Health Insurance Coverage and the Uninsured in New Jersey: Current Status and Policy Options

Joel C. Cantor, Sc.D.
Professor and Director
Rutgers Center for State Health Policy

Robert Wood Johnson Medical School
Department of Medicine
Grand Rounds
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Collaborators & Sponsors

- **Research team**
  - Alan Monheit, UMDNJ School of Public Health
  - Margaret Koller, CSHP Senior Associate Director
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Rutgers Center for State Health Policy

History
Established in 1999 with a major grant from the Robert Wood Johnson Foundation within Rutgers Institute for Health, Health Care Policy and Aging Research

Mission
To inform, support and stimulate sound and creative state health policy in New Jersey and around the nation
Outline

- Health Insurance Coverage in New Jersey
  - What drives coverage trends?
  - Where we stand today?
  - How did we get here?
- Policy Options
- Future of Coverage Policy
Drivers: On the One Hand

- Robust demand for coverage
  - #1 Median Income ($60k, nearly 1/3 higher than US)
  - Moderate poverty (13% poverty rate vs. 17% US average)
  - High-wage jobs, fairly robust economy

- Generous public program eligibility
  - Highest S-CHIP (NJ FamilyCare) eligibility – 350% FPL ($60,000 for fam. of 3)
  - Some parents eligible for S-CHIP – one of only a few states
  - High Medicaid eligibility for pregnant women – 200% FPL ($34,300 for fam. of 3)
  - Significant charity care funding – third highest Medicaid DSH
Drivers: On the *Other* Hand

- Significant gaps in public coverage
  - Adults who are not parents, aged, blind or disabled
    - 88 Medicaid enrollees per 100 in poverty in NJ vs. 109 in US
  - Charity care limited to hospitals and clinics, pays well below cost
  - Lowest Medicaid provider payment rates
- High cost
  - Highest Medicare Part A&B spending per beneficiary
    - $8,076 NJ vs. $6,611 US
  - Comparatively high employer premiums
  - High-cost practice patterns
Potentially Avoidable Hospital Use

Annual Percent

Best State | Median State | New Jersey

Medicare beneficiaries 30-day readmission: 11.2 | 17.5 | 18.4

Long-stay nursing home residents with admission: 8.3 | 16.1 | 23.2

Nursing home 90-day readmission: 6.7 | 11.7 | 16.0

Decedents Seeing 10+ Physicians in Last 6 Months

NJ Hospital
Referral Regions:
• New Brunswick
• Newark
• Camden

Source: Dartmouth Atlas, Medicare Part B Claims
Drivers: On the Other Hand (continued)

- Demographic challenges
  - 11% non-citizen (2nd ranked)
    - 40% of uninsured live in families with 1+ non-citizen
  - 16% Hispanic (8th ranked)
Where We Stand

Non-Elderly, 2005-06

NJ Fares Poorly for a Wealthy State

Late 1980’s/Early 1990’s

- All-Payer Hospital Rate Setting
  - First use of DRGs, cost containment goal
  - Cross-subsidized public goods
  - Medicare pulled out (1988)
  - BCBS in financial trouble (main source of non-group coverage)
  - Subsidized BCBS as “carrier of last resort”
  - Competition paradigm favored, hospital coalition weakens

- 1992 Comprehensive Reforms
Key Features of 1992 Reforms

• Rate setting repealed
• New (less stable) funding mechanism for charity care
• BCBS no longer carrier of last resort
• New Private Insurance Market Regulations
  ○ Guaranteed Issue, Renewal, Portability
  ○ No health and limited demographic premium rating
  ○ Standardization of policies
  ○ Minimum loss ratio (75%)
  ○ Encourage participation (especially non-group market)
Additional Features of Non-Group Market Reforms

- **Community rating**
  - Non-group pure community rated
  - Small-group permits limited demographic/geographic variation

- **Carrier loss assessment mechanism**
  - Spread unexpected high risk broadly & encourage competition
  - Initially *very* poorly structured, some insurers gamed system

- **Subsidies for low income participants**
  - Subsidized enrolled peaked at 20,000
  - Phased out starting 1997 in favor of SCHIP

- **Trouble starting 1996** *(more in a moment)*
Other Important Developments (1997-present)

- **NJ FamilyCare (1997)**
  - Children eligible up to 350% FPL
  - Parents eligible, with some difficulty sustaining

- **Non-Group Market “Basic and Essential” plan (2003)**
  - Modified community rating (e.g., premiums vary with age)
  - Limited benefits, but riders permitted
  - 22% of non-group market lives (Q4-2006)

- **NJ FamilyCare Full-Cost Buy In for Children (2006)**
  - Not implemented

- **Under 30 dependent coverage (2006)**
  - Requires insurers to offer dependent coverage for some adult children
  - About 7,000 covered lives (Q1-2007)
NJ Small-Group Coverage

Enrollment X1,000

Source: NJ Small Employer Health Benefit Program
NJ Non-Group Coverage

NJ Non-Group Coverage


Internal Forces – 1995-1997
• End of state subsidy program, 1995
• Unintended impact of “loss assessment”

External Forces – 1998-2001
• Tight labor market, rise in employer coverage
• Small-group modified community rating

Leveling Off – 2002...
• Weaker labor market
• Rising employer costs
• Basic & Essential plan
Older Average Age in Non-Group Market
Percentage age 45-64

## NJ Health Insurance Coverage by Source

<table>
<thead>
<tr>
<th>Source</th>
<th>Coverage Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid &amp; FamilyCare</td>
<td>10%</td>
</tr>
<tr>
<td>Under 65 Public</td>
<td>12%</td>
</tr>
<tr>
<td>Uninsured</td>
<td>15%</td>
</tr>
<tr>
<td>Medicaid &amp; FamilyCare</td>
<td>8%</td>
</tr>
<tr>
<td>State Health Benefit Plan</td>
<td>10%</td>
</tr>
<tr>
<td>Large Group</td>
<td>18%</td>
</tr>
<tr>
<td>Small Group</td>
<td>11%</td>
</tr>
<tr>
<td>Non-Group</td>
<td>1%</td>
</tr>
<tr>
<td>Self-funded plans</td>
<td>28%</td>
</tr>
<tr>
<td>Over 65 Public</td>
<td>12%</td>
</tr>
<tr>
<td>Total</td>
<td>8.7 million persons</td>
</tr>
</tbody>
</table>

Source: Adapted from NJ Dept. of Banking and Insurance analysis of CPS & administrative sources - 2004
Need for Reform

- Dysfunctional non-group market
  - 3% per quarter enrollment decline since 1996
  - Enrollment growing older and sicker
- 1.3 million uninsured
  - Around national average, despite high incomes and eligibility
Outline

- Health Insurance Coverage in New Jersey
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- Policy Options
- Future of Coverage Policy
  - Expand existing public programs
  - Regulatory reforms
  - Reinsurance
  - Individual mandates
Policy Option: Expand Public Programs

• Enroll eligible but uninsured
  ◦ Majority of uninsured children & many adults are currently eligible
  ◦ Assertive outreach
  ◦ Simplify enrollment process
  ◦ Improve provider networks (increase reimbursement)

• Expand eligibility
  ◦ Full-cost buy in (children, parents)
  ◦ More parents of enrolled children (currently eligible to 133% poverty)
  ◦ Adults who are not blind, disabled, or parent
Policy Option: Regulatory Reform

- Adopt demographic rating in non-group market
- State-subsidized “reinsurance” strategies
Change in Monthly Non-Group Single Premium
Simulation of Age Rating with 3.5 to 1 Rate Bands

*Monthly premium for the lowest cost HMO in the NJ non-group market ($15 copay plan in October, 2004).
**Monthly Non-Group Single Premiums**
Baseline and Demographic Rating Scenarios

$461^*$

$525$

$523$

$534$

$107$

$159$

$150$

$461^*$

$0$

$100$

$200$

$300$

$400$

$500$

$600$

PCR MCR Age/Gender
3.5:1

MCR Age-Only
3.5:1

MCR Age/Gender
5:1

Monthly Premium
Lowest Highest rating category

*Monthly premium for the lowest cost HMO product in the NJ non-group market ($15 copay plan in October, 2004). PCR is pure community rating and MCR is modified community rating*
Non-Group Enrollment
Baseline and Demographic Rating Scenarios

Notes: Enrollment in four of the five largest carriers, representing 95% of total covered lives. PCR is pure community rating and MCR is modified community rating.
Policy Option: Regulatory Reform

- Adopt demographic rating in non-group market
- State-subsidized “reinsurance” strategies
Illustration of Reinsurance

Spending for Insured Person

Not to scale

- $500
- $15,000
- $100,000

Features
- Mandatory & tax subsidized
- Lowers cost of capital
- Reduces premiums
- Improves risk pool
- Transparent to insured
- Encourages insurer entry
Monthly Non-Group Single Premiums
Baseline & Age/Gender Rated and Reinsurance Scenarios

*Monthly premium for the lowest cost HMO product in the NJ non-group market ($15 copay plan in October, 2004). PCR is pure community rating and MCR is modified community rating.
Non-Group Enrollment
Baseline & Age/Gender Rated and Reinsurance Scenarios

Notes: Enrollment in four of the five largest carriers, representing 95% of total covered lives. PCR is pure community rating and MCR is modified community rating.
Policy Option: Individual Mandate

- Enacted in Massachusetts, proposed in California
- Everyone must purchase coverage, or face penalty
- Builds on employer coverage base
- Create more affordable options
  - Expand eligibility for existing programs
  - Other income-related subsidies
  - Create new state-run plan
Policy Option: Individual Mandate

New Jersey
- Structural budget deficit ($2b)
- 17% uninsured (non-elderly)
- 11% non-citizen

Massachusetts
- Budget surplus
- 12% uninsured (non-elderly)
- 8% non-citizen
- Required to reprogram $385 million in Medicaid funding
Discussion of Options

• Expand public programs
  ○ Insures have not offered full-cost buy in
  ○ Eligibility expansion is costly
  ○ Provider network cannot handle much more enrollment
  ○ Federal S-CHIP reauthorization this year

• Rating reforms in non-group market
  ○ Reduce uninsured by 50,000 - 100,000 with few or no state dollars
  ○ Higher premiums for older adults, but few drop out
  ○ Still, opposition likely from older constituents
Discussion of Options (continued)

- **Reinsurance**
  - State responsibility for funding guaranteed issue and community rating
  - Modest budget impact, simple to administer
  - Holds older adults harmless

- **Individual mandate**
  - Advanced by senior legislator
  - New Funding and/or major restructuring needed
CSHP Role

- Eleven studies/projects since 2002
  - Simulation of demographic rating and reinsurance in non-group market
  - Analysis of Full-Cost Buy In
  - Retention of children in NJ FamilyCare
  - Experts panels on insurance market regulation & reinsurance strategies
- Extensive policymaker & stakeholder briefings, reports, articles...
- Findings at www.cshp.rutgers.edu
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What’s Next?

- Governor calls health reform a high priority
  - Severe budget constraints
- Legislative proposal expected this spring/summer
  - Work group has been vetting individual mandate proposal
- CSHP to conduct public opinion poll later this spring

Questions?