CSHP
Rutgers Center for State Health Policy

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

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Grand Rounds
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Collaborators & Sponsors

- Research team
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- Results of studies supported by
  - The Robert Wood Johnson Foundation
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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

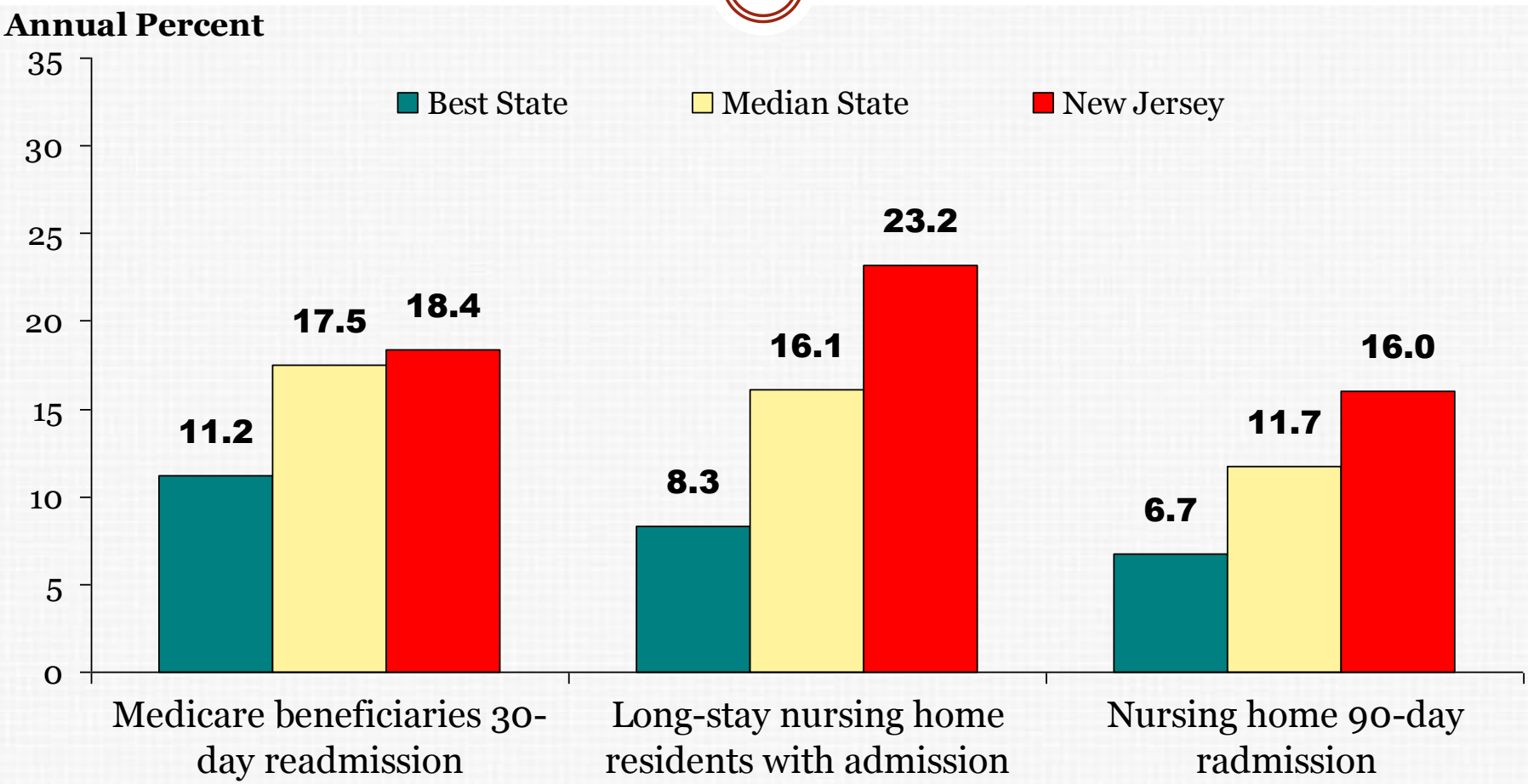
Drivers: On the *One* Hand

- 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

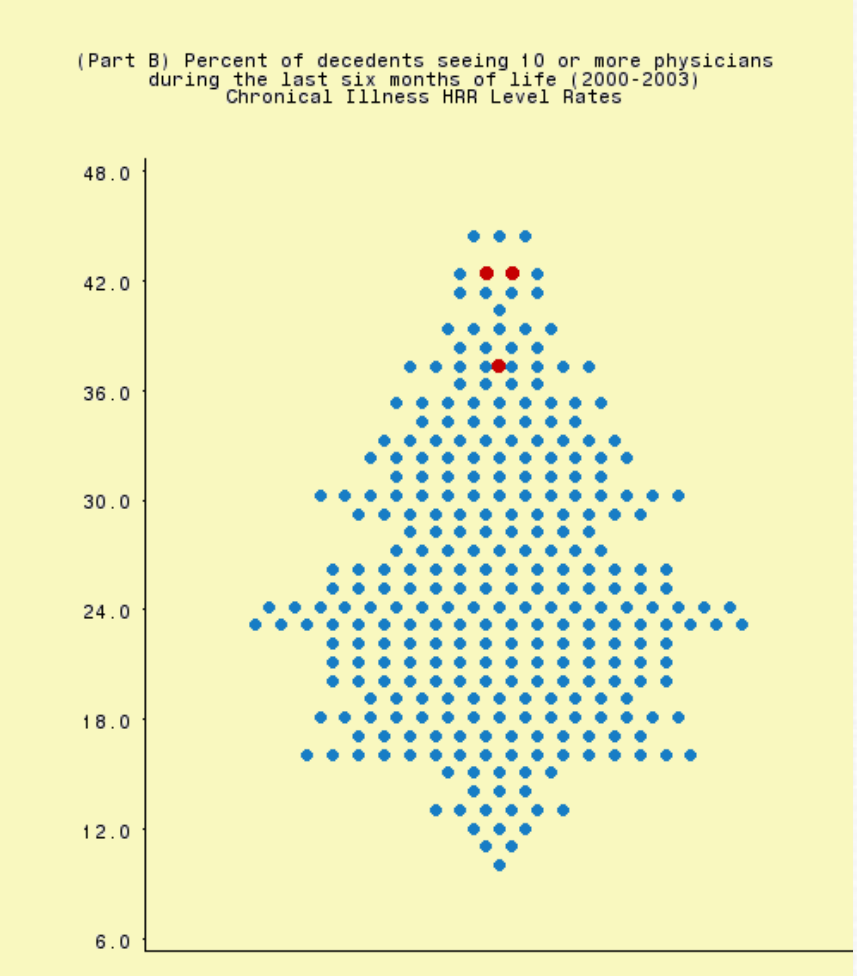
- Significant gaps in public coverage
  - Adults who are not parents, aged, blind or disabled
    - 88 Medicaid enrollees per 100 in poverty in NJ vs. 109 in US
  - Charity care limited to hospitals and clinics, pays well below cost
  - Lowest Medicaid provider payment rates
- High cost
  - Highest Medicare 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



Data: Nursing home – Mor, Brown University analysis of 2000 Medicare and Part A claims data; Home health – 2004 Outcome and Assessment Information Set (AHRQ 2005); Medicare readmissions – Anderson Johns Hopkins University analysis of 2003 Medicare Inpatient Data

Decedents Seeing 10+ Physicians in Last 6 Months



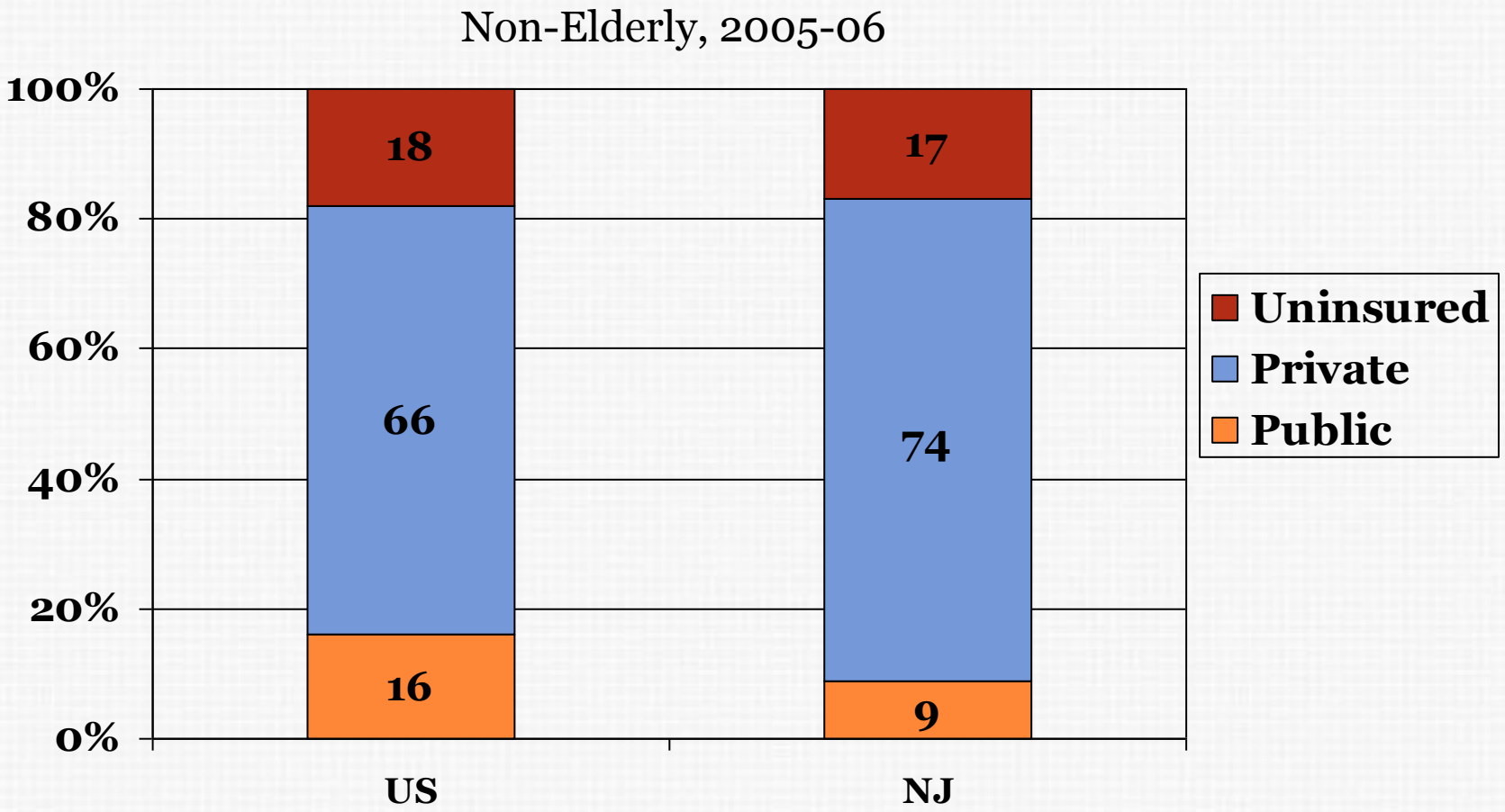
NJ Hospital Referral Regions:
- New Brunswick
- Newark
- Camden

Source: Dartmouth Atlas, Medicare Part B Claims

Drivers: On the *Other* Hand (continued)

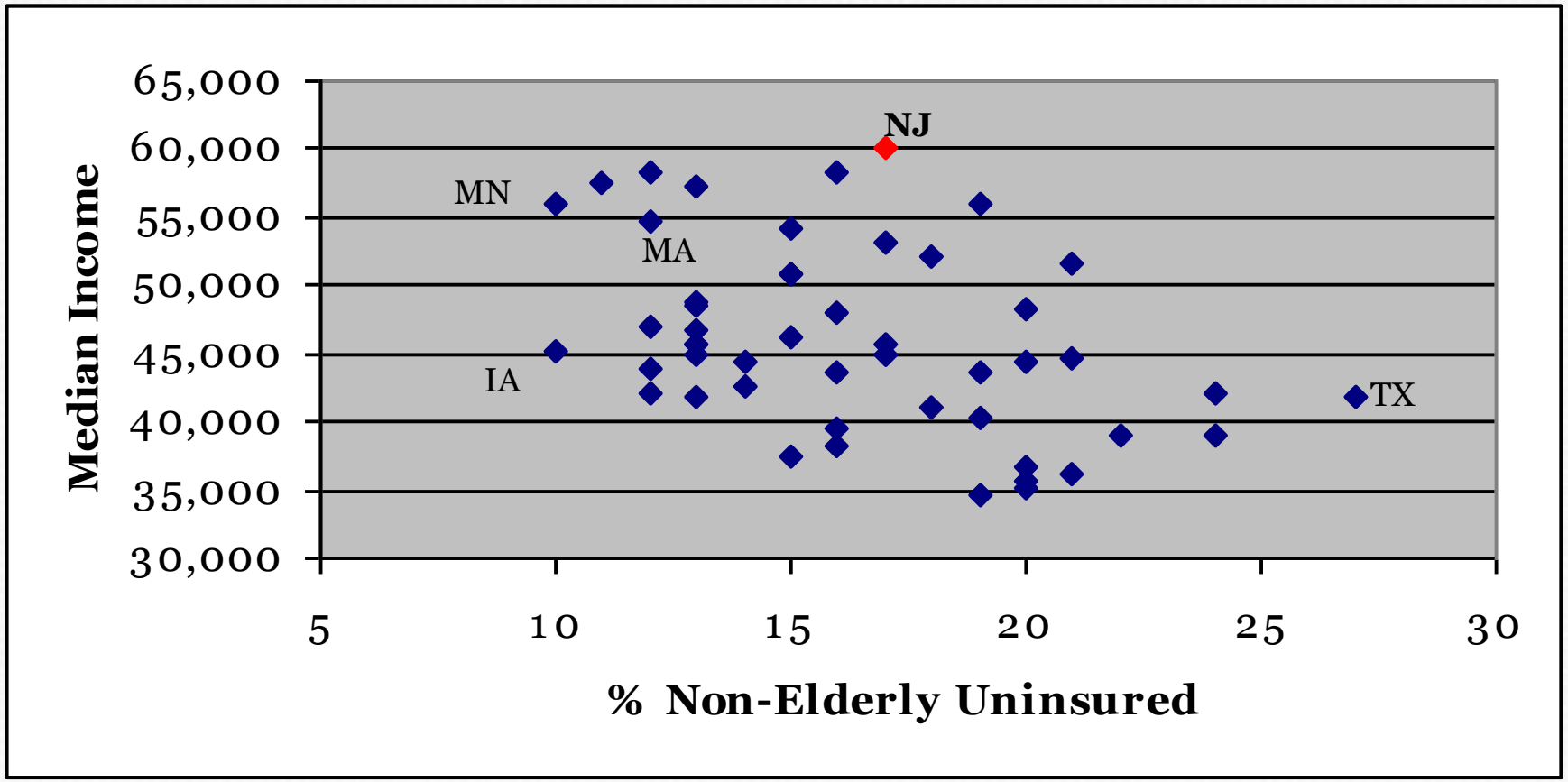
- Demographic challenges
  - 11% non-citizen (2nd ranked)
    - 40% of uninsured live in families with 1+ non-citizen
  - 16% Hispanic (8th ranked)

Where We Stand



Source: Kaiser State Health Facts, Current Population Survey, 2005-06

NJ Fares Poorly for a Wealthy State



Source: Kaiser State Health Facts, Current Population Survey, 2005-06

NJ Policy Context

Late 1980's/Early 1990's

- All-Payer Hospital Rate Setting
  - First use of DRGs, cost containment goal
  - Cross-subsidized public goods
    - Charity care
    - Medical education
    - Subsidized BCBS as "carrier of last resort"
  - Medicare pullout (1988)
  - BCBS monopoly broken (main source of non-group coverage)
  - ERISA challenge from self-funded employer plans
  - 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)

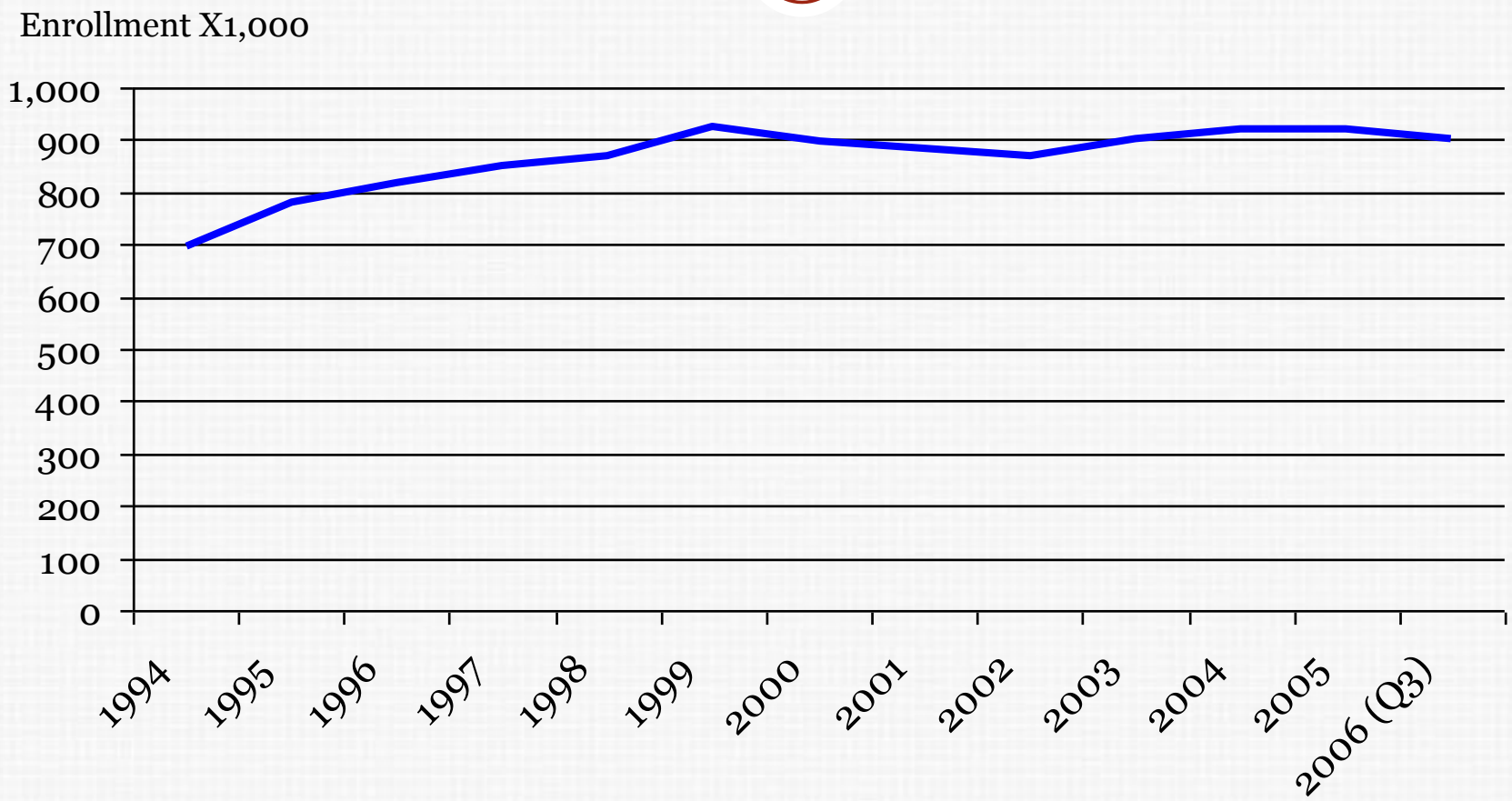
Additional Features of Non-Group Market Reforms

- 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)

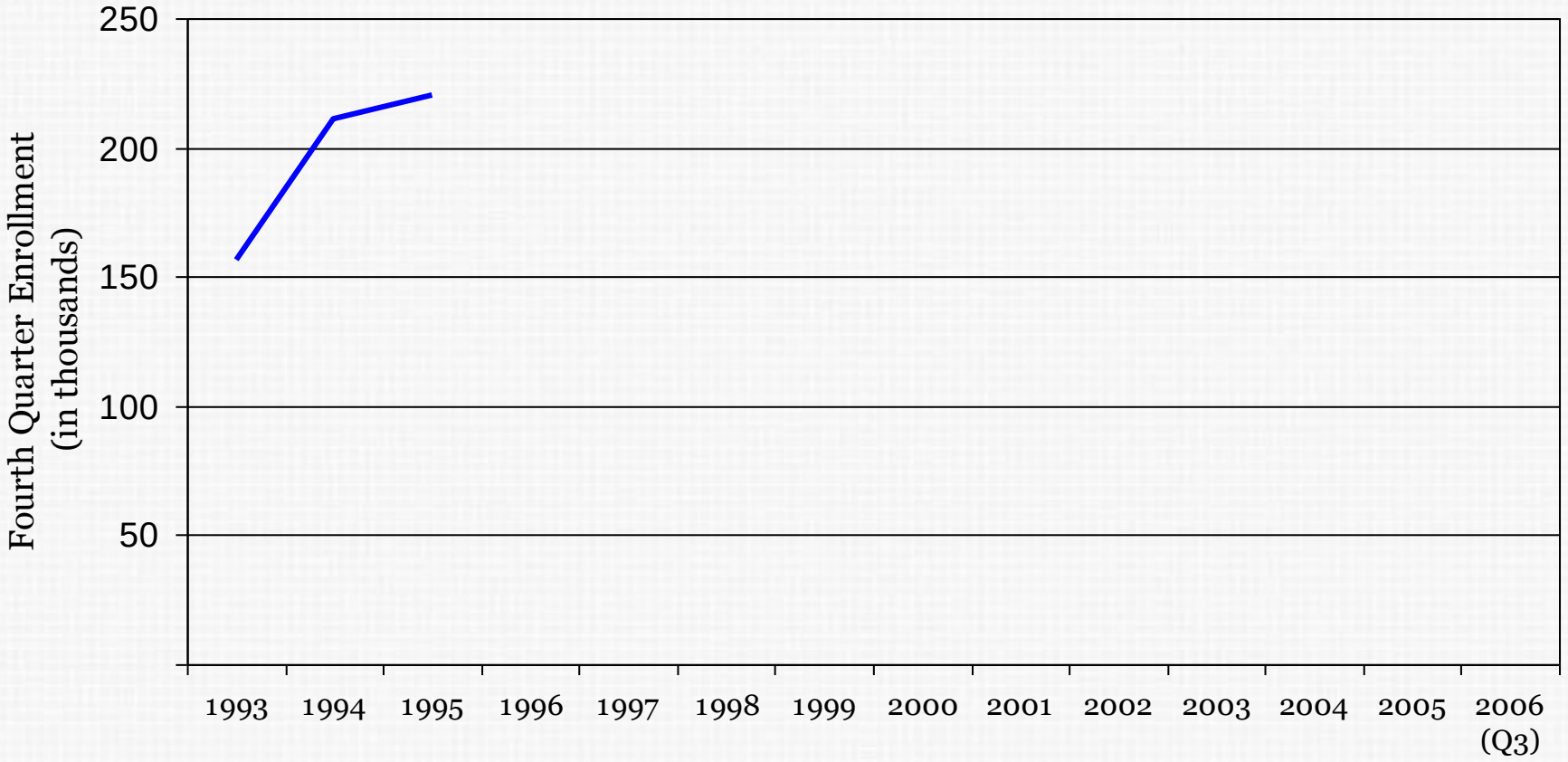
- NJ FamilyCare (1997)
  - Children eligible up to 350% FPL
  - Parents eligible, with some difficulty sustaining
- Non-Group Market "Basic and Essential" plan (2003)
  - Modified community rating (e.g., premiums vary with age)
  - Limited benefits, but riders permitted
  - 22% of non-group market lives (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



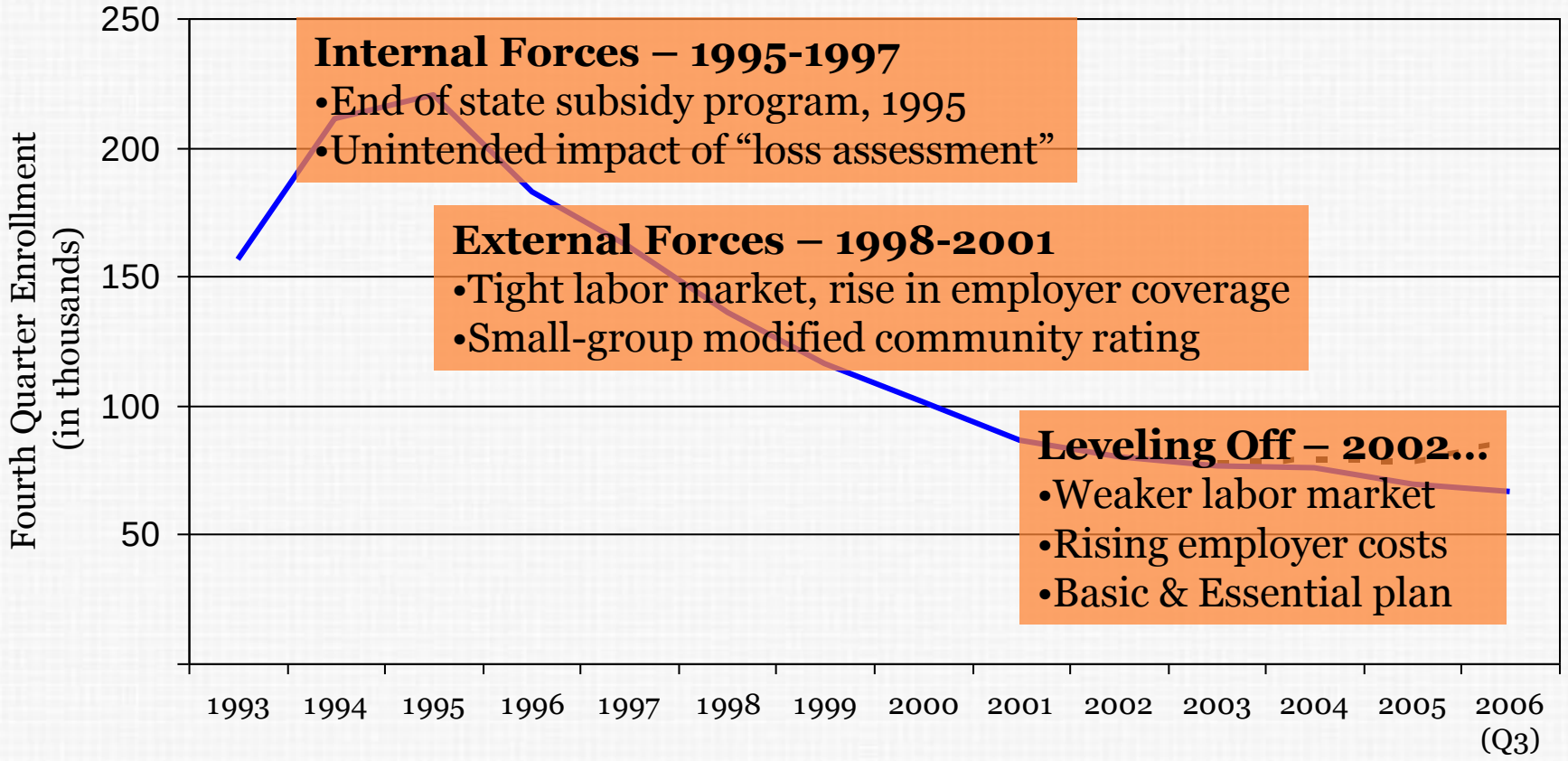
Source: NJ Small Employer Health Benefit Program

NJ Non-Group Coverage



Source: NJ Individual Health Coverage Program & Monheit, et al. Health Affairs, July/August 2004.

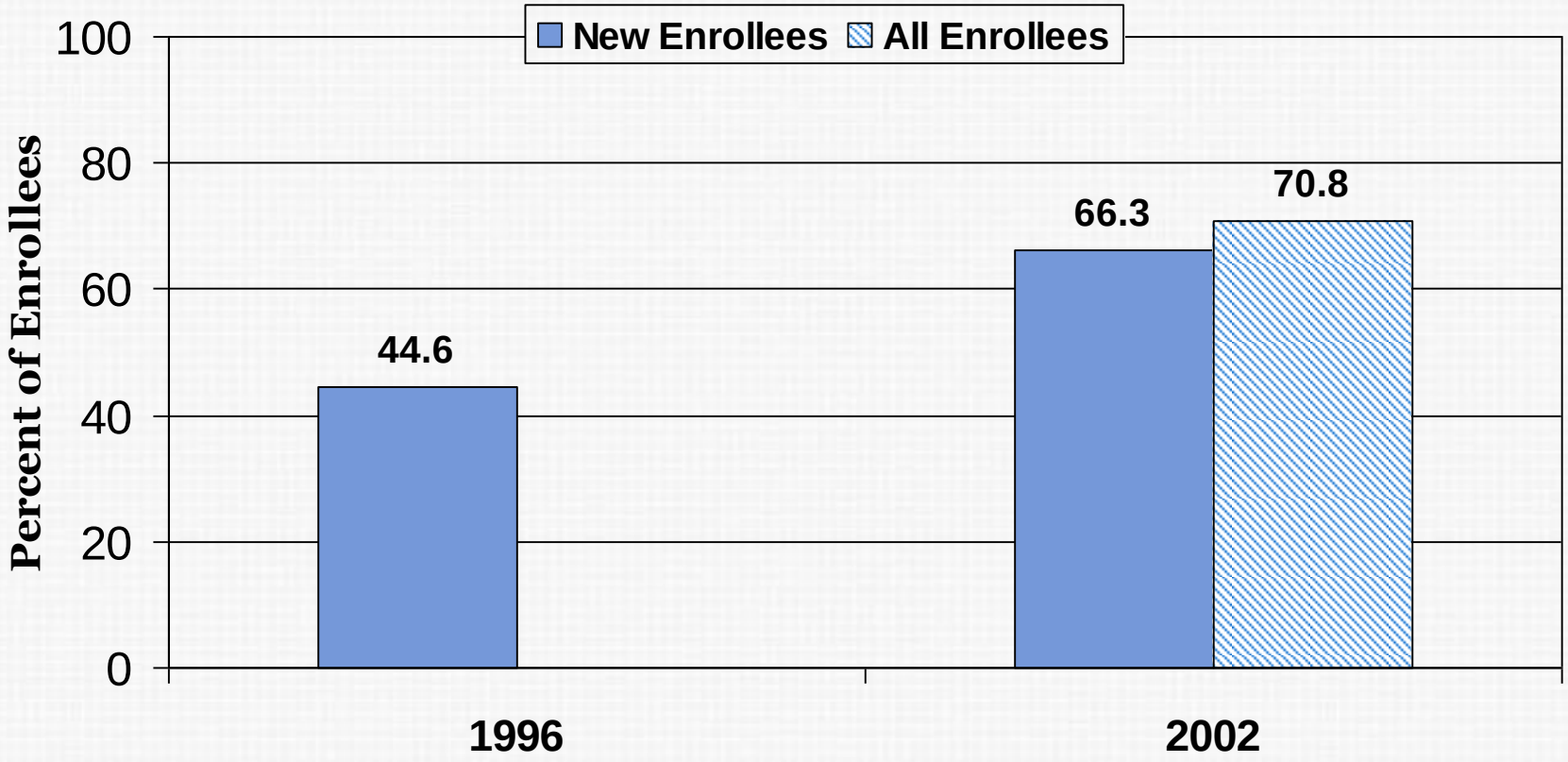
NJ Non-Group Coverage



Source: NJ Individual Health Coverage Program & Monheit, et al. Health Affairs, July/August 2004.

Older Average Age in Non-Group Market

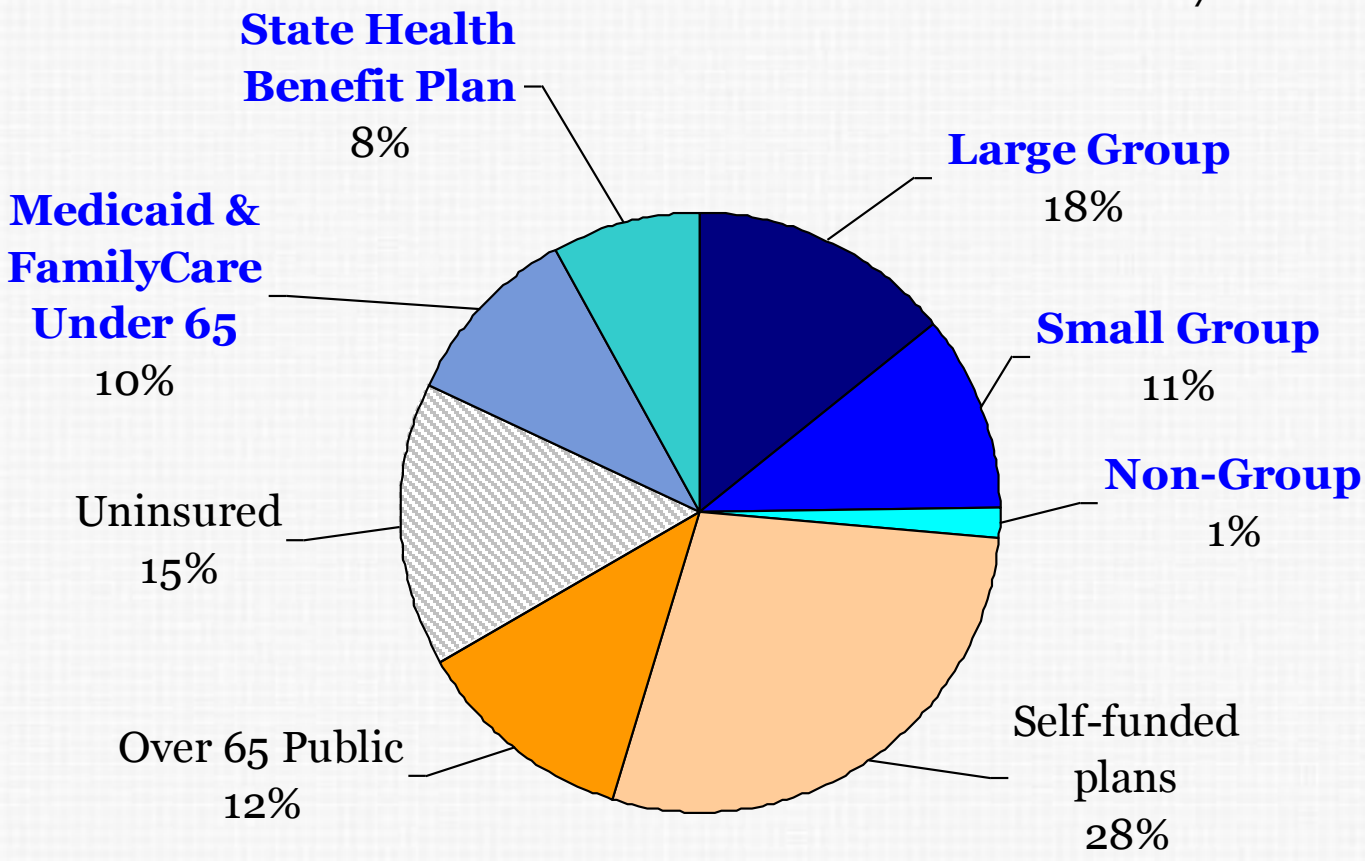
Percentage age 45-64



Sources: 1996 data from Swartz and Garnick and 2002 data from Monheit, et al.

NJ Health Insurance Coverage by Source

8.7 million persons



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
  - What drives coverage trends?
  - Where we stand today?
  - How did we get here?
- Policy Options
- Future of Coverage Policy
  - Expand existing public programs
  - Regulatory reforms
  - Reinsurance
  - Individual mandates

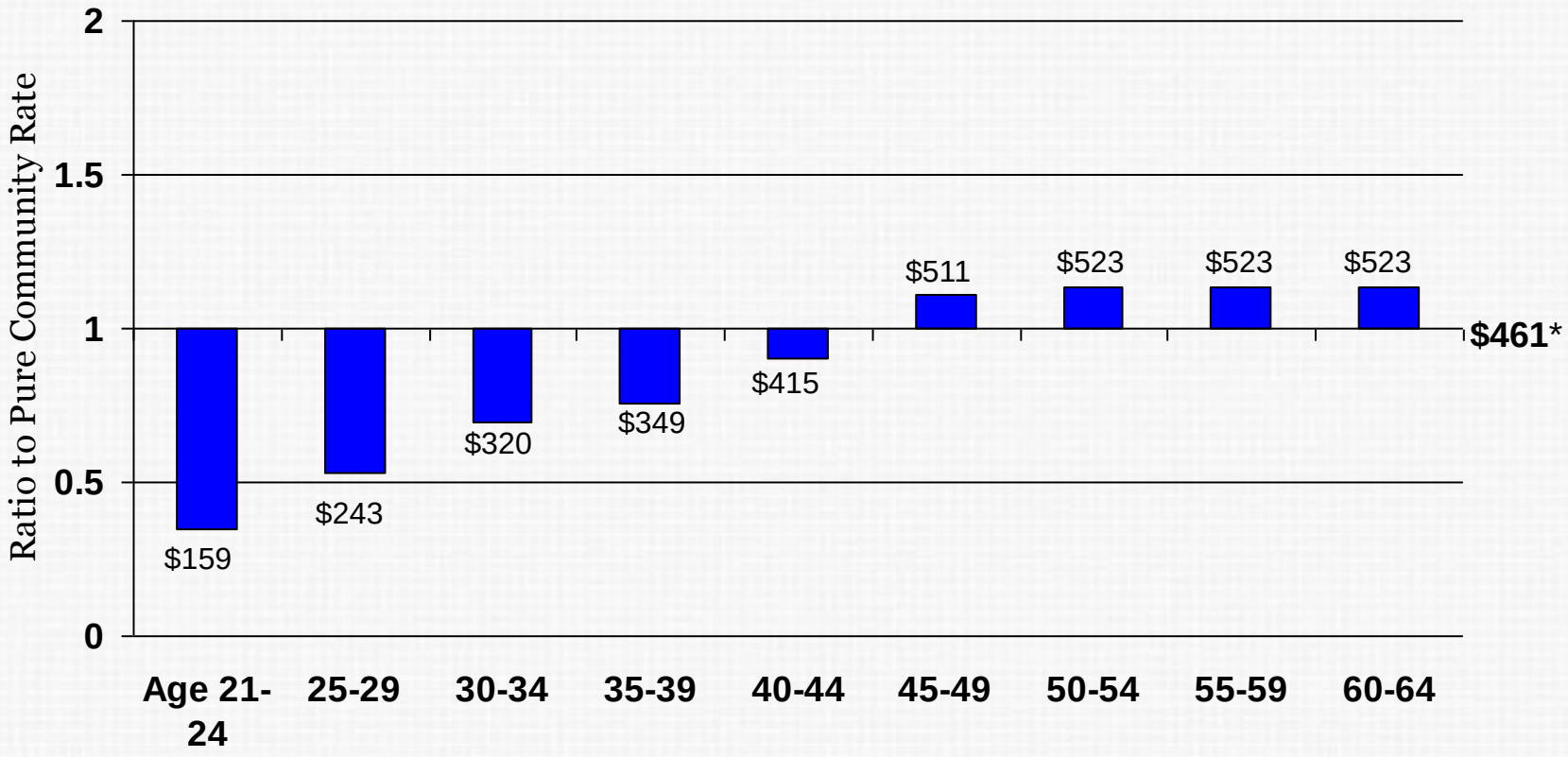
Policy Option: Expand Public Programs

- 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

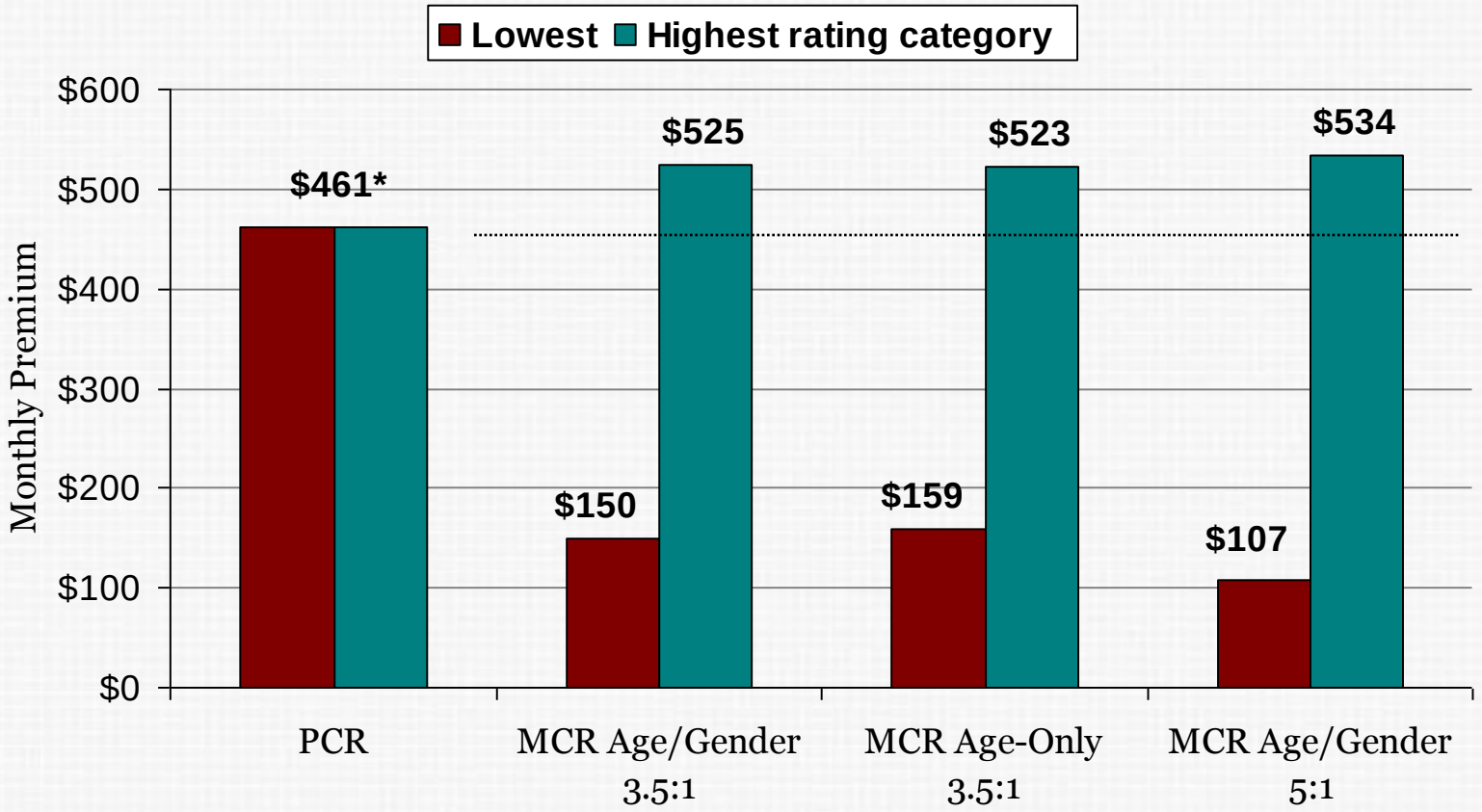
- Adopt demographic rating in non-group market
- State-subsidized “reinsurance” strategies

Change in Monthly Non-Group Single Premium
Simulation of Age Rating with 3.5 to 1 Rate Bands



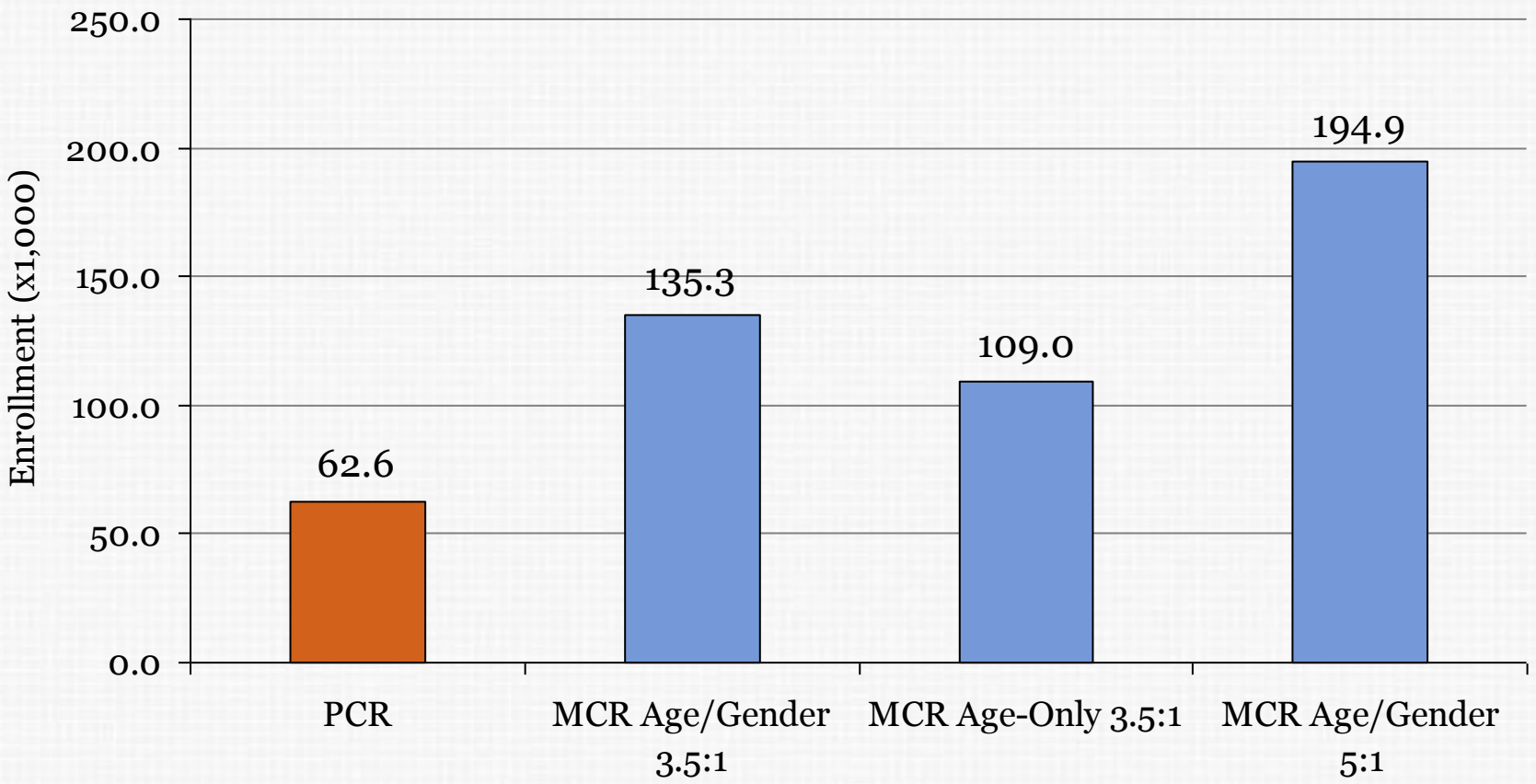
*Monthly premium for the lowest cost HMO in the NJ non-group market ($15 copay plan in October, 2004).

Monthly Non-Group Single Premiums
Baseline and Demographic Rating Scenarios



*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

Reinsurance

Primary Insurer

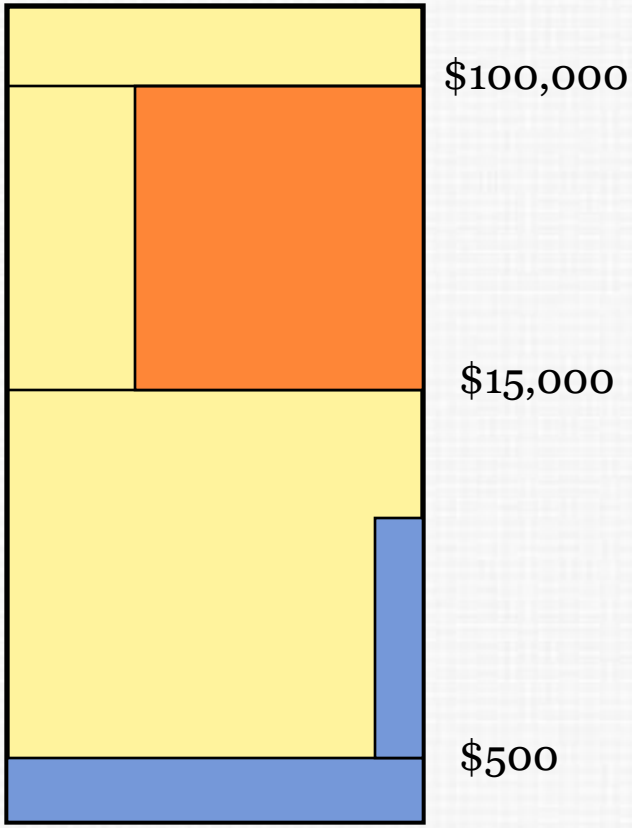
Consumer cost share

Features

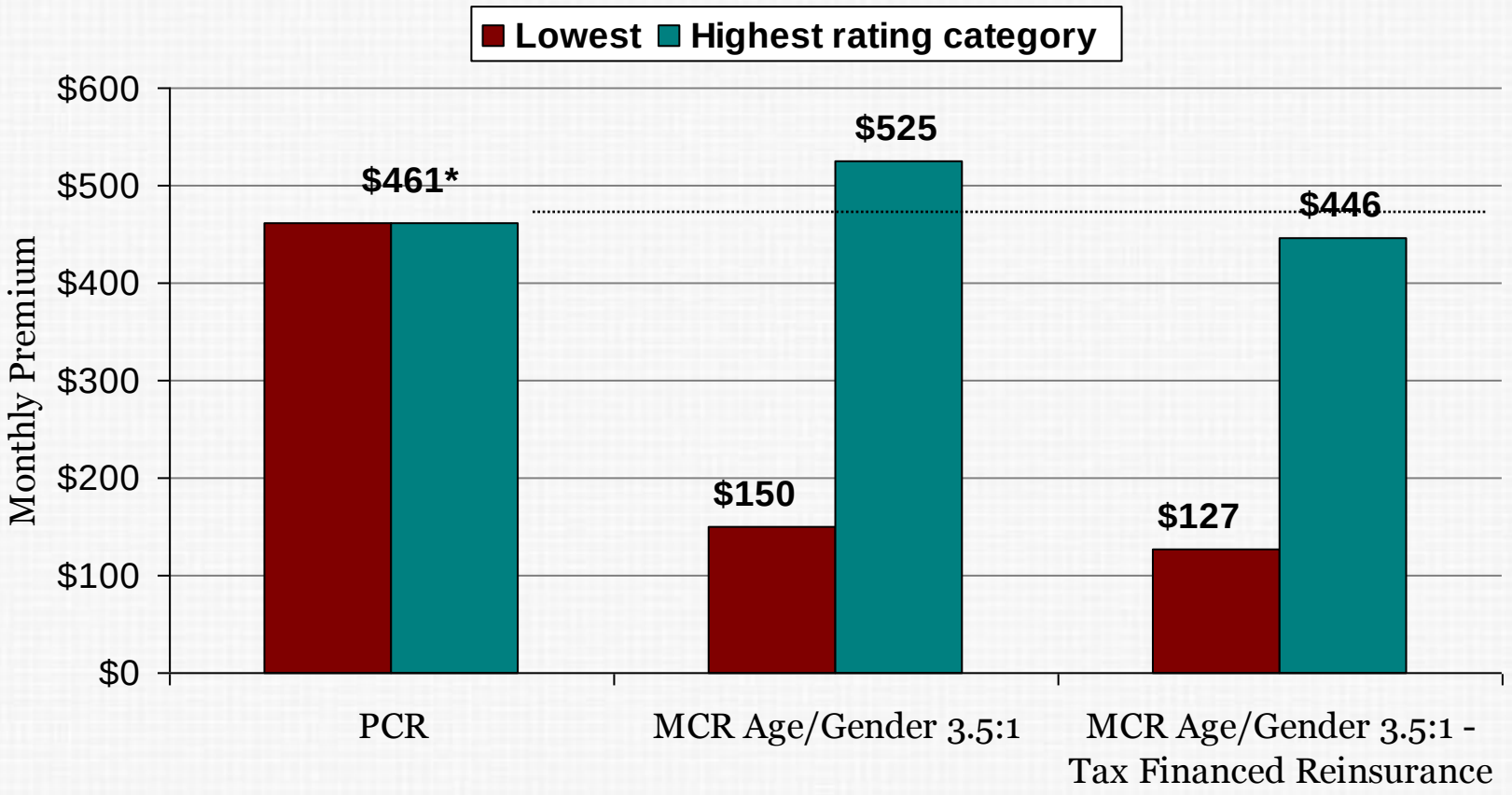
- Mandatory & tax subsidized
- Lowers cost of capital
- Reduces premiums
- Improves risk pool
- Transparent to insured
- Encourages insurer entry

Spending for Insured Person

Not to scale



Monthly Non-Group Single Premiums
Baseline & Age/Gender Rated and Reinsurance Scenarios



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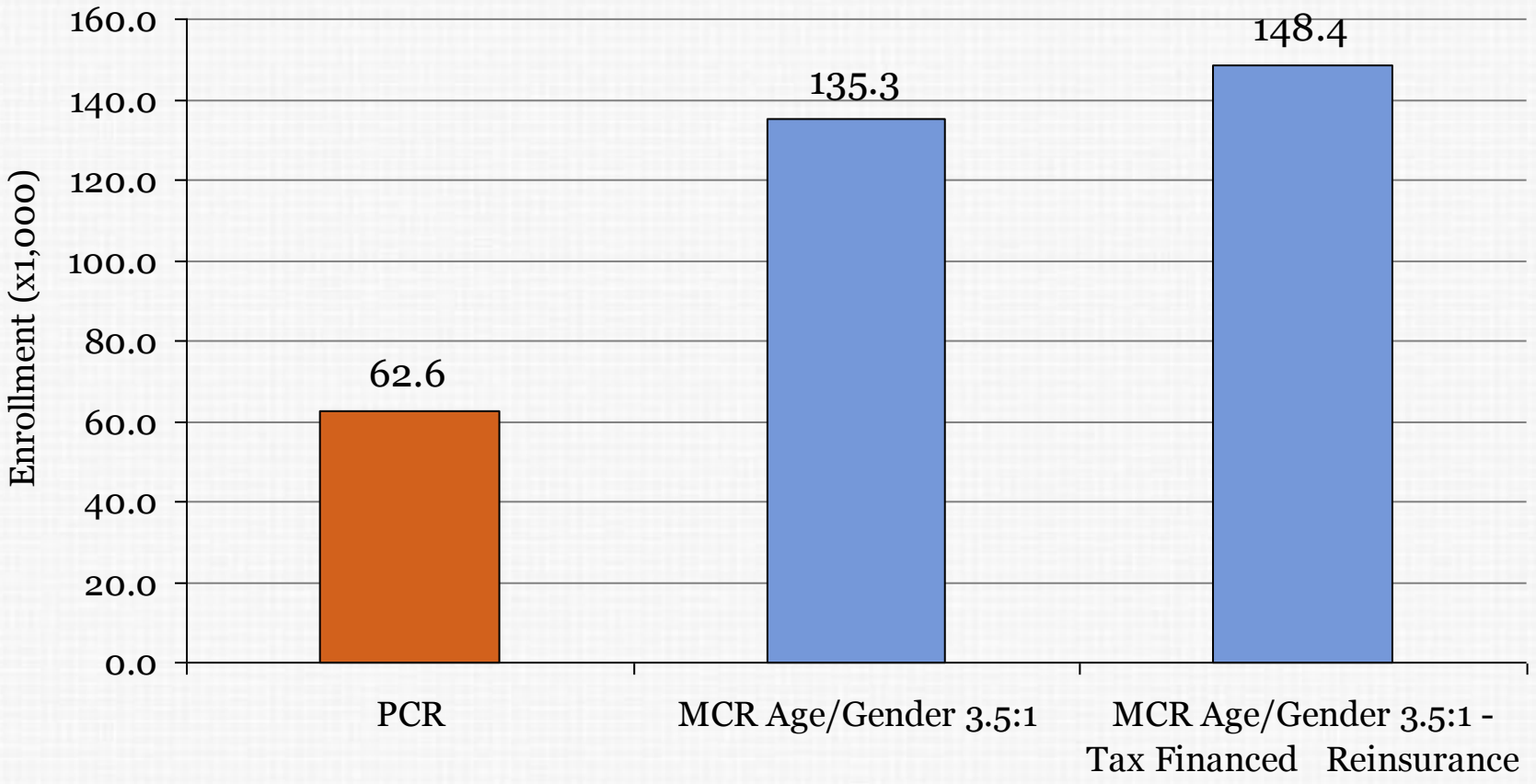
Non-Group Enrollment

Baseline & Age/Gender Rated and Reinsurance Scenarios



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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?