Access to Affordable Health Insurance:
New Jersey
State Planning Grant

Interim Report

January 2005

State of New Jersey
Department of Human Services

In Collaboration with
Rutgers Center for State Health Policy

Project funded by the U.S. Department of Health & Human Services, Health Resources and Services Administration,
State Planning Grant # 1 P09 OA 00040-01

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Lead Agency
New Jersey Department of Human Services (NJDHS)

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Rutgers Center for State Health Policy

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EXECUTIVE SUMMARY

In July 2002, the State of New Jersey was awarded a HRSA State Planning Grant to conduct multiple research projects to study the issue of the uninsured. The New Jersey Department of Human Services (DHS) was designated as "lead agency" in this effort and contracted with Rutgers Center for State Health Policy to complete all research-related activities. In September 2003, New Jersey received a supplemental grant to pursue three additional projects. That same month, the State received a one-year extension for the initial project activities, which concluded in August 2004. The Department of Human Services also received authorization to carry over 2003 fiscal year funding to complete project activities outlined in the supplemental award. Lastly, in September 2004, the project team was notified of a second supplemental award to complete work on a tenth analytical project.

While still premature to assess the policy impact of the research completed thus far, we have identified several key lessons and preliminary findings that will help to inform future policy decisions as well as our remaining project activities. To summarize:

- Approximately 1.08 million residents (15% of the non-elderly population) in NJ were uninsured in 2001-2002. Households with annual income below $20,000 are most likely to be uninsured, while most uninsured households have annual income between $20,000 and $50,000. Hispanic households are most likely to be uninsured, followed by other minorities. One quarter of those in fair or poor health report being uninsured. Finally, non-elderly (i.e., 18-64 years of age) are most likely to be uninsured and also make up the greatest proportion of New Jersey's uninsured population (additional data from Rutgers Center for State Health Policy's 2001 New Jersey Family Health Survey can be found in Appendix C, *"New Jersey's Medically Uninsured: A Chartbook"*).
- Under the SPG, New Jersey conducted a supplemental survey to the New Jersey Family Health Survey to learn more about differences that may exist between those who disenrolled from NJ FamilyCare but are still eligible for the program and those who are enrolled or disenrolled but have other insurance. Foreign-born children are much more likely than U.S. born children to be disenrolled but still eligible for FamilyCare. Families with only one child were much more likely than larger families to be disenrolled but still eligible for FamilyCare. Infants were more likely than older children to have disenrolled but still be eligible. Meanwhile, children aged 6 years or older were more likely to have found another form of health insurance.
- In an effort to increase access to employment-based health insurance, the New Jersey Premium Support Program subsidizes the employee portion of the health insurance premium for qualified applicants who are enrolled in NJ FamilyCare. Under the State Planning Grant, New Jersey interviewed state officials of similar programs in Illinois, Iowa, Maryland, Massachusetts, Oregon, Pennsylvania, and Rhode Island and found that many states with high enrollment in their subsidy programs have passed legislation requiring insurers to recognize enrollment in the subsidy program as a qualifying event for enrollment in the employer plan. In addition, New Jersey learned that other states use a variety of methods to qualify an employer plan for premium support including different levels of employer

premium contributions and different methods of measuring cost effectiveness. The impact of incorporating these various methods on enrollment in New Jersey's Premium Support Program would be negligible.

- Collection of data from New Jersey employers under Project 1, proved to be a significant challenge. New Jersey had originally planned to conduct three two-hour employer focus groups to discuss health insurance offering decisions in an effort to identify ways to maximize employment-based health insurance coverage in the state. However, focus groups proved to be too burdensome for New Jersey employers who did not have time to participate and were hesitant to discuss personal information about their company and their opinions regarding offering health insurance. As a result, New Jersey changed the focus group data collection strategy to short telephone interviews instead. Twenty-six employers participated in the telephone interviews including those who offer health insurance as an employee benefit and those who do not, as well as both small and larger employers.
- Telephone interviews with New Jersey employers offered some insight into employer decision-making and incentives around offering health insurance. On average, interviewed employers that did not offer health insurance had a greater proportion of employees that worked part-time or seasonally. More than one-third of employers that offered coverage allowed part-time workers to enroll. Most employers offering coverage contributed at least 75% of the premium, but about one-third contributed 50 to 60 percent. Most employers that offered coverage had very high take-up rates. However, those employers with lower premium contributions also had lower take-up rates. The primary reason employers gave for offering coverage was attracting and retaining high quality employees. The major reasons why employers do not offer coverage are high cost of premiums and employees having access to other coverage. Another interesting finding is that NJ employers are committed to their offering status. Most that do not offer coverage had never offered coverage, while those that do offer coverage have done so for a long time. In response to rising premiums, employers have increased cost sharing requirements by reducing the employer contribution.

While many of our projects have ended or are near conclusion, as previously noted, there are still substantial research activities currently in progress under this grant. While we look forward to reporting additional research findings in our Final Report to the Secretary, we can provide a summary of additional on-going project work under this grant:

- A Chartbook detailing the enrollment and retention of children in NJ FamilyCare (based on survey data) will be completed in winter 2005.
- A report analyzing the NJ FamilyCare administrative data will be completed in spring 2005.
- A Chartbook examining the low-income uninsured, and their eligibility vs enrollment in public coverage will be completed in spring 2005.
- Work on a detailed profile of the low-income uninsured and analysis of the affordability of health insurance coverage in New Jersey is continuing and a report will be complete in winter 2005.
- Results from an analysis of disparities in coverage between urban and non-urban areas are nearly complete and will be shared with the Steering Committee in early 2005.
- A review of the impact of benefit mandates is currently underway. A summary and analysis based on the available literature will be completed in summer 2005.

As we previously reported, on June 10, 2003, former Governor James E. McGreevey hosted the *Conference on Healthcare Coverage* to accelerate the process of engaging experts and stakeholders from both the public and private sectors in the policy debate. Working collaboratively with members of his cabinet, including the Commissioners of the Departments of Banking and Insurance, Human Services and Health and Senior Services, the Governor positioned this conference as the first in a continuum of activities designed to inform the health policy discussion. As there was considerable synergy between the State Planning Grant projects and the activities that followed the Governor's conference, we used HRSA funding to provide research support to three post-conference workgroups. One group focused on identifying and describing New Jersey's uninsured. The second group examined existing mechanisms to provide health coverage. The third group debated new options for improving access to coverage. Each group submitted a statement of deliberations to the Commissioner of the NJ Department of Banking and Insurance. Those recommendations were subsequently sent to the Office of the Governor.

INTRODUCTION

In July 2002, the State of New Jersey was awarded a $982,075 HRSA State Planning Grant (SPG). Former Governor James E. McGreevey designated the New Jersey Department of Human Services (DHS) the lead agency for project activities and Deborah C. Bradley Kilstein, then Acting Deputy Commissioner and later Chief of Staff at DHS, assumed the role of Project Director. Following Ms. Bradley Kilstein's departure, Matt D'Oria, Acting Director in the Division of Medical Assistance and Health Services (note that the Division is part of the NJ Department of Human Services), was named SPG Project Director. In September 2003, New Jersey was awarded an $185,000 Supplement under this grant. With the departure of Matt D'Oria in January 2004, Dennis Doderer, Deputy Assistant Director of the Division of Medical Assistance and Health Services, became the SPG Project Director. Mr. Doderer has been an active member of the SPG interdepartmental Steering Committee, which functions as the governance body for this grant, since the start of the grant in 2002, assuring continuity of leadership for the SPG. Additional details about the role and composition of the Steering Committee will be described below.

Throughout the past two years, the Department of Human Services has successfully partnered and worked closely with Rutgers Center for State Health Policy (CSHP or "Center") to pursue the project goals outlined in the 2002, 2003 and 2004 grant applications. They include: (1) optimizing the effectiveness of New Jersey's current innovative and substantial coverage initiatives and, (2) describing remaining gaps in access and affordable coverage and exploring policy approaches to addressing these gaps. This collaboration continues to provide the opportunity for policymakers to call upon the expertise and academic rigor of one of the state's leading research institutions as they contend with shrinking budgets and attempt to identify health policy alternatives for the estimated 1 million individuals currently uninsured in New Jersey.

Six projects were funded under the initial grant application. Three additional projects were initiated with 2003 supplemental funding and a final project is now underway using a 2004 supplemental award.

Grant Management and Administration Upon award of New Jersey's State Planning Grant, a Steering Committee comprised of senior policymakers from the Departments of Human Services, Health and Senior Services, Banking and Insurance, and the Treasury was convened. Dennis Doderer, representing DHS, and Joel Cantor, Principal Investigator from Rutgers Center for State Health Policy, provide ongoing committee leadership. See Appendix A for a list of Steering Committee members.

In addition to the contributions made by the members of the Steering Committee, the project team is also working with advisory groups that were selected for their diversity and involvement in health policy development in the state. These groups include the Covering Kids Coalition and the Individual Health Coverage Program and Small Employer Health Benefits Program Boards. In the fall of 2003, we briefed both the Covering Kids Coalition and the NJ FamilyCare Advisory Board (note that the NJ FamilyCare Advisory Board no longer exists. There was a large overlap in membership between the Advisory Board and the Covering Kids Coalition, so the former group was disbanded) on the progress of all of our project activities. As we move forward into the third year of our grant, we anticipate engaging these stakeholders more

frequently as we broaden our outreach efforts and develop a strategy for briefings and dissemination of our final research findings.

PROFILE OF NEW JERSEY'S UNINSURED

Characteristics of the Uninsured (Sections 1.1 and 1.2)

In 2001 and early 2002, Rutgers Center for State Health Policy conducted the New Jersey Family Health Survey (NJFHS) to provide timely and policy-relevant information about the health and health care utilization of New Jersey residents to policymakers. NJFHS data were collected in late 2001 through January 2002 with funding from The Robert Wood Johnson Foundation. The NJFHS sample is designed to represent New Jersey as well as five regions of the state and includes measures of health insurance coverage, health status, utilization, access to care, employment and earnings, and demographics. A detailed description of the NJFHS design and content is included in Appendix B.

According to the NJFHS, approximately 1.08 million residents, or 15% of the non-elderly population, were uninsured in 2001-2002. The highest uninsured rates are found in the densely populated urban areas of northeastern New Jersey. The survey reveals further that lack of insurance is strongly related to household income. Although residents of households with annual income less than $20,000 are the most likely to be uninsured, the majority of the uninsured come from households with higher annual income. Specifically, half of the state's uninsured residents live in households with incomes between $20,000 and $50,000. In part, these numbers reflect the greater eligibility for public insurance programs among the lowest income residents. Although residents from households with annual income exceeding $50,000 are the least likely to be uninsured, approximately one-fourth of the uninsured come from these households – a finding that reflects the large number of state residents who fall into this category of household income.

Put another way, children living in families with income below 200% of the federal poverty level (FPL) have a much higher uninsured rate than children in wealthier families. While only 6% of children in families with income above 200% of the FPL are uninsured, these children account for one-third of all uninsured children in NJ.

Lack of insurance is also related to general health status as reported by survey respondents. Twenty-five percent of those who report their health as "fair" or "poor" lack health insurance, compared to 20% of those who report "good" health and 11% of those who report "excellent" or "very good" health. However, since most residents of the state are not in fair or poor health (as reported in the NJFHS), poor health is not the dominant characteristic of the majority of the uninsured. In fact, approximately one-half of the uninsured describe their health as "very good" or "excellent".

Insurance status varies considerably by race and ethnicity. Only 10% of White non-Hispanic residents are uninsured compared to 34% of Hispanics, 17% of Blacks, and 17% who classify themselves as members of other race/ethnicity categories. Nevertheless, since White non-Hispanics make up the large majority of residents in NJ, they also account for the largest share (40%) of the uninsured population, followed very closely by Hispanics at 36% of the total. Children who are born outside of the U.S. and are not citizens have a 47% uninsured rate, which is five times higher than the uninsured rate for children born in the U.S.

Finally, age plays a role in the lack of health insurance. In New Jersey, the number of uninsured adults ages 19 to 64 (855,000) is over three times greater than the number of uninsured children (238,000). With regard to the duration without coverage, we learned that most (63%) of these uninsured children have been without coverage for 12 months or longer. An even greater percentage (74%) of uninsured adults have been without coverage for 12 months or longer. For both adults and children who have health insurance, employer-sponsored insurance is the most frequently found source of coverage.

A copy of *"The Medically Uninsured in New Jersey: A Chartbook"*, describing New Jersey's uninsured, can be found in Appendix C. In addition, a second chartbook funded under this grant, which examines New Jersey's low-income uninsured population will be completed in spring 2005. We will report on the key findings of that analysis in our Final Report to the Secretary in September 2005.

Population Groups in Particular Need of Health Insurance (Section 1.3)

Clearly, certain population groups face greater risks of being uninsured than others. Nevertheless, New Jersey's uninsured population overall exhibits considerable diversity in health and demographic characteristics. These findings underscore the difficulty involved in targeting coverage expansions to meet the dual goals of providing relief to the neediest populations while significantly reducing the total number of uninsured.

Specifically, if the goal is to help the neediest populations we would focus on those with annual household income below $20,000, those with fair or poor health status, Hispanics (and possibly other minorities), and non-elderly adults. However, if our goal is to provide the greatest number of people with health insurance, we would focus on those with annual household income between $20,000 and $50,000, very good or excellent health, White non-Hispanic, and non-elderly adults. Regardless of the specific policy goal, a broad category of non-elderly adults remain uninsured.

Affordable Coverage and Willingness to Pay for Coverage (Section 1.4)

In one of the SPG projects still underway, the Center for State Health Policy team is assessing access to affordable health insurance in New Jersey. The assessment of whether health insurance is affordable for uninsured New Jersey residents recognizes that by its very nature, the concept of "affordability" is a subjective concept. Consequently, there is no objective standard upon which to assess whether coverage is affordable.

Several approaches to estimating the affordability of coverage have appeared in the literature. Some researchers have used a *consumption-based definition* of affordability, which compares consumption expenditures between insured and uninsured households to determine whether health insurance is affordable (Levy and De Leire). Others have used a *behavioral approach* to define affordability (Bundorf and Pauly). The behavioral approach compares individuals in similar circumstances and deems health insurance affordable when most people with similar characteristics are insured. Finally, some researchers have looked at a *normative definition* of affordability, which selects a consumption standard representing a minimal or acceptable level of spending to meet objectives for nutrition, housing, etc. (e.g., federal poverty level or some multiple) and if income is not high enough to support this minimum standard and pay for health insurance, then health insurance is unaffordable (Bundorf and Pauly).

Our approach follows the *normative definition* of affordability. In particular, we plan to apply NJ Family Care income thresholds as the minimum *consumption standard* (i.e., what a family should have left for consumption after health insurance costs). Note that this consumption standard reflects a 'political consensus' on what level of income should be available to spend on basic needs other than health insurance. We will provide alternative estimates differentiating between persons with/without access to employer-based health insurance. For the former, we will use data on health insurance premiums for employment-based coverage in New Jersey (derived from the Medical Expenditure Panel Survey Insurance Component or from the New Jersey Small Employer Health Benefits Program); for the latter, we will use data on individually-purchased coverage (from the New Jersey Individual Health Coverage Program) as well as premiums from NJ Family Care for persons deemed eligible for such coverage. The basic data on individual income, health insurance, and demographic characteristics will come from the New Jersey Family Health Survey. The results of this analysis are nearly complete and will be included in the Final Report to the Secretary.

Analysis of Enrollment and Disenrollment in NJ FamilyCare (Sections 1.5 - 1.6)

As part of New Jersey's State Planning Grant activities, CSHP conducted a supplemental survey to the NJ Family Health Survey. This sample includes 684 families covered through NJ FamilyCare or Medicaid, including groups that retained coverage and others that disenrolled. In order to assess patterns of self-selection into and out of NJ FamilyCare, the project team collected data on health status, health care utilization, and attitudes toward health care and health insurance for enrollees, disenrollees, and eligible non-participants for NJ FamilyCare, and on disenrollees from Medicaid.

Descriptive comparisons and multivariate analyses were conducted to discern whether systematic differences exist among NJ FamilyCare-eligible disenrollees, enrollees and disenrollees with other insurance in their demographic characteristics (such as family structure, the age, and the race and ethnicity of family heads), satisfaction with NJ FamilyCare, health status, and health utilization. Reports of children's enrollment in NJ FamilyCare were, in some cases, inconsistent with administrative records. These differences are being resolved with the cooperation of NJ FamilyCare staff. However, preliminary analysis has been completed to compare children who left the program and found other insurance to those who remain enrolled.

Differences in disenrollment by race/ethnicity were not statistically significant in the supplemental survey. Families with only one child enrolled in NJ FamilyCare were no more likely than large families to have found other insurance, but disenrolled children aged 6 or older were more likely to have found other insurance. One-third of households reported at least one adult with low self-rated health. One in seven households reported at least one child with low self-rated health. There were no differences in the prevalence of low self-rated health by enrollment status at the time of the survey.

Most survey respondents were very satisfied with NJ FamilyCare. More than half of respondents rated NJ FamilyCare as "excellent" or "very good." Those who were disenrolled with other insurance were less likely than others to report that getting a new doctor when they joined NJ FamilyCare was not a problem.

In addition, comparisons across groups were made for a series of attitudinal variables to determine whether underlying differences in the value placed on health insurance and attitudes toward risk and the medical care system help to explain enrollment and retention decisions.

Families that were disenrolled with other insurance were more likely to agree that: "I am a lot more likely to take risks than the average person", "Most doctors will treat you even if you can't afford to pay the full amount", "Having my medical needs taken care of at a public or free facility is just fine with me", and "Families should help each other pay for health insurance in financially tight times".

Non-Monetary Barriers to Purchasing Health Insurance (Section 1.10)

Clearly, one major barrier to purchasing health insurance is the lack of affordable health coverage. Among uninsured adults, 49% are unemployed, not in the labor force, or work part-time. Fifty-one percent of uninsured adults in NJ work full-time. Another relevant factor is immigration status. Non-citizen immigrants in New Jersey face a much greater risk of being uninsured than those who are citizens (48% compared to 21%). Additional data from Rutgers Center for State Health Policy's 2001 New Jersey Family Health Survey can be found in Appendix C, *"New Jersey's Medically Uninsured: A Chartbook"*.

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How the Uninsured Meet Medical Needs (Section 1.11)

This is not under the scope of work in our current grant activities.

EMPLOYER-BASED COVERAGE

Throughout the past two years, the SPG project team has been evaluating options to optimize New Jersey's *Premium Support Program*, which is part of the Department of Human Services and calls for the subsidy of the employee portion of the health insurance premium for qualified applicants who are enrolled in NJ FamilyCare. Within the scope of our project, CSHP has conducted twenty-six qualitative interviews with employers to learn more about their insurance offering decisions. In addition, CSHP, working with RAND, has created a linked employer-household database. Results from the employer-household data analysis are nearly complete and findings will be available in the Final Report to the Secretary in September 2005.

Characteristics of Firms that Do Not Offer Coverage Compared to Those That Do (Section 2.1)

CSHP project staff conducted telephone interviews with twenty-six employers in April, May, and June of 2003. Selected findings from this report can be found in Appendix D. Among those employers interviewed, non-offerers tended to be very small employers with between one and ten employees. There was no clear difference in industry between offering and non-offering employers. On average, employers whom we interviewed that did not offer health insurance had a greater proportion of part-time or seasonal employees. More than one-third of employers that offer coverage permitted part-time workers to be eligible. However, employers who only offer to full-time workers were not interested in covering part-time workers, even with a subsidy.

Among interviewed employers that offer health insurance coverage to their employees, nearly one-third had seen increases of 30 to 35 percent per year and another third had increases of 15 to 20 percent per year over the last few years. Most offering employers contributed 75 percent or more of the premium. However, one-third of offering employers contributed 50 to 60 percent of the premium, while one employer contributed none of the premium. Most employers that offered insurance had take-up rates of at least 70%, not accounting for employees who may have coverage through another source. Employers that contributed less toward the coverage generally reported lower employee take-up.

Employer Decision-Making about Offering Insurance Coverage (Sections 2.2-2.4)

The primary reason that employers gave for offering coverage was to attract and retain high quality employees. Other reasons were that they felt a moral responsibility to offer coverage, and that others in their industry offer coverage. Only two employers reported offering coverage to their employees in order to get coverage for themselves.

Employers that did not offer coverage cited expensive premiums as the primary reason that they did not offer. The second most common reason was that employees got coverage elsewhere and were not interested in getting coverage through that employer. Other reasons mentioned were the inflexibility of the minimum participation rate in New Jersey's small group health insurance market (employers must cover 75% of eligible employees), that employees do not stay on the job long enough or work too few hours to provide coverage, and that other employers in the same industry do not offer coverage.

One interesting finding from these interviews is that most employers that did not offer coverage had never offered coverage and most employers that did offer coverage had done so for a long time. Also, the vast majority of employers that offered coverage got their information on available health plans through an insurance broker, while non-offering employers were more likely to get information on available health plans through the carriers.

As mentioned earlier, offering employers have seen high increases in health insurance premiums over the past few years. Employers have responded to this added pressure in three ways. One, employers have begun purchasing lower cost policies. In most cases, these policies have higher deductibles and greater cost sharing on the part of enrollees, but benefits have been maintained. Two, some employers have reduced the percentage of their contribution toward the premium. And three, a few employers said they did not provide wage increases in response to higher health insurance costs. In response to the increased financial burden placed on employees through higher cost sharing, higher premiums, and a lower employer contribution, many employees have chosen to disenroll from the employer's health insurance plan. This was particularly prevalent for those employers with lower contributions toward coverage.

Incentives for Employers to Offer Health Insurance Coverage (Sections 2.6 and 2.7)

Willingness to pay for health insurance may be a significant challenge to encouraging non-offering employers to offer coverage. Of the eleven non-offering employers we spoke to, only five had ever looked into buying health insurance for their employees or were able to identify what they would be willing to pay. The price quotes that these five employers had remembered receiving over the past year or two were fairly low – approximately $300 per month for single coverage and prices quotes ranging from $500 to $900 per month for family coverage. Most of these employers were unsure of what they would be willing to pay, if anything, to get coverage. The three employers that offered rough estimates of what they would be willing to pay generally estimated only $200-$450 per month for family coverage.

Five of the eleven non-offering employers said that they would be at least somewhat interested in tax incentives or employer subsidies to offer coverage if the incentive made the cost low enough so that it was affordable. However, of those five, only one said they would be very likely to offer coverage with these tax incentives or subsidies. This is because most non-offering employers felt that if the government gave them a subsidy it would not be enough to cover the costs, would add to their administrative hassles, and/or would come out of their pockets through higher taxes. Slightly more employers that did not offer said they would be very likely to offer coverage through a purchasing alliance. Six employers expressed interest in joining purchasing alliances to help reduce the costs of health insurance for their employees. Of these six, five said they would be very likely to offer coverage if purchasing alliances existed and reduced premium costs enough to make it affordable. However, several employers were simply not interested in offering coverage and had no thoughts of what might encourage them to offer. They were committed to not offering coverage.

Many employers that offered health insurance as well as those that did not offer coverage felt the state should play a stronger regulatory role in reducing premium costs and holding them to a reasonable level. Small employers with low-wage workers, one of whom expressed concern about his workers' ability to continue paying their portion of the cost, wanted the state to offer more affordable product options with low co-payments and deductibles. Another employer wanted a prescription drug benefit for seniors because otherwise retirees choose to stay in the

employment-based health plan so that they have drug coverage. Two employers thought that capping malpractice awards could also reduce premium costs. One employer that did not offer coverage believed that the availability of government health insurance programs such as NJ FamilyCare may unintentionally put employers that offer health insurance at a competitive disadvantage as workers may be attracted to those companies that do not offer but pay higher wages, knowing they can get health coverage from the state. He also suggested that the government pursue businesses that pay workers off the books in his industry for similar reasons.

HEALTH CARE MARKETPLACE

Prevalence of Self-Insured Firms and Impact on the Marketplace (Section 3.3)

This is not under the scope of work in our current grant activities.

Looking at the Experiences of Other States in the Health Insurance Marketplace (Section 3.9)

A challenging fiscal environment and shrinking state budgets make expansion of public programs very difficult to consider at this time. Therefore, in an effort to promote public/private partnerships, many states, including New Jersey, have created premium assistance programs that provide a subsidy to enable Medicaid and SCHIP eligible individuals and families to purchase employer-sponsored health insurance. As part of the scope of work in one of the SPG projects that has recently been completed (the *Premium Support Program* analysis referenced above), we looked at the experiences of other states that had similar programs in an effort to optimize enrollment and enhance program participation in New Jersey's *Premium Support Program*.

In December 2002 and January 2003, the SPG project team conducted in-depth interviews with officials in Illinois, Iowa, Maryland, Massachusetts, Oregon, Pennsylvania, and Rhode Island to learn more about their Medicaid and SCHIP premium assistance programs. Appendix E, Table 1 offers a brief description of these states' premium assistance programs at the time the interviews were conducted. These states offered useful operational insights including best practices for determining program eligibility, collecting employer information, and determining cost effectiveness and subsidy amount.

One obstacle that the New Jersey *Premium Support Program* faces is that employers and insurance companies do not consider enrollment in the program as a qualifying event for enrollment in the employer's health insurance plan. Therefore, in many cases, this means that a family's enrollment into an employer-sponsored plan may be delayed several months until an open enrollment period. This would not be the case, however, in New Jersey's Small Employer Group Market where there is continuous enrollment.

We discovered through these interviews that many states with successful premium assistance programs require employers and insurance companies to consider eligibility for the program as a qualifying event to enrollment in their employer plan. Oregon also has an interesting approach to optimizing enrollment in their program. We learned that officials in that state contacted nearly all of the state's insurers and informally arranged for the families' enrollment in the employer-sponsored plan upon acceptance to Oregon's *Family Health Insurance Assistance Program.*

Within this project, we also looked at the experiences of other states, including Massachusetts and New York, which provide incentives for employers to offer health insurance coverage. These interviews were also conducted in December 2002 and January 2003 and descriptions of these programs are included in Appendix E, Table 2. Massachusetts' *Insurance Partnership Program* subsidizes employers for their portion of the health insurance premium for low-income individuals who qualify for MassHealth's Premium Assistance Program. Very small employers and employers with a high proportion of low-wage workers benefit greatly from this subsidy because it makes offering coverage to all their employees much more affordable. New York's *Healthy NY Program* requires that all HMOs in the state also offer a plan for small employers that have at least 30 percent of their employees earning less than $31,000 per year, and *Healthy NY* pays 90 percent of the claims between $30,000 and $100,000. This reduces the financial risk to the insurance companies, thereby allowing them to charge lower premiums to the employer.

Information gathered from these interviews indicates that states have different ways of qualifying people for their premium assistance programs. The CSHP and RAND project teams conducted simulations using the combined employer-household database to determine the impact on enrollment in New Jersey's *Premium Support Program* when loosening program requirements. These simulations look at the impact of reducing the employer contribution requirement, and several methods of determining cost-effectiveness used by other states. Results show that loosening guidelines that qualify an employer plan for premium subsidization have a negligible impact on enrollment in New Jersey's Premium Support Program. We look forward to including more detail on this analysis and its findings in the Final Report to the Secretary.

OPTIONS FOR EXPANDING COVERAGE **(Sections 4.1 - 4.15)**

New Jersey has among the most expansive eligibility for adults and children under its Medicaid and NJ FamilyCare (SCHIP) programs. During the 1990s, the state also benefited from a robust employer-based health insurance market. Currently, however, state revenue shortfalls and underlying forces in private health insurance markets have begun to seriously threaten the progress New Jersey has enjoyed in providing coverage to its residents. In this context, discussions of coverage policy in the state have focused on sustaining public coverage initiatives, while shoring up private health insurance markets and preparing for a rise in the number of uninsured.

In 2003-2004 New Jersey experienced an unprecedented budget shortfall, a gap of roughly $5 billion. Despite this, the Governor and Legislature sustained a high level of coverage for children (up to 350% FPL) and parents (up to 200% FPL) under NJ FamilyCare and maintained a broad scope of services under Medicaid. During the budget deliberations that took place in the spring of 2003, it appeared that nearly 60,000 adults might lose NJ FamilyCare coverage, cuts that were ultimately restored in the budget process. However, prior to the conclusion of the budget debate, and at the request of the SPG Steering Committee, CSHP prepared an analysis of the full-cost buy-in options for FamilyCare coverage. A memorandum examining experiences with an adult full-cost buy-in option in several states, including Washington and Minnesota, as well as child full-cost buy-in programs in Florida, New York, Connecticut, and North Carolina was prepared and presented at a May 2003 Steering Committee meeting.

Market Regulation Considerations (Sections 4.1 - 4.3, 4.9, and 4.12)

New Jersey was among a number of states that implemented health insurance market reforms in the early 1990s to improve access to affordable health coverage. Accelerating health insurance costs and reemerging growth in the number of uninsured nationally have led many states to take stock of their health coverage policies. With over a decade of experience with insurance market reforms, research has begun to emerge analyzing the effects and sustainability of state health insurance reforms like those in New Jersey. Today, as many states reexamine their strategies, it is important that emerging studies be brought to light and carefully evaluated. The State Planning Grant afforded New Jersey that opportunity.

In April 2003, the New Jersey Departments of Human Services and Banking and Insurance and Health and Senior Services, in collaboration with Rutgers Center for State Health Policy, sponsored an Expert Panel discussion on state health insurance regulation titled, *"Toward Inclusive and Sustainable Health Insurance Markets: A Dialogue between Policymakers & Researchers."* The purpose of the Expert Panel was to stimulate a broad dialogue about the emerging body of research evidence among representatives from the policy, research, insurance carrier and consumer advocate communities. This conference was intended to provide a forum for discussion of the future of state regulations in the non-group and small-group health coverage markets and the policy changes that may be required to sustain healthy markets.

We are pleased to report that the Expert Panel was extremely well received by attendees. The audience, which numbered over one hundred, included senior officials from the Office of the Governor, the Departments of Banking and Insurance, Human Services, Health and Senior Services, the Office of Management and Budget, as well as senior representatives from health insurance carriers, community groups and The Robert Wood Johnson Foundation

At the suggestion of HRSA, following the Expert Panel we also convened a half-day roundtable discussion that included panelists and key senior agency officials, who also serve on the SPG Steering Committee. The purpose of this "informal" roundtable was to critically assess the current condition of the non-group and small-group markets and, based in part on the previous day's discussion as well as the experiences of these national experts, identify both short and long term policy options to improve market performance.

Those who participated in the roundtable brought with them a broad array of perspectives. As a consequence, the group debated policy options that ranged from incremental reforms that included such things as a modified community rating structure in the non-group market and a limit on plan options (e.g., only offer HMO coverage) to more substantial reform options such as combining the non-group and small-group markets.

It is premature to comment on any immediate impact from the Expert Panel, and while no specific policy changes have been embraced, the Commissioner of the New Jersey Department of Banking and Insurance is pleased with the outcome of the Conference. In September 2004, a monograph (not funded under the SPG) compiling papers written by presenters at the Expert Panel conference was published. The Table of Contents from this monograph is included in Appendix F.

CONSENSUS BUILDING STRATEGIES

Governance Structure and Key Constituencies (Section 5.1 and 5.2)

As previously discussed, the New Jersey Department of Human Services (DHS) serves as the lead agency for the New Jersey State Planning Grant, and in turn is accountable to an inter-agency Steering Committee. The Office of the Governor, and four agencies of state government – DHS, the Department of Health and Senior Services (DHSS), the Department of Banking and Insurance (DOBI) and the Office of Management and Budget (OMB) of the State Department of Treasury – are represented on the Steering Committee. DHS has traditionally led the development, implementation and management of state coverage initiatives, including Medicaid and SCHIP. DHSS is responsible for regulating health care institutions (including HMOs) and has traditionally played important roles in coverage policy development in the state. DOBI is the insurance regulator in the state and houses two key boards – the Individual Health Coverage Board and the Small Employer Health Benefits Board. OMB is responsible for managing the state budget and for fiscal oversight of agencies.

Throughout the past two years, the Steering Committee has met every four to six weeks to discuss new project developments and approve all SPG-related products prior to their release. In addition to the scheduled meetings, Steering Committee members keep in close contact with the CSHP research team to ensure that work done is appropriate and useful to the State. This structure mirrors the workgroup that successfully developed the NJ KidCare and NJ FamilyCare initiatives.

In addition to the project activities initiated under the State Planning Grant, former Governor James E. McGreevey's *Conference on Healthcare Coverage* took place on June 10, 2003, and provided an important opportunity to include a wider array of stakeholders in the policy development dialogue. Vicki Mangiaracina, Special Deputy Commissioner for Affordable and Available Health Care at the New Jersey Department of Banking and Insurance (DOBI), and member of the SPG Steering Committee, directed activities for this conference on behalf of DOBI. She called upon the research expertise of Joel Cantor and Alan Monheit from the Center, and they worked closely with her in the planning and implementation of this conference. Drs. Cantor and Monheit served as advisors in the development of the conference agenda and the selection of panel participants. In addition, Dr. Cantor and Dr. Monheit, respectively, served as facilitator and resource person for panel discussions.

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In an effort to further the dialogue on issues of health care coverage in New Jersey the former Governor requested that the DOBI Commissioner arrange three workgroups including policymakers, insurers, providers, researchers, and consumer advocates to explore ways that NJ might improve coverage. These three workgroups looked at changes that could be made to the existing individual and small group health insurance markets, new options for these health insurance markets, and approaches to reducing the uninsured. The workgroup meetings took place in winter 2003-2004. As part of SPG supplemental funding, CSHP offered technical support to these workgroups by providing requested information from the literature, current research, and the experiences of other states. CSHP also assisted in editing and fact-checking the Statements of Deliberations that were submitted by each workgroup to the Commissioner upon completion. These reports are currently under review.

Soliciting Input from the Public and Key Constituents (Section 5.2)

In addition to the contributions made by the members of the Steering Committee, the project team is also working with an Advisory Committee consisting of external groups that were selected for their diversity and involvement in health policy development in the state. These groups are:

- **Covering Kids and Families Coalition** – This group, which is convened by the Health Research and Educational Trust of New Jersey, is a group of more than fifty agencies and organizations in New Jersey including health care providers, social service organizations, educational groups, consumer advocacy organizations, local government, and business, interested in improving coverage for low-income uninsured children in the state. In addition, this Coalition has recently taken on the previous role of the NJ FamilyCare Advisory Committee, which was disbanded because membership overlapped significantly with this group. The Coalition has agreed to convene to advise the SPG project.
- **Individual Health Coverage Program and the Small Employer Health Benefits Program Boards** – These boards are established by New Jersey statute and are responsible for implementing health insurance reforms and regulating the individual and small group coverage markets. The Board members represent insurers, HMOs, consumers, labor unions, business, physicians, and DOBI. The Boards are state agencies with rulemaking authority and are funded entirely by assessments of health insurers and HMOs. Relevant work of the SPG will be presented and discussed with the full Boards, as appropriate.
- **New Jersey Family Health Survey Advisory Board** – This group of 38 individuals representing government agencies, academia, health care providers, consumer groups and others was initially convened in 2000 by Rutgers Center for State Health Policy to assist in the design of the New Jersey Family Health Survey. The members are generally technically oriented, either on policy matters or research methodology issues.

As we move forward, we anticipate engaging these stakeholders more frequently as we broaden our outreach efforts and develop a strategy for briefings and dissemination of our research findings.

In addition, as mentioned earlier, the former Governor McGreevey arranged for the Department of Banking and Insurance to organize Healthcare Workgroups to explore potential approaches to increasing insurance coverage and improving access to health care in New Jersey. Under the SPG, CSHP provided technical assistance to these workgroups, bringing applicable research to bear on the issues discussed. These workgroups were comprised of key health care constituents including representatives from hospital organizations, physician groups, insurance companies, insurance brokers, consumer groups, business and employer organizations. All workgroup members had the opportunity to contribute to the Statements of Deliberations.

Building Public Awareness (Section 5.3)

The project team is working with the Steering and Advisory Committees to identify additional audiences with whom we should share the remaining SPG project related findings. Our dissemination strategy will focus on working with state colleagues to maximize public awareness of the key policy issues in the coverage debate.

Once reviewed and approved by the Steering Committee and agency officials, SPG reports have been distributed to appropriate stakeholders and policymakers, as well as posted on the Center's website at www.cshp.rutgers.edu. During the past year, we have also reached out to the non-partisan New Jersey Office of Legislative Services, sharing copies of our relevant SPG reports. On a number of occasions, our project team has been called upon to provide data or address specific legislative inquiries as a result of the work that we completed on the SPG. In one recent example, the project team provided estimates of the uninsured to a legislative working group, at the request of colleagues from the Division of Medical Assistance and Health Services.

Impact of the State Planning Grant on the Policy Environment and Likelihood that Coverage Expansion Proposals will be Implemented (Section 5.4)

As we have received approval to carry over SPG projects through August 2005, it is premature to comment on the policy impact of our projects. Options to optimize coverage have been analyzed and discussed with member of the Steering Committee throughout the past two years. A final analysis of the policy impact of the SPG activities, along with any relevant implementation strategies, will be provided in the Final Report to the Secretary.

LESSONS LEARNED AND RECOMMENDATIONS TO STATES

Data Collection and Usefulness (Sections 6.1-6.5)

State-specific data are critical to formulating useful policy to enhance health insurance coverage and allow isolation of variations in health insurance coverage and health related decisions apart from differences in culture, geography, industry, and the like. At this time, all proposed data collection efforts under the SPG are complete.

The project team did make one noteworthy change in data collection methodology. At the outset of this project, the Center for State Health Policy planned on conducting three 2-hour employer focus groups to learn more about health insurance offering decisions among New Jersey employers *(Project 1, Optimizing the Premium Support Program*). However, the project team met with considerable resistance in recruiting employers to attend these focus groups. In addition to being constrained by time (the focus groups would have required a three-hour time commitment), employers were generally hesitant to discuss personal information about their company and their opinions about offering health insurance to their employees.

As a result of these difficulties, and after consultation with the Steering Committee, CSHP decided to conduct short telephone interviews with employers, rather than convening focus groups. The project team conducted twenty-six fifteen-minute interviews both with employers that offer health insurance and those who do not. Response to the short telephone interview has been much more positive, though most employers remain uncomfortable speaking

about health insurance and decline participation. Findings from these employer interviews are discussed in Section 2 of this report.

Operational, Insurance Market and Employer Community Lessons Learned (Sections 6.6-6.7)

It is premature to comment on lessons learned from SPG project activities. We look forward to incorporating this information in the Final Report to the Secretary.

Recommendations to Other States (Section 6.8)

Throughout the State Planning Grant, the project team has reached out to other states to learn more about what they are doing and how it has worked to identify best practices for New Jersey. However, it is premature for the State of New Jersey to make any recommendation to other states on the health coverage policy planning process. We look forward to incorporating this information in the Final Report to the Secretary.

Changes to the Political and Economic Environment in New Jersey (Section 6.9)

As is the case in many other states, New Jersey is once again facing an extraordinary budget deficit, estimated at between $4 and $5 billion. In addition to the State's fiscal challenges, there has also been significant political turnover in recent months. Former Governor James McGreevey resigned from office, and Richard Codey became acting Governor in November 2004. Acting Governor Codey is also president of the New Jersey State Senate, a post that he will retain while serving as acting Governor under New Jersey's constitution. Acting Governor Codey, a Democrat and former insurance broker, will have the advantage of working with both a Democratically controlled Senate and Assembly. There have been some notable departures in the executive cabinet, and while it is premature to assess the impact on the political and policy environment, more cabinet departures are expected before the conclusion of acting Governor Codey's interim term in January 2006.

It is significant to note, however, that despite the grim budget forecast, legislators and policymakers have expressed a strong commitment to maintaining and optimizing public coverage programs. An example of that commitment can be seen in the state's Express Enrollment pilot program. In June 2004, the Legislature passed a bill requiring the Commissioner of Education, working with the Commissioner of Human Services to establish a "NJ Express Enrolment for Children's Health Coverage" pilot program. This pilot project, currently underway, will facilitate enrollment of uninsured children in NJ FamilyCare and Medicaid health coverage by distributing an abbreviated Express Enrollment health coverage application in conjunction with the school lunch form. The Center for State Health Policy has been contracted to facilitate the pilot program and evaluate the results. A preliminary report is due in January 2005, with a final report submitted in April 2005. That last report prepared by the Center will include a recommendation whether to expand the Express Enrollment pilot statewide.

As of December 31, 2004, 1111 Express Enrollment applications have been received by the Division of Medical Assistance & Health Services. In addition, the Division is also piloting the one-page health coverage application in selected hospitals in New Jersey. We look forward to sharing the findings of these pilot programs in our Final Report to the Secretary.

It is also significant to note that in January 2005, State Senator Joseph Vitale, the Chairman of the Senate Health and Human Services Committee and one of the strongest proponents of NJ FamilyCare, introduced legislation that calls for an additional $53 million in spending for NJ FamilyCare. The increased funding would allow the state to enroll an additional 55,000 children and 33,000 parents in the program next year. Hearings have just begun, and the outcome of this pending legislation will be described in our Final Report to the Secretary.

Changes to Project Goals during the Grant (Section 6.10)

We have completed activities outlined in our original State Planning Grant proposal and received approval to carry over funding to complete activities in the supplemental proposal by August 2005.

Next Steps (Section 6.11)

We hope to complement the research currently underway with additional project activities endorsed by the SPG Steering Committee and outlined in our request for additional supplemental funding.

RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

It is premature at this time to offer any recommendations to the federal government. However, as we continue our course over the coming year, we will work with the SPG Steering Committee to identify possible roles for the federal government and opportunities for successful intervention and federal/state partnership. We look forward to providing any relevant policy recommendations in our Final Report to the Secretary.

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ENDNOTES

[1] Bundorf, M. Kate and Mark V. Pauly. 2002. "Is Health Insurance Affordable for the Uninsured?" Unpublished manuscript. October.

[2] Levy, Helen and Thomas DeLeire. 2002. "What Do People Buy When they Don't Buy Health Insurance?" Unpublished manuscript. May.

APPENDIX A

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2003-2004 NJ State Planning Grant
Steering Committee Members

MEMBER	TITLE	DEPARTMENT
Marie Boragine	Project Administrator	Division of Medical Assistance & Health Services, NJ Department of Human Services
Joel Cantor	Director and Professor (Research team Principal Investigator)	Rutgers Center for State Health Policy
Marilyn M. Dahl	Deputy Commissioner	NJ Department of Health & Senior Services
Dennis Doderer, Project Director and Committee Chair	Deputy Assistant Director (Project Director)	Division of Medical Assistance & Health Services, NJ Department of Human Services
Virginia Kelly	Manager	Division of Medical Assistance & Health Services, NJ Department of Human Services
Ann Clemency Kohler	Director	Division of Medical Assistance & Health Services, NJ Department of Human Services
Vicki A. Mangiaracina	Special Deputy Commissioner for Affordable and Available Health Care	NJ Department of Banking and Insurance
Freida Phillips	Special Assistant to the Deputy Commissioner	NJ Department of Human Services
Wardell Sanders	Executive Director, New Jersey Individual Health Coverage Program and New Jersey Small Employer Health Benefits Program Boards	NJ Department of Banking and Insurance
Joseph Tricarico	Assistant Commissioner, Managed Care and Health Care Finance	NJ Department of Health and Senior Services
Michelle Walsky	Chief of Operations	Division of Medical Assistance & Health Services, NJ Department of Human Services

APPENDIX B
New Jersey Family Health Survey Content

INTRODUCTION: Screener and Family Relationships within Household

SECTION A: Health Insurance Coverage
- Current coverage; # months covered in past year; type of coverage (e.g., HMO); prescription drug coverage.
- Among uninsured, eligibility for employer coverage; ever enrolled/apply/hear of Medicaid or NJ FamilyCare.

SECTION B: Health Status
- Respondent-assessed general health and oral health status, current and compared to a year ago
- Ever had asthma or diabetes diagnoses
- Prevalence of 15 serious and morbid symptoms among adults and careseeking for up to 4 symptoms
- Activity limitation (age-specific), if mental health limitation, name of problem
- Activities of Daily Living (age appropriate) and Instrumental Activities of Daily Living (adults).

SECTION C: Utilization
- Use of inpatient, ER, well-child, preventive care, other doctor visits and telephone contacts, dental, RNs, NPs, nurse midwife, chiropractors, health aide/homemaker services past year.
- Doctor visits during uninsured periods.
- Mental health visits in past 12 months: type of MH professional, name of problem, other MH problems for which did not seek care.
- Prescription drug use, past 3 months, number of different medications.
- Family out-of-pocket costs in past 12 months for prescribed medicines and dental care
- Financial impact of out-of-pocket medical costs in past 12 months on family
- Respondent satisfaction with care, medical provider inquires about medications, medical errors

SECTION D: Access to Care
- Usual place of care and type of place
- Difficulty getting needed care
- Symptom response index

SECTION F: Attitudes about Care-Seeking, Coverage and Caregiving
- Attitudes about health insurance and risk, health worry; family financial obligations to pay for health insurance and care, acceptability of free/discounted care; private physician discount availability, medical errors/safety, efficacy of medical care, etc.

SECTION G: Caregiver Assistance and Health Planning
- Extent of caregiving to care recipients in and outside the family, relationship to care recipient, characteristics of care recipient
- Employment impact of caregiving
- Health planning (e.g., long-term care insurance, advanced directives, etc.)

SECTION H: Employment and Earnings
- Employment status past week, characteristics of current job(s)
- Family income and assets
- Own, rent, or occupy without payment (of cash rent) home or apartment

SECTION I: Demographics
- Education, Hispanic origin, Race, country of birth, US citizen status
- Primary language spoken in home, religious preference
- Migration history

APPENDIX C

The Medically Uninsured in New Jersey: A Chartbook (February 2004)

Electronic copy available at www.cshp.rutgers.edu

APPENDIX D

Excerpts from *Maximizing Enrollment in the Premium Support Program: Results from Employer Interviews* (September 2004)

INTRODUCTION

New Jersey's Premium Support Program (PSP) subsidizes employer-sponsored health insurance coverage for persons enrolled in NJ FamilyCare who are employed and eligible for employer-sponsored health insurance that meet certain requirements and where it is cost-effective to do so. Buying into employer plans through PSP can result in considerable savings for the NJ FamilyCare program. For current PSP enrollees, the state saves approximately $2,925 per enrollee per year. However, enrollment in PSP has been lower than expected. As of January 2005, only 852 individuals enrolled in PSP.

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Based on PSP administrative data, the most common barrier to participation in the PSP program is lack of access to employer-sponsored health insurance. While most NJ FamilyCare enrollees are employed, many of their employers do not offer health insurance. Other employers may offer health insurance but the NJ FamilyCare enrollee is ineligible for coverage, possibly because of part-time or seasonal work status or because the enrollee has been employed there for only a short time. Only a small percentage of NJ FamilyCare enrollees are ineligible for PSP because the plan that their employer offers does not meet minimum plan requirements.

Lack of employer-sponsored coverage in businesses that employ low-income workers is an issue of concern both for maximizing PSP enrollment and also for reducing the number of uninsured persons in the state. To assist NJ officials in understanding the current challenges that NJ employers face in offering health insurance coverage, the Center for State Health Policy conducted interviews with employers of various firm size that both offer and do not offer health insurance. The primary purpose of the interviews was:

1) To identify reasons why employers do and do not offer health insurance
2) For non-offerers, to identify barriers to providing health insurance coverage, their willingness to pay for insurance, their attitudes about health plan options available to them and potential incentives that might encourage these employers to offer
3) For offerers, to identify the major challenges that employers have faced in maintaining coverage for all employees and how they have dealt with those challenges

METHODS

The Center for State Health Policy contacted 200 New Jersey businesses that NJ FamilyCare enrollees identified as their place of employment on forms submitted to the Premium Support Program. The list included both large and small businesses that offered and did not offer health insurance based on the self-report of enrollees.

As shown in Table 1, many employers could not be reached, or were deemed ineligible because the central headquarters that administered health benefits was located out of state or they were a government-related entity eligible for public coverage. Of the 116 eligible employers that we

were able to reach by phone, twenty-six employers agreed to be interviewed. Table 2 provides a breakdown of employers interviewed by firm size and type of industry and by whether they offered health insurance. Fifteen employers interviewed offered health insurance and eleven did not offer insurance. Ten of the firms interviewed had ten or fewer employees, five had between eleven and fifty employees, eight had between 51 and 149 employees, and three had 150 or more employees. The employers represented many industries in the state, but were primarily concentrated in the retail goods and services sector.

Table 1: Employers Contacted from PSP List Sample by Status

	#	%
Total Employers Contacted*	200	100%
Total Disconnected/Wrong #	20	10%
Total Ineligible	39	20%
Total No Answer/ Answering Machine	25	13%
Total Refused to Participate*	46	23%
Total Knowledgeable Person Could Not be Reached/Did Not Take Call/Did Not Return Calls	44	22%
Total Interviews Completed*	26	13%

*Includes 3 employers who showed interest in speaking to us when we called for the focus groups. Of those three, two completed an interview and one refused.

APPENDIX D (CONT'D)

Excerpts from *Maximizing Enrollment in the Premium Support Program: Results from Employer Interviews* (September 2004)

Table 2: Characteristics of Employers Interviewed

	#	%
Firm Size*		
Less than 10	10	38%
11-50	5	19%
51-149	8	31%
150+	3	12%
Industry		
Retail Goods and Services	6	23%
Manufacturing	3	12%
Construction	3	12%
Health Services	3	12%
Business Services	3	12%
Transportation/Storage	4	15%
Restaurant	4	15%
Health Insurance		
Offers	15	58%
Does Not Offer	11	42%
TOTAL EMPLOYERS	26	100%

**Based on the number of full-time workers.*

FINDINGS

Reasons Why NJ Employers Do Not Offer Health Insurance (Table 3)

- ***Too expensive.*** Most employers that did not offer health insurance indicated that their reason for not offering was the high cost of coverage. A few explained that the low wages of many of their employees' restricted their ability to pay a significant portion of the premium, leaving the employer to contribute a significant portion of the costs in order to ensure sufficient take-up. Most employers did not feel that they support these costs and thus could not afford to offer coverage.

- ***Employees get coverage elsewhere.*** The second most common reason that employers did not offer health insurance is that most employees purchased coverage through other sources, such as through their spouse's plan, so there was no reason to offer coverage. This reason was most commonly mentioned by very small employers with only a few employees.

- ***Lack of employee interest.*** Related to the reason above, four of the eleven employers that do not offer said that lack of employee interest in coverage makes it difficult to offer health insurance. These employers indicated that employees were not interested in coverage either because they could not afford to contribute anything toward coverage, because they did not plan to stay on the job for long, or because they had coverage through other sources. However, the other seven employers that did not offer did not feel that lack of interest was a particular barrier.

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- ***Other reasons.*** Other individual reasons mentioned by one or two employers included that:
  1) most of their employees were covered under NJ FamilyCare and that the NJ FamilyCare benefit was far more generous than anything they could offer, for a very reasonable cost;
  2) the inflexibility of having a minimum participation rate of all employees, limited the ability to offer coverage to only certain staff. This employer had wanted to provide coverage to management and office workers but thought he was not allowed to without offering to all of the employees.
  3) employees do not stay on the job long enough or work too few hours to provide coverage and
  4) no one in the industry offers and employees don't expect coverage. (Note that some of the employers we interviewed that offered were in a similar industry.)

Table 3: Reasons for Not Offering Health Insurance

Reasons*	Total Number of Employers (n=11)
Health insurance is too expensive.	8
Employees get coverage elsewhere.	4
Not legally required to offer health insurance.	1
Not my problem.	1
Administrative hassles.	1
Other	4

*Includes all reasons mentioned. Respondents often cited more than one reason for not offering.

Reasons Why NJ Employers Offer Coverage (Table 4)

- ***Getting and retaining employees.*** The primary reason for offering health insurance coverage is to attract and retain high quality employees. These employers felt that offering a health insurance benefit was important to their prospective employees and that not offering coverage would significantly impede their ability to hire and retain good employees.

APPENDIX D (CONT'D)
Excerpts from *Maximizing Enrollment in the Premium Support Program: Results from Employer Interviews* (September 2004)

- ***Felt a moral responsibility to offer coverage.*** One-third of employers offering coverage felt a moral responsibility to provide this benefit. These employers understood that most often health insurance coverage is provided through an employee's place of work and wanted to feel they had done right by their employees by providing them with this protection.

- ***Others in my industry offer coverage.*** Many employers felt that providing a comprehensive benefit package helped them compete in a tight labor market. They felt that without this benefit other employers in their industry would have an advantage in hiring high quality industry employees.

- ***Employer wants coverage for self.*** Only two employers reported that they offered coverage to their employees in order to get coverage for themselves. These employers also provided a greater employer contribution for upper management than for subordinates.

- ***Other reasons.*** Two employers indicated that their employees were unionized and they had to provide health insurance. Others offered to maintain good relationships with employees.

Table 4: Reasons for Offering Health Insurance

Reasons*	Total Number of Employers (n=15)
Getting and retaining employees.	11
Felt a moral responsibility to offer coverage.	5
Others in my industry offer coverage.	4
Employer wants coverage for self.	2
Other	4

*Includes all reasons mentioned. Respondents often cited more than one reason for not offering.

APPENDIX D (CONT'D)
Excerpts from *Maximizing Enrollment in the Premium Support Program: Results from Employer Interviews* (September 2004)

Differences between NJ Employers that Offer and Do Not Offer Health Insurance

- ***Most employers that do not offer have never offered, but those that offer have done so for a long time.*** NJ employers that offer health insurance have done so for a long period of time. Thirteen of the fifteen employers who offer health insurance indicated that they have always offered insurance as an employee benefit and the remaining two employers have offered coverage for five to seven years. In contrast, with only one exception, NJ employers that do not offer had never offered health insurance to their employees. The one employer who had offered insurance in the past, stopped offering two years ago because his long-time, committed employees retired or moved away and since then most of the workers he has hired have been more transitory, often leaving after a few months. This employer would be willing to offer insurance once again if he could hire employees that remained on the job for longer periods. The fact that most non-offering employers never offered coverage may indicate that this group would always be difficult to convert to offering employers.

- ***Non-offerers tend to be very small businesses.*** Consistent with data on offer rates nationally and in New Jersey, the NJ small employers were much less likely to offer health insurance than larger employers. Nearly all of the employers that did not offer health insurance were small businesses with less than 10 full-time employees (Table 5).

Table 5: Employers that Offer and Do Not Offer Health Insurance by Size

	Very Small (1 to 10 employees)	Small (11 to 50 employees)	Medium (51 to 149 employees)	Large (150 + employees)	TOTAL
Offer	3	2	7	3	15
Does Not Offer	7	3	1	0	11
TOTAL	10	5	8	3	26

- ***No clear difference in offering by industry.*** Although the sample for this study is too small to generalize to the broader population, there were no particular industries among the employers that we spoke with that were more or less likely to offer health insurance than other industries.

APPENDIX D (CONT'D)
Excerpts from *Maximizing Enrollment in the Premium Support Program: Results from Employer Interviews* (September 2004)

- ***Differences in source of information on health coverage options.*** The vast majority of employers that offered health insurance got their information on available health plans through an insurance broker. Only a few got their information by calling health insurance carriers themselves, through mailings, or through the internet. In contrast, most employers that do not offer health insurance but had investigated their options got most of their information through the carriers themselves, either by calling the carriers directly, through mailings, carriers' Internet sites, or phone calls from carriers. Only two non-offering employers reported getting information from brokers. None of the employers we spoke with – offerers or non-offerers -- mentioned the DOBI Small Group Plan Handbook or website specifically as a source of information. Most employers felt that the information they got from whatever source they used was helpful to them in making insurance coverage decisions. A few of the employers that did not offer felt the information available was not helpful because it did not help them to overcome other challenges to offering coverage such as employee turn-over and the cost of coverage.

- ***Employers that offer health insurance more satisfied with plan options available.*** Most employers that offer health insurance are happy with the plan options available to them. However, a few of those that offer would have liked to cover more employees, wanted more services for less cost, and wanted employees to be able to buy insurance for only the services they would use (not understanding the concept of insurance). In contrast, more than half of employers that did not offer health insurance were not satisfied with the plan options available to them. Several indicated that the plans available were simply too expensive. One indicated that this was partly because they offered such comprehensive coverage; his employees could only afford minimal coverage. In contrast, one employer believed that the health insurance available did not cover all medical needs and was worried that she would get sick with an illness they would not cover. Another was concerned about the available plans not covering pre-existing conditions. Both of these employers indicated that if the plans covered all services and pre-existing conditions at a reasonable cost they would buy coverage.

<u>Coverage Issues for Part-time Workers</u>

- ***More than one-third of employers that offer allow part-time workers to be eligible -*** In most cases only full-time workers, are eligible for the health insurance benefit as shown in Table 6. However, while employers are not obligated to provide health insurance to part-time workers, several employers, particularly those in small businesses or those whose workers are unionized, offered coverage to both part-time and full-time employees. One large hospital system said they cover some part-time employees in order to attract employees to positions that are generally harder to fill, such as nursing.

APPENDIX D (CONT'D)

Excerpts from *Maximizing Enrollment in the Premium Support Program: Results from Employer Interviews* (September 2004)

Table 6: Employee Eligibility for Health Insurance

	Part-Time Employees Eligible	Only Full-time Employees Eligible
Very Small (1 to 10 employees)	1	2
Small (11 to 50 employees)	2	0
Medium (51 to 149 employees)	1	6
Large (150+ employees)	1	2
TOTAL	5	10

- ***Most employers define 'full-time' much more conservatively than State.*** While the state of New Jersey defines eligibility for health insurance benefits in the small group market as those employees who work 25 hours or more, only 4 of the employers that offered and 3 that did not offer health insurance used this definition (Table 7). In fact, most employers interviewed consider full-time workers those who work 30, 35, or 40 hours per week.

Table 7: Number of Hours an Employee Must Work to be Considered Full-Time

	40 Hours	35 Hours	30 Hours	25 Hours	20 Hours
Offerer (n=15)	5	2	4	2	2
Non-Offerer (n=11)	3	3	3	0	1
TOTAL (n=26)	8	5	7	2	3

Note: One Non-Offering employer did not respond to this question.

- ***Employers who only offer to full-time workers not interested in covering part-time workers, even with subsidy.*** Most employers that do not offer health insurance to part-time workers were generally uninterested in adding part-time workers to their plan even if an employee subsidy were available. A few mentioned concerns about the administrative burden and the costs of having to contribute toward this coverage. Only two employers said that they would include part-time workers if a subsidy were available to those workers to cover premium costs.

APPENDIX D (CONT'D)
Excerpts from *Maximizing Enrollment in the Premium Support Program: Results from Employer Interviews* (September 2004)

Employer Contributions, Take-Up and Knowledge of PSP Among NJ Employers that Offer Health Insurance

- ***Employer contributions high and usually uniform for all eligible employees.*** Most employers that offered health insurance contributed more than 75% of the cost of the premium for the employee (Table 8). This finding is consistent with the experience of the PSP program that has found if an employer offers coverage, the plan usually meets the minimum contribution standards. Generally the employer contribution was the same for all employees, but a few paid higher contributions for office employees or for management. Two only provided an employer contribution toward the employees' coverage leaving the employee to pay the full cost of family coverage.

Table 8: Employer Contributions toward Employee Health Insurance Premiums

	TOTAL (n=15)
75% or more	9
50%- 60% of Premium	5
None of the Premium	1

- ***Employees often purchase insurance if employers offer coverage.*** Reflecting the high employer contribution rates, take-up rates by NJ employees in businesses that offered were generally high. Most had take-up rates of greater than 70%, not accounting for employees that may be covered by another source. Employers that offered lower employer contributions generally reported lower employee take-up, reflecting the higher cost to the employee.

- ***Limited knowledge of the NJ Premium Support Program.*** Despite the fact that the employers contacted came from a list provided by the Premium Support Program, few of the employers knew of NJ's Premium Support Program specifically. Only one employer had some experience trying to enroll one employee in the program, but the employee was never enrolled.

Challenges in Maintaining Coverage in Businesses that Offer Health Insurance

- ***Increasing Premium Costs.*** The greatest challenge that employers have faced in maintaining insurance has been the increasing costs of health insurance. Nearly one-third of offering employers had seen increases in premiums of 30 to 35 percent per year and another third have had increases of about 15 to 20 percent.

APPENDIX D (CONT'D)
Excerpts from *Maximizing Enrollment in the Premium Support Program: Results from Employer Interviews* (September 2004)

- ***Employers respond by purchasing lower cost packages, lowering contributions, and foregoing wage increases.*** In response to increasing premiums, employers were most likely to decrease the benefit package, primarily through purchasing lower cost plans with higher co-payments and deductibles (Table 9). Several employers reported that employees preferred higher cost sharing to higher premiums or reduced services. In fact, few employers reduced the services offered under their plan. Other employers decreased the employer contribution, particularly those that saw premium increases of 20-30%. One third of employers that offered also indicated that they had sustained the increases by foregoing wage increases.

- ***Employees disenroll.*** According to employers that offer, employees have responded to rising health insurance costs by disenrolling from employment-based plans where they are required to pay a higher proportion of the premium (Table 9). Employees subject to moderate employer contributions are more likely than others to disenroll in response to rising costs.

Table 9: Actions Taken by Employers and Employees in Response to Rising Premiums

Responses	Total # of Employers (n=15)
Decreased Benefit Package	11
Employees Disenrolled	6
Decreased Employer Contribution	6
Forego Wage Increases	5

Potential Incentives for Offering or Maintaining Coverage

- ***Willingness to pay for coverage.*** Of the eleven non-offering employers we spoke to, only five had ever looked into buying health insurance for their employees or were able to identify what they would be willing to pay. The price quotes that these five employers had remembered receiving over the past year or two were fairly low – approximately $300 per month for single coverage and prices quotes ranging from $500 to $900 per month for family coverage. Most of these employers were unsure of what they would be willing to pay, if anything, to get coverage. The three employers that offered rough estimates of what they would be willing to pay generally estimated only $200-$450 for family coverage.

APPENDIX D (CONT'D)
Excerpts from *Maximizing Enrollment in the Premium Support Program: Results from Employer Interviews* (September 2004)

- ***Interest in Tax Incentives, Employer Subsidies, or Purchasing Alliances.*** Five of the eleven employers said that they would be at least somewhat interested in tax incentives or employer subsidies to offer coverage if the incentive made the cost low enough so that it was affordable. However, of those five, only one said they would be very likely to offer coverage with these tax incentives or subsidies. Slightly more employers that did not offer said they would be very likely to offer coverage through a purchasing alliance. Six employers expressed interest in joining purchasing alliances to help reduce the costs of health insurance for their employees. Of these six, five said they would be very likely to offer coverage if purchasing alliances existed and reduced premium costs enough to make it affordable. However, several employers were simply not interested in offering coverage and had no thoughts of what might encourage them to offer. They were committed to not offering.

- ***Other Potential Ways the State Can Encourage Coverage.*** Many employers that offered health insurance as well as those that did not offer coverage felt the state should play a stronger regulatory role in reducing premium costs and holding them to a reasonable level. Small employers with low-wage workers, one of whom expressed concern about his workers' ability to continue paying their portion of the cost, wanted the state to offer more affordable product options with low co-payments and deductibles. Another employer wanted a prescription drug benefit for seniors because otherwise retirees choose to stay in the employment-based health plan so that they have drug coverage. Two employers thought that capping malpractice awards could also reduce premium costs. One employer that did not offer coverage believed that the availability of government health insurance programs such as NJ FamilyCare may unintentionally put employers that offer health insurance at a competitive disadvantage as workers may be attracted to those companies that do not offer but pay higher wages, knowing they can get health coverage from the state. He also suggested that the government pursue businesses that pay workers off the books in his industry for similar reasons. Another employer suggested that the state provide more information on the insurance options available, which he did not feel he was fully aware of.

SUMMARY OF KEY FINDINGS AND IMPLICATIONS FOR PSP AND SMALL GROUP MARKET INITIATIVES

Our interviews with a small number of employers in the state that employ NJ FamilyCare enrollees, while not necessarily generalizeable to the entire NJ employer population, do offer some insights that may be helpful to the Premium Support Program as well as regulators looking at changes in the small group market.

Consistent with findings of many other employer focus groups and surveys conducted nationally and in other states, the primary reason that NJ employers do not offer health insurance and the primary challenge of maintaining coverage for NJ employers that offer coverage is that health insurance is increasingly unaffordable. As premiums rise by double digits with no respite

in sight, many employers -- both offerers and non-offerers -- are looking for the government to take a larger regulatory role in controlling insurance costs and in offering lower cost product options.

That being said, from the employers we spoke with, those who do not offer health insurance show a long-time commitment to not offering coverage and may not be amenable to offering even with significant state support. Non-offerers tend to be extremely small businesses with workers who work part-time and/or earn too little to afford coverage, or are covered through another source and are not pressuring their employer to offer this benefit. Somewhat surprisingly, the employers that did not offer did not seem particularly interested in subsidies or tax incentives. Less than half of these employers said that they would be at least somewhat likely to offer if subsidies or tax incentives were available, putting the viability of this type of an approach in doubt. Some felt this was a 'government-handout' that would not reduce costs over time, so premiums would continue to increase. It may be difficult for the state to significantly increase coverage among employers through subsidies.

Since the primary reason that employers do not offer health insurance is the high-price of health insurance, many non-offering employers were more interested in options that could significantly reduce the cost of insurance, including pooled purchasing. While more than half of those we interviewed showed considerable interest in purchasing alliances, none were aware that legislation had been passed in New Jersey to support such alliances. While purchasing alliances may or may not be a realistic solution for reducing employers' costs, the state could play a more active role in informing employers of these options or supporting a state-sponsored alliance for employers to join.

Fortunately, the NJ employers that do offer coverage appear fairly committed to maintaining this coverage. Those who choose to offer health insurance are committed to this benefit and have always offered health insurance. The employers we spoke to show no sign of eliminating coverage or even drastically reducing the benefit package. However, many were reducing the employer contribution, which could lead to greater employee disenrollment over time. Most had moderately increased cost sharing through higher co-payments and deductibles in order to keep premium costs manageable.

Many of the smallest employers did not offer insurance. A little over half of interviewed employers with 50 or fewer employees provided fairly comprehensive benefits with generous employer contributions. Also, small employers were surprisingly more likely than other employers to offer coverage to both part-time and full-time employees. This may be because the small group market requires that coverage be offered to those working 25 hours or more. However, many of these employers suggested that their reasons were more due to "moral obligation" or "to maintain a good relationship with the employees" -- laudable ideals but ones that are not necessarily conducive to getting other employers to follow suit.

APPENDIX D (CONT'D)

Excerpts from *Maximizing Enrollment in the Premium Support Program: Results from Employer Interviews* (September 2004)

For the Premium Support Program, the greatest challenge appears to be that, even if the state were able to encourage greater coverage through purchasing alliances, many NJ FamilyCare enrollees may still not be eligible because they do not work full time. Employers were split on the issue of creating incentives to provide coverage to part-time workers. Those who valued it were already offering this coverage; those that did not did not want to cover them even with subsidies to support them due to the administrative hassles, job turnover, and potential increased employer contributions to cover them. Furthermore, most employers had not heard of the Premium Support Program but may have eligible employees either because the employee is enrolled in NJ FamilyCare or an employee's dependent is enrolled. The State may be interested in better informing New Jersey employers about this subsidy program so that they can communicate this opportunity to their employees. Employees may also have children that are eligible for NJ KidCare, which could provide a subsidy for family coverage through the employer, possibly making the employment-based coverage more affordable.

APPENDIX E
Interviews with Other State Employee & Employer Premium Assistance Programs

Table 1: Selected State Employee Premium Assistance Programs

Program	Eligibility (% FPL)	Key Features	Enrollment (End of 2002)
Illinois KidCare Rebate (1998)	Kids 134% to 185%	Optional rebate of up to $75 per month per child available for any private coverage premium. Do not have to be enrolled in SCHIP program and may already be insured. Calculate rebate by subtracting the single premium from the family premium and dividing the balance by the number of other family members covered.	2,500 Families, 5,643 Kids
Iowa HIPP Program (1991)	Medicaid eligibles	Subsidize the full employee premium share or premiums of individual policies when cost effective to do so as determined through an actuarial comparison of Medicaid fee-for-service claims compared to the employer plan.	5,370 Medicaid eligibles, 3,135 Family members
Maryland Premium Assistance Program (2001)	Kids 200% to 300%	Families are subsidized for the cost of adding the children to an employer plan, after paying for the cost of single coverage. Mandatory for families where parent already insured through employer-sponsored coverage. Option of enrolling in premium assistance or in state managed care plan for families where parent is not currently purchasing employer plan.	159 Kids
Massachusetts MassHealth's Family Assistance Program (1999)	Medicaid eligibles Kids Up to 200%	Medicaid eligibles are subsidized for the full premium while kids contribute $10 each up to $30 per family.	19,000 People
Oregon Family Health Insurance Assistance Program (1998)	Adults and Kids 0% to 185%	Employee subsidy program separate from Medicaid that provides subsidies coverage for eligible adults and children. Enrollment cap of 12,000. No measure of cost-effectiveness. Participants responsible for co-pays and deductibles. Program was expanded under HIFA waiver in 2002.	3,221 People
Pennsylvania HIPP Program (1994)	Medicaid eligibles	Highly automated; result is increased enrolled and cost effectiveness	20,000 People
Rhode Island Rite Share Program (2001)	Parents Up to 185% Kids and Pregnant Women Up to 250%	Require premium contribution from participants over 150% FPL. Set two-tiered and four-tiered cost effectiveness ceilings based on managed care experience.	3,289 People 1,080 Families

APPENDIX E (CONT'D)
Interviews with Other State Employee & Employer Premium Assistance Programs

Table 2: State-Sponsored Employer Subsidy Programs

Program	Eligibility	Description	Enrollment (End of 2002)
Massachusetts MassHealth's Insurance Partnership Program (1999)	Employers of those eligible for Premium Assistance who have <50 employees	Subsidizes the employer premium contribution for employees who are enrolled in Premium Assistance up to $600 for single coverage and $1000 for family coverage.	4,000 Employers 5,039 People
New York Healthy New York (2000)	Employers with < 50 employees, 30 percent of which earn less than $31,000/year. Employer contributes 50 percent of premium and must not have offered coverage in the past year.	HMOs in the state must offer a Healthy NY plan, which has a benefit package similar to the small group benefit package but excluding home care, chiropractic, and outpatient substance and alcohol abuse treatment. The state reimburses the HMO 90 percent of claims between $30,000 and $100,000.	1,086 Employers 9,000 People

APPENDIX F
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State Health Insurance Market Reform: Toward Inclusive and Sustainable Health Insurance Markets. Alan C. Monheit, Joel C. Cantor (eds.). London: Routledge, 2004.

For ordering information, please visit: http://www.routledge.com/

Since the late 1908s many US states have sought to incrementally reform their health insurance markets. The intent of such reform has been quite straightforward: to ensure access to affordable health insurance by addressing insurer practices perceived to be exclusionary. In the light of this, a compelling public policy issue is whether these efforts to address disparities in the population's access to health insurance have been successful.

This volume provides a critical assessment of the current state of knowledge on insurance market reforms that is accessible of the current state of knowledge on insurance market reforms that is accessible to both policymakers and researchers. The contributions provide a critical evaluation of empirical research findings, applied methodologies, and policy implications associated with state reform of small group and individual insurance markets.

With contributions from internationally respected health economists, as well as industry, regulatory, and consumer representatives, this book will prove to be a useful read for all those with an interest in the economics of healthcare.

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