A Report to the New Jersey State Legislature

The Effects on the Individual and Small Employer Health Coverage Markets of Permitting Individuals to Purchase Small Employer Health Benefits Plans

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Written and presented by
The New Jersey Small Employer Health Benefits Program Board
in conjunction with
The New Jersey Individual Health Coverage Program Board and
The New Jersey Department of Banking and Insurance

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Executive Summary

The New Jersey State Legislature directed the New Jersey Small Employer Health Benefits Program ("SEH") Board to conduct a study to determine the impact on the individual and small employer health insurance markets of permitting individuals to purchase small employer health benefits plans. Under current law, a self-employed individual without access to group health coverage or Medicare may purchase guaranteed issue health coverage only in the individual health insurance market. An employer with two to 49 employees may purchase coverage in the small employer health insurance market.

The Legislature's request for this study was inspired, at least in part, by concerns that self-employed individuals were placed at an unjustified disadvantage, in terms of plan choice and price, in the individual market as compared to the small group market. The findings of this study include the following:

- the creation of separate individual and small employer markets rests on a logical distinction between the purchasing behavior and health risks of individuals versus groups;
- self-employed individuals currently have guaranteed access to five standardized traditional indemnity plans and an HMO plan, with multiple deductible and copayment options, offered by over 20 private carriers. The plans are community rated, without regard to health status, age, claims history, or any other factor. Small employers do, as a general matter, have broader choices of health plans and pay less than individuals for comparable coverage;

- median rates for the most popular individual plans have remained consistent with medical inflation over time. Median rates for HMO coverage have not increased in over two years. Rates currently available to families for individual coverage compare favorably with the nationwide average cost of family health coverage purchased through an employer group; and
- recently enacted federal legislation will reduce the real and perceived disadvantages self-employed individuals face by permitting them to deduct a larger percentage of the cost of their health plans and to use pre-tax income to fund their health care costs using medical savings accounts.

The SEH Board surveyed six carriers in the individual and small employer markets in an effort to quantify the potential effects on rates of changing the structure of New Jersey's health insurance markets to address the real and perceived disadvantages facing self-employed individuals.

Based on the results of the carrier survey, the SEH Board concluded that:

- if the self-employed were allowed to purchase coverage in the small group market, most self-employed individuals would see no savings over the cost of comparable individual coverage currently available to them. The costs for individual policyholders remaining in the individual market and some 775,000 persons covered by small employer plans would be likely to increase.
- if all individuals, whether or not employed, were eligible to purchase coverage in a single market consolidated with small employers, approximately 213,000 individuals covered currently in the individual market would have access to lower cost coverage. However, the rates for some 775,000 persons currently covered by small employer plans would be likely to increase substantially.
- If the structure of the individual and small group markets were changed in accordance with either model studied, a far greater number of individuals would likely have to pay more for health coverage than would pay less. Accordingly, a cost-benefit analysis would counsel against changing market structures at this time.

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Background

In 1992, the New Jersey State Legislature created two programs to guarantee access to health coverage for individuals and small employers, regardless of health status, age, claims history, or any other risk factor. The New Jersey Individual Health Coverage ("IHC") Program, created under P.L. 1992, c. 161, and Small Employer Health Benefits ("SEH") Program, created under P.L. 1992, c. 162, have reformed the individual and small employer (employers with 2-49 employees) health insurance markets. Each program is run by a Board of Directors with rulemaking authority.

The IHC Program has been fully operational since August 1, 1993, and enrollment has grown to approximately 185,000 individuals covered by standard individual health benefits plans offered by private carriers, as of June 30, 1996. The SEH Program went into effect on January 1, 1994, and has grown to approximately 775,000 people covered by standard and non-standard health benefits plans subject to the rules of the reformed market, as of June 30, 1996.

In its most recent amendments to the SEH Program, under section 5 of P.L. 1992, c. 340, the Legislature directed the SEH Board to conduct a study, in conjunction with the IHC Board and the Department of Banking and Insurance, to determine the impact on the individual and small employer health insurance markets of permitting individuals to purchase small employer health benefits plans.

The Legislature directed that the study include consideration of:

- the benefits structure of the standard plans in the individual market;
- the effect on purchasers of rating differentials between the individual and small group markets; and
- the impact on rates of assessments for reimbursable losses in the individual market.

The SEH Board assumes, in addressing these questions and formulating this study, that the Legislature's charge could encompass two different systems in which individuals could purchase small group coverage:

- the continuation of separate individual and small employer markets, with self-employed individuals purchasing coverage in the small group market, while maintaining an individual market for unemployed individuals and those who work for employers that do not offer health coverage; or
- the creation of a single market open to individuals and small employers.

This study does not address the concept of combining the Individual Health Coverage Program Board and Small Employer Health Benefits Program Board, to create a single entity to administer separate programs, a proposal which is the subject of legislation before the General Assembly.

Coverage of the Self-Employed

While a complete statistical portrait of the self-employed in New Jersey is not available, the following details are known:

- There were 371,035 self-employed individuals in New Jersey in 1994 Seventeen percent, or 63,409, were covered by individual health insurance policies; Nineteen percent, or 71,147, were uninsured;
- The percentage of self-employed persons without coverage was about 30% higher than the 14.5% of all workers under age 65 without health coverage;
- Self-employed individuals were much more likely to be insured than employees of small employers with fewer than 10 employees (27% uninsured) or 10-24 employees (23% uninsured);
- of the individuals applying for coverage since the beginning of 1994 who reported their employment status, 32% reported being unemployed and 68% reported being employed (presumably meaning they were either self-employed or worked for an employer that did not provide health coverage), according to quarterly carrier enrollment data reported to the IHC Board.

Health Coverage of the Self-Employed, 1994

A self-employed individual currently could be covered by one of many different types of plans:

- a standard individual health benefits plan issued on or after August 1, 1993;
- an individual health benefits plan issued by Blue Cross and Blue Shield of New Jersey prior to August 1, 1993, on an open enrollment basis;
- an individual health benefits plan issued prior to August 1, 1993, on other than an open enrollment basis, which could include coverage by a certificate issued from a group plan issued to an association or trust. These plans were "grandfathered" and are not subject to the Individual Health Insurance Reform Act of 1992;
- a group conversion plan;
- a small employer plan, if the self-employed person works exclusively for the small employer as an independent contractor on a full-time basis;
- a small employer plan, if the self-employed person works full-time and has a full-time employee;
- as a dependent under a spouse's group plan;
- through COBRA continuation under a former employer's group plan;
- as a retiree under a former employer's group health plan; or
- Medicare, Medicaid, or other government health plan.

Access to Health Coverage Markets Under Current Law

Under current law, a self-employed individual without access to group health coverage through a spouse or former employer, through a small employer as an independent contractor, or through Medicare, is considered an "eligible person" who may purchase health coverage only in the individual health insurance market. N.J.S.A. 17B:27A-2. All individual plans are offered on a guaranteed issue basis, with community rating and limited preexisting condition exclusions. A small employer with two to 49 employees who seeks to offer coverage to his or her employees may purchase coverage in the small employer health insurance market. All small employer plans are offered on a guaranteed issue basis with modified community rating, and with limited preexisting condition exclusions on groups of 2-5 employees.

The most significant structural difference between the individual and small employer markets is how the available health plans are rated. Rates in the individual market do not vary based on the characteristics of the person covered, whereas rates in the small group market may take into account the age and gender of employees in the group and the location of the business in the State Carriers calculate their individual and small employer rates separately, taking into account the collective loss experience of the persons or employers covered by each plan.

There are other fundamental differences between the individual and group markets that justify the existence of separate markets for individuals and groups. The most significant is the behavior of the health coverage consumer. An individual, whether self-employed or unemployed, may choose whether or not to purchase a health plan based on her projected medical needs. Further, she may choose among health plans based on her actual health care needs. The ability of an individual to choose a health plan according to her specific health care needs is an example of a phenomenon called "adverse selection." By contrast, in the group market, an employer typically selects a health plan or plans for all employees. As a result, an individual employee may be covered by an employer's group health plan regardless of her projected medical needs. An employer's selection of a health plan also tends to reduce the likelihood of adverse selection.

A second distinction between individuals and employer-based groups is that individuals tend to be more likely to need medical services, and to submit medical claims under a health policy, than people in employer-based groups. As a general matter, people with serious medical conditions are more likely to be unemployed and, therefore, to be covered by an individual health plan. Accordingly, the rates in the individual market are calculated to reflect the higher levels of adverse selection and health risks inherent in covering individuals, while the rates in the small employer market reflect the lower levels of adverse selection and health risks of covering small groups.

Is a Self-Employed Individual at a Disadvantage in the Individual Health Coverage Market?

The Legislature's request for this study was inspired, at least in part, by assertions of more than one group marketing health coverage to the self-employed that self-employed individuals are placed at a disadvantage under the State's current system, which requires self-employed individuals without access to group coverage or Medicare to purchase coverage in the individual market. The disadvantages of the individual market, as compared to the small group market, have been described as fewer choices of health benefits plans and higher rates for comparable coverage.

Self-employed individuals historically have faced one clear disadvantage compared to small employer groups with respect to the limited deductibility of the cost of coverage for federal income tax purposes. This disadvantage, however, is not related to behavior or risk. Recently enacted federal legislation will go a long way toward eliminating this inequity by gradually increasing the allowable deduction for a self-employed person's health insurance costs from 40% in 1997 to 80% in 2006 and allows the use of pre-tax income to fund medical savings accounts.

Plan Variety

Individuals in New Jersey have guaranteed access to five standard traditional indemnity plans: Plans A, B, C, D, and E; and an HMO plan. Plans B-E are available with three deductible options each, and the HMO plan with three copayment options. The standard plans are offered by more than 20 carriers, consisting of insurance companies, HMOs, and a health service corporation.

The small employer market offers consumers a greater variety of health benefits plans than the individual market. Small employers may purchase standard plans that are equivalent to those offered in the individual market. Unlike the individual market, however, the standard plans' benefits may be enhanced by an unlimited number of optional benefits riders. Carriers have filed more than 100 such riders with the SEH Board to date.

Small employers also may renew or purchase, on a limited basis, nonstandard health benefits plans that were available prior to the creation of the SEH Program and have been continued under various amendments to the SEH Act. Further, many small employer carriers offer varieties of managed care plans, such as preferred provider organization (PPO)and point-of-service (POS) plan options not offered currently in the individual market. The standard plans are offered by more than 50 carriers, consisting of insurance companies, HMOs, a health service corporation and a hospital service corporation.

While individuals, self-employed or otherwise, may have fewer plan options than small employers in New Jersey, the availability of guaranteed issue coverage from all carriers is a significant benefit not offered in most states. For example, only 14 states require carriers to guarantee access to coverage for the self-employed. Only seven of those states

require carriers to guarantee access to all individuals, and some of those states restrict the plans to which individuals have guaranteed access.

A Cost Comparison of Individual versus Small Group Coverage

A key issue is whether a self-employed individual pays more for individual health coverage than a person covered by a comparable small employer plan. As a general matter, individual health benefits plans are more expensive than comparable plans offered in the small group market. However, the differences in cost vary, depending on plan design and a given carrier's experience in the separate markets.

Carriers' rates for the same standard plan can vary dramatically because the cost of a plan is a function of the benefits provided under the plan and the utilization of those benefits by those persons covered by it. Since all coverage is guaranteed issue and community rated, carriers cannot control the selection of coverage by individuals with serious medical conditions or charge them more for their coverage. If the claims of the persons covered by a plan are high, premiums charged to everyone covered by that plan also are likely to be high. If claims are low, the cost of coverage is likely to be low.

The different rating factors permitted in the individual and small group markets make an "apples to apples" comparison difficult. While every individual is charged the same price for the same plan offered by a given carrier, the premium charged to two groups of a given size may differ depending on the age and gender of the employees, and location of the employer. Nonetheless, a rough comparison of rates has been made possible by a "premium comparison survey," recently published by the SEH Board using data collected from carriers by the Department of Banking and Insurance.

The Department asked every carrier offering small employer coverage in New Jersey to calculate the cost of covering a hypothetical small employer group of six employees and their dependents under each of the standard plans. Carriers provided rates effective January 1, 1996.

In order to compare rates in the individual and small group markets, the chart below lists the average cost of covering the survey's hypothetical small employer group of six employees and their dependents with comparable individual health benefits plans offered by the same carriers, with rates effective on January 1, 1996.

On average, small employers pay less for comparable coverage than individuals. However, the difference is smallest for traditional plans with $1,000 deductibles and for the HMO plan with the highest copayment option. In the cases of a few carriers, the cost of individual coverage was actually lower than the premium charged to the model small group for the same $1,000 deductible plan. Therefore, an individual who is willing to shop for the lowest priced carrier and enroll in a plan with a $1,000 deductible can

purchase individual coverage at a price comparable to small group coverage under the same plan.

The prices available for individual family indemnity coverage in New Jersey also compare favorably with the nationwide cost of group indemnity coverage provided through an employer's health plan. Listed below are the five lowest rates for family coverage in the individual market, as of July 1, 1996.

The rates for family coverage under Plan D, $1,000, which is a comprehensive indemnity plan, are equal to or less than the nationwide average cost of traditional family coverage under an employer's group health plan. The comparison above would seem to refute the notion that an individual in New Jersey faces significantly higher costs for health coverage than individuals in other states, whether they are covered by their own plan or through an employer.

The Effect of Rating Differences Between the Markets

The individual market is community rated, which means that a carrier must offer the same rate for the same plan to all individuals, regardless of age, gender, medical condition, claims history, or any other factor. By contrast, the small group market is modified community rated, which means that a carrier may vary the premium it charges each small employer group of the same size only on the basis of the age of the employees covered, their gender, and the location of the business in the State.

The difference in rating factors used in the two markets creates incentives for adverse selection against the community rated individual market. Adverse selection can occur between markets when an individual may choose to enter one market over the other on the basis of finding rates in one market that are lower for him or her than the other market. For example, a younger person could expect to receive a lower rate under a modified community rated system that allows the use of age as a rating factor than under a pure community rated system, where age is not a factor. Therefore, younger people have an incentive to buy coverage in the small group market, where their age has a beneficial effect on the rate carriers charge, as compared to the individual market's community rate. Accordingly, older individuals have an incentive to purchase in the individual market, where their age does not have a negative effect on the rates carriers charge them, as compared to the small group market's modified community rate.

For example, a small business that employs older workers may decide not to purchase a group plan because comparable individual coverage is less expensive. A self-employed individual whose spouse works with him or her at least 25 hours per week may choose to purchase an individual "husband and wife" plan or a small group plan covering two employees. The effect of the employees' age on a carrier's rates is likely to be a significant factor in their choosing one market over the other. Similarly, though to a

lesser extent, the effect of the factors of a small business's location in the State and the gender of the employees could result in adverse selection.

There is no way to calculate the impact of such adverse selection on the cost of coverage in either market, since carriers cannot capture data on an applicant's decision making process, but logic would suggest that the different rating factors used in the two markets produces significant adverse selection against the individual market. In each case described above, adverse selection is likely to occur because the incentives exist for younger people to leave the individual market, driving up the community rate, and for older people to enter the individual market, again driving up the community rate.

Comparable rating in the two markets, either community rating in both markets or modified community rating in both markets, would reduce adverse selection against the individual market and help stabilize rates.

A History of Rates in the Individual Market

In order to completely explore whether self-employed individuals, or any individuals, are disadvantaged by access to only the individual market, the issues of rate increases and rate volatility are addressed below.

The Effects of Adverse Selection on Rates

Individuals with costly medical claims appear to have adversely selected against the $250 and $500 deductible plan options, leading carriers to raise rates to reflect claims experience under those options. Carriers are required to set their rates in accordance with an anticipated minimum loss ratio of 75%, creating separate rating pools, by plan and by deductible. This results in plan design and loss experience of the people covered under each deductible option dictating the rating differences among deductible tiers.

Initially, the lower deductible options were a relative bargain for individuals with expensive medical conditions, and they chose plans accordingly. As a result of this method of rating and adverse selection, the rates for the lower deductible plans reflect the higher loss experience under the deductible option out of proportion to the additional benefits the plan provides over a higher deductible option. In other words, the additional cost to the policyholder of a lower deductible can be several times the value of the additional benefits afforded under the lower deductible plan.

The rates for lower deductible plans increased, most people migrated to higher deductible plans, but pricing would indicate that those who remained in the $250 and $500 deductible plans submitted disproportionately higher medical claims.

With some exceptions, carriers' premiums offered in the small group market do not reflect comparable effects of adverse selection on the pricing of deductible options. The disproportionate rates for lower deductible options, shown above, are a symptom of adverse selection. This symptom reflects the fundamental difference between the individual and group markets, which is that adverse selection is most evident where an individual makes a choice of health plan based on her specific health care needs, as opposed to an employer's making a choice of health plan for all employees. Therefore, apparent effects of adverse selection might suggest that lower deductible plans naturally attract adverse selection and may not be viable products in a guaranteed issue individual market. By contrast, identical lower deductible options may remain affordable in the small employer market.

An Analysis of Individual Rates Over Time

Some carriers have raised rates significantly over the last two years on their individual plans. The causes of those rate increases are manifold, and include: new carriers' inexperience in a guaranteed issue, community rated market; inaccurate assessment of risk; adverse selection; rising medical costs; and the growing pains inherent in a transition from a single carrier of last resort to multiple carriers sharing the burden of covering a large number of high-risk individuals. Notwithstanding some carriers' rate increases, other carriers' rates have remained relatively stable, particularly for $1,000 deductible and HMO plans.

The median of all carriers' rates for single coverage under Plan C, $1,000 deductible has increased by 8% on an annual basis over a two-and-a-quarter-year period. The median rate for Plan D, $1,000 deductible has increased by 4% on an annual basis over the same period.

To put these numbers in context, individual rates over this period must be compared to health care inflation over the same period. The chart below shows median single rates from January, 1994 through March, 1996, and then shows what the effect on the January, 1994 rates would be if multiplied by the healthcare price index ("HCI") over the same period.

While actual rates for Plan C were 6% higher than the rates adjusted by the HCI, the cost of Plan D and the HMO plan fell below the HCI-adjusted rates, by 1% and 9% respectively, over nine calendar quarters.

Neither an average of the rates available in the market, nor the median, is the most accurate measurement of what individuals actually paid for coverage in a given period. In a standardized market in which all carriers offer the same products with the same benefits, health coverage is more like a commodity, and price drives consumer choice. Accordingly, the fact that one carrier may have rates on file that are twice the rates of another carrier for the same plan does not suggest that averaging the two carriers' rates

describes what individuals are paying for coverage. All other factors being equal, which they should be in a standardized market, two rational consumers with knowledge of the market and prices will both buy the lower cost plan, making the lowest price the more accurate measurement of what policyholders pay for coverage.

The average annual increase among the six lowest priced carriers ranged from 0%, for HMO coverage, to 21% for Plan D, $1,000 deductible.

Volatility of Rates Charged by Certain Carriers

The Individual Health Coverage Program is unique among the states that have addressed health insurance reform. It is the only standardized, guaranteed issue, community rated individual health insurance market in the country. By law, the State of New Jersey does not make pricing decisions for carriers and is not responsible for recommending or approving carriers' rates. Carriers are free to file rates, on a "file-and-use" basis, as long as they can demonstrate, at year end, that they have paid out at least $.75 in benefits for every dollar collected in premium.

When the IHC Program went into effect, Blue Cross was the only carrier that had any experience pricing guaranteed issue individual health coverage in New Jersey. Consequently, several carriers entering the market for the first time initially offered relatively low rates -- most notably, Time Insurance Company; the Mutual Group; and National Casualty Insurance Company -- but soon found that claims were far higher than anticipated, and raised their rates to try to cover claims.

Are Individuals Paying a "Fair" Price for Coverage?

As long as medical expenses are costly and health insurance coverage is voluntary, the cost of coverage in a guaranteed issue market will be high. The insurance mechanism cannot substantially reduce the cost of health care. Rather, insurance spreads the risk and, in the case of community rating, attempts to distribute the costs of coverage as evenly as possible.

Neither the IHC Board nor the Commissioner of Banking and Insurance regulates rates. Rather, carriers in the individual market are required to comply with a mandatory minimum loss ratio of 75%. This means carriers must set their rates on the assumption that they will pay out in claims at least $.75 for every dollar collected in premium from all policyholders in the same plan. In theory, this permits a carrier to spend up to 25% of premium on expenses (such as claims processing, overhead, agent commissions, etc.) and profit. At year end, carriers must demonstrate that, in fact, they have met or exceeded the 75% requirement for the past year. Any carrier that has paid out less than $.75 in claims for every dollar collected must refund the difference to the policyholders. Since the IHC

Board does not approve rates, the minimum loss ratio is the only systemic control on rates which ensures that policyholders receive good value for their health care dollar.

In fact, carriers experience average loss ratios far in excess of 75% in the individual market.

Carriers are paying out in claims a significant portion of what they collect in premium, in excess of what the law requires. The loss ratios individual carriers have experienced over the last two years meet or exceed what one would expect in the group market. Therefore, while the cost of coverage is high, a self-employed individual is not getting a lower return or a worse "deal" in the individual market than that individual would be likely to receive in the small group market. However, the self-employed individual is paying a premium based on a carrier's evaluation of the risks inherent in covering individuals, rather than groups, in terms of adverse selection and anticipated claims experience.

The Effects of the "Pay or Play" Loss Assessment

The IHC Program introduced a pay or play assessment system to encourage carriers to enter the market and offer individual coverage at competitive rates. Carriers that offer group health benefits plans in New Jersey are required to also offer individual coverage and assume a proportionate share of the individual market, or pay an assessment to cover the losses of eligible carriers participating in the individual market.

The assessment mechanism has succeeded in bringing carriers into a high-risk market they otherwise might not have entered. Where only Blue Cross offered guaranteed issue coverage to individuals in 1992,21 over 20 carriers offered the standard plans at the end of the first quarter of 1996. Ten of those carriers were HMOs, which have made managed care plans available on an individual basis for the first time in New Jersey.

The assessment mechanism also has encouraged carriers to price coverage competitively to attract market share. This incentive exists because a carrier that assumes a proportionate share of the individual market, as determined by the IHC Board, may choose to be exempt from paying an assessment to reimburse the losses of other carriers in the individual market. Consequently, some carriers are willing to offer individual coverage at a break-even level, or a loss, in order to avoid paying a substantial loss assessment. The assessment has, in this respect, not only made coverage available but also may have suppressed the cost of coverage.

The impact of individual loss assessment on the cost of health coverage, generally, depends first on whether a carrier charges the assessment to its health insurance business. Carriers may not charge their share of reimbursable losses exclusively to their individual line of business. Assuming carriers charge the assessment to their health business, proportionately across all lines, including large group, small group, and individual, the

assessment would have increased the cost of coverage by an average 1.07% from 1994 through 1996, the years that the 1993 through 1995 assessments were payable.

Effect of Loss Assessment on Cost of Health Coverage

The impact of individual loss assessment also depends on whether a carrier participates in the individual market and chooses to be exempt from assessment. Carriers may, each year, decide whether to enter the individual market and mitigate their loss assessment by requesting an exemption from assessment and enrolling their fair share of individual lives.

For carriers that offered individual coverage and were exempt from assessment, the loss assessment had no effect on the cost of their health business. Carriers that account for over half of the health insurance market in New Jersey (including individual, small group, and large group) were either partially or completely exempt from assessment. For those carriers that chose not to enter the individual market, or entered the market but did not apply for exemptions (which account for less than half of the total health insurance market), the effect ranged from 1.21% of net earned premium in 1994, to 3% in 1995.

It is worth noting that Blue Cross, which has been the primary recipient of loss reimbursement for the IHC Program's first three years, has received an exemption from assessment and will not, therefore, be eligible to seek reimbursement of losses for calendar year 1996. Therefore, the effect of the assessment on the cost of health coverage may decrease in 1997, unless other carriers' reimbursable losses replace the Blue Cross claim for reimbursement.

The Effects of Allowing Individuals to Purchase Small Employer Health Coverage

Representatives of associations that market health coverage to the self-employed have suggested that self-employed persons should be allowed to purchase small group coverage, rather than individual coverage. In order to estimate the effect of this structural change of current markets, the SEH Board conducted a survey of carriers currently participating in the individual and small group markets to project how their current rates for the most popular plans would be affected by this change in market structure. The six carriers participating in this survey account for over 53% of the individual market and 45% of the small employer market. The discussion below is not intended to predict the effect on rates with scientific certainty. Rather, the numbers provide general projections, by carrier actuaries, of the effects on rates of changes in the structure of existing markets.

Two Markets, with Self-Employed in Small Group Market

This first scenario would continue the existence of separate individual and small employer markets, but would vary from the current structure by permitting self-employed individuals to purchase coverage in the small group market. Unemployed individuals and those who work for employers that do not offer health coverage would remain in the individual market.

Such a change would require numerous changes to the small employer market, with respect to application of participation and contribution requirements, the potential need for a loss reimbursement mechanism, the availability to self-employed individuals of optional benefit riders, etc. Implementation of those changes by the Boards and Department would be a substantial undertaking.

Effect On Individual Rates

The carriers responding to the survey predicted that individual rates would increase by an average of 4%. Two carriers, together covering almost one-fourth of the individual market, expected no change in rates and three, together covering about one-third of the market, predicted an increase of 6-8%.

Effect On Small Employer Rates

If the self-employed had access to small group coverage, their presence in the small employer market would have the effect of increasing rates for all small employers. Carriers predicted increases of between 5% and 45% for Plan B, between 2% and 6% for Plan C, between 5% and 7% for Plan D, and between 0% and 20% for the HMO plan. The average of carriers' predicted increases for all plans was 8%.

Savings To The Self-Employed

The average increases reported by carriers for the individual and small group markets of 4% and 8%, respectively, to the rate comparison chart listed in section III(b). If the rates listed for the three most popular individual plans, Plan C, $1,000 deductible, Plan D, $1,000 deductible and the HMO plan were adjusted in accordance with carriers' predictions, the increase in the small group rates, coupled with the increase in rates for individual coverage, would eliminate whatever price advantage exists currently in the small group market, except with respect to HMO coverage.

The projected cost of small group coverage under Plan C and D, $1,000 deductible would be higher than the comparable plans were in the individual market under the current structure. Accordingly, the change would result in the self-employed paying more for

coverage under Plans C and D, $1,000 deductible in the small employer market than they paid for the comparable plan in the individual market.

The cost of Plans C and D, $500 deductible would be lower than the comparable plans were in the individual market under the current structure. However, the self-employed person would have to pay $625 more for Plan C $500 deductible in the small employer market than he paid for the $1,000 deductible option in the individual market for a potential marginal benefit of only $500. He would have to pay $542 more for Plan D, $500 deductible than he paid for the $1,000 deductible option in the individual market, for a potential marginal benefit of $500.

The self-employed person could save 25% by purchasing HMO coverage in the small group market over what he paid for the comparable plan in the individual market. Assuming 20% of the self-employed would purchase HMO coverage in the small group market, about 12,600 self-employed individuals would save on the cost of their coverage.

With the exception of HMO coverage, the self-employed person would pay more for coverage in the small employer market than he or she would have paid in the individual market under the current structure. Furthermore, individuals remaining in that market would see their rates increase by 4% and the approximately 775,000 persons covered by standard small employer plans would see their rates increase by 8%.

Effect on the "Pay or Play" Loss Assessment It is difficult to project the effect of the self-employed leaving the individual market on the reimbursable losses reported by carriers. Assuming that the estimated 63,409 self-employed individuals currently covered in the individual market moved to the small employer market, the individual market would then consist of approximately 57,000 policyholders, about two-thirds of whom were unemployed. In other words, using a very rough estimate, the percentage of unemployed policyholders remaining in the individual market could double, from one-third of the total to two-thirds. As a general matter, carriers assume that unemployed individuals present a higher risk of needing medical services than employed people. Consequently, the risk pool in the individual market would be viewed as higher risk if it consisted of a much higher percentage of unemployed individuals. The deterioration of risk in the individual market could result in higher reimbursable losses, unless rates increased significantly to cover proportionately higher claims. Such rate increases might force younger, healthier individuals to drop their coverage and thereby further deteriorate the risk pool. The increased concentration of unemployed and older individuals could send the individual market into a rate spiral from which it could not recover, absent significant subsidies to individuals to help them pay higher premiums, or to carriers to artificially suppress premiums. It is not likely that reimbursable losses assessed to carriers would decrease.

A Single Market for 1 to 49 persons

This second scenario would vary from the current market structure by eliminating the distinction between the individual and small employer markets, thus creating a single market open to individuals and small groups. Accordingly, carriers would set rates assuming some mix of individuals and small groups covered under all plans. Presumably, the market would be modified community rated, on the basis of age, gender, and geography, and there would be no loss assessment or reimbursement mechanism.

A consolidated market approach would require a thorough restructuring of the current markets. Policymakers would need to explore the application of participation and contribution requirements, the potential, indeed likely, need for a loss reimbursement or risk adjustment mechanism, maintaining the availability of optional benefit riders, etc. Of paramount importance is the question of what regulatory body would implement changes and oversee the new market. Implementation of those changes by a Board and or the Department would be a substantial undertaking that would take at least six months.

Effect On Rates Charged To Individuals

Carriers predicted that, under a consolidated market, individuals would see rates decrease by as much as 15%. On average, carriers predicted a decrease in rates of about 8%. Under modified community rating, however, the savings to a particular individual would depend on her age, gender and location in the State.

Effect On Rates Charged To Small Employers

Carriers predicted that small employers would see an increase in the cost of health coverage currently available in the small employer market. Under a consolidated market, carriers predicted current rates would increase from a low of 15% to a high of almost 29%. Any savings to individuals would have to be weighed against the adverse effect on persons covered in the small group market. The approximately 185,000 people covered in the standard individual plans could see their rates decrease by about 8%. On the other hand, the approximately 775,000 persons covered by standard small employer plans could see their rates increase by 23%.

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The Effect on the "Pay or Play" Loss Assessment

Currently, there is no loss reimbursement mechanism, or loss assessment to fund it, in the small group market. However, placing all individuals in the small group market would probably necessitate some kind of loss reimbursement or risk adjustment mechanism. It is impossible to predict the cost of such a mechanism until its details were known.

Conclusion

The creation of separate individual and small employer markets rests on a logical distinction between the purchasing behavior and health risks of individuals versus employer groups. Under the current market structure, self-employed individuals have guaranteed access to a range of traditional and managed care health benefits plans in New Jersey. However, small employers have a broader range of choices and generally pay less for coverage.

Allowing the self-employed to purchase health coverage in the small group market would not result in savings to self-employed individuals purchasing non-HMO coverage. Assuming 20% of the self-employed would purchase HMO coverage in the small group market, about 12,600 self-employed individuals would save on the cost of their coverage. By contrast, the individual policyholders remaining in the individual market and approximately 775,000 persons covered in the small employer market would probably have to pay more for coverage.

Under a combined market, approximately 185,000 individuals currently covered by standard individual plans could save about 8%, although the approximately 775,000 persons covered by standard and non-standard small employer plans could see their rates increase by 23%. In both situations studied, the costs of changing access to markets would appear to outweigh the benefits.

As long as health coverage is voluntary, access is guaranteed, and medical services are expensive, the cost of health coverage will remain high. However, reasonable steps could be taken to reduce and stabilize the cost of individual coverage while maintaining the current market structure. In addition, recently enacted federal legislation will remove some of the major disadvantages to the self-employed, in terms of federal tax treatment of health insurance costs, and place the self-employed on a more level playing field with small employers.

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