

HEALTHCARE AGENDA

2006-2007

The cost of health insurance is one of the biggest challenges facing New Jersey businesses. Its skyrocketing cost hurts employers' ability to compete in the world economy and create new jobs. Achieving affordable, quality health coverage concerns everyone since costs are out of control for both employers and employees.

New Jersey's health insurance system has identifiable flaws that can be fixed. Our goal should be to build on the successes of the employer-based system to expand coverage while improving the affordability, quality and value of coverage for all.

Lawmakers can do much to accomplish these goals by refusing to enact costly new coverage mandates, injecting more flexibility into the State's regulated insurance markets, and giving employers who do provide coverage a State tax benefit.

Build on What Works, Mend What's Broken.

NJBIA supports targeted, market-based reforms that enhance the employer-based system to provide affordable access to quality care. In our view, the employer-based system that provides health insurance for more than 5.5 million New Jerseyans must be strengthened and built upon to provide further access to coverage.

Our agenda offers reasonable solutions that address the greatest problem areas in New Jersey's existing system of regulated health insurance coverage.

- ❖ **Expand Access and Choice: Reform of the Small Employer Market.** Any plan to reform the State's health insurance system should target employers who purchase their health insurance through the State's regulated health insurance programs. These include the Individual Health Coverage Program (IHC), which covers individuals (including sole proprietors of small businesses); the Small Employer Health Benefits Program (SEH), which covers groups with 2-50 employees; and the regulated large-employer market (51 or more employees).

Twenty-nine percent of New Jersey's population (about 2.5 million people) currently receives insurance coverage through these regulated insurance programs. (The rest of the covered population receives its insurance predominately through employer self-funded plans, Medicare and Medicaid.)

The State's highly regulated programs for individual (IHC) and small group insurance (SEH) were put in place in 1992. These programs must be overhauled to give purchasers more choice and flexibility in plan design. Revamping of the marketplace is necessary to ensure employers have access to affordable coverage. Components of reform should include:

- **Allow small employers more flexibility in designing their own plans.** Reform must allow small employers and sole proprietors more flexibility in the plan design. This would permit them to purchase those insurance benefits that best suited their particular employees, while allowing them to exclude certain medical services that they do not need or want.
 - **Create a “basic” health plan that is more affordable.** To ensure that small businesses and the self employed have access to affordable health insurance, a new basic health plan should be allowed in New Jersey that provides basic health coverage. The plan should not be subject to state mandated benefit laws.
 - **Change the 75 percent participation rule for small companies.** NJBIA supports changing the 75 percent participation rule, which requires that at least 75 percent of a small business’ employees participate in the company health plan. The rule has been a barrier for many small employers attempting to purchase health insurance in the Small Employer Health Benefits market. To assist employers with between 2 and 10 employees, the participation rule should be lowered to 50 percent.
 - **Reduce the number of standard plans.** While plan standardization serves a valuable function for purchasers in these markets, the need for five standard plans seems unnecessary (especially since only a few of these “standards” are sold regularly). Reduce the number of standard health plans, to three from five, that all HMO/insurance providers must offer. Too many standard plans drive up administrative and insurance costs.
 - **Rating:** A modified community rating system would allow rates to reflect reasonable risk. Health plans should be able to take age, health status, gender and geography into account in rating. Combined, the rate bands should be capped at 3.5-to-1, so that those paying the most do not pay more than three and a half times than those paying the least.
- ❖ **Reform the Individual Market.** We recognize that a growing number of New Jerseyans do not have a connection to the large employers who are best able to sponsor comprehensive health coverage. Furthermore, new and start-up businesses who are growing a business or using non-traditional workers and work arrangements should not be made to conform to an employee benefits model that does not suit the realities of their business.

Demographic forecasts suggest that the number of sole proprietors will continue to grow, so NJBIA believes providing affordable non-group or individual market coverage is critical. Key components of reform should include:

- **Modify the rating of the individual market.** The rating system in the individual market has led to skyrocketing rates and dropping enrollment. Originally, it may have seemed reasonable to implement pure community rating -- where all buyers pay the same rate -- but this system has led to very high rates for all purchasers. Since 1995, the individual market has seen a decline of nearly 45 percent in membership. Pure community rating prohibits carriers from appropriately rating risk, and has the insidious effect of pricing many younger people out of the market altogether. Movement toward modified community rating (premiums offered within a defined range) would allow products to be priced more appropriately, making insurance more affordable over time.
- **Require plans to participate in both the individual and small employer markets.** In order to end the needless litigation that has plagued the Individual Health Coverage Program, the current assessment system to reimburse carriers for excessive losses should be eliminated. Instead, a carrier that participates in the Small Employer Market should be required to also participate in the Individual Health Coverage Program.

❖ **Explore Creating a Reinsurance Program and/or Insurance Exchange.**

Reinsurance is an indirect way to reduce health insurance premiums. Reinsurance means that the State would cover a portion of the health plan's claims; this "stop-loss" mechanism may cover all or part of catastrophic claims above a certain dollar amount. One example is the Healthy New York program which, based on this concept, reduced premiums by 17 percent.

The exchange is based on the idea that there should be a "one-stop" shop for health insurance featuring several carriers offering health insurance plans. These carriers would be subject to uniform rating and enrollment underwriting rules. The exchange can act as a payment aggregator mimicking the human resources office of larger employers.

An exchange could effectively merge the group market and the individual market. It would offer a place where currently uninsured workers could go to purchase health insurance from competing health insurance carriers. An exchange would: offer portability of coverage as workers change jobs; allow tax deductibility of premium contributions for workers; and, create a large risk pool.

An exchange could be a reform measure that could provide health insurance to part-time, seasonal, low-wage workers and reduce the administrative burden on small employers.

❖ **Improve the Quality of Healthcare in New Jersey.** System-wide changes have the potential to reduce healthcare costs by promoting quality and efficiency. The Legislature should act to promote Health IT, greater use of report cards, value

based reimbursement, and reduced medical errors. Among the steps that can be taken:

- **Expand use of health information technology (Health IT).** New Jersey needs to implement a computerized health records and intelligent physician order entry system. Health IT could transform healthcare from a largely paper-based system to an electronically integrated network of patient care. The payoff of a paperless system includes reducing healthcare costs by providing more efficient and higher quality care.
 - ✓ **Establish a regional health information organization.** NJBIA supports the State's efforts to facilitate the development of data management and sharing standards, with the ultimate goal of establishing a regional health information organization. This will maximize the time and money invested by providers and payers.
- **Promote greater transparency in healthcare.** We must make employer and consumer-friendly comparative information more widely available. Costs and quality care varies enormously from hospital to hospital, physician to physician, and area to area. NJBIA supports the development of provider-based performance data that can be used to guide consumers to better health plans and providers. That information should be made available on a comprehensive web site in meaningful, usable formats.
 - ✓ **Prescription Drug Transparency:** The NJHCQI report on pricing discrepancies has led to a new law that requires the cost of the top 150 prescription drugs be available.
 - ✓ **Fee Schedules:** Hospitals and providers should be required to post their fee schedule for commonly billed procedures to assist consumers in making informed decisions.
 - ✓ **Quality Report Cards:** We commend the DOHSS for its work in developing the cardiac surgery report card, among others. We believe that quality report cards are important tools and support additional quality report cards for other high volume and/or high-risk services, so long as the measurement tools are recognized industry standards. To reduce administrative redundancy, we advocate adoption of quality measures that are consistent with those used by the Centers for Medicare and Medicaid Services. Numerous states have created public reports on the quality of care provided by health plans, hospitals and nursing homes. Minnesota has led the way on this.
- **Advance value based purchasing (a.k.a. pay-for-performance).** The "pay-for-performance" movement—rewarding physicians and hospitals for delivering high-quality care—should be advanced. This trend should be considered for the SHBP and FamilyCare programs, so those providers who are both high-quality and low-cost over the course of a patient's treatment are rewarded for their excellence. Doing so would spur the development of best practices and provide guidance to private insurers looking for effective ways to promote high-

performance care. The State should act to encourage evidence based medicine protocols, as well as the financial incentives to use them, as a critical step to create a high benefit-lower cost approach to delivering high quality healthcare.

- **Prevent and manage chronic diseases.** Several states have focused cost containment efforts on their high cost populations, such as those with chronic conditions. At least 25 states have implemented these programs for their Medicaid programs. These programs focus on the chronically ill and use an integrated approach to improve health outcomes and reduce healthcare costs. This approach should be explored in an attempt to rein in the spiraling premiums in the Individual Health Coverage Program.
 - ✓ **Expanded Wellness Program:** Wellness programs are primarily based at the employer level. These programs should be encouraged and employers who undertake them should receive a State tax benefit.
- **Reduce medical errors.** Medical errors are one of the nation's leading causes of death and injury. The Institute of Medicine estimates that as many as 44,000 to 98,000 people die in U.S. hospitals each year as the result of medical errors. Much progress has been made, but patient safety experts agree progress has been far from sufficient.
 - ✓ **Physician Grievance and Complaint System:** Currently, consumers who suspect their healthcare providers of misconduct have a difficult time learning how to file a complaint. Certainly no one wants to encourage needless litigation, but consumers should have ready access to a New Jersey physician grievance system to ensure that bad doctors are quickly identified by the Board of Medical Examiners.
- **Protect consumer from balance billing.** "Balance Billing" refers to the practice of charging the patient directly for the difference between what is paid to the provider by the health plan for a particular service and what the provider declares as their "retail price." Balance billing is a direct out-of-pocket expense for the patient. When a provider contracts with a health plan and agrees to a specific level of reimbursement, they also receive the benefit of direct and timely payment for services. In turn, the provider agrees not to "balance bill" the patient, who is then protected from additional out-of-pocket expenses.
 - ✓ Legislation is needed to prohibit the practice of "balance billing" and to empower DOBI to discipline providers who charge fees in excess of the co-payment.
 - ✓ To alert patients to potential charges, in-network healthcare facilities should be required to disclose to patients information about services that may be performed at the facility by non-contracted providers.
- **Reduce healthcare fraud.** Every effort needs to be made to ensure that fraud in the health insurance arena is reduced or eliminated.

- **Review whether hospital consolidation is needed.** It has been suggested that New Jersey has too many hospital beds per capita and a significant number of these beds are located in overlapping markets. This contributes to costly duplication of services. Only 58 percent of New Jersey hospitals/systems are profitable, and the overall margin is only 1.0 percent. Poor profitability, in turn, results in undercapitalization and a struggle to address the aging infrastructure while keeping pace with advancing technology. A thorough and forthright assessment of hospital need and distribution should be undertaken to facilitate a process to consolidate or close facilities, where appropriate.

- ❖ **Hold the Line on State-Imposed Health Coverage Mandates.** Through the years, the State Legislature has passed dozens of laws mandating costly insurance coverage of previously uncovered medical treatments and services. Often these mandated benefits are not based on good medical science, but rather are adopted based on the emotional appeals of affected parties. Many new mandates are pending. NJBIA asks the Legislature to continue to hold the line on any new health mandates that would increase the already high cost of health insurance.
 - **Support the Mandated Health Benefits Advisory Commission (MHBAC).** The MHBAC should review all pending mandates and provide an objective assessment of proposed legislation.

 - **Improve future affordability.** The Legislature should consider sunset provisions on all benefit mandates that become law to provide for future cost-benefit analysis based on the actual experience.
 - **Allow the MHBAC to review existing coverage mandates.** There are dozens of health insurance coverage mandates that have been passed by the Legislature in recent years, yet no comprehensive review of the impact has been conducted. The MHBAC's mission should be expanded to include a review of the medical efficacy of these mandates, as well as the impact on health insurance premiums. Examples of mandates that should be reexamined:
 - ✓ Review the infertility mandate. The law requires coverage of a maximum of four egg retrievals with no dollar limit. The coverage includes artificial insemination, IVF, GIFT and ZIFT; with infertility medication co-payments being the same as the office co-payment. Some have estimated this mandate to increase premiums by three percent.
 - ✓ Encourage mail service delivery of prescription drugs. The law requires one copayment per 30 day prescription, but there can be no advantage to using mail order over going to the pharmacy. (So a 60 day supply would require two times the copayment or three times the copayment.) Prior to enactment of this law, consumers were given an incentive to use mail service with a lower co-payment because the cost of mail service prescriptions is lower than prescriptions filled at retail pharmacies.

- ❖ **Solve Charity Care Funding and Reduce the Number of Uninsured.** One thing is clear: the number of the uninsured is rising. But, the reasons for the increase are

complex and include the economy, the cost of healthcare and the labor market. This leads to a greater reliance on charity care and employers pay the price through higher hospital charges, UI diversions, the HMO tax, etc. NJBIA supports reforms that would expand the pool of New Jerseyans who enjoy insurance coverage by allowing access to affordable coverage.

- **Reform charity care funding.** In 2004, New Jersey hospitals provided approximately \$1 billion in mandatory charity care services. The State reimbursed the hospitals \$583 million for this care. Due to the distribution formula some hospitals received as little as 12 cents on the Medicaid dollar, while others received 96 cents on the dollar reimbursement. In 2004, the minimum reimbursement rose to 43 cents on the dollar.
- **Review the FamilyCare premium assistance program.** FamilyCare provides health coverage for lower-income children and their parents, generally up to 350 percent of poverty. When an individual applies for the FamilyCare program, the Premium Assistance Program's (PAP) mission is to enroll the applicant directly into the employer's health plan whenever possible. The PAP would subsidize the employee's portion of the premium. The State can tap into federal dollars to match the State's costs.

However, burdensome federal rules have limited the use of the PAP. Recent changes to federal law now give the State more flexibility. To facilitate use of the PAP, the Legislature should act to revamp the PAP. In Pennsylvania, the premium assistance program saved the state \$76.3 million.

- ❖ **Provide Direct State Tax Incentives.** One way to assist employers in their efforts to provide healthcare coverage is to provide direct tax relief to small businesses that provide employee health coverage. Individuals and small businesses should be allowed to deduct the full cost of that coverage from their State income taxes or they should be given a State tax credit. Such a tax benefit would help employers defray soaring health insurance costs.

At this time, we do not identify specific funding sources for those proposals requiring new public spending or revenue. We look forward to engaging in thoughtful consideration of resources for this important, basic purpose. Expanded private market participation will decrease reliance on direct and indirect public subsidies for healthcare, and decreased regulation and informed purchasing decisions will lower healthcare expenditures.

- **Create State tax credit for individuals and businesses.** NJBIA supports current legislation which would provide refundable tax credits to individuals and employers equal to their full insurance costs.
- **Eliminate State tax on HSAs contributions.** New Jersey has amended its insurance laws to allow high deductible health plans that meet the federal

guidelines, but New Jersey should go further by making contributions to these accounts tax-deductible under State income tax law. Only seven states tax income on HSAs contributions, while 34 states have made contributions tax free.

- **Allow all participants in employer health plans to pay cost-sharing premiums on a pre-tax basis.** Currently, New Jersey law does not permit Section 125 Cafeteria Plan reductions in compensation to be made on a pre-tax basis. These contributions are used for qualified medical and dependent care expenses. This is inconsistent with federal law and makes open enrollment education and payroll administration more complicated. Typically, Cafeteria Plans are used to pay deductibles, co-insurance and such non-covered items as dental and vision expenses. Additionally, they can be the pre-tax vehicle through which the employee's share of medical insurance premiums are paid.

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