NJHA
NEW JERSEY HOSPITAL ASSOCIATION

American Health Insurance Exchange for New Jersey: Issues and Recommendations

Overview

The *Patient Protection and Affordable Care Act (ACA)* mandates that New Jersey establish by Jan. 1, 2014, an American Health Benefit Exchange (referred to throughout this paper as "the Exchange" or one or more "Exchange(s)"). Simply put, the Exchange is a marketplace through which individuals and employers may purchase (in some cases with subsidies or tax credits) federally prescribed health insurance coverage. Individuals qualified to obtain coverage through the Exchange include citizens and legal immigrants who are not incarcerated and do not have access to affordable employer coverage. Small businesses (defined as having up to 100 employees) can obtain coverage for their employees through the Exchange.

Prior to 2016, states have the option to limit Exchanges to businesses with up to 50 employees; beginning in 2017, states may allow businesses with more than 100 employees to purchase coverage for their employees through an Exchange. The Exchange will serve as a portal for individuals and employers who are directly seeking health insurance, or for agents or brokers who may act on their behalf. Although the federal government is responsible for setting minimum standards, providing start-up funds to states and offering financial subsidies to qualified individuals, states are granted a great deal of flexibility in the creation and operation of their Exchanges.

If New Jersey fails to act to set up an Exchange by Jan. 1, 2014, ACA authorizes the Federal government to set up and run the New Jersey Exchange, either directly or through an agreement with a nonprofit entity. As can be seen from the discussion below, New Jersey faces a number of key decision points in determining how to implement the Exchange requirements, many of which will have a significant impact for the provider community.

Among other responsibilities, Exchanges will be tasked with providing a virtual marketplace for consumers and small businesses where they can shop for the most appropriate health insurance policy. Federal subsidies will be available to assist low-income individuals—defined as those making up to 400 percent of the federal poverty level—with purchasing insurance offered through the Exchanges.

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The Exchange must establish a web portal and toll-free hotline to assist consumers in purchasing health insurance, and must also regulate the plans offered within the Exchange. Consumers will have the choice of purchasing from at least four different types of plans: Bronze, Silver, Gold, and Platinum, differentiated by the amount of cost-sharing for which a patient is responsible. Patients opting for Bronze plans will be covered for 60 percent of healthcare costs, Silver for 70 percent, Gold for 80 percent and Platinum for 90 percent. To participate in the Exchange, a carrier must be certified as a "quality health plan," which requires that the carrier provides an "essential benefits package," is licensed by the state to provide insurance, agrees to offer at least one silver and one gold plan and agrees to charge the same price for its plans within and outside of the Exchange. States also need to decide whether to set up a statewide Exchange or regional Exchanges, and will also have flexibility to determine whether the Exchange(s) will be structured as a "clearinghouse" model, in which all plans that meet certification requirements are able to obtain qualified health plan status, or an "active purchaser" model that certifies a limited number of health plans for participation in the Exchange(s). Effective beginning July 1, 2013, states also have an option to form interstate compacts to facilitate the purchase of health insurance.

In addition to certifying health plans as "qualified health plans" based on ACA requirements, Exchanges will make public disclosure of the following plan-provided information in plain language: claims payment policies and practices; periodic financial disclosures; data on enrollment, denied claims and rating procedures; information on cost-sharing and payments for out-of-network coverage; and enrollee and participant rights.

As noted above, the Secretary of the Department of Health and Human Services will provide guidelines and minimum standards for participation in the Exchange, but ultimately ACA leaves key decisions to the states. The objective behind the Exchange is to offer more choice to consumers, but also promote healthy competition for insurance products. Healthcare providers will play an essential role in treating the increased number of insured patients and must be adequately compensated for their services, as inadequate reimbursement rates will jeopardize access to care for many patients. New Jersey's mandated American Health Benefit Exchange will only work effectively if providers and carriers have an equal voice in assisting the state in developing this vital program.

Key Implementation Dates

2010 – 2012**:** The Department of Health and Human Services will work with the National Association of Insurance Commissioners (NAIC) to develop minimum standards for participation in state health insurance Exchanges. At the same time, states will begin to move forward on Exchange design, and federal start-up grants will become available. Initial Exchange Planning and Establishment grants of up to $1 million to each state are anticipated to be awarded by Sep. 30, 2010[1].

2013**:** New Jersey is obligated to demonstrate by Jan. 1, 2013 an implementation plan for establishing the Exchange(s) by Jan. 1, 2014; the HHS Secretary will then begin to certify these Exchanges.

2014**:** Exchanges are required to become fully operational.

2015**:** Exchanges are required to become self-funded.

2017**:** Exchanges can add large employers.

[1] State Planning and Establishment Grants for the Affordance Care Act's Exchanges, Catalog of Federal Domestic Assistance (CDFA) Number 93.525.

KEY ISSUES FOR PROVIDERS

Introduction

The Health Insurance Exchange and other key provisions of ACA rightly focus on affording access to "quality" plans for individuals and small businesses and providing subsidies to individuals and tax credits to small businesses to achieve that goal. However, equal emphasis needs to be placed during the implementation phase on ensuring that plans offered through the Exchanges provide adequate reimbursement rates to providers. Without an adequate and financially stable system for the provision of healthcare services, the promise of ACA will go largely unfulfilled. The implementation of managed care in New Jersey has clearly demonstrated that inadequate provider payment rates inevitably leads to plan networks lacking in sufficient numbers of both primary care physicians and specialists.

Payers also may seek to argue that a mere increase in the number of insured patients will of necessity improve provider finances, and therefore attempt to justify reduced rates or reduced subsidies, particularly for indigent and charity care patients. For the same reason, commercial payers may bargain more aggressively against any perceived "cross-subsidization" in private pay plans for indigent, charity care and provider bad debt. But these simplistic calculations must be resisted—providers, after all, agreed up-front to hundreds of billions of dollars in cuts to Medicare, DSH, and other reimbursement that made ACA viable in the first place. Assumptions about how many of the currently un- or under-insured will become insured, either through the Exchanges or through enhancements to the Medicaid program contained elsewhere in ACA, must be made conservatively and carefully. Modeling will need to be done to evaluate the types of individuals and businesses that will utilize the Exchanges—and why.

Moreover, charity care will remain vital and integral to the broader safety net of both service provision and coverage regardless of the impact of the Exchanges on providing insurance coverage for the uninsured. Exchange-based coverage will take years to fully implement, and even when fully implemented, will not reach undocumented immigrants and legal residents of less than five years, who are ineligible for Exchange-sponsored coverage, and others who are eligible but will remain unenrolled, either because the insurance options are not affordable or because they opt out of the mandate and face resulting penalties[2]. NJ hospitals

[2] See Kaiser Permanente Institute for Health Policy, "The Implications of Health Reform for U.S. Charity Care Programs: Policy Considerations" (No 7, Summer 2010), which argues that state charity care programs, rather than continuing doing what they are doing now, or ceasing to operate entirely, should "re-tool to adapt to the needs of the remaining uninsured population." The Kaiser report is available at http://www.kpihp.org/kpihp/CMS/Files/InFocus-Summer2010-TheImplicationsofHealthReform-FINAL.pdf.

provide $1.365 million in documented audited charity care, but are reimbursed only $665 million for treating these patients. Care must be taken that funding for indigent care is not removed if real documented charity care is still being provided by hospitals.

Provider Rates

Stated simply, plans offered through the Exchanges must provide adequate reimbursement rates to providers. As a necessary corollary, rates paid by plans within the Exchanges must not undercut rates paid by plans outside of the Exchanges.

Network Adequacy

As noted above, the failure to ensure adequate primary care and specialist provider participation in networks has plagued managed care in New Jersey since its inception. Implementation of the Exchange requirement in New Jersey should be seen as an opportunity to address these shortcomings, both within and outside of the Exchange(s) to ensure that insurance companies provide up-to-date provider directories and maintain adequate provider networks. Specifically, there needs to be a mechanism to ensure that qualified health plans have adequate networks and sufficient capacity to accept new patients both initially and throughout the plan year. Health plans need to prove that consumers will be able to access necessary services at a reasonable distance and in a reasonable timeframe. Plans should be required to submit and make publicly available encounter data so that the Exchange can evaluate whether enrollees are actually receiving services and are not being required to travel excessive distances to do so. Finally, "any willing provider" legislation should be enacted as part of the Exchange implementation package, so that providers cannot be denied access to a carrier's network if they meet all of the terms and conditions of a payer's policy.

Benefits Packages

The success of the Health Insurance Exchange will not only be based on the number of people enrolled in an insurance policy, but also the amount of creditable coverage each person has. If thousands of people are enrolled yet do not have essential services covered, then the Exchange will not have succeeded at providing greater access to care for New Jerseyans . Since under charity care and EMTALA, New Jersey hospitals must treat all patients in all situations, benefit packages need to be structured to cover all essential benefits offered at hospital facilities. While ACA outlines a basic definition of essential health benefits and requires the Secretary of HHS to further define them, the Secretary's exercise of that discretion is supposed to ensure that the coverage is equal to the typical coverage provided by an employer, among other principles laid out in the Act. In addition, while ACA allows states to require that qualified health plans offer benefits in addition to the essential health benefits defined by HHS, the state is responsible for defraying the cost of any additional required benefits by making a payment to either the individual purchasing

coverage or the plan in which such individual is enrolled. This provision of ACA has particular relevance in New Jersey, which mandates certain benefits in addition to those required by ACA.

Facilitating Enrollment

The success of ACA in general and the Exchanges in particular will depend on enrolling large numbers of eligible individuals in the broad array of health insurance options that will soon be available to the currently uninsured. Past expansions in Medicaid eligibility have fallen short of their promise in large part because of impediments to enrolling newly eligible individuals quickly and efficiently. Implementation of the Exchanges and of the enhanced Medicaid eligibility provided for by ACA must allow for enhanced provider-based enrollment, since it is often the case that the point-of-service provides the first and best opportunity to enroll an eligible individual or family.

Exchange Configuration

New Jersey must quickly determine whether its Exchange will be run by the state, or by a nonprofit entity, and must likewise assess whether a single state Exchange, multiple regional Exchanges, or interstate compacts with one or more other states will best meet the healthcare needs of all New Jerseyans.

Subsidy Levels for Individuals

The national standard subsidies prescribed by ACA may be insufficient in high-cost states such as New Jersey to sufficiently incent eligible consumers to purchase coverage[3]. Recognizing this potential, ACA requires HHS to conduct a study to examine the feasibility of adjusting Federal Poverty Levels ("FPLs") for the purposes of determining subsidies and cost-sharing for different geographic areas of the country. HHS is required to submit a report to Congress, including a recommended methodology for making any such adjustments, by Jan. 1, 2013.

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[3] In addition, subsidies will not be available to people who have access to health coverage through an employer. However, if an employer health plan does not have an actuarial value of at least 60 percent -- meaning that the plan covers at least 60 percent of the cost of covered benefits in the aggregate for a standard population—or if an employee's share of the employer premium exceeds 9.5 percent of income, the employee may enroll in a plan in the exchange and be eligible for premium and cost-sharing subsidies. In addition, employers offering minimum essential coverage will still be required to provide "free choice vouchers" to employees with incomes less than 400 percent of FPL and whose contribution for the employer coverage exceeds 8 percent, but does not exceed 9.8 percent of their income. Individuals can use these vouchers enroll in an exchange, rather than participating in their employer's plan.

Employer Eligibility for Exchange(s) Participation

Prior to 2016, New Jersey will need to decide whether its Exchange(s) will allow employers with up to 100 employees eligible to purchase insurance through the Exchange(s); after 2017, it will have to decide whether to make all employers, regardless of the number of their employees, eligible to participate in the Exchange(s). In addition, New Jersey will need to decide on what role, if any, the current Individual and Small Employer Health Plan programs will play once the Exchange(s) become operational.

Other Implementation Issues

New Jersey has the option under ACA of creating a Basic Health Program, through which it may enter into contracts with health plans to provide essential health benefits to individuals under age 65 with incomes above the new Medicaid threshold of 133 percent FPL and up to 200 percent FPL who would otherwise access coverage through the Exchange(s). If a state chooses to offer such a Basic Health Program, ACA requires the Secretary of HHS to transfer to that state 95 percent of the tax credits and cost-sharing reductions that would have been provided to individuals enrolled in standard health plans through the Exchange(s). New Jersey needs to carefully evaluate whether to establish a Basic Health Program, including whether it will provide an adequate coverage option for eligible individuals, and what benefit options will be available beyond federally-mandated essential benefits. In addition, if a Basic Health Program is established, how will New Jersey ensure a seamless transition among Medicaid, the Basic Health Program, and private health insurance both within and outside of the Exchange(s)?

EXPERIENCE TO DATE: MASSACHUSETTS AND UTAH

Introduction

Both Massachusetts and Utah established health insurance exchanges prior to the enactment of ACA. Experiences with their Exchanges can provide valuable lessons for New Jersey. NJHA staff has held one conference call with Massachusetts Hospital Association staff regarding their experiences under the Massachusetts model and further discussions are planned with both Massachusetts and Utah

Massachusetts

The Massachusetts Connector consists of Commonwealth Care for low-income individuals and Commonwealth Choice for middle-class uninsured and small businesses; current enrollment in these plans is 185,000 and 36,000 members, respectively. The Connector is an independent public authority, similar in the structure to the NJ Turnpike Authority. State cost in FY 2010 was slightly less than $350 million. Administrative finances are self-sustaining at $30 million, or approximately 3% of premiums.

Massachusetts currently has an uninsured rate of 2.6 – 2.7 percent. The compliance rate with the individual mandate is greater than 98 percent. The Connector received $25 million in initial capitalization funds and has since repaid $13 million of that amount. Massachusetts merged its individual and small group markets, leading to increased costs to small businesses, but a reduction in costs to individuals. The Connector promotes carrier bidding and issues an annual RFP to insurers to participate in the Exchange.

Utah

Utah's Exchange is housed in the Governor's Office of Economic Development. In contrast to the Massachusetts connector, the Utah Exchange operates as a facilitator in the market and does not play an active role in promoting health insurance policies. Prior to implementation, Utah had an uninsured rate of 11.2 percent and had a high rate of "young immortals," that is, those who do not believe they need to buy health insurance. The Exchange does not have a small employer or an individual mandate. Because it is a small-business state, this model has worked well to reduce their uninsured. Last year, the Exchange had a budget of $670,000.

PRELIMINARY RECOMMENDATIONS

Structure and Operation of Exchange

The Exchange should operate as a Semi-Independent Public Agency. Exchanges can be structured as a government agency, an independent nonprofit, a public authority or a public-private partnership. If an Exchange is to effectively embark on market-driven commercial transactions and provide attractive products to its customers, it must be independent and have access to the business expertise it needs. However, if it is to achieve policy objectives through tax-financed subsidies and some degree of regulation, it also must be publicly accountable. This combination of requirements suggests the model of a semi-independent public authority, managed outside of both the civil service structure and the budget-making process for state agencies. The authority would be governed by a publicly-accountable board that has relevant expertise and represents a broad spectrum of stakeholders.

New Jersey should establish one statewide Exchange and fully consider partnering with neighboring states to pool resources. To promote parity within the health insurance market, individuals and small businesses should operate under one Exchange and not be subject to different rules or price differentials under multiple regional Exchanges. A single statewide Exchange must nevertheless have the capacity to address regional demographic and market variations. In determining whether to embrace interstate compacts beginning in 2016, New Jersey should fully consider the positive and negative impacts of allowing plans to sell products across state lines.

The Exchange should be fully funded and self-sustaining after start-up costs are absorbed. The Exchange may take a portion of premium collection for administrative costs. (As noted above, the Massachusetts Connector operates at a Medical Loss Ratio of 3 percent).

Accessibility

The state should lead a coordinated, streamlined enrollment process that involves various stakeholders across the healthcare continuum. Because many people will sign on and off of multiple insurance products within the Exchange and Medicaid, it is essential that the state coordinate efforts both inside and outside of the Exchange to maximize the flow of enrollments, retention levels and smooth transition across products to avoid gaps and ensure coverage stability. The Exchange should establish a virtual gateway and corresponding policies, similar to Massachusetts, that will allow, or "deputize," providers to collect personal and financial information from patients (self-declared/ self-attested information), input it into a central database and then allow the state to use the information to facilitate enrollment of individuals, supplemented by verification via existing resources or collection of required documentation from all or a sample of applicants.

Hospitals should play an essential role in the enrollment activities of the Exchange. Hospitals should have the option to enroll (and re-enroll, or "reset the clock") patients in Medicaid and Exchange-sponsored plans at the point of service, and should establish good communication lines with the Exchange to share patient financial information. NJHA's Health Research and Education Trust already plays a crucial role in outreach for NJ FamilyCare and could be utilized to assist the state in its efforts for both Medicaid expansion and Exchange-sponsored coverage.

Education

The state should work constructively with various stakeholders within the healthcare industry to educate the public on the benefits of the Exchange. The state should coordinate efforts with providers, payers, business leaders and consumer groups on promoting the benefits of the health insurance reforms.

Benefit Design

The Exchange should play an active role in selecting health plans - There may be value in permitting Exchanges to actively negotiate with insurers seeking to participate, rather than simply performing "clearinghouse" functions. In markets with a few dominant competitors, for example, Exchange-negotiated plans may provide a pro-competitive counterweight. Exchanges also are in a good position to identify and represent consumer preferences in areas where buyers have little experience. By communicating with consumers and surveying the experiences of all types of plan users, Exchanges can identify unexpected traps and difficulties that consumers face and negotiate plan terms and arrangements that better protect consumers with differing healthcare needs.

The Exchange should require a strict certification process for plans that goes beyond federal minimum standards to ensure that plans offer essential covered benefits and access to service, consistent with existing New Jersey standards for determining plan adequacy. The Exchange also should promote network adequacy to ensure that patients who purchase insurance have access to sustainable primary and specialty care.

To maintain consistency both in and out of the Exchange, the state should require each carrier to offer all four benefits plans within the Exchange. Additionally, insurers operating outside the Exchange should be governed by the same rules on plan requirements as those inside the Exchange to prevent carriers from operating solely outside the Exchange to "cherry pick" healthier patients. The state should make the rules for any insurance markets outside the Exchange fully consistent with the rules that apply inside the Exchange. For example, the state should take action to prevent insurers from providing higher commissions to brokers marketing insurance outside the Exchange to reduce the chances that brokers will steer individuals or small firms away from the Exchange. The state must make sure that enforcement of consumer protections and other standards for insurers is uniform inside and outside the Exchange.

The state should merge the individual and small-group markets together over time -
Merging the small-group and individual insurance markets within a state will allow one Exchange to serve both individuals and small businesses, substantially increasing its potential enrollment volume. Greater enrollment, in turn, will promote more robust competition among insurers and help ensure that the pool of people in the Exchange is balanced between the healthy and the sick. In Massachusetts, merging the individual market with the larger and more stable small-group market helped bring down premium costs for people purchasing coverage on their own. Merging the markets would mean that insurers would establish the same base prices for products sold to individuals and small businesses, prior to applying premium differentials related to age and other allowable factors. In other words, insurers

would treat their individual and small-group enrollees as one pool when setting their prices and offer them the same products[4].

[4] Some have argued that while ACA provides some protection in the Exchanges against adverse selection, states should consider doing more, including making the rules for any insurance markets outside the Exchange consistent with the rules that apply inside the Exchange, and requiring insurers to offer the same products inside and outside the Exchange, even when not mandated to do so by ACA. See Center on Budget and Policy Priorities, "States Should Structure Insurance Exchanges to Minimize Adverse Selection," (Aug. 17, 2010), available at http://www.cbpp.org/files/8-17-10health.pdf.