STATE REPORT

Hidden Assets: Health Insurance Reform In New Jersey

Despite the widely held belief that states lack power to alter insurance companies’ behavior, New Jersey’s individual health insurance market reform unearthed ways for states to expand coverage.

by Katherine Swartz and Deborah W. Garnick

Since 1988 the fraction of the population covered by employer-group health insurance has fallen from 65 percent to 61 percent. Moreover, the current economic prosperity has not caused the proportion to return to its level in the early 1980s, as might have been expected. Because this decline coincides with public opposition to larger public entitlement programs, it increases the pressure to develop private-sector solutions to expand access to health insurance. Toward that end, in March 1998 congressional Republicans proposed one such solution: a tax credit for a person or family who purchases health insurance directly from an insurer. In May 1998 Rep. Bill Thomas (R-CA) went further and proposed eliminating the tax break that employers receive for providing insurance and giving individuals tax credits to purchase their own coverage. By mid-March 1999 at least six bills had been introduced in Congress, by both Democrats and Republicans, calling for self-employed workers to be able to immediately deduct the full cost of health insurance from their incomes.

Policies written for individuals and families who are not members of an employer group or association constitute the market for individual health insurance. In many states the individual market seems to be competitive, with multiple insurers writing policies. But the individual insurance market comprises many niches, in which insurers specialize in tailored policies and specific types of people. The niches exist because insurers fear adverse selection—when persons who anticipate high medical care costs are more likely to purchase health insurance than are those who do not have reason to believe they need medical care.

To protect themselves from high-risk applicants, insurers have sophisticated mechanisms to restrict the types of persons whom they will insure. Such mechanisms include refusing to issue or renew a policy (the 1996 Health Insurance Portability and Accountability Act only prohibits these actions for a limited class of “eligible persons”), using impairment waivers to exclude coverage of services for preexisting conditions, and differentiating their policies from those of competitors by writing “limited benefits” policies rather than comprehensive, major medical policies.

These restrictions sharply reduce actual competition across the entire individual health insurance market. Thus, at first glance, the various proposals to use the tax code to encourage individuals to purchase insurance may provoke skepticism. Analysts could reasonably conclude that the individual market does not offer promise for absorbing large numbers of uninsured persons.

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For persons familiar with New Jersey’s health insurance initiatives, however, such skepticism of the potential for increasing use of the individual insurance market is too gloomy a view. Since August 1993 New Jersey has successfully operated the Individual Health Coverage Program (IHCP). As of this writing the IHCP represents the most sweeping set of state reforms to promote broadly based competition in the market for individual health insurance.

Overview Of The Reforms

The IHCP reforms forced changes in five areas. (1) To broaden the size of the potential market, insurers are sharply limited in their ability to choose whom they will insure. The regulations require guaranteed issue and renewal of policies, portability of coverage across carriers, and limits to preexisting condition exclusions. (2) To encourage indemnity insurance companies and managed care organizations (hereafter collectively referred to as carriers) to enter the market, all carriers selling health insurance in New Jersey must either offer policies in the individual market or share in the losses of carriers that do sell policies and incur losses. (3) To give consumers more leverage in the market, carriers in the market may only sell up to six types of policies with standardized benefit packages, a standardization that facilitates comparisons by consumers. (4) To extend access to higher-risk persons, the state required carriers to use pure community rating in setting premiums for the standardized policies; age-rating bands or variations in premiums based on where a person resides in the state are not permitted. In setting premiums, carriers also are required to meet a minimum loss ratio, so that at least 75 percent of premiums are used for provision of services. However, carriers do not have to seek approval from a state agency for any changes in premiums that they might want to implement, which we discuss in more detail below. (5) To implement the IHCP and monitor industry compliance with the regulations, the authorizing legislation called for oversight by a board, which runs the program independently of the New Jersey Department of Banking and Insurance. Four of the nine board members are representatives of carriers and elected by the companies.

New Jersey’s reforms are remarkable, particularly today, when states are assumed to have little power to bargain with corporations. In recent years mutual fund firms, automobile factories, professional baseball teams, and many other corporations have extracted large government concessions by threatening to move elsewhere. Yet New Jersey imposed major regulations and risk sharing on health insurers, with major carriers taking a leadership role in the process.

Potential For Public/Private Solutions

A brief review of the IHCP’s history explains how these reforms were possible and has implications for policymakers in other states. First, states have assets to bargain with. States have regulatory authority and powers that they should regard as assets in interacting with carriers. In an era of deregulation, health insurance remains a relatively regulated industry. By using their regulatory power to channel corporate self-interest, states can make the market for individual health insurance behave more like a single competitive market than a market with many segments and restricted access. Second, policy entrepreneurs exist in the private sector, too. Once a state harnesses corporate self-interest, it will find persons in the corporate sector who have ideas and innovations and will devise proposals that may address the state’s particular needs. Third, additional efforts are needed to expand coverage. Even a well-functioning individual health insurance market has limits on what it can accomplish. A combination of New Jersey–style reforms with federal tax credits might raise health insurance coverage in most states, but additional efforts will be needed to greatly reduce the number of uninsured persons.
Origins Of The Problem

Until August 1993, when the IHCP began operations, persons in New Jersey had three sources from which to purchase individual health insurance: Blue Cross and Blue Shield (BC/BS) of New Jersey (which was the state’s insurer of last resort); indemnity carriers that sold “one-life” group policies to self-employed persons and their families; and self-insured association plans that sold individual policies. The latter two sources were not available to all, however, because these sources used medical underwriting to reject applicants and determine premiums, and one had to be either self-employed or a member of an association. In 1992 BC/BS had written individual policies covering 175,000 persons. Thus, a year before the IHCP was implemented, the general consensus was that approximately 175,000 persons were covered by individual insurance policies, and an indeterminate but much smaller number of others were covered by one-life group policies or association policies. Despite receiving state subsidies for being the insurer of last resort, BC/BS’s individual policies were generating substantial losses—$20 million in 1992, according to one estimate.6

Although only a handful of carriers wrote policies in the individual market, all New Jersey insurers had a stake in the market through a set of hospital rate surcharges. The surcharges were instituted in 1971 to fund both hospital uncompensated care and BC/BS’s losses from individual policies. Despite receiving state subsidies for being the insurer of last resort, BC/BS’s individual policies were generating substantial losses—$20 million in 1992, according to one estimate.6

The judge’s decision inspired a variety of reactions. Democratic Governor James Florio was facing reelection in 1993. To him, the specter of BC/BS’s either going bankrupt or greatly raising premiums and thereby enlarging the uninsured population was unthinkable. A small number of executives of the state’s largest carriers saw the judge’s decision as an opportunity to alter the state’s cost-sharing mechanism for the subsidies to BC/BS and uncompensated hospital care. These executives wanted to spread the losses from uncompensated care and the individual market across all carriers in a “fair” manner. However, they were unwilling to accept higher assessments without some mechanism to force BC/BS to reduce costs and operate more efficiently. Most carriers suspected that BC/BS was losing money because it was badly run, not because it was the insurer of last resort.

BC/BS also wanted a solution, of course. Earlier in 1992, before the judge’s ruling, BC/BS had drafted a proposal for sharing the burden of losses in the individual insurance market. The proposal called for all carriers selling health coverage in New Jersey to either enroll uninsured individuals or pay an assessment to insurance carriers (such as BC/BS) that did enroll individuals. Significantly, BC/BS did not address accountability for carriers’ costs of operations, so the subsidy component of its proposal did not alleviate other carriers’ fear of subsidizing BC/BS’s costs of operations.

Judge Wolin’s decision, however, immediately elevated the BC/BS plan to a serious pro-
posal. A number of influential carriers, unhappy with the BC/BS proposal, met to consider alternative options. The guest list for this meeting was impressive: It included Aetna, CIGNA, the Guardian, Metropolitan, Prudential, Travelers, a representative from the New Jersey office of the Health Insurance Association of America, and two health maintenance organizations (HMOs): U.S. Healthcare and HIP-Rutgers. As one person said to us, “All the senior people [from each of the carriers] came because other senior people were coming and they didn’t trust each other to do the right thing.”

Right after the meeting, three carriers—HIP-Rutgers, U.S. Healthcare, and Prudential—quickly began to develop the plan that ultimately would become the IHCP. These carriers believed that their potential losses from selling individual policies would be less than their assessments to subsidize BC/BS, because well-run managed care plans could control costs better than indemnity carriers could. Moreover, they resented having to compete with BC/BS, even as they were helping to subsidize them.

The three carriers created a simple proposal. It called for any carrier selling health policies in New Jersey (group or individual) to participate in the individual market, either by sharing in the losses of the carriers that did sell policies or by selling at least an assigned target number of individual policies. A carrier’s share of any losses incurred by those carriers selling individual policies was to be determined by its share of total revenues (what are termed net earned premiums) from all carriers’ group and individual policies sold in the state. A carrier’s target number of individual policies to sell also was to be determined by its share of all revenues from health insurance. Most importantly, if a carrier met its target number of policies, it was exempt from paying its share of other carriers’ losses. Also, if a carrier expected losses from selling its target number of policies, it had to decide by April each year if its assessment for the total losses of carriers seeking reimbursement was greater than its own losses. Although the loss-assessment mechanism does not distinguish between losses resulting from management inefficiency and losses resulting from high-cost enrollees, the three carriers clearly believed that only large carriers could absorb the costs of some high-cost enrollees (given their larger books of business). Further, they believed that managed care plans in particular would be more likely to be efficient in minimizing costs.

To prevent carriers from selecting only persons with low probabilities of using expensive medical care, carriers that sold policies had to accept all applicants (guaranteed issue) and could not refuse to renew policies (guaranteed renewal). Only a limited set of policies with standardized benefit packages could be sold. The focus on standardized packages was strongly influenced by Alain Enthoven’s proposals for managed competition and the federal Omnibus Budget Reconciliation Act (OBRA) of 1990, with its requirement that all Medigap policies conform to one of ten uniform benefit packages.

The three carriers that crafted this proposal believed that if carriers were restricted in their ability to select risk, then carriers that were efficient would be able to offer the lowest premiums in the market. Moreover, they believed that their plan provided an incentive for carriers with relatively large shares of the health insurance business in the state to sell policies: Any losses from selling policies would be less than the share of the subsidies they otherwise would have to pay BC/BS.

Final Compromise
After developing the proposal, the three carriers convinced CIGNA to add its support and then took their proposal outline to the legislature and to Governor Florio within three weeks of their initial meeting. The governor responded positively to the carriers’ proposal but demanded the addition of community-rated premiums. He believed that experience rating of premiums made insurance unaffordable for many persons with previous health problems. From the four carriers’ perspective, the governor’s demand presented a
problem. In New Jersey any change in a health insurance policy’s premium required prior approval from the Department of Banking and Insurance—a cumbersome, time-consuming process. The carriers knew that community-rated premiums combined with the slow approval process would erase industry support for the proposal.

To keep the proposal alive, executives of the four carriers then proposed that in exchange for community rating they be permitted to simply file changes in premiums, but not with the Department of Banking and Insurance. Instead, they proposed creating an oversight board for the individual insurance market, which would be the recipient of premium change filings. With the addition of community rating, the oversight board, and freedom to change premiums without prior approval from the Department of Banking and Insurance, the basic proposal for the IHCP was in place by early July 1992. The IHCP-authorizing legislation was approved by the legislature and signed into law by the governor 30 November. Thus, only six months after Judge Wolin’s decision, New Jersey transformed its individual health insurance market.

**What The IHCP Created**

The IHCP has been an unprecedented achievement. Within the first two years of operations, twenty-eight carriers were actively selling policies, whereas before 1993 only one carrier offered policies to all applicants. By mid-1998 mergers and acquisitions had reduced the number of carriers selling policies to twenty-three. All of the carriers selling health coverage in New Jersey acceded to the loss-assessment mechanism devised to reimburse those carriers selling policies and incurring losses. No carriers chose to stop selling health insurance in New Jersey rather than participating in the IHCP.

By the end of 1995, 192,000 persons were enrolled in IHCP policies. But beginning in early 1996 enrollment began to decline slowly, and by March 1998, 147,000 persons were enrolled. This decline should not mask the fact that many more than 192,000 persons have been covered by IHCP policies during its first four years, because the IHCP provided access for persons who needed short-term as well as long-term coverage. Equally important, individuals have far greater choice of carriers now than they did before 1993.

During the first two years of the IHCP, the lowest available premiums declined from the premium levels for comparable policies sold before 1993. The lowest available premiums fell to $116 per month for policies covering a single person. However, beginning at the end of 1995 premiums started to increase; by March 1998 the lowest premiums were between $196 and $213 per month for a policy covering a single person (either with an HMO policy or an indemnity policy with a $1,000 deductible). The cost-sharing required also has shifted during the first four years of the program, so that most people now have either an HMO plan with a $20 copayment or an indemnity plan with a $1,000 per person/$2,000 per family deductible and a 30 percent coinsurance rate. Also, the board eliminated one of the original standardized indemnity plans, in part because few people were choosing it. Although the out-of-pocket costs for health care and premiums for IHCP policies are not as low as some had hoped would emerge from competition in this market, the lowest premiums are only a third to a fourth of what some critics had forecast.

The program has incurred losses, which are redistributed among all carriers that have not met their target enrollments. In 1996, the last year for which losses have been assessed, eight small indemnity carriers submitted losses totaling $43.5 million. These losses were attributable in large part to the incentives in the loss-assessment mechanism.
which initially had little risk for carriers with small market shares to incur losses. Under the loss-assessment mechanism, these smaller carriers had to pay a relatively small portion of their own losses. However, after they began to incur losses, these carriers rapidly raised their premiums, and most of their enrollees shifted to other carriers or dropped coverage altogether. The premium increases of the smaller indemnity carriers that submitted losses explain much of the increase in the lowest available premiums and the IHCP’s enrollment decline after 1995.

The larger carriers believe that these small carriers are not large enough to bear the risks of the individual market. If so, then the losses are an example of how market forces operate to winnow out companies that cannot compete. The bottom line, however, is that state regulations created a competitive market for individual insurance in New Jersey, and the market is not run by the government.

**Lessons For Other States**

- **States have assets to bargain with.** With increasing numbers of people losing access to employer-sponsored health insurance (especially employees of small employers), the individual health insurance market in each state has the potential to be an important factor in maintaining access to health insurance. States can use their regulatory powers as assets in strategies that force carriers to sell coverage to a wide spectrum of people. All states have one or both of two strong assets for such strategies: (1) mechanisms used to subsidize an insurer of last resort, and (2) the process by which carriers have to request and justify an increase in premiums for policies sold in the individual market.

Most states have an official or de facto insurer of last resort. Even in states without an officially designated insurer of last resort, the Blues often have ended up with a disproportionate share of high-cost individuals and have been subsidized for their higher-cost enrollees. In many of these states the method used to raise revenues for the subsidies for the designated carrier is viewed as unfair. For example, when revenues for subsidies are derived from surcharges to hospital rates, this favors carriers that have fewer persons who need to be hospitalized. When subsidies are not linked to the financial performance of the insurer of last resort (as in New Jersey before 1993), many carriers view the subsidies as supporting inefficiency. Given the strong belief that competition yields economic efficiency, states can trade changes in the subsidy arrangements for concessions from carriers that will yield greater access to insurance coverage.

States’ other asset is the fact that carriers want to avoid dealing with the requirements of insurance departments, especially those that mandate filing of cost reports in support of a request for a premium increase. The final compromise in the IHCP development process, when community rating of premiums was agreed to in exchange for removing state approval of premium increases, is an example of how existing regulation strengthened New Jersey’s hand. The approval process provided “chips” that New Jersey could use in bargaining with insurers. Moreover, many carriers believe that state insurance departments are incapable of keeping up with changes in the insurance industry and that department requests for information hinder carriers’ efforts to become more efficient. Under these circumstances, states can create oversight boards with carrier participation similar to that in the IHCP. Such actions provide states with the expertise of people in the insurance industry in exchange for concessions that can create a New Jersey-style market for individual coverage.

New Jersey’s ability to use an implicit threat of increased regulation to obtain carrier agreement to the IHCP was not unique. It is true that New Jersey had a two-decade-old history of hospital rate surcharges that were used to finance uncompensated hospital care and to subsidize BC/BS for being the insurer of last resort. But many other states have similar histories of carrier-shared financing of high-risk pools or funds to compensate hospitals for providing uncompensated care or car-
riers that end up with high-cost enrollees. More than half of the states have such a history of regulatory authority in health insurance or health care financing. These states are in a strong position to broker concessions from carriers and create competitive individual insurance markets akin to New Jersey’s IHCP.

Policy entrepreneurs are in the private sector, too. The fact that policy entrepreneurs are in the private sector and can be tapped for developing public policies is often missed in descriptions of public policy implementation. In many histories of public policy innovation, the key actors (so-called policy entrepreneurs) come from the public sector. The New Jersey experience demonstrates that policy entrepreneurs exist in the private sector, too. The IHCP is almost entirely the brainchild of fifteen executives and managers from New Jersey’s larger carriers. Such people exist in all states; they just need to see that their corporate interests coincide with state policymakers’ desires to increase access to health insurance. Moreover, tapping local knowledge and innovative thinking no doubt yields proposals that fit each state’s situation best. The Robert Wood Johnson Foundation’s State Initiatives in Health Care Reform program has long recognized the value of engaging private-sector entrepreneurs in developing reforms that respond to the particular needs or politics in each state.

Additional efforts are needed to increase coverage. Even a well-functioning individual health insurance market has limits on what it can accomplish. The IHCP did not dramatically raise the number of New Jersey residents with individual coverage. Surely one reason more people have not purchased policies is that the premiums are not affordable for those with low incomes. The various congressional proposals to provide tax deductions or credits might induce some people to purchase individual policies who otherwise would not, but for people with low incomes, other efforts will be needed. The federal Earned Income Tax Credit offers a model of how the federal government could issue a tax credit that provides money during the year for the purchase of insurance. Such an “earned insurance tax credit” also would help to bring in younger workers, who typically earn low salaries, and thereby increase the proportion of healthy persons in each carrier’s individual plans.

Similarly, if the tax code were revised and incentives for employer-sponsored coverage were replaced by tax credits for individuals purchasing insurance, large numbers of people would enter the individual markets. The result would be a sharp increase in the proportion of healthy persons in the individual markets. Either of these tax-induced increases in the proportion of healthy persons with individual coverage would lower the expected expenditures per insured person. Competition among carriers in this expanded market then would increase, keeping premiums close to costs.

New Jersey’s IHCP is a model for other states wishing to increase access to health insurance via market-oriented solutions that do not involve increased government financial obligations. States have assets they can trade upon to force competition in an expanded individual insurance market—a factor that should be of greater importance in states’ strategies for increasing access to health insurance.

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