Rutgers Center for State Health Policy

Non-Group Health Insurance in New Jersey

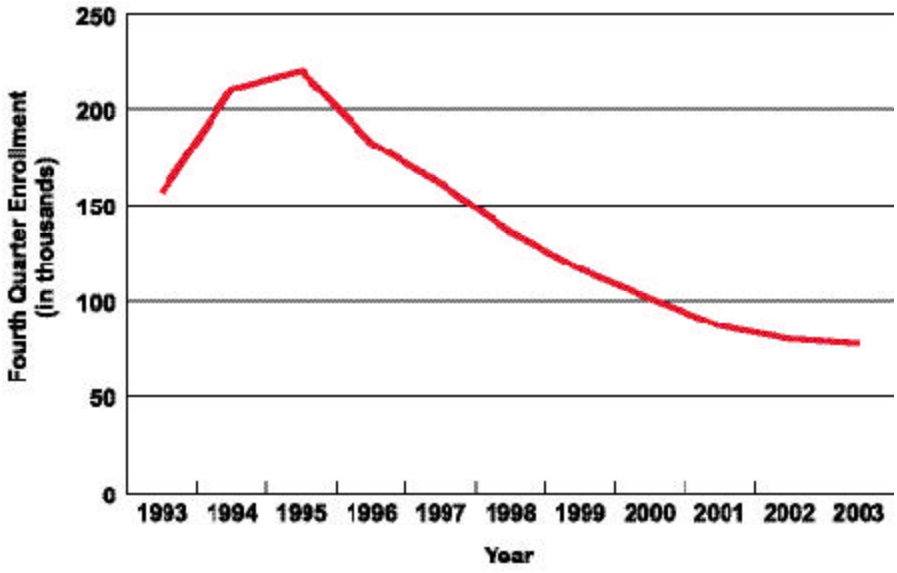
July 2004 New Jersey Family Health Survey No. 3

An Important Source of Health Coverage

Non-group or individual health insurance is available to persons without access to employer-sponsored health benefits and not eligible for Medicare. New Jersey's Individual Health Coverage Program (IHCP) was established in 1993 to assure state residents access to non-group insurance, regardless of health risk. IHCP regulations establish ground rules for non-group coverage offered through private insurers in the state. IHCP reforms were enacted by the Legislature in response to serious financial difficulties experienced by the state's "insurer of last resort," Blue Cross Blue Shield of New Jersey (now "Horizon Blue Cross Blue Shield of NJ"), in the late 1980s and early 1990s.

The IHCP regulations are designed to assure access to coverage, encourage health insurers to sell products in this market, and stimulate price competition among the insurers. The box at left highlights some of the key provisions of the IHCP regulations.

Figure 1: Enrollment in the New Jersey Individual Health Coverage Program



Source: New Jersey Individual Health Coverage Program

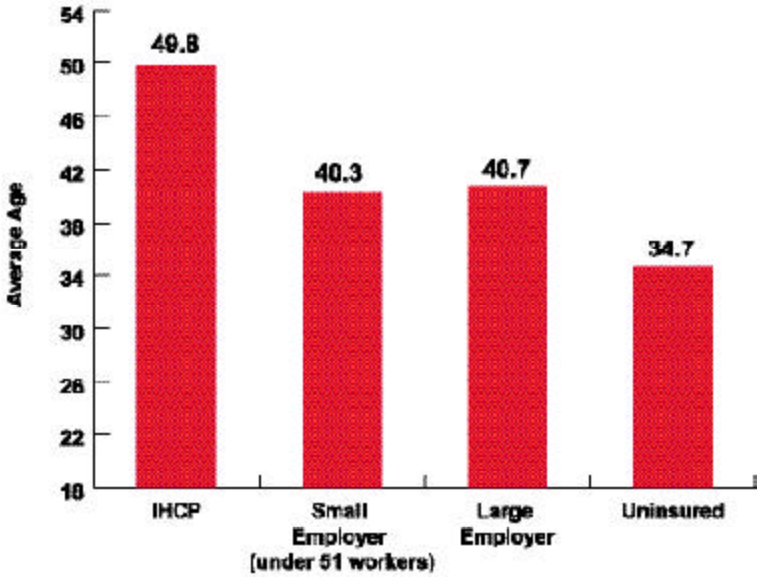
Selected Provisions of the IHCP Reforms:

- Standardized benefit plans to enable consumers to comparison shop based on premiums
- Guaranteed issue and renewal of plans, regardless of age or health status
- Pure community premium rating (with some exceptions)
- Incentives for insurers to actively sell non-group coverage.

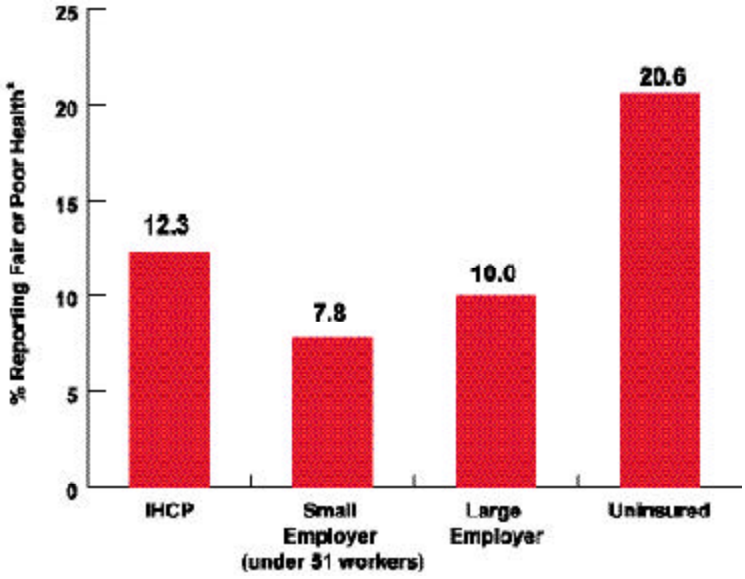
"Pure community rating" requires that carriers offer each plan at the same premium, regardless of subscriber age or health status. While initial trends suggested that the IHCP had achieved the goals of stabilizing the market and making coverage more available, recent work by the Rutgers Center for State Health Policy (CSHP) suggests that the IHCP may not be sustainable under current rules.

Figure 2: Age and Health Status of New Jersey Residents by Type of Private Coverage Adults Ages 18-64

A. Average Age



B. Perceived Health Status



Source: Rutgers Center for State Health Policy, NJ Family Health Survey, 2001 and NJFHS-IHCP Supplement, 2002.

[a] Compared to "Good," "Very Good," or "Excellent."

What Has Happened in the IHCP?

Since its peak of over 200,000 enrollees in 1996, IHCP enrollment has declined by about 3% per quarter (Figure 1). A study by CSHP researchers published in the July-August 2004 issue of *Health Affairs* delves into the causes of this decline.[1] That study concludes that the strong New Jersey economy and tight labor markets during the mid-1990s were important contributors to the IHCP decline, as more workers gained access to employer-sponsored coverage with lower out-of-pocket premiums.

Two other forces appear to have contributed to the IHCP enrollment decline as well. First, in 1995, the state implemented, and then almost immediately began phasing out, a program of state subsidies for modest income IHCP enrollees. At the peak of the subsidy program, there were about 23,000 subsidized IHCP enrollees (about 10% of total enrollment), a number that declined as this mechanism was eliminated.

Second, a provision of the IHCP regulations, called the carrier loss assessment, was designed to mitigate against carriers incurring major losses in this market. However, in response to these measures, several small carriers appear to have offered premiums well below the prevailing market rate. The adverse incentives of these early regulations were removed in 1998, and the market share of these carriers declined from a peak of 27% in 1996 to less than 1% in 1998. It is probable that many individuals who purchased these artificially low-cost plans left the market after this regulatory "loophole" was closed.

Whether the IHCP, with open access and full community rating, would have maintained higher enrollment without these forces is unclear, but it is clear that regulators and

Table 1: New IHCP Enrollees in 2002 are Older and Sicker than They were in 1996
Adults Ages 18–64 Who Enrolled in Prior 11 Months

	1996	2002
Average (Mean) Age	41.9	48.4
Percent Reported in Fair or Poor Health	4.3	8.1

the Legislature will be taking a hard look at whether the current regulatory framework can be sustained in the future.

Who Does the IHCP Serve?

The IHCP is the primary source of health insurance for individuals who are not offered coverage through an employer and are ineligible for Medicare, Medicaid, or NJ FamilyCare. In effect, the IHCP is the "safety net" source of health insurance for this segment of the New Jersey population.

Figure 2A illustrates that, compared to adults with employer-sponsored coverage or no coverage, IHCP subscribers are, on average, older. Figure 2B shows that IHCP subscribers are more likely to report being in "fair" or "poor" health compared to those covered through an employer. Notable, however, is the large difference in health status between those with coverage, whether through the IHCP or an employer, and those with no coverage at all. Even though they are younger on average, the uninsured report worse health than those with coverage.

The age and health profile of IHCP enrollees has changed since program enrollment began its decline. A 1996 study of the IHCP showed little difference in age or perceived health status between IHCP subscribers and

Table 2: Indicators of Health Status and Health Service Use by New Jersey Residents Covered through the IHCP or Employer-Sponsored Coverage and the Uninsured Adults Ages 18-64

Number (n)	IHCP	Small Employer	Large Employer[b]	Uninsured
Somewhat or Much Worse Health Compared to a Year Earlier[a]	5.9	7.7	5.8	8.9
Asthma	8.3	9.6	10.2	8.8
Diabetes	6.1	3.3	4.9	5.8
Hospital Stay Past 12 Months	6.4	3.9	8.4	4.6
Emergency Department Visit Past 12 Months	11.4	10.1	14.1	14.3

Source: Rutgers Center for State Health Policy, New Jersey Family Health Survey, 2001
Notes: [a] Compared to "Much Better," "Somewhat Better" or "About the Same."
[b] Includes small number of cases for which firm size was not known.

those with employer coverage.[2] The shift in the average age and health of IHCP subscribers contributed to a cycle of rising premiums and declining enrollment in the program.

Although the average IHCP subscriber was older and sicker in 2002 compared to 1996, indicators of the current status of the IHCP enrollee suggest that this group is not an exceptionally poor insurance risk. Table 1 provides additional indicators of health and health services use for those insured through the IHCP and private employer groups as well as the uninsured. These indicators paint a mixed picture, but they do not show that IHCP subscribers are substantially sicker than their counterparts in the other groups.

Policy Dilemma

Although the decline of enrollment in the IHCP has abated in recent quarters, New Jersey policy makers face trade-offs if they seek to restore higher levels of individual market enrollment. If they permit insurers to exclude or charge higher premiums for older or sicker applicants, coverage would become less affordable for those who need it most. On the other hand, doing nothing could lead to further erosion of IHCP enrollment in the future.

[1] Monheit, A.C., J.C. Cantor, M. Koller and K. Fox. "Community Rating and Sustainable Individual Health Insurance Markets: Trends in the New Jersey Individual Health Coverage Program." *Health Affairs*. July/August 2004, 23(4):167-175.

[2] Swartz K. and Garnick D. "Can Adverse Selection Be Avoided in a Market for Individual Health Insurance?" *Medical Care Research & Review*, September, 1999, 56(3):373-388.

About *Facts & Findings*

This is the third in a series of *Facts & Findings* from Rutgers Center for State Health Policy. These briefs highlight findings from major research initiatives at the Center, including the New Jersey Family Health Survey (NJFHS) and the New Jersey State Physician Census.

Facts & Findings data reported in this issue were drawn from the Center's 2001 New Jersey Family Health Survey and a 2002 NJFHS supplement in which IHCP members were interviewed. This study was funded by The Robert Wood Johnson Foundation Health Care Financing and Organization Initiative and The Commonwealth Fund. We thank Horizon Blue Cross Blue Shield of NJ, Aetna Health, Oxford Health Plan, and AmeriHealth for their participation in this study. Views expressed in this *Facts and Findings* are solely those of the authors.

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Rutgers Center for State Health Policy informs, supports, and stimulates sound and creative state health policy in New Jersey and around the nation.