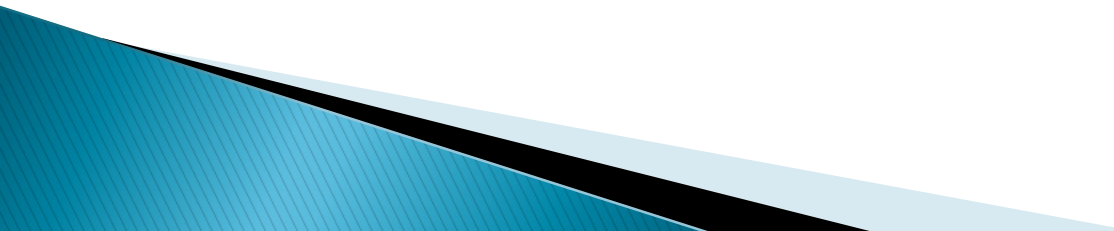


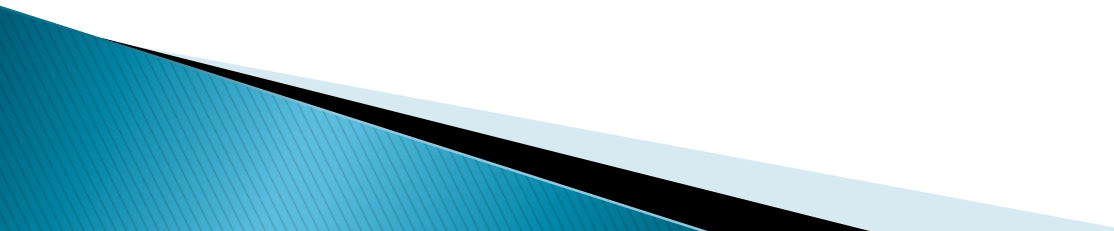
Fifteen Years of Health Reform in NJ What Works, What Doesn't

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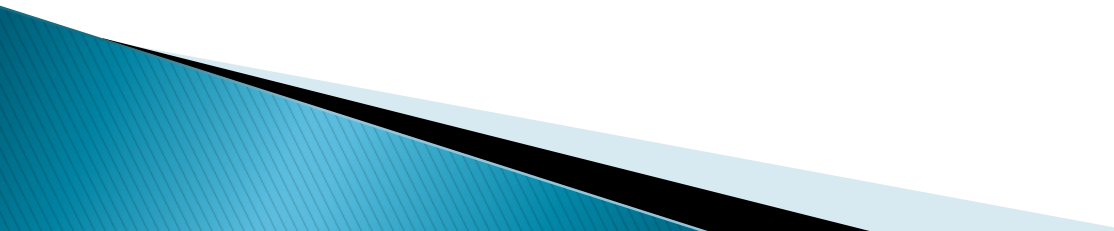
Disclaimer

- ▶ This paper and talk are the opinions and analysis of the author. They do not reflect the point of view of the government of New Jersey. Their purpose is to discuss the history of health care reform programs in New Jersey. No endorsement of any specific program at the state or national level is intended.
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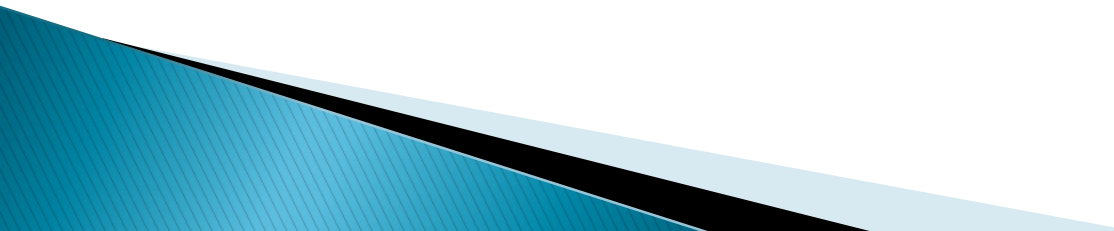
Introduction

- ▶ Individual and Small Employer (2–50) began in the early 1990's. Key elements were guaranteed issue, community rating, and minimum loss ratios.
 - ▶ Small group (SEH) is regarded as successful. About 900,000 covered lives (more than 10% of the population).
 - ▶ Individual (IHC) is not as successful, enrolling about 1% of the population (87,000).
 - ▶ Both programs are self-supporting. Companies are allowed a 75% minimum loss ratio.
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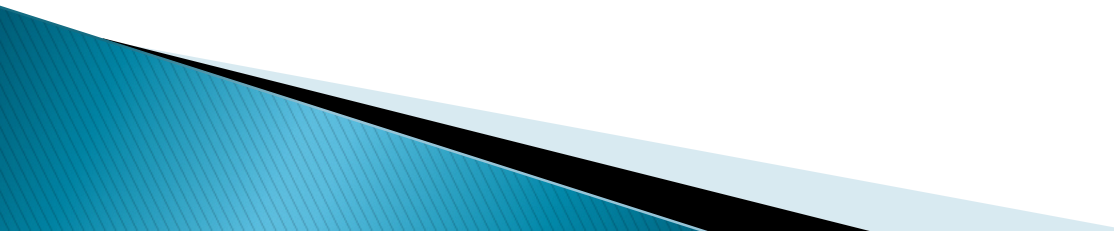
What can we learn?

- ▶ History “What actually happened?”
 - ▶ Economics “Is what happened consistent with the predictions of economic theory”
 - ▶ Public Policy “Is this what we wanted to happen?”
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Goals of NJ Reform

- ▶ Universal Access – Coverage is available regardless of employment status or medical condition
 - ▶ Affordability – Coverage is available at average rates (not depending on medical conditions). Subsidies may be available
 - ▶ Adequacy and Uniformity of Coverage – Coverage must meet minimum standards and be comparable among carriers
 - ▶ Private Carrier participation – Coverage to be offered by private carriers responding to market or “play or pay” incentives.
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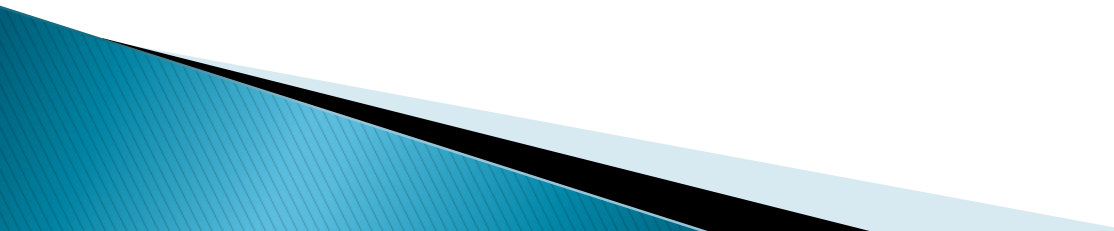
Design of Reform

- ▶ Guaranteed Issue
 - ▶ Community Rating
 - ▶ Minimum Loss Ratios
 - ▶ Standardized Plans
 - ▶ “Play or Pay”
 - ▶ Subsidies
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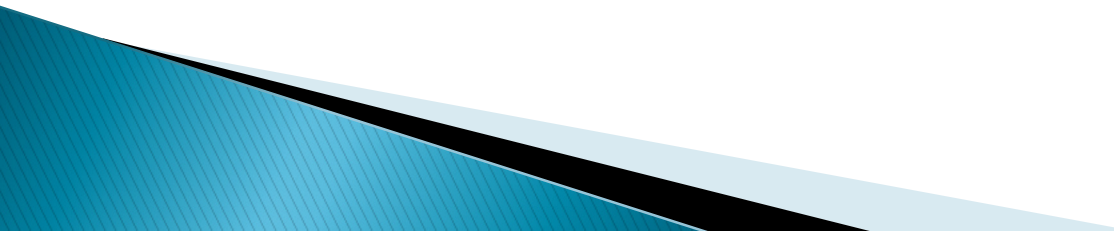
Guaranteed Issue

- ▶ No medical underwriting
 - ▶ Preexisting conditions exclusions for IHC and SEH (2–5 ees)
 - ▶ No “crowd out”; can’t elect IHC if eligible for group
 - ▶ IHC: richer plan can only be elected annually (no “step up”)
 - ▶ Minimum eeparticipation (75%) and er contrib. (10%) for SEH
 - ▶ Exclusive Markets – No underwritten “trust” coverage
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- ▶ Permissive small group defn. (“Mom and Pop”)
 - ▶ Small groups can buy multiple plans (“Slice and Dice”)

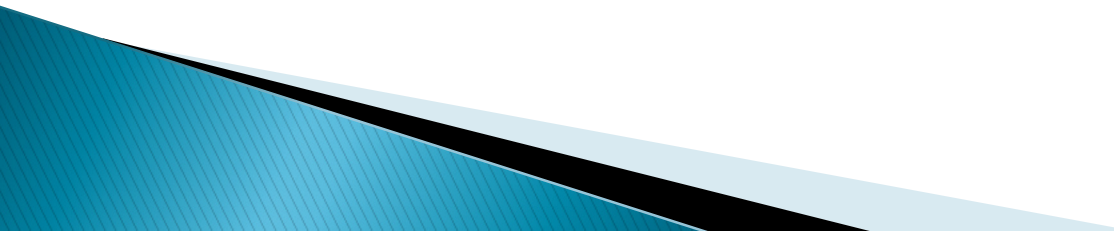
Community Rating

- ▶ No medical rating
 - ▶ SEH factors age/gender/location subject 2:1 highest to lowest (“compression”)
 - ▶ IHC Standard (75% of enrollment) no rating variables permitted (“pure community rating”)
 - ▶ IHC Basic & Essential (B&E) same factors as SEH but 3.5 to 1 permitted.
 - ▶ Rating by duration not permitted
 - ▶ Rating by group size not permitted
 - ▶ Four rating tiers (Single, 2Adult, Parent/Children, Family)
 - ▶ No required rate relationship between plans or tiers
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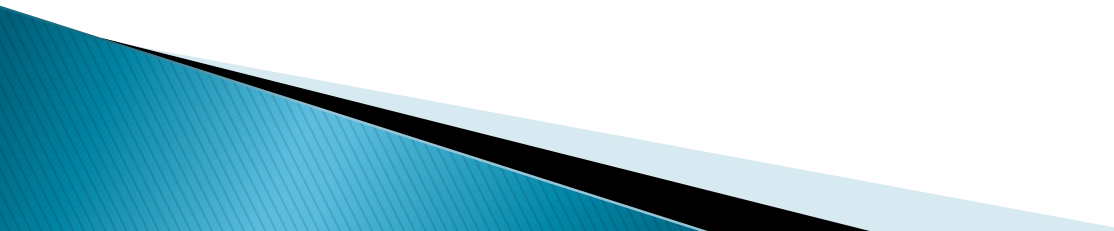
Minimum Loss Ratios

- ▶ Rates set to meet 75% minimum loss ratio (actuarial certification)
 - ▶ Annual reporting, refunds if loss ratio is less than 75%
 - ▶ Loss Ratio standard is tested on a company wide basis, not plan by plan
 - ▶ Medical management expenses (Pre-auth and UR) not included in medical claims
 - ▶ Loss ratio calculation is based on 6 months claims runout, plus residual reserve
 - ▶ 75% loss ratio standard has been in place since the outset
 - ▶ Some inconsistencies in the refund formula
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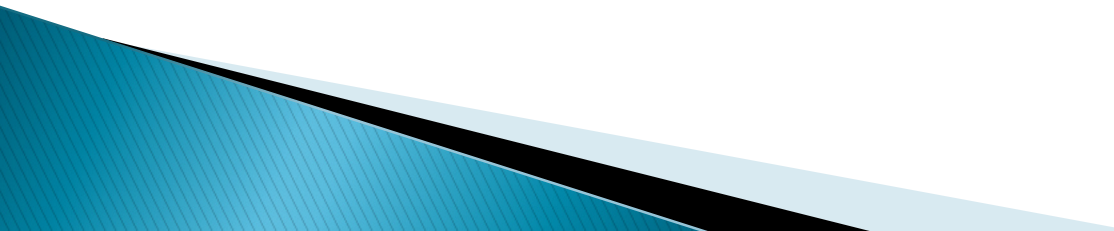
Standard Plan Designs

- ▶ SEH – Standard Plans required to be offered, but benefits can be increased or decreased by rider. HMO, POS, and PPO plans are permitted. Plans must meet general requirements for mandates and minimums.
 - ▶ IHC – Only standard plans permitted (B&E is an exception). No flexibility in Rx. PPO plans, but not POS plans, are permitted. Plans must meet general requirements for mandates and minimums.
 - ▶ IHC Basic and Essential – Minimum plan not subject to all mandates. Benefits may be increased by rider.
 - ▶ Both IHC and SEH must pay out-of-network based on 80th percentile of PHCS (“HIAA”) for non-facility and billed charges for facility
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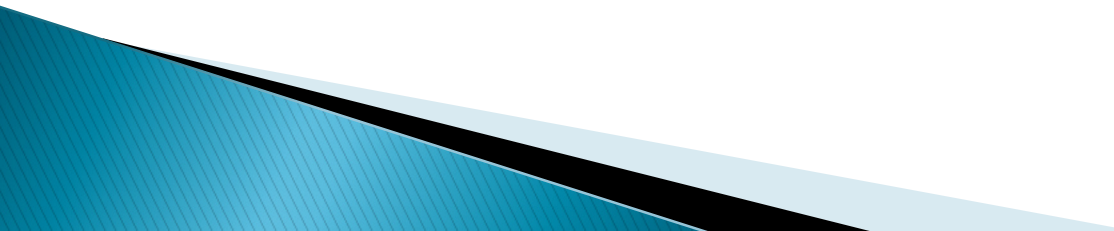
Carrier Participation

- ▶ No required carrier participation in SEH.
 - ▶ IHC has a “play or pay” mechanism where non-participating carriers contribute to an assessment for reimbursable losses.
 - ▶ Loss reimbursement changed in 1997. Reduced size of assessment largely eliminated incentive to “play”.
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Subsidies

- ▶ No subsidies in SEH – except for a small Family Care program
 - ▶ IHC originally subsidized premiums for low income (“Health Access”). Enrollment ended in 1995 with a peak of about 20,000
 - ▶ IHC originally reimbursed losses in excess of 75% of premium with the assessment on all health premiums. This led to underpricing, which was effectively a subsidy of the IHC market by the broader market. This ended after 1996, when the loss reimbursement threshold was raised to 115%.
 - ▶ Litigation over loss assessments and loss reimbursements from the early 90’s is still in process.
 - ▶ IHC Loss Reimbursement functions as a kind of “aggregate reinsurance”.
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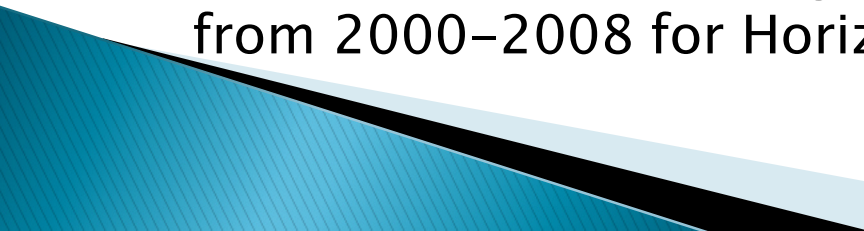
Structure of Reform

- ▶ Coverage offered by Commercial Market carriers
 - ▶ Provider/Carrier interface is like the rest of the commercial market (large employer, self-funded ASO)
 - ▶ Regulated by two Boards (SEH, IHC) with carrier, public, and government representation
 - ▶ Boards share dedicated staff who are government employees
 - ▶ Administrative assessment on premiums to cover program costs
 - ▶ DOBI retains some direct oversight of SEH (decreasing benefit riders, rates, loss ratio reports, premium surveys)
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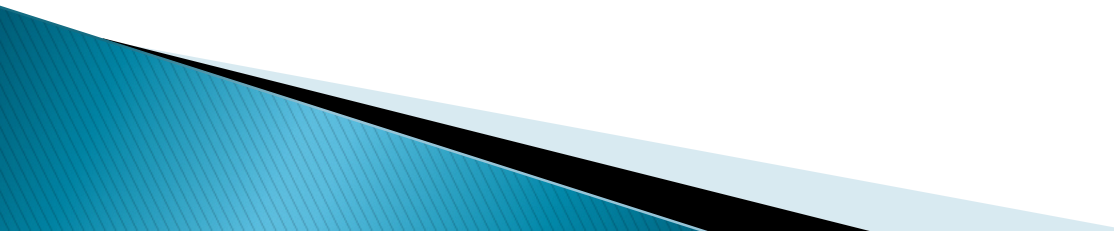
Other Programs

- ▶ Medicaid/Family Care – Children in families up to 350% of FPL. (At higher income range, pay a substantial premium, about \$120/mo for one child.) Parents up to 133% (?) FPL
- ▶ Uncompensated Care – Care required to be provided by hospitals. Care provided for low income people (“Charity Care”) compensated according to a formula – level of reimbursement depends on the hospital. Total of around \$800 mm per year
- ▶ Dependent under 30, since May 2006. Children can continue on parent’s coverage for a rate that is less (about 70%) than COBRA. This program enrolls about 8,000 young adults
- ▶ Family Care Buy In – Children in families over 350% FPL can buy Family Care coverage at cost (about \$140/mo). Just beginning.

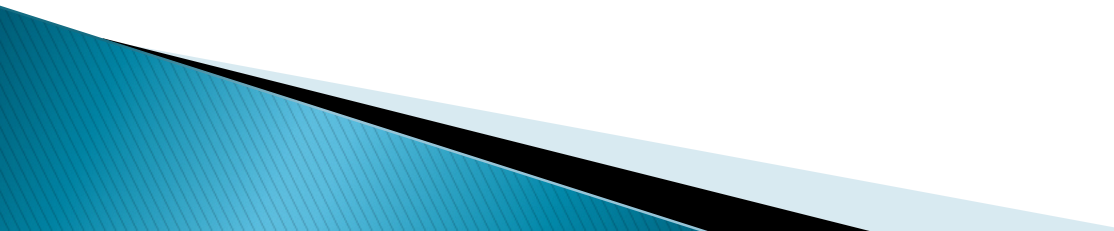
SEH Program--Demand

- ▶ Enrollment grew from 700,000 in 1994 to 900,000 currently
 - ▶ Percentage who are dependents decreased slightly, from over 50% to under 50%.
 - ▶ About 3.5 employees per contract (skewed due to mult. Contracts)
 - ▶ About 37% of enrollees have a network-only HMO contract (compared to 22% in large group); the rest have POS or PPO(2005)
 - ▶ Offer rate is above national average, take up rate is below national average.
 - ▶ Average premium (2006) about \$310/mo per person or \$370/mo per adult.
 - ▶ Premiums for a sample group and plan grew about 8% a year from 2000–2008 for Horizon, about 17% a year for Aetna
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SEH Program -- Supply

- ▶ Six major carriers – two BCBS, 4 national commercial carriers
 - ▶ 2006 market share Aetna 35%, Horizon 30%, United/Oxford 19%
 - ▶ Average loss ratio in 2006 was about 82%, well above 75%
 - ▶ Estimated underwriting profit margin in recent years about 4% of premium
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IHC Program -- Demand

- ▶ Enrollment peaked at over 220,000 in 1995, decreased to 77,000 in 2005, and has now increased to 87,000 (Sept. 2007)
 - ▶ B&E plans with age/gender rating account for over 25% of current enrollment
 - ▶ Standard HMO plan available for about \$500/mo
 - ▶ B&E rates at age 25 are \$150–\$200 man, \$250 –\$300 woman
 - ▶ From 2000 to 2008, the rate for a benchmark indemnity policy (2500D, 70%) grew at 25% per year
 - ▶ From 2000 to 2008, the rate for benchmark HMO policy (\$30 copay) grew at about 8.5% per year.
 - ▶ 2005 enrollment distribution 72% HMO, 15.5% PPO, 12.5% Indemnity
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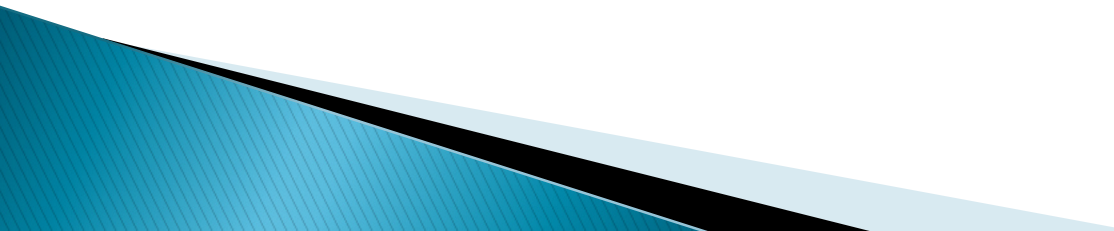
IHC Program -- Supply

- ▶ There are only 4 major carriers. Horizon BCBS has about 57% of the enrollment (2005)
- ▶ Loss Ratios vary widely by carrier- for 2006, Horizon 78%, Oxford/United 84%, Amerihealth 86% and Aetna 106%. In 2005, the average loss ratio for the IHC was about 85%.

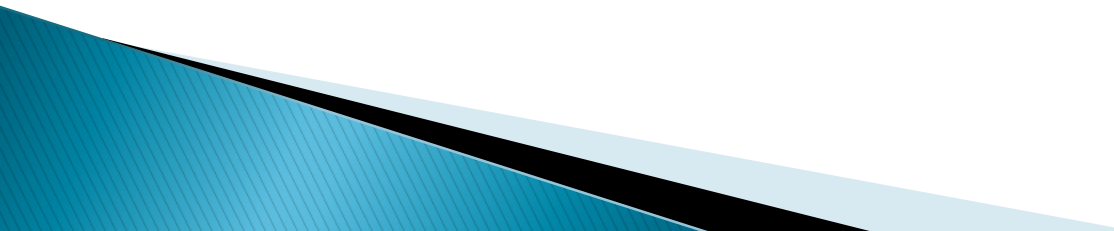
Predictions of Economic Theory

- ▶ Voluntary, Guarantee Issue, Community Rated systems fail, because
 - ▶ Insurance purchasers are risk-averse people who are maximizing the expected utility of wealth. They will not purchase insurance if the premium is too high in relation to the expected loss, thus
 - ▶ Only “high-risk” people (people with high known or expected loss) will purchase insurance, driving premiums ever higher and enrollment ever lower, in a so-called “death spiral”.
 - ▶ Why didn't the SEH fail, and why was the “failure” of the IHC so gradual?
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Some Possible Explanations

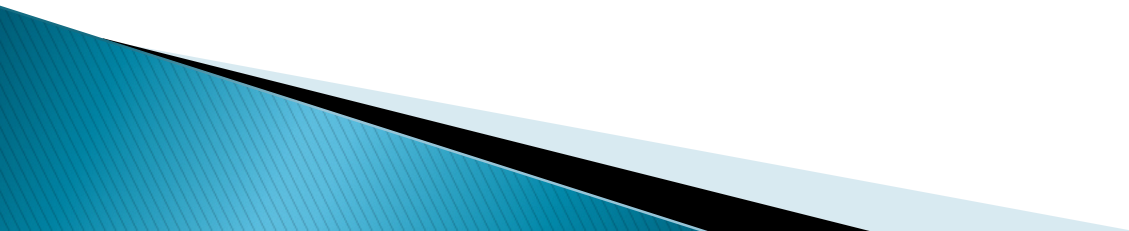
- ▶ The purchasing decision for health insurance is different – it is not a form a expected wealth maximization.
 - ▶ Pre-existing conditions exclusions and the unpredictability of medical expenses do not allow a “wait until you are sick” strategy.
 - ▶ Rating by risk does not have to be very precise to get a positive effect
 - ▶ Higher risk people tend to buy more expensive products. This self-selection permits some risk-based rating
 - ▶ Carriers are allowed to adjust rates to reflect experience
 - ▶ Small employer purchasing may not be closely correlated with risk
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Impact of Subsidies

- ▶ In its early years, the IHC program was subsidized by an assessment on all health premiums.
 - ▶ SEH premiums receive an implicit Federal Tax subsidy that is not generally available to individuals (except for the self-employed or above a threshold).
 - ▶ Many state programs place the medically uninsurable in high risk pools. State support for these pools should be considered a subsidy to the individual market
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What Have We Learned?

- ▶ Guaranteed Issue can work, but requires proper design
- ▶ Community rating can work, but allow age to some extent
- ▶ Minimum Loss Ratios are good for consumers and good for carriers
- ▶ Subsidies can lower costs and increase enrollment



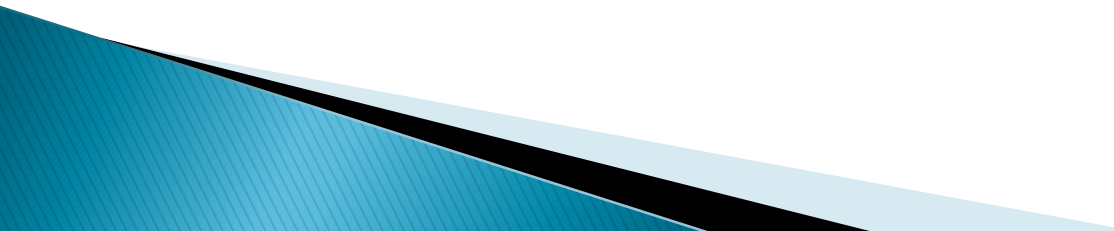
Guaranteed Issue

- ▶ Pre-existing conditions
 - ▶ Anti-crowd out
 - ▶ Participation and employer contribution requirements
 - ▶ Rating by plan (self-selection)
 - ▶ Limits on plan increases
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- ▶ Eliminate slice and dice
 - ▶ Individual or employer mandates

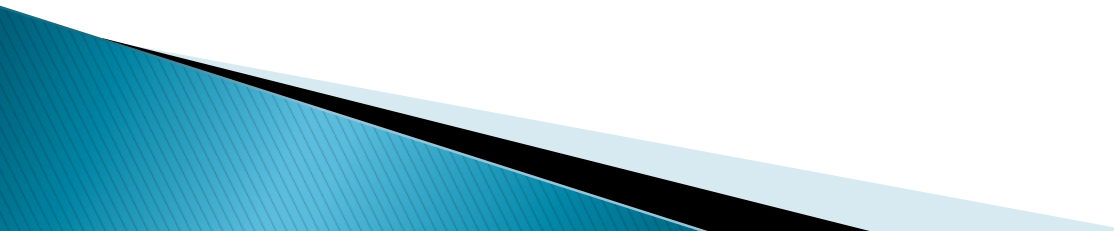
Community Rating

- ▶ Age rating is probably necessary
- ▶ Gender/Territory rating – necessity not as apparent
- ▶ Even 2:1 ratio can be effective
- ▶ Try rating by participation rate, group size, or duration?

Minimum Loss Ratios

- ▶ Carriers should be able to make money if 1) Loss Ratio is reasonable and 2) Claim prediction is accurate
 - ▶ Purchasers should feel that prices and increases are reasonable, even if they are “high”
 - ▶ What should the loss ratio be?
 - ▶ Should there be a credibility standard?
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Subsidies

- ▶ Current market is unsubsidized, so this is not a requirement
 - ▶ Is there a rationale for subsidies?
 - ▶ Subsidies can be provided through premium payments for the low income, or through loss reimbursement (aggregate reinsurance).
 - ▶ At the state level (not just in NJ) there is a lot of discussion of specific excess of loss reinsurance in guaranteed issue markets. If this reinsurance is funded from outside the market it will provide a subsidy, it will reduce variability (and thus the need for capital) and it will equalize between the carriers the impact of adverse selection by high risks.
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Conclusion

Thank you for the opportunity to talk to you to today. More than thirty years after beginning my teaching career at Temple, I continue to have happy memories of the Philadelphia actuarial community

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IHC and SEH markets www.state.nj.us/dobi/reform.htm

General Health Market www.state.nj.us/dobi/lhactuar.htm

Rutgers research: www.cshp.rutgers.edu

