

New Jersey Individual Health Coverage Program Board
 And
 New Jersey Small Employer Health Benefits Program Board

*A Report to the Governor
 and the New Jersey State Legislature*

**An Evaluation of the Effectiveness of P.L. 2001, c.368:
 The Basic and Essential Health Care Services Plan**

March 9, 2004

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NJ IHC and SEH Programs
Legislative Report on P.L.2001, c.368

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I. EXECUTIVE SUMMARY

In an effort to make "health insurance available for younger families who do not have the resources to pay for coverage in the individual market,"¹ the New Jersey Legislature passed P.L.2001, c.368 (the "Act"), a law which requires individual market carriers to offer a limited benefits plan which may be rated up to a 3.5 to 1 ratio based on the age, gender and geographic location of the applicant. The Act sets forth the benefits in the limited benefits plan which the New Jersey Individual Health Coverage Program ("IHC") Board has called the "Basic and Essential Health Care Services Plan" or the "B&E Plan." In short, the B&E Plan provides for 90 days per year for hospitalization; limited wellness and practitioner visits benefits; and some other limited benefits. The plan does not cover certain benefits that some consumers may have come to expect in health plans such as chemotherapy, outpatient drugs, pre-natal care, ambulance services, speech and occupational therapy, home health care, hospice care, or prosthetic devices. The Act permits carriers to file optional benefit riders to increase or decrease the benefits in the B&E Plan. Prior to the implementation of the Act, carriers in the individual market were only permitted to offer the standard, comprehensive health benefits plans developed by the IHC Board. By law, all of those plans were and continue to be community rated, meaning that carriers may not vary the rates for any plan based on any factors. Further, no optional riders may be offered with the standard plans.

The New Jersey State Legislature directed the IHC Board, in consultation with the New Jersey Small Employer Health Benefits Program ("SEH") Board, to provide a report to the Governor and the Legislature by January 8, 2004 which would:

1. "report the number of [B&E] policies or contracts sold, the premiums charged and the effect, if any, that the health benefits plan has had on the five standard health benefits plans offered to individuals in the State;"
2. "evaluate the effectiveness of this act in providing affordable health care coverage;"
3. address "whether the health benefits plan established in this act or a similar plan should be made available to small employers."

The Boards, in response to that directive, prepared this report. The Boards share the Legislature's concerns about the number of uninsured in New Jersey and the high cost of health insurance and health care and thank the Legislature for offering the Board the opportunity to provide input on the effectiveness of the Act.

The IHC Board has collected the data specifically requested in the Act as well as other relevant data on the B&E Plan. The Boards note that since carriers did not begin to offer the B&E Plan until March of 2003, little time has elapsed between the first offer of the B&E Plan and the submission date of this report. As a result, the Boards believe that too little data is available in order to make a truly informed evaluation on the three points noted above.

The IHC Board collected the premium and enrollment data set forth below from carriers in the individual market. The data set forth below is as of September 30, 2003, the most recent date for which information could be collected. Enrollment data for the fourth quarter of 2003 will not be available until March 2004.

¹ Senate Health Committee Statement to S.13 dated November 9, 2000.

ENROLLMENT

- There were 388 B&E policies issued during the second and third quarters of 2003; during that same period there were 11,625 standard individual plans issued. Thus, approximately 3 percent of all plans issued during this period were B&E Plans.
- There were 379 B&E contracts in force covering 503 people (that is, contractholders and their dependents). At that time for the entire individual market, there were 56,913 contracts in force covering 77,394 people. Thus, a little more than one half of one percent of individual market enrollees were covered under the B&E Plan.

RATING and PREMIUM

- Of the 10 carriers in the individual market, three had chosen to pure community rate the B&E Plan; two varied rates based on age only; four varied rates based on age and gender only; one varied rates based on age, gender and geography.
- The lowest single, monthly premium available to the individual in the most advantageous risk category was \$120.

DEMOGRAPHIC INFORMATION OF B&E PLAN PURCHASERS

- The average age for a contractholder in the individual market is about 49 years old, but 68% of the B&E contractholders were 39 years old or younger.²
- Enrollees in the B&E Plan were disproportionately male compared to enrollees in the standard plans: females represent 57% of the standard plan enrollment but only 40% of the B&E enrollment.

PLAN DESIGN

- One carrier, AmeriHealth, chose to issue an optional benefit rider of increasing value with the B&E Plan.

FINDINGS AND RECOMMENDATIONS

The Boards believe that the B&E Plan legislation has been modestly effective at providing affordable health coverage to young, male residents, but that the effectiveness has been largely due to the implementation of modified community rating, rather than the attractiveness of the plan design. Most of the savings to these young consumers is based on the rating flexibility provided for the B&E Plan rather than the plan design. Enrollment to date in the B&E Plan indicates that these plans can be modestly effective in increasing IHC enrollment and reducing the number of uninsured residents. The Boards do not recommend that small employer market carriers be required to offer the B&E Plan or a similar plan because the plan design does not produce significant savings compared to the standard plans, excludes significant and essential benefits, and includes cost sharing provisions that are difficult for indemnity carriers and HMO carriers to accommodate. Neither consumers nor carriers appear to be interested in having another limited benefits plan in the small employer market. Further, there are market-based reasons why any limited benefits plan sold in the small group market may result in some severe

² The average age in the standard individual market is from the Rutgers Center for State Health Policy, Report to the IHC Board dated December 9, 2003, based on a survey of the four largest IHC Program carriers from May to August 2002. The only age data available for B&E enrollees is from reporting from carriers to the Board expressed in terms of five-year age bands; an average age could not be accurately determined from this data.

unintended consequences. These consequences are described more fully below. Nevertheless, the Boards would not rule out supporting a law to allow carriers to voluntarily offer some type of up-to-date limited benefit package in the small group market if the unintended consequences can be adequately addressed.

II. Background on the IHC and SEH Programs

On November 30, 1992, Governor Florio signed two bills creating the New Jersey Individual Health Coverage ("IHC") Program and the New Jersey Small Employer Health Benefits ("SEH") Program. The reform laws were designed to address a number of problems faced by individuals and small employers. In the individual market prior to reform, individuals lacked choice and access to health coverage, and the burden of covering higher-risk individuals was concentrated with Horizon Blue Cross Blue Shield which was required to accept all persons regardless of health status. Horizon was in financial jeopardy partly as a consequence of being the "carrier of last resort." In the small employer market prior to reform, small employers were unable to obtain and keep good health coverage for their employees, especially if there were high-risk individuals in the group. The key purpose of the reforms was to address these problems by creating better access to coverage and to distribute among the many carriers the concentration of higher-risk individuals that were then covered by Horizon.

A. Key Features of Reform

The specific reform measures in these two markets closely mirror one another. These provisions are the same for both the individual and small employer markets:

- Guaranteed access and renewal;
- Portability of coverage and limitations on preexisting conditions exclusions;
- Standardized plans (however, the law permits carriers to issue optional benefit riders to modify the standard plans for small employers but not for individuals);
- Rating restrictions (the small group market is modified community rated; the individual market is pure community rated);
- 75% minimum loss ratio; and
- Interested parties as regulators.

The first two features of New Jersey's reforms, guaranteed access/renewal of coverage and also portability of coverage, are now embodied in federal law. In 1996, the federal government passed the Health Insurance Portability and Accountability Act, or "HIPAA," which set minimum standards for states to meet with respect to guaranteed issuance and renewal of plans and portability of coverage. New Jersey's 1992 individual and small employer market reforms in most cases meet, and in many cases exceed, the federal requirements.

B. The Boards' Development of the Five Standard Plans

The reform laws directed the IHC and SEH Boards to create five standard health benefits plans of increasing actuarial value that all carriers in the market would be required to offer. The implementing legislation set forth the framework of the basic plan, which the Boards called "Plan A." This is essentially a 30-day hospitalization only plan with some other minor benefits. For the remaining four plans, the law provided that one of the indemnity plans contain benefits and

cost sharing levels which are equivalent to an HMO plan. The law also provided that all of the policy forms contain "basic hospital and medical-surgical benefits including but not limited to: (1) basic inpatient and outpatient hospital care; (2) basic and extended medical-surgical benefits; (3) diagnostic tests, including X-rays; (4) maternity benefits, including prenatal and postnatal care; and (5) preventative medicine, including periodic physical examinations and inoculations." Lastly, the laws provide that at least three of the plans "shall provide for major medical benefits in varying lifetime aggregates, one of which shall provide at least \$1 million in lifetime aggregate benefits."

Since the basic plan, or Plan A, was already defined by the law, the Board proceeded by designing the four remaining standard plans to contain a common, comprehensive set of covered services, and varied the actuarial value of the plans, and their prices, by changing the policyholder coinsurance levels and deductible options: Plan B has a 40% policyholder coinsurance; Plan C, 30%; Plan D, 20%; and Plan E, 10%. Each of the plans has varying deductible options. The Board also designed an HMO plan with different copayment options. The standard plans include comprehensive coverage for the following: office visits; hospital care; prenatal and maternity care; immunizations and well-child care; screenings such as mammograms, pap smears and prostate exams; x-ray and laboratory services; certain mental health and substance abuse services; prescription drugs; and preventive care.

When developing the standard plans in 1993, the Boards considered changing the actuarial value of the plans by including different benefits in each of the plans. However, after careful study, the Boards jointly determined this approach to be unwise. In fact, the SEH Board, in conjunction with the IHC Board, commissioned an independent actuarial study by the actuarial consulting firm of Milliman and Robertson. Aided by that study, the Boards concluded that adding or eliminating a specific covered service or benefit from a plan would not rise to the level of having plans of increasing actuarial value because adding or deleting such benefits would have had such a small impact on the cost of the plans. The only benefit that was significant enough to rise to the level of increasing the actuarial value was a maternity benefit. The level of policyholder coinsurance and deductible, on the other hand, had a significant effect on the cost of the plan, and provided a sound basis for having plans of "increasing actuarial value."

Moreover, the Boards considered the basic insurance principle that adding or eliminating specific benefits to the plan in a guaranteed issuance environment would generate adverse selection problems. For example, if only one of the plans contained generous mental health benefits, all the individuals or groups seeking that benefit would purchase that plan, significantly raising the cost of that coverage. By creating plans with nearly identical covered services, the Boards furthered the statutory goals of simplifying the market while reducing the likelihood of adverse selection among plans.

Since the Boards' initial development of the standard plans in 1993, some changes have taken place. The Boards have amended the plans to allow issuance of coverage through a selective contracting arrangement (PPO or POS); benefits mandated by the State and Federal government have been included; some benefits have been added, clarified and modified at the discretion of the Boards; and the cost-sharing options have been changed. In addition, the IHC Board, pursuant to its authority under N.J.S.A. 17B:27A-3b, eliminated Plan A (the bare bones plan) and Plan E (the most benefit rich plan) as few people had enrolled in either of

those plans and the premium rates for those plans compared to the other standard plans made those plans unattractive.

III. P.L.2001, c.368

A. Summary of P.L.2001, c.368

As outlined in the Act, the individual market B&E Plan provides the following basic benefits, which are subject to specific copayments, deductibles and coinsurance: 90 days per year for hospitalization; \$600 per year wellness benefit; \$700 per year benefit for practitioner visits for illness or injury; \$500 per year benefit for out-of-hospital diagnostic testing; and limited benefits for biologically based mental illnesses, alcohol and substance abuse, and physical therapy. The plan does not cover certain benefits that some consumers may have come to expect in health plans such as chemotherapy, outpatient drugs, pre-natal care, ambulance services, speech and occupational therapy, home health care, hospice care, or prosthetic devices. These are only some of the benefits that are excluded. Carriers are permitted, but not required, to offer the B&E Plan with optional benefit riders to increase the benefits. In an attempt to attract more younger consumers and consumers with a better risk profile to the individual market, the Act permits carriers to rate the B&E Plan using factors for age, gender, and geographic location. In contrast to the existing standard individual plans, which are community rated, the new plan may have premium rates that vary by the factors noted above, but by no more than a 3.5 to 1 ratio.

B. Legislative Directive for the Boards' Report

As part of the Act, the New Jersey State Legislature directed the IHC Board, in consultation with the SEH Board, to evaluate the effectiveness of the Act in providing affordable health care coverage. The Legislature also directed the Boards to consider whether the health benefits plan established in the Act, which the IHC Board has called the "Basic and Essential Health Care Services Plan" or the "B&E Plan", or a similar plan should be made available to small employers. The Act directs the Boards to include in the report the number of policies or contracts sold, the premium charged and the effect, if any, that the B&E Plan has had on the standard health benefits plans in the individual market. This report was prepared by the Boards in response to that Legislative directive.

C. Comments on the Legislative Findings in P.L.2001, c.368

The findings and declarations set forth in the Act at P.L. 2001, c.368, section 3, and codified at N.J.S.A. 17B:27A-4.4, state that the Legislature had anticipated that the plans developed by the IHC Board in 1993 would vary in actuarial value on the basis of specified covered services rather than cost sharing. The findings further stated the Board failed to take "affirmative action to remedy this situation." The IHC Board was unaware of this intent, which was not apparent to the Board from P.L. 1992, c.161, the original law establishing the IHC Program. Furthermore, in the approximately ten years of operation of the IHC Board, which included numerous public meetings and proposals of rules for public comment (including rules regarding design of the standard plans), there is no prior record of any statement by the Legislature or its members that the IHC Board had misread the intent of the original legislation.

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The findings and declarations also note in N.J.S.A. 17B:27A-4.4b. that "the original intent of the Legislature was to give policyholders a wider range of coverage options, including policies that provide reimbursement for basic and essential health care services but do not contain either the traditional mandated benefits to which the standard plans are subject or reimbursement for services which the consumer can more economically pay for himself, rather than having those services paid for through a third-party system, which adds significantly to the cost." The first part of this quotation suggests that the Board should have excluded legislatively mandated coverages from some of the standard plans. However, the Boards can think of no mandated benefits laws enacted by the Legislature which are worded in such a way that would allow their exclusion from the standard plans. The Boards have not believed that they have been given the authority to exclude mandated benefits.

The second part of the quoted sentence states that providing reimbursement for services through a third-party payer, i.e., an insurance company or HMO, adds significantly to the cost. The Boards have found that the opposite is true: payment through a carrier for nearly all services is often substantially cheaper than a direct payment to a provider for a non-covered benefit. This is due to negotiated fee arrangements carriers may have with network providers or discounts that carriers can obtain through negotiation or participation in passive networks. Individuals simply do not have this negotiating ability. Consequently, individuals pay higher amounts for non-covered services.

The Legislature, in its legislative findings, criticized the IHC Board's efforts to address rising costs by increasing deductible and copay options. The Boards were exercising their best judgement, and were acting in a manner that corresponds with employer responses to the rising cost of health insurance. Many employers in both the small and large employer markets, not just in New Jersey but nationwide, have moved to plans with greater cost sharing rather than scaling back on covered benefits. Many believe that such cost sharing induces consumers to spend health care dollars more efficiently. Moreover, the tax provisions of the Federal Medicare Prescription Drug, Improvement and Modernization Act of 2003 further enhance the financial efficiency of plan designs with greater cost sharing.³ In short, the Boards believe that the movement to plans with increased cost sharing will dovetail nicely with these changes in federal tax law, whereas limited benefit plans with lower deductibles will not.

Lastly, and perhaps most importantly, the findings in N.J.S.A. 17B:27A-4.4d suggest that the B&E Plan, despite its limitations, still provides "essential" coverage. "Essential" is a subjective term; nevertheless, the Boards believe that the B&E Plan does not provide what most people would consider "essential" coverage in a number of areas. For example, as noted above, the plan does not cover hospitalization charges in excess of 90 days, chemotherapy, outpatient drugs, pre-natal care, ambulance services, speech and occupational therapy, home health care, hospice care, or prosthetic devices, to name but a few of the benefits that are not covered. These omissions of services and supplies which many consumers consider to be "essential" could be financially devastating to people covered under the B&E Plan should they require such services.

³ This law includes tax advantages for Health Savings Accounts or "HSAs." Beginning January 1, 2004, any individual in a qualified high deductible plan may deposit funds in a personally owned account to cover the cost of out-of-pocket health care expenses. The account is funded with pre-tax dollars, the contributions and interest accumulate tax free, and may be deducted for qualified expenses tax-free.

D. The IHC Board's Implementation P.L.2001, c.368 and the Basic and Essential Plan

The Act was enacted on January 8, 2002. The IHC Board proposed its rules to implement the Act on November 13, 2002 (35 N.J.R. 73(a) published on January 6, 2003) and adopted the rules on January 28, 2003 (35 N.J.R. 1290(a) published on March 3, 2003). Included in the rulemaking were rate filing requirements for the B&E Plan, good faith marketing requirements for the plan, and a proposed specimen policy form that carriers could either use as is or as a model to design their own B&E Plan.

The specimen policy form was created at the request of a number of carriers, which were unsure about transforming the provisions in the Act into a policy form. The IHC Board believed that creation of a specimen form would expedite the approval process and bring the product to the market more quickly. In fact, only one carrier did not use the specimen form.

The Board found the implementation of the Act to be difficult: taking a list of benefits with cost sharing noted and translating this information to policy forms was a challenging process. Much of the confusion stemmed from the fact that the law specified cost sharing features that normally only apply to network benefits (copays) as well as cost sharing features that normally only apply to non-network benefits (deductible and coinsurance), yet required *all* carriers, whether they were HMOs or non-HMOs to offer plans with these cost sharing arrangements. As an example, the carriers and the Board grappled with the concept of a copayment by non-managed care plans and the financial consequence to consumers. Normally, with copay, a consumer pays a flat fee to a provider and the carrier pays an agreed-upon amount to the provider for that service. Where the carrier does not have a contract with a provider, however, a copayment does not result in full payment to the provider. To resolve this, the Board included in its specimen policy form text that alerts consumers to the fact that they may be required to pay an amount in excess of the copayment if the provider bill exceeds the reasonable and customary charge. In effect, the copay is not a copay at all in the sense that a copayment is typically understood.

To help promote understanding about this new plan option in the individual market, the IHC Board issued a press release on the B&E Plan. The release was also published in the Department of Banking and Insurance *Banking and Insurance Quarterly*, which is mailed to the approximately 57,000 New Jersey licensed producers and other interested parties. Additionally, the Boards' staff gave presentations on B&E Plan at numerous speaking engagements to insurance producers and business groups.

IV. Data and Observations on the Basic and Essential Plan

The Act was approved on January 8, 2002. The law required carriers to file rates and a policy form with the Board no later than one year after the effective date of the law. Most carriers met this deadline. The IHC Board then reviewed the submissions relating to the B&E Plan within the 30-day time period set forth in its regulations. As a result, carriers were not offering the B&E Plan until March of 2003. This report thus considers only six months of information about the B&E Plan. Set forth below is data and observations that the Boards considered in making its recommendations and which is responsive to the data that the Legislature directed the Boards to provide.

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A. Number of Policies or Contracts Sold

All ten carriers (considering HMOs and their non-HMO affiliates as one carrier) offered the B&E Plan at least as of March of 2003. The Boards note the following highlights:

ENROLLMENT

- There were 388 B&E policies issued during the second and third quarters of 2003; during that same period there were 11,625 standard individual plans issued. Thus, approximately three percent of all plans issued during this period were B&E Plans.
- There were 379 B&E contracts in force covering 503 people (that is, contractholders and their dependents). At that time for the entire individual market, there were 56,913 contracts in force covering 77,394 people. Thus, a little more than one half of one percent of individual market enrollees were covered under the B&E Plan.
- Of the 10 carriers in the individual market (which considers HMOs and their affiliates as one carrier), three had in force B&E Plans and seven did not, but all ten had filed rates and appeared to have fulfilled the requirements of the law to offer B&E Plans.

DEMOGRAPHIC INFORMATION

Table 1 below shows the age/gender distribution of enrollees in the B&E Plan.

TABLE 1

Covered Males by Age Group		% of male enrollees	% of all enrollees
Age 0-24	72	30%	18%
Age 25-29	50	21%	13%
Age 30-34	19	8%	5%
Age 35-39	25	11%	6%
Age 40-44	32	13%	8%
Age 45-49	27	11%	7%
Age 50-54	9	4%	2%
Age 55-59	1	0%	0%
Age 60 & Over	3	1%	1%
Total	238	100%	60%

Covered Females by Age Group		% of female enrollees	% of all enrollees
Age 0-24	45	28%	11%
Age 25-29	20	13%	5%
Age 30-34	10	6%	3%
Age 35-39	24	15%	6%
Age 40-44	18	11%	5%
Age 45-49	28	18%	7%
Age 50-54	11	7%	3%
Age 55-59	4	3%	1%
Age 60 & Over	-	0%	0%
Total	160	100%	40%

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- The average age in the individual market is about 49 years old,⁴ but 68% of the B&E enrollees were 39 years old or younger.
- Enrollees in the B&E Plan were disproportionately male compared to enrollees in the standard plans: females represent 57% of the standard plan enrollment but only 40% of the B&E enrollment.

Table 2 below shows the prior coverage status of enrollees. Carriers have had a difficult time reporting this information. It serves no independent purpose for carriers and carriers have indicated that they do not track this information well. As a result, the Board believes that these numbers are not reliable for either the B&E Plan or the standard plans.

TABLE 2

# of Contracts by Previous Insured Status:		% of total
Uninsured	196	49%
Covered by An IHC Policy	55	14%
Covered By Another Policy Type	146	37%
Unknown	2	1%
Total	399	100%

Table 3 below compares geographic concentration of B&E enrollees to the overall population distribution in New Jersey. The geographic groupings in the table correspond to the permissible rating territories for B&E policies.

TABLE 3

Counties	Geographic Distribution of B&E Enrollment	% of NJ Population ⁵
Essex, Hudson and Union:	18%	23%
Bergen and Passaic:	7%	16%
Monmouth, Morris, Sussex and Warren:	11%	16%
Hunterdon, Middlesex and Somerset:	11%	14%
Burlington, Camden, and Mercer:	11%	15%
Atlantic, Cape May, Ocean, Salem:	43%	16%

- Since none of the carriers that successfully *issued* B&E Plans chose to use geography as a rate factor for the B&E Plan, the Board believes that the uneven distribution is not attributable to risk. The Board believes that the disproportionately high enrollment in three southern New Jersey counties reflects the fact that the carrier that issued most of the B&E Plans, AmeriHealth, has significant name recognition in southern New Jersey.

⁴ Rutgers Center for State Health Policy, Report to the IHC Board dated December 9, 2003, based on a survey of the four largest IHC Program carriers from May to August 2002.

⁵ U.S. Census Bureau, Population Estimates Program, data for July 1, 2002.

PLAN DESIGN

- One carrier, AmeriHealth, chose to issue an optional benefit rider of increasing value with the B&E Plan.⁶
- One carrier, Oxford, did not use the specimen form but rather filed its own form; this was largely to accommodate the issuance of the plan through an Exclusive Provider Organization ("EPO") arrangement.⁷
- Five carriers are issuing coverage as indemnity coverage, four carriers are issuing the plan as HMO, and one carrier is issuing the coverage through an EPO.

B. Premiums Charged

Table 4 set forth below is intended to provide a snapshot of key information regarding the B&E Plan and the standard individual market. It identifies all carriers issuing individual coverage (and considers indemnity carriers affiliated with HMOs as one carrier), the number of B&E covered lives, the rating structure for the B&E Plan, the delivery system for the B&E Plan and the lowest and highest single, monthly premium. To show how this compares to the standard market, the table also lists the total covered lives by carrier, market share, and covered lives under standard plans, and then provides the filed community rates for three popular standard plan options.

⁶ AmeriHealth's rider requires a \$30 copayment for PCP and specialist visits, deletes the deductible and coinsurance on wellness services, and deletes the maximum benefit limits on wellness services and out of hospital diagnostic tests. The rider also adds coverage for three pre-natal visits and deletes the exclusion for local anesthesia charges billed separately, outpatient laboratory tests, routine examinations and wellness care and second opinion charges. The additional cost of the rider is minimal (less than \$.50 per month) and all of the B&E Plans issued by AmeriHealth have been issued with the rider.

⁷ To consumers, Exclusive Provider Organization plans which are offered by non-HMO carriers, appear to be much like HMO plans: they limit benefits to in-network providers, except in cases of emergency.

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TABLE 4

Carrier	Market Share	Standard Plans			Basic & Essential Plans			
		Single Tier Premium			Covered Lives	Delivery System & Rating	Single Tier	
		HMO*	Plan A/50	Plan C			Lowest Premium	Highest Premium
		\$20 or \$30 copay	\$2500 ded	\$2500 ded				
Aetna Inc.	16%	\$406	\$514	\$718	-	Indemnity ⁽¹⁾	\$612	\$1,135
AmeriHealth	6%	\$354	-	-	465	HMO ⁽²⁾	\$120	\$420
Celtic	0%	-	\$777	\$2395	-	Indemnity ⁽²⁾	\$854	\$2,987
CIGNA	1%	\$551	-	-	-	HMO ⁽³⁾	\$365	\$1,269
Guardian	0%	-	\$574	\$774	-	Indemnity ⁽³⁾	\$675	\$2,024
HealthNet	1%	\$508	-	-	-	HMO ⁽²⁾	\$148	\$513
Horizon	58%	\$417	\$515	\$567	4	Indemnity ⁽⁴⁾	\$495	\$495
Oxford ⁽⁵⁾	16%	\$381	\$402	\$332	34	EPO ⁽²⁾	\$128	\$416
Trustmark	0%	-	\$1,843	\$2,457	-	Indemnity ⁽⁴⁾	\$2,633	\$2,633
United HealthCare	1%	\$447	\$612	\$861	-	HMO ⁽⁴⁾	\$394	\$394
Totals	100%				503			
⁽¹⁾ Rating Structure = Age, Gender, and Location								
⁽²⁾ Rating Structure = Age and Gender								
⁽³⁾ Rating Structure = Age								
⁽⁴⁾ Rating Structure = Community Rated								
⁽⁵⁾ Rate shown is for the PPO								
*Rate shown for CIGNA and HealthNet are for \$20 Copay; rate shown for others are for \$30 Copay								

Table 4 shows the following:

- Of the 10 carriers in the individual market, three had chosen to fully community rate the B&E Plan, two varied rates based on age only, four varied rates based on age and gender only, one varied rates based on age, gender and geography.
- The lowest single, monthly premium available to the individual in the most advantageous risk category was \$120.
- The highest single, monthly premium available to the individual in the least advantageous risk category ranged from \$416 (Oxford) to \$2987 (Celtic).
- The two carriers with the largest enrollment of B&E plans had the lowest rates.
- Oxford, a carrier with comparatively lower rates for the B&E Plan, citing implementation issues, originally community rated the B&E Plan, but converted to modified community rating in September 2003.

C. Basic and Essential Plan's Effect on Other Plans

The Legislation requires the Boards to comment on whether the B&E Plan has had an effect on the other plans. Because carriers have been offering the B&E Plan only since March of 2003, the Boards believe that there is insufficient data to draw any meaningful conclusions, based on actual experience, about the impact of the sale of the B&E Plan on the standard individual health benefits plans. However, it is clear that the introduction of the B&E Plan did not lead to a large scale switching of insureds from the standard IHC plans to the B&E Plan.

Even with data, the impact of the issuance of the B&E Plan on the standard plans will be impossible to measure with certainty. Theory would suggest that the B&E Plan, which may be rated based on age, gender, and geography, would cause individuals (primarily young males, and to a lesser extent young females) to switch from the standard IHC plans to the B&E Plan. This would, theoretically, lead to an increase in the average cost for insureds remaining in the community rated standard plans, and (further) increase the rates for those plans. However, this impact may not occur, or it may be small since the average age in the individual market, about 50, is already quite high and thus there are few young people covered under the standard plans to switch to the B&E Plan. Further, young people in the individual market may be there because of existing medical conditions. This would cause them not to switch, or would lessen the cost impact of the switch.

D. Claims Data

Insufficient time has elapsed since the B&E Plan was first issued to provide any meaningful data about carriers' claims experience. For example, the Board notes that individuals without prior coverage with preexisting conditions would be subject to a preexisting condition limitation for a period of one year from enrollment. As a result, claims information, if available, would likely be unreliable at this point in time in evaluating expected claim costs for the plan.

E. Complaints and Consumer Understanding of the Basic and Essential Plan

The DOBI and the IHC Board's staff have not received any specific complaints about coverage under the B&E Plan. However, the Boards believe that insufficient time has elapsed since the B&E Plan was first issued to provide any meaningful data on consumer complaints about the B&E Plan at this time. The Boards note that one of the key features of the B&E Plan is internal benefit limits. Since consumers have only had the plans for a short period, the newness of the plans may have reduced the likelihood of complaints regarding internal benefit limits.

The Boards note that consumer understanding of bare bones plans is always of concern, especially with the sale of such products by HMOs which traditionally have not offered products with limited benefits. In response to consumer complaints about the individual market Plan A, a prior bare bones plan, the DOBI issued Bulletin 96-11 in 1996, a copy of which is attached as Exhibit 2, to encourage producers and carriers to disclose the limitations of the plan. Anecdotally, some carriers and producers have expressed concerns about the sale of bare bones plans citing consumer confusion and the fear of lawsuits in the event a consumer is in need of a benefit, traditionally found in a health benefits plan, but which is not present in a bare bones plan. Producers (i.e., brokers and agents), who are required to purchase errors and emissions liability

coverage, also expressed a concern about the impact of offering bare bones plans to consumers on their errors and omissions liability coverage rates.

V. Effectiveness of Act in Providing Affordable Health Coverage

The Legislature asked the Board to evaluate the effectiveness of the law creating the B&E Plan in providing affordable health care coverage. Carriers began offering the plan in March of 2003, so the Boards have not had adequate data to form a comprehensive evaluation of B&E Plan and its effectiveness.

Nevertheless, the Boards believe that the premium data clearly shows that the law was effective in making the B&E Plan available at a lower rate, for young males and to a lesser extent, young females. The carriers that have successfully marketed this plan elected to use modified community rates for the plans, and the rate classifications followed conventional actuarial assumptions providing more advantageous rates for younger applicants but accounting for maternity costs for female applicants of childbearing age. The enrollment data show that price attributed to the success of the B&E Plan, with its enrollment distributed mostly in the younger rate categories and with males. Older individuals shopping for individual coverage were undoubtedly not attracted to the B&E Plan, which because of age-rating by the carriers with the most attractive prices, resulted in the B&E Plan costing more for them than a standard comprehensive HMO \$30 Copay plan.

This enrollment and pricing data further suggest that the success of the Act in making coverage more affordable for younger residents is largely due to the fact that the B&E Plan is not competing with the standard plans on a level playing field due to the different rating rules. To attempt to control for the rating differences to evaluate the attractiveness of the B&E Plan design, the IHC Board requested that individual market carriers provide hypothetical modified community rated premiums for some of the standard plans at 3.5:1 ratio which currently must be fully community rated. This ratio mirrors the rating rules that carriers may use for the B&E Plan. Set forth below as Table 5 is a chart listing the three carriers that have issued B&E Plans, their low rate for the B&E plan (young/males), the standard HMO \$30 Copay Plan community rate, the hypothetical low rate for the standard HMO \$30 Copay Plan if the carrier were permitted to rate the plan at a 3.5:1 ratio like the B&E Plan (based on an IHC Board survey), and lastly the relationship between the B&E rate and the standard HMO \$30 Copay Plan rate. All information is for September 30, 2003.

TABLE 5

Carrier	B&E Low Rate	Standard HMO \$30 Copay Community Rate	Standard HMO \$30 Copay Low Rate If Rated at 3.5:1 (In response to Board survey)	B&E Rate % of HMO \$30 Copay
AmeriHealth	\$120	\$354	\$142	84%
Horizon	\$495 (community rated)	\$417	\$167	121%
Oxford	\$128	\$381	\$191	67%

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As Table 5 shows, carrier pricing for the B&E Plan was not uniform in the market. But for all of the carriers, the restricted benefits in the B&E Plan did not yield great savings. AmeriHealth's most affordable standard plan, the HMO Plan with a \$30 Copay, has a community rate of \$354. AmeriHealth reported that if modified community rating were permitted for this standard plan at a 3.5:1 ratio, the rates for that standard HMO plan would range from \$142 to \$498. Under modified community rating, an additional 16% increase in premium from the B&E Plan would fund a standard plan with comprehensive benefits (including 50% coverage for outpatient drugs) without the limitations and exclusions of the B&E Plan. The Board believes that if all products in the individual market were rated on the same basis, few consumers would select the B&E Plan.

In evaluating the effectiveness of the Act in providing for affordable coverage, the Legislature quite appropriately asked the Board to evaluate the impact of the B&E Plan on the other plans in the market. At this point, the IHC Board could find no discernable impact on the standard plans by the introduction of the B&E Plan. As noted above, the Boards only have data on enrollment for a six-month period and enrollment in the B&E Plan accounts for less than 1% of the IHC market. But as noted above, the Board believes that insufficient time has elapsed in order to fully evaluate this issue.

The Boards do not have information about the administrative costs for carriers in administering the plan. In fact, this would be difficult for carriers to measure. However, the Boards expect that the introduction of the B&E Plan increased administrative costs for carriers. For those carriers that chose to rate the plan using modified community rating, administrative costs would have increased as the carrier had to begin considering rating factors where previously in the community rated individual market they did not have to undertake this task. Additionally, these carriers would have to incur systems costs to modify their billing system for one individual plan. Also, since the benefit structure of this plan is so unlike any other product that carriers offer, claims systems needed to be developed to handle this product or, alternatively, if the carrier had issued few plans, the carrier may have chosen to administer the claims by hand.

However, it appears that the plan design is not attractive to consumers and that this bare bones plan is not likely to capture a significant percentage of the market, but that modified community rating of the plan has been effective at producing an affordable, albeit benefit-poor option, in the individual market, at least for younger residents.

VI. Recommendation on Expanding, or Making Modifications to, the Standard SEH Plans to Include the Basic and Essential or Similar Plan

The Boards believe that carriers should not be *required* to offer the B&E Plan, or a similar Plan, in the small employer market.

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First, the Boards believe that the plan design for the B&E Plan, or a minor modification to that Plan, is not a good starting point for developing a limited benefits package for the small group market. The Legislative history of the Act indicates that the B&E Plan is modeled on "indemnity plans that dominated the market in the 1970's."⁸ It is the Boards' understanding that it was a 30-year old Blue Cross plan that was used as the model for the B&E Plan. So much has changed in health insurance and health care in the intervening 30 years, including the introduction of managed care and countless technological advances, that using that plan design or using it as a starting point would not be effective should the Legislature determine that another limited benefits plan is appropriate for the small employer market.

The Board believes that a strong case can be made that the consumer appetite for limited benefits packages is significantly smaller in the small employer market compared to the individual market. In the small employer market, a bare bones plan must really meet approval of two consumers: the employer, who must chose to offer the plan, and the employee, who must choose to accept the plan, especially when the employee contributes to the cost of the coverage. Evidence of this reduced appetite may be found in charting enrollment in the legislatively mandated bare bones plan that was outlined in both the IHC Program and SEH Program enabling statutes, which both Boards referred to as "Plan A." Plan A is a limited benefits plan, covering 30 days of hospitalization with a \$250 deductible with some other modest benefits. As Table 6 below shows, enrollment in the individual market Plan A peaked at a little over 4% of all individual market enrollees as of January 1, 1995. In contrast, in the small group market, enrollment in Plan A has never exceeded one half of one percent of the market. Pursuant to N.J.S.A. 17B:27A- 4b, the IHC Board reduced the number of plans that carriers were required to offer, in part, by eliminating Plan A. The SEH Board did not have similar authority to reduce the number of plan offerings in the market; today, small employer market carriers are still required to offer Plan A. As of September 30, 2003, there were 23 people out of 896,881 covered under Plan A.

TABLE 6

Quarter	IHC Plan A % of Total Plans	SEH Plan A % of Total Plans
4Q94	4.082%	0.029%
4Q95	2.587%	0.049%
4Q96	3.332%	0.047%
4Q97	3.313%	0.041%
4Q98	2.505%	0.001%
4Q99	0.088%	0.004%
4Q01	N/A	0.005%
1Q03	N/A	0.000%

Note: Plan A was terminated in the individual market; it is still available in the small employer market.

⁸ Senate Health Committee Statement to S.13 dated November 9, 2000.

Similarly, carrier appetite for offering truly limited benefit packages is small. In the small employer market, carriers are permitted to offer riders of decreasing value with the standard health benefits plans. In contrast, the law does not permit individual market carriers to file optional benefit riders. While small employer market carriers may not offer riders which eliminate coverage mandated by the legislature or by the federal government, carriers are free to offer riders that could drastically reduce the benefits in the standard plans. Carriers have filed riders that increase cost sharing and create myriad prescription drug options, but no carrier has chosen to file a rider which would significantly reduce the benefits in the standard plans. Neither the buyers nor the sellers in the small employer market appear to have made a case for bare bones plans.

Ironically, the effort to increase consumer choice by requiring carriers to offer a new limited benefits plan in the small employer market, if successful, may in fact produce less consumer choice. Pursuant to N.J.S.A. 17B:27A-17, an individual is not eligible for coverage in the individual market if she is eligible for employer-based group coverage. An exception is provided for in N.J.S.A. 17B:27A-3c, the effect of which permits a person eligible for employer-based group coverage to opt out during the individual market open enrollment period to purchase a plan that is not the "same or similar" to their group coverage, so long as the employee would have to contribute toward the cost of the group coverage. There are two circumstances when this is attractive to an employee: when they believe that their group coverage is too rich and they want to spend less money on less rich coverage, or when their group coverage is too limited and they want to spend more money on richer coverage in the individual market. If an employer actually purchased a bare bones group plan and its employees were not required to contribute toward the cost of coverage, these employees would be precluded by applicable law from buying a comprehensive plan in the individual market. If a small employer purchased a bare bones plan and required employee contributions, the employee would need to take the limited group coverage, drop their individual coverage if she had it, then opt back into the individual market during the one-month open enrollment period in the individual market, currently October of each year for an effective date of January of the following year. For someone with catastrophic health needs, either being blocked from comprehensive individual coverage or having to temporarily switch to a limited bare bones plan for up to 14 months⁹ before being able to get into a comprehensive individual market plan, this experience could be financially devastating.

Another possible danger of the issuance of bare bones plan in the small employer market may result from two requirements under the federal Health Insurance Portability and Accountability Act of 1996. That law requires that small employer market carriers guarantee-issue all products to eligible small employers, and requires carriers to give credit toward meeting a preexisting condition exclusion waiting period for coverage under a prior plan. These two federal requirements could result in a what economists refer to as a "moral hazard." Employers could purchase a bare bones plan when the members of the group are healthy and then immediately demand more comprehensive coverage from the same carrier should an employee or dependent of the group become ill. The likelihood of this kind of decision making is smaller with large employers, but in the small employer market where the average contract covers

⁹ An employee of a small employer if offered coverage by her employer under a limited benefits plan in November would need to drop her individual coverage under applicable state law. She could then opt out of her group coverage the following October for coverage effective the following January. Thus, under this fact pattern, she would have had 14 months of coverage under the small employer plan before being legally permitted to enroll in an individual plan.

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between three and four employees, the chances of this kind of decision-making are substantially greater. The SEH Act does have a provision which attempts to protect against this conduct by limiting an employer's ability to purchase a plan of greater actuarial value until after it has reached its first year anniversary date. However, there does not appear to be an exception under federal law to the guaranteed issuance requirements for State laws such as this. This type of moral hazard has been cited as a reason for the lack of popularity of bare bones plans among carriers nationally.¹⁰

For the reasons expressed above, the Boards do not believe that carriers should be required to offer the B&E Plan or a similar Plan in the SEH market. The Boards do not mean to preclude consideration of other limited benefits plans, especially on a voluntary basis, based on a different model, and with some modifications to individual and small employer market rules to address some of the concerns from brokers and the unintended outcomes outlined above.

VII. Conclusions

The IHC and SEH Boards are composed of key interested parties appointed by the Governor or elected by carriers and include carriers, employers, consumers, labor, producers, and representatives from the Department of Banking and Insurance and the Department of Health and Senior Services. The Legislature purposefully designed the Boards to represent divergent and often-conflicting interests. Such composition was designed so that no single interest dominates, and so that the spectrum of interests represented could enhance the creation of sound public policy. It is always a challenge for either Board to speak with one voice on any issue because of their composition. Nevertheless, this report represents a consensus document on which all members agree.

The Boards and their staff have attempted to diligently exercise their duties in implementing the law and running these two programs. The Boards as entities have refrained from voicing positions on matters of public policy or on legislation, believing that is the role of the existing executive branch agencies, and because the individual members of the Board may also speak out on these issues in their personal capacity. This report was designed to respond to the specific directions set forth in P.L.2001, c.368, and to provide a recommendation regarding the inclusion of the B&E Plan in the small employer market and no more. The Boards have purposefully avoided recommendations outside the scope of the Legislative directive, such as the desirability of changes in rating bands in either the individual or small employer markets.

In conclusion, the Boards believe that the B&E Plan legislation was modestly effective at providing affordable health coverage to younger, male residents, but that the effectiveness was largely due to the implementation of modified community rating, rather than the attractiveness of the plan design. The Boards would not recommend that small employer market carriers be required to offer the B&E Plan or a similar plan because the plan design is not an effective plan design in 2004. Further, there are market-based reasons why any limited benefits plan may result in some unintended consequences should it be successfully offered in the small group market. Nevertheless, the Boards would not rule out some type of up-to-date limited benefit package in the small group market if the unintended consequences can be adequately addressed.

¹⁰ Riley, Trish and Yondorf, Barbara, "The Flood Tide Forum - - Access for the Uninsured: Lessons from 25 Years of State Initiatives," National Academy for State Health Policy, January 2000.

Exhibit 1

IHC Board Members

1. **Sandi Kelly** for Horizon Blue Cross Blue Shield [Health Service Corporation seat]
2. **Mary McClure** for Aetna [Health Maintenance Organization seat]
3. **Sanford Herman** for Guardian Life Ins. Co. [Insurer authorized to write health insurance in this State subject to Subtitle 3 of Title 17B of the New Jersey Statutes seat]
4. **Darrel Farkus** for Oxford Health Insurance [Foreign Health Insurance Company Authorized to Do Business in the State seat]
5. **Eileen M. Shrem** [seat for an employer]
6. **Charles Wowkanech** [seat for labor]
7. **Frank Giannattasio** [seat for a consumers of health plans]
8. **Lisa Yourman** [seat for a consumer of health plans]
9. **Vicki Mangiaracina** designee for Holly C. Bakke, Commissioner of the Department Banking and Insurance

SEH Board Members

1. **James Stenger** [seat for small businesses]
2. **Thomas F. Collins, Jr.** [seat for minority small businesses]
3. **Lilton R. Taliaferro, Jr.** for AmeriHealth Ins. Co. of NJ [seat for a carrier primarily in the small employer market]
4. **Sanford Herman** for Guardian Life Ins. Co. [seat for a carrier primarily in the small employer market]
5. **Jack Kalosy** for Health Net, Inc [seat for a carrier primarily in the small employer market]
6. **Robert Shalongo** for United HealthCare of NJ [seat for a carrier primarily in the large employer market]
7. **Michael Torrese** for Horizon Blue Cross Blue Shield of NJ [seat for a health, hospital or medical service corporation]
8. **Darrel Farkus** Oxford Health Plans of NJ [seat for an HMO]
9. **Mary McClure** for Aetna Health, Inc [seat for an HMO]
10. **Vicki Mangiaracina** designee for Holly C. Bakke, Commissioner of the Department of Banking & Insurance
11. **Joseph Tricarico, Jr., D.M.D.** designee for Clifford Lacy, M.D., Commissioner of the Department of Health & Senior Services
12. **Dutch Vanderhoof** [seat for an insurance producer]
13. **Gary Cupo** insurance [seat for an insurance producer]

As of January 5, 2004

Individual Health Coverage Program

Historical Comparison of Enrollment

Small Employer Health Benefits Program

Quarter	Individual Health Coverage Program							Small Employer Health Benefits Program							Combined					
	Plans	Covered Lives					Plans	Covered Lives					Total	% +/-						
		Pre-Ref	Standard	B&E	Total	Change		% +/-	Non-Std	Standard	EES	Dps			Total	Change	% +/-			
4Q93		134,837	21,728		156,565															
4Q94		97,889	112,964		210,853	19,295	10.07%	504,662	189,650	340,184	354,128	694,312								
4Q95		34,254	186,130		220,384	12,384	5.95%	353,534	425,765	375,169	404,130	779,299	3,771	0.49%	905,165					
4Q96		16,487	166,101		182,588	-15,298	-7.73%	216,677	600,039	397,788	418,928	816,716	146	0.02%	999,683					
4Q97		92,195	154,256		161,207	-7,580	-4.69%	97,173	724,540	416,234	432,312	848,546	5,223	0.62%	1,009,753					
4Q98		83,177	131,168		135,827	-6,458	-4.54%	105,982	811,898	430,894	436,700	869,594	-5,423	-0.62%	1,005,421					
4Q99		76,005	112,948		116,295	-4,218	-3.50%	113,619	892,149	462,882	463,780	926,662	28,286	3.15%	1,042,957					
4Q00		68,712	98,769		101,103	-5,925	-5.54%	114,215	20,129	448,628	450,533	899,162	-5,152	-0.57%	1,000,285					
4Q01		60,926	1,687	84,968	86,655	-4,794	-5.24%	113,665	14,733	445,490	434,232	884,021	-83	-0.01%	970,676					
4Q02		57,418	1,172	78,698	79,870	-1,073	-1.33%	115,097	11,419	445,490	425,282	870,772	6,370	0.74%	950,642					
4Q03		56,447	812	75,839	814	-879	-1.12%	120,350	8,884	463,848	436,782	899,630	2,749	0.31%	977,095					
4Q04		57,756	649	75,047	77,465	27	0.03%	126,915	6,747	477,130	441,532	918,662	3,341	0.37%	997,175					
1Q05		58,101	618	74,212	78,482	-31	-0.04%	127,436	6,030	479,412	436,214	915,626	-3,036	-0.33%	994,108					
2Q05		58,168	584	73,651	78,433	-49	-0.06%	127,436	6,030	479,900	435,524	915,424	-202	-0.02%	993,857					
3Q05		58,330	554	71,398	77,738	-695	-0.89%	130,486	6,628	479,871	441,415	921,286	5,862	0.64%	999,024					
4Q05		58,566	529	69,197	77,571	-167	-0.21%	130,742	6,409	478,769	441,184	919,953	-1,333	-0.14%	997,524					
1Q06		60,569	501	67,361	79,729	2,158	2.78%	132,213	10,110	476,417	430,648	907,065	-12,888	-1.40%	986,794					
2Q06		63,580	445	66,167	82,903	3,174	3.98%	132,337	9,999	475,508	431,417	906,925	-140	-0.02%	989,828					
3Q06		64,390	414	66,394	85,571	2,668	3.22%	133,556	9,952	473,946	426,187	900,133	-6,792	-0.75%	985,704					
IHC Change from 4Q93 to 3Q06													-45%			SEH Change from 4Q94 to 3Q06		30%		

B & E Plans were first available in March, 2003.

SEH Q1 and Q2 of 2006 Non-Standard Plans has been revised due to Oxford previously including the enrollment figures with the Standard Plans

12/19/06