." Accessed on 1/7/2008 at www.state.nj.us/dobi/division_insurance/ihcseh/sehrates.htm.

¹⁴ New Jersey State Legislature. Bill S1557 and A2624.

¹⁵ New Jersey Department of Banking and Insurance, "New Jersey Small Employer Health Benefits Plans General Information," January 2005. Accessed on 1/22/2008 at www.nj.gov/dobi/division_insurance/ihcseh/sehguide.pdf.

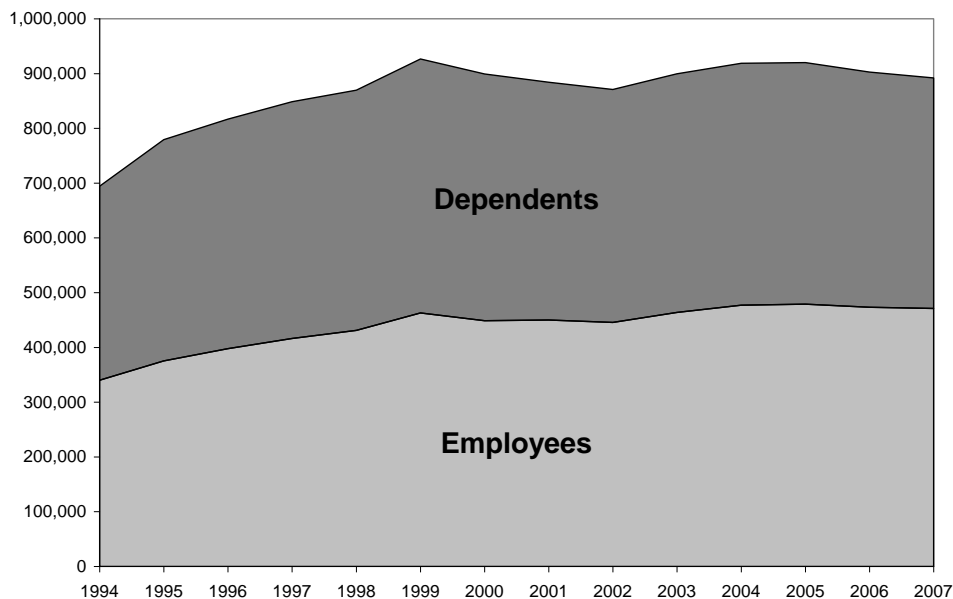
¹⁶ The only exception to this is for late enrollees who were uninsured before enrolling in the SEHBP.

Enrollment in the SEHBP market grew from 1994, when the program was first implemented, to 1999 and then leveled off and has remained stable at around 900,000 since (Figure 6). 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.¹⁷ In fact, in 2005, the percentage of New Jersey’s full-time eligible employees who enrolled in coverage at small firms that offered coverage was slightly higher than the national average, 78.9 percent in New Jersey and 78.5 percent in the nation¹⁸. Ten different insurance carriers participate in the SEHBP, and competition is considered adequate. Horizon Blue Cross Blue Shield of New Jersey (BCBSNJ), Aetna, and United Healthcare/Oxford insure the greatest proportion of the small group market (Horizon 44 percent, Aetna 25 percent, and United Healthcare/Oxford 17 percent in the third quarter of 2007).¹⁹

Large Businesses

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.

Figure 6: 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.”

¹⁷ NJ Department of Banking and Insurance, Life and Health. “New Jersey Commercial Health Market – 2005 Preliminary Report.”
¹⁸ 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.
¹⁹ NJ Department of Banking and Insurance, Insurance Division. “Historical Comparison of Enrollment Data 3rd Quarter – 2007.”

IV. State Regulations for All Fully Insured Markets

New Jersey law mandates coverage of certain benefits in all fully insured health insurance plans including those sold in the SEHBP.²⁰ The legislature may refer proposed mandate bills to an advisory commission made up of seventeen members. This advisory commission reviews the referred 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's or guardian's policy from age eighteen. These expansions allowed for greater access to health insurance coverage, including within the SEHBP.

V. Management and Administrative Challenges in the Small Employer Health Benefits Program

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 is responsible for administration of 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 bi-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 are responsible for implementing any legislative changes to New Jersey insurance regulation that impact the SEHBP.

Stakeholders point to the creation of a diverse board of directors as an important factor contributing to the successful implementation of the SEHBP reform. High level representatives of all the key stakeholders in the market were able to share their expertise and perspectives early on and positively influence implementation of the legislation. As a consequence, these stakeholders supported the final market regulations. Since then, the board's impact has diminished as it now makes fewer decisions

²⁰ New Jersey Department of Banking and Insurance, "Questions and Answers on the Mandated Health Benefits Advisory Commission Act." Accessed 1/10/2008 at www.state.nj.us/dobi/mandatedhbac.htm.

²¹ New Jersey Department of Banking and Insurance, "What Is New Jersey Health Insurance Reform?"

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.

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 promote affordability of premiums charged to small groups, insurance carriers are required to have a minimum loss ratio of 75 percent, so that at least 75 cents of every premium dollar is paid out on health service claims. If this minimum loss ratio is not met then carriers must pay that portion back to policyholders. In 2006, the average loss ratio for the SEHBP was 81.8 percent, 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 percent.²⁴ Increasing the minimum loss ratio may have been a concession in exchange for allowing the industry to introduce age rating in the IHCP.

Stakeholders in the SEHBP— including regulators, insurers, and brokers — report that this market is healthy. Enrollment is considered stable and there are many coverage options with several competing carriers. The loss ratios are high so the premiums are seen as appropriate relative to claims. However, small businesses and their employees feel that premiums are expensive in the SEHBP. Some stakeholders believe 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 some small businesses. Insurance carriers and brokers in New Jersey have suggested administrative changes to the SEHBP to help stabilize premiums.

Insurance carriers report that the administrative burden of the SEHBP should be reduced. The biggest management issue cited by these 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 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

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 percent, the loss ratio for the individual market was 85.1 percent, and the loss ratio in the large group market was 81.7 percent. 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 New Jersey State Legislature. Bill S1557 and A2624.

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 and recently passed will continue the use of standard plans, but the number of standard plans would be reduced from five to three and allow insurance carriers to use riders to modify those standard plans.²⁵ In addition, to improve price transparency in this market, the legislation will 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 will 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. 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 the time of 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 appropriate fee schedule to reimburse out-of-network claims. The SEHBP currently requires insurers to reimburse out-of-network claims at 80 percent 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 a reimbursement mechanism of 150 percent to 200 percent of the Medicare Resource Based Relative Value Scale (RBRVS) physician payment schedule. 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.

²⁵ Ibid.

VI. Market Reforms Considered for the IHCP and SEHBP

New Jersey policymakers consider the IHCP less stable because of declines in enrollment and increases in premiums. In addition, it is widely believed that sole proprietors are fleeing the IHCP by legally employing their spouse as a means of joining the SEHBP.²⁶ As a result, the difficulties of the IHCP affect 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 of the interdependency of these markets. However, some in the insurance industry feel that changes to the SEHBP are unwarranted, given that it 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 stabilize or even reduce premiums in the IHCP by requiring that the cost of high risk enrollees be subsidized by carriers serving small or large group markets or by state government.²⁷ When claims costs reach a predetermined “attachment point,” the reinsurance mechanism would cover a portion 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 percent to 200 percent 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. There is little political support for a high risk pool in New Jersey, and any strategy (reinsurance or high risk pool) that requires state funding is not presently being considered because of New Jersey’s current fiscal challenges. Reinsurance or a high risk pool funded through assessments on New Jersey’s insurance carriers may be possible. However, these assessments are likely to be passed on to the insured population through higher premiums for coverage. As such, these options have garnered less 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 sole proprietors and other individuals 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.²⁸ Commissioner Goldman would like to merge the markets (using SEHBP rating regulations) and add a reinsurance mechanism to prevent premium increases for older individuals in the IHCP as well as SEHBP enrollees. Estimates from the NJ DOBI indicate that merging the individual and small group markets, without a reinsurance mechanism, would increase premiums for small groups by less than 1 percent and

²⁶ Data to support this belief are not available as it is difficult to identify which spouses legitimately work for the business 25 or more hours per week, and which do not.

²⁷ Belloff, D., J.C. Cantor, M.M. Koller, and A.C. Monheit. “Reinsurance Options for New Jersey’s Health Insurance Markets.” Rutgers Center for State Health Policy, January 2007, www.cshp.rutgers.edu/Downloads/7140.pdf.

²⁸ 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. Current data to support this assertion are not available.

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.²⁹ 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 who 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.³⁰ In June 2008, the bill was passed by both Houses of the legislature. The bill allows modified community rating based on age with 3.5 to 1 rate bands for the IHCP market, in addition to the Basic and 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.

²⁹ Monheit, A.C., J.C. Cantor, and P. Banerjee. "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. www.cshp.rutgers.edu/DOWNLOADS/6600.PDF.

³⁰ New Jersey State Legislature. Bill S1557 and A2624.

VII. 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.