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Statement on Senate Bill No. 1319 ("New Jersey Health Benefits Exchange Act") to the N.J. Senate Commerce Committee

My name is John Sarno, president and general counsel of the Employers Association of New Jersey (EANJ), a nonprofit trade association comprised of New Jersey employers. I appreciate the opportunity to share my views with the Committee on Senate Bill No. 1319, the New Jersey Health Benefits Exchange Act.

EANJ does not engage in lobbying. Since 1916, it has provided advice, counsel and training to employers on labor, employment and health care issues. EANJ members are also eligible to participate in the Affiliated Physicians & Employers Health Trust, which is a Multiple Employer Welfare Arrangement (MEWA) administered by Qualcare, Inc,

A MEWA is a self-insured group benefits plan regulated by federal and state law. More than 900 New Jersey employers currently purchase their health care from the Plan.

I want to address my remarks to the formation of the health benefits exchange within the context of the existing small group market in New Jersey and to offer what I believe will be some of the most pressing policy issues yet decided.

The last time I was before the Committee was on March 3, 2011, when together with the Health Committee, members took testimony from experts on the implementation of the Affordable Care Act, specifically on an insurance exchange that would be available to individuals and small employers (firms with 50 employees or less).

Since that time, the Rutgers Center of State Health Policy has issued its reports summarizing the various stakeholder meetings it has facilitated, including its report conducted with Seton Hall Law School which lays out health care exchange options.

Earlier this month, the Assembly Health and Senior Services committee reported out A2171, which defines New Jersey's health insurance exchange and which is identical to the bill being discussed now.

Much of the discussion during the Assembly hearing focused on the type of exchange that would be implemented - an active purchaser or a clearinghouse model.

An active purchaser would, among other things, establish minimum requirements for the selection, certification, and recertification of qualified health care plans as well as criteria and procedures for decertifying plans.

In contrast, the clearinghouse model allows all insurers to compete for customers, as long as their plans meet federal reform standards.

The goals of health care reform cannot be achieved without a critical mass of participants in the Exchange, which will depend on many factors but with the cost of health care as the most important. A large corporation with thousands of employees pays far less in insurance premiums than a small employer. The primary reason is because of purchasing power.

Upon review of the pending bill, the Exchange would be neither an active purchaser nor a clearinghouse; rather the bill would create a hybrid exchange. If my reading is correct, it would mean the creation of a new entity in New Jersey which would not have the power to regulate directly, but instead would be authorized to be a powerful gatekeeper, making some current regulations that govern the small group market superfluous. Moreover, it is critical that such an entity be flexible and adaptable, considering that New Jersey's existing small employer group market is, in my opinion, on an unsustainable course.

The Unsustainable Small Health Care Market

At the March 3, 2011 hearing I reported that that from March through October 2010, EANJ convened ten groups of employers in five regions of the state. 458 private sector employers that employ 41,200 employees in New Jersey attended, about a third of the EANJ's membership. The meetings resulted in a real time cross section of the state's employers and their concerns. Among the top concerns expressed by these employers were:

1. Increased health care costs (78%);
2. Maintaining the productivity of the existing workforce (62%);
3. The mismatch of skills of current and future workers (39%); and
4. Finding the money to make capital investments (32%).

A year later, an updated survey shows basically the same concerns. And as I tried to explain last time, these concerns are inter-related. Increasing health care costs have also eaten into paychecks. Employers continue to pass health-insurance costs onto employees as firms struggle to remain competitive, more of them are reducing benefits they offer workers or making workers pay more for them.

The number of individuals insured by small employer plans peaked in 1999 at 937,784 but has since declined to about 800,000. Layoffs are the major cause of this decline, but regardless of hiring, it appears that fewer employers are going to provide workers with health care coverage under the strain of increasing premiums.

Thus, a critical challenge for us all is whether health care will be accessible and affordable for small employers.

Meeting the Challenge

Last year, President Obama acknowledged during a meeting with state governors at the White House that states might need more flexibility in implementing the Affordable Care Act. He highlighted a part of the law that would allow states to tailor their own solutions to healthcare reform in 2017 if they fulfilled the same goals as the federal law. He supported a measure put forward in Congress to move that date up to 2014. "If your state can create a plan that covers as many people as affordably and comprehensively as the Affordable Care Act does - without increasing the deficit - you can implement that plan," the President told the governors. "And we'll work with you to do it," he added.

The pending bill, together with A2171, represents New Jersey's response to the President's offer.

The New Jersey Small Employer Health Benefits Program

New Jersey's existing small group market was essentially created in 1992, when the State enacted the Small Employer Health Benefits Program (Program). Under the Program, employers with 50 or fewer employees are eligible to purchase health care if they can show that 75 percent of employees who regularly work 25 or more hours during the workweek are covered.

The Program offers 5 standard small employer health benefits plans, generically known as Plans A through E, plus a standard HMO plan.

The Program restricts carrier use of small group participation requirements, employer contribution requirements, preexisting condition limitation provisions, and health factors related to rates for the plans. The following coverage is mandated:

1. Alcoholism Treatment
2. Autism
3. Biologically Based Mental Illness
4. Bone Marrow Transplants
5. Childhood Immunization, Lead Poisoning, Hearing Loss
6. Colorectal Screening
7. Congenital Bleeding Disorders
8. Dental Anesthesia and Dental Benefits
9. Diabetes
10. Domestic Violence Injuries
11. Home Health Care
12. Infertility Treatment
13. Mammograms
14. Maternity Without Regard to Marital Status
15. Minimum Maternity Stay
16. Minimum Mastectomy Stay
17. Nonstandard Infant Formula
18. Off-Label Drug Use
19. Out-of-Network Services
20. Nursing Home Care
21. Pap Smears
22. Prescription Female Contraceptive
23. Prostate Cancer Screening
24. Reconstructive Breast Surgery
25. Second Medical/Surgical Opinions
26. Wellness Examinations
27. Treatment of Wilm's tumor
28. Orthotic and Prosthetic Appliances
29. Hearing Aids for Persons Aged 15 or Younger

By guaranteeing a policy without regard to pre-existing conditions and other health factors, New Jersey has done a good job in making health care more accessible to small employers and individuals. In important ways, New Jersey already has a small employer health care market that tracks the Patient Protection and Affordable Care Act. Thus, like the federal law, the Program requires guaranteed issued policies regardless of pre-existing conditions. Basic coverage must be provided on a modified community rated basis, meaning that everyone within a band can purchase insurance for the same price regardless of medical condition.

The Patient Protection and Affordable Care Act

Similarly, New Jersey's standard small employer plans and coverage mandates parallel the federal coverage mandates. Each of the health plans to be offered through the Exchange must include an essential set of benefits that provide essential health care services with different levels of cost sharing, including prevention services without deductibles, co-pays and annual or lifetime limits.

The benefit categories include:

- Bronze Plan: provides essential health benefits and pays for 60 percent of the costs of the plan with the HSA out-of-pocket limits
- Silver Plan: provides essential health benefits and pays for 70 percent of the costs of the plan with the HSA out-of-pocket limits
- Gold Plan: provides the essential health benefits and pays for 80 percent of the costs of the plan with the HSA out-of-pocket limits
- Platinum Plan: provides the essential health benefits and pays for 90 percent of the costs of the plan with the HSA out-of-pocket limits
- Catastrophic Plan: available to those up to age 30 or to those who are exempt from the mandate to purchase coverage

If a purchaser cannot afford to purchase a plan in an exchange, he or she may be eligible for a subsidy based on income and family size. If the purchaser's yearly income is higher than 133 percent of the federal poverty level but less than 400 percent of the poverty level (about \$43,000 for an individual and \$82,000 for a family of four), a subsidy will pay the health plan's premiums and out-of-pocket expenses.

Employers with 50 or more full-time employees could be penalized if an employee receives a subsidy to purchase health care, although as noted below, the cost-benefit analysis may actually create an incentive for employers to discontinue coverage.

Essential coverage falls into the following categories:

- Ambulatory patient services,
- Emergency services,
- Hospitalization,
- Maternity and newborn care,
- Mental health and substance use disorder services, including behavioral health treatment,
- Prescription drugs,
- Rehabilitative and habilitative services and devices,

- Laboratory services,
- Preventive and wellness services and chronic disease management, and
- Pediatric services, including oral and vision care.

The Congressional Budget Office estimates the costs of the federal mandates will raise premiums 5-10 percent, forcing many smaller employers to discontinue coverage.

Costs and the Role of the Exchange

In New Jersey, the cost of health care premiums have already rose nearly five times faster than wages since 2000, according to Families USA, a Washington-based nonprofit group. Their report issued in 2008, found premiums in New Jersey rose 71 percent while earnings increased just 15 percent between 2000 and 2007. New Jersey is ranked 28th among states in the rate of growth in premiums compared with earnings.

New Jersey has the second highest premiums in the country. Slightly more than one in ten employers state that they will consider discontinuing coverage this year because of costs. As fewer employers participate in the Program, premiums will continue to skyrocket – a vicious cycle. This is the reality of the small group market in the State and this is the reality of what confronts the insurance exchange.

The federal law enables a state insurance exchange to accomplish at least four important goals:

1. Offering consumers a choice of health plans and focusing competition on price. Exchanges offer enrollees a choice of private health insurance plans. Covered services and cost sharing (i.e., deductibles, coinsurance or copayments, and out-of-pocket limits) would be organized or standardized in ways that make comparisons across plans easier for consumers. The aim is to focus competition among plans on the price of coverage and minimize the tendency for plans to vary benefits in order to attract healthier than average enrollees.

2. Providing information to consumers. In conjunction with offering a choice of plans, an exchange is intended to provide consumers with transparent information about plan provisions such as premium costs and covered benefits, as well as a plan's performance in encouraging wellness, managing chronic illnesses, and improving consumer satisfaction. The exchange could also serve a customer assistance function—typical for large employers—to assist consumers who encounter billing or access problems with their plans.

3. Creating an administrative mechanism for enrollment. For people who obtain private insurance coverage through work, the employer typically facilitates enrollment in a plan and the payment of the premium. This is especially true in larger businesses. An

exchange could serve a similar function for people without access to that kind of assistance, including people buying insurance on their own or who work for small businesses. The exchange could also be used to determine eligibility for and administer income-related subsidies.

4. Moving towards portability of coverage. Coverage through an exchange can be de-linked from employment, helping to make health insurance more portable for people moving from job to job. Exchanges also could coordinate enrollment shifts between Medicaid and subsidized private coverage for people with very low and potentially changing incomes.

Another function of an exchange could also be to facilitate changes in the rules governing how insurers sell coverage. Although these types of changes can be implemented simply by changing insurance laws and do not necessarily require the creation of exchanges, some argue that exchanges can make these insurance market reforms more effective by monitoring marketing practices and administering a uniform system for enrolling in a health insurance plan.

Since New Jersey already has in place a regulatory infrastructure, the physical creation of an exchange can be accomplished efficiently. But like the State's existing small employer market, the success of the exchange depends on enrolling a critical mass of small employers and individuals. The Federal law relies, in part, on the personal mandate to accomplish this end. Massachusetts has also enacted a personal mandate so we may look to that state for an example of the perils of implementing health care reform.

The Massachusetts Experience

Massachusetts enacted its reform in 2006. Its insurance regulations were similar to New Jersey's and the 2006 law was, in many ways, the model for the federal law, including the personal mandate to purchase insurance and the creation of an insurance exchange. Coverage increased from about 88% to 96% the first year but the cost of insurance still increased, more so for small employers. When insurance companies announced premium increases in 2010 up to 30%, Governor Deval Patrick authorized a price-fixing inquiry. Carriers in Massachusetts argued that hospitals and big medical practices held too much bargaining power and therefore they had no choice but to pay them monopoly rates for medical care. The premium increases were necessary to stay in business, they said.

In January, 2011, the Patrick administration introduced a bill to create an 18-member board to regulate how much providers should be paid for what service. Some have called this an attempt to impose price controls, a regulatory strategy to mitigate price inflation.

We hear the echoes of this criticism from those who argue that New Jersey's exchange should adopt an open market model. Today, Horizon Blue Cross Blue Shield of New Jersey has about one-third of the small group market. Other participating carriers are: Aetna Health Inc., AmeriHealth Insurance Company of New Jersey, CIGNA Healthcare of New Jersey, and Oxford Health Plans of New Jersey.

The Massachusetts health care law, like the Federal law relies on tax breaks, subsidies, penalties, the personal mandate and the insurance exchange to expand care and create consumer purchasing power. Two federal courts have found the Affordable Care Act unconstitutional, although three courts have upheld the law. But whether the Supreme Court of the United States upholds or invalidates the law this year, New Jersey will still have a health insurance system that is unsustainable over the long haul.

The New Jersey Experience

This is a critical time for New Jersey's economy. Employers are weighing whether to hire this year or buy new equipment, or both. Projected health care increases could be as high as 25%.

The recession has already taken a toll on employer-sponsored health care in the state. In the first quarter of 2010, the small employer group market had about 775,000 covered lives, down 16.5% from 2000, as small employers have dropped coverage.

Other responses from the EANJ employer focus groups were:

- Percentage that will consider changing health care coverage within the next year: 68%
- Percentage that will consider eliminating health care coverage next year: 12%
- Percentage that will consider paying penalty in 2014 rather than offer health care coverage: 48%

As one participant, a senior manager at an optical instrument manufacturer employing 90 employees put it:

"Pension and health benefits traditionally have been annoying distractions from core business functions and increasingly have become very expensive cost centers. I don't think that I will lose much sleep about shifting my employee benefits obligations, as long as employees can get decent coverage in the exchange, at reasonable cost and I save money after paying federal penalties."

The participant above is commenting on a cost-benefit simulation that shows the cost of continuing to pay 80% of health care premiums for employees against discontinuing coverage and paying an annual penalty based on full-time headcount, minus the first 30 employees, when at least one employee receives a subsidy to purchase their own

insurance. In the simulation, the employer reaps a substantial savings for discontinuing coverage.

For employers with 50 or fewer employees, there is no penalty under federal law to discontinue coverage. Arguably, as small employers get out of the health and welfare business they can focus more intensely on their core competencies. Employees can buy their own portable insurance in the Insurance Exchange. Employers can choose to offset the costs to employees with a savings plan if they choose to. In either case, portable health care would be a win-win for both the employer and employee.

However, none of this can happen without a critical mass of participants in the Exchange, which will depend on many factors but with the cost as the most important. A large corporation with thousands of employees pays far less in insurance premiums than a small employer. The primary reason is because of purchasing power.

S1319 – the New Jersey Health Benefits Exchange Act

Under the pending bill, it appears that the carriers would need to submit more than an actuarial report to justify a rate increase, as they do now. The pending bill would require carriers to:

“submit a justification to the board [of the Exchange] for any premium increase in a qualified health benefits plan prior to implementation of the increase ... which the board shall consider in determining whether to make the health benefits plan available through the exchange, in addition to considering any information and recommendations provided to the board by the department [of banking and insurance] and any excess of premium growth outside the exchange as compared to the rate of that growth inside the exchange.”

The pending bill would require carriers to provide the Exchange with information about claims payment policies and practices, including:

- periodic financial disclosures;
- data on enrollment and disenrollment;
- data on the number of claims that are denied;
- data on rating practices;
- information on cost sharing and payments with respect to any out-of-network coverage.

As noted earlier, the bill it would create a new entity in New Jersey which would not have the power to regulate directly but instead would be authorized to be a powerful gatekeeper. While not a regulator, the Exchange will greatly influence the purchasing decisions that employers make and thus have a substantial influence the small group market.

Board Composition and Governance

This leads to my final observation - the composition of the Exchange's board and its organizational structure. Since the Exchange will have a substantial impact on the insurance market, it is important that the board members be as objective as possible without conflicts of interest in order to achieve difficult goals.

The bill calls for the appointment of a seven-member board, whose members will include the state commissioners of insurance and human services. The other five public members can't be employees of health insurance or healthcare companies and are barred from working in the health care insurance industry for two years after leaving the board; although the bill permits the board to consult with industry stakeholders.

Of the five members, one person must be a member in good standing of the American Academy of Actuaries; and four other persons, two of whom are to be appointed upon the recommendation of the President of the Senate and two upon the recommendation of the Speaker of the General Assembly.

The public members of the board appointed upon the recommendation of the President of the Senate and the Speaker of the Assembly are to be appointed in such a manner as to ensure that the public membership of the board includes individuals who have demonstrated expertise in the following areas: individual health care coverage; small employer health care coverage; health benefits plan administration; health care finance; and consumer health care advocacy.

The board is to appoint an executive director of the Exchange to supervise the administrative affairs and general management and operations. The executive director will serve at the pleasure of the board and receive such compensation as the board determines. All employees of the exchange, except the executive director, are to be in the career service of the Civil Service.

The Exchange will exist within the Department of Banking and Insurance but is to be independent of any supervision or control by the Department. Board meetings are subject to the Open Public Meetings Act.

The Exchange must be flexible and adaptable to the market. Its gatekeeper function is not passive but instead will be dynamic as it seeks to achieve at least four goals set out by the federal law:

1. Offering consumers a choice of health plans and focusing competition on price,
2. Providing information to consumers,
3. Creating an administrative mechanism for enrollment, and
4. Moving towards portability of coverage.

I commend the members of the Committee for introducing this important legislation. I would be happy to answer any questions that you may have. Thank you.