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Combining New Jersey's Individual and Small-Group Health Insurance Risk Pools

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Executive Summary

The Patient Protection and Affordable Care Act (ACA) will require states to make numerous changes in private health insurance regulations. The federal reform law provides an overall framework for insurance regulation, requiring some specific changes but offering states discretion over other aspects of market reform. Among these regulatory options, the ACA permits states to combine non-group (also known as individual) and small-group insurance market risk pools or they may rate these markets separately, as New Jersey currently does. This Policy Brief describes ACA guidance on combining non-group and small-group risk pools in the context of New Jersey's regulatory and market circumstances, and evaluates potential advantages and disadvantages of combining the markets into a single risk pool. This Brief does not examine whether New Jersey should combine administrative functions of the markets which can take place absent a merged risk pool.

- New Jersey reformed its non-group and small-group markets in the early 1990s when it created the Individual Health Coverage Program (IHCP) and Small Employer Health Benefits Program (SEHBP). In many respects, New Jersey's reforms mirror ACA requirements. Still, the ACA will require some changes to rating and issue rules in New Jersey's regulated markets, such as eliminating gender rating, modifying rating bands, and abolishing pre-existing condition waiting periods.
- The impact on premiums of combining risk pools depends, to a large extent, on the composition of the respective pools. Contrary to earlier studies of market merger in New Jersey and other states that suggest that premiums in the non-group market would decline significantly and small-group rates would rise only modestly if pooled, analysis in this Brief of current New Jersey markets suggests that this would not be the case. In fact, analysis of current circumstances suggests that premiums may increase in New Jersey's non-group market following a merger. This finding stems largely from the recent shift in enrollment in New Jersey's IHCP to limited benefit Basic & Essential (B&E) plans, which now represents over 60% of non-group covered lives. It is likely the B&E enrollees are comparatively young and healthy, while morbidity in the diminishing market of more comprehensive plans has worsened in recent years.

- Analysis of risk among uninsured populations that will gain coverage under the ACA in 2014 indicates that average morbidity will remain fairly stable in the non-group market, suggesting that the anticipated expansion of this market will not lead to lower premiums with or without merging risk pools.
- Other potential benefits of merging markets, such as achieving greater economies of scale in plan management and regulation and introducing more competition among plans may not materialize in a combined New Jersey market. New Jersey's current markets are already fairly large, and anticipated growth in the non-group market in 2014 will increase scale even more, thus gaining more operational economies seems unlikely. The IHCP and SEHBP are fairly concentrated markets (e.g., the top three plans cover over 90% of lives in both markets), but the same insurance carriers operate in both markets so combining the risk pools will not in itself spur competition.
- Combining the markets would require that IHCP and SEHBP rating and offer rules that currently vary be made identical, creating disruptions to the markets by increasing premiums for some and decreasing them for others.

This Brief suggests that many of the common arguments for merging the non-group and small-group risk pools – such as making individual coverage more affordable, achieving administrative efficiencies, and attracting greater health plan competition – may not apply in New Jersey's current market and regulatory context. However, these observations are made with considerable uncertainty about the composition of market enrollment with the implementation of ACA coverage expansions and before many key policy decisions have been made.

Combining New Jersey’s Individual and Small-Group Health Insurance Risk Pools

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Introduction

The Patient Protection and Affordable Care Act (ACA) requires that all states implement reforms to their individual and small-group health insurance markets and provides them with the option of creating state-based health insurance exchanges to support the purchase of health insurance policies.¹ Among many design possibilities available to states, the ACA offers the option of combining non-group (also known as individual) and small-group insurance market risk pools or leaving them separate.

This Policy Brief describes ACA guidance on combining non-group and small-group risk pools in the context of New Jersey’s regulatory and market circumstances, and evaluates potential advantages and disadvantages of combining the markets into a single risk pool. Following a discussion of the federal and state policy contexts, this Brief describes available evidence on the potential consequences of merging New Jersey’s risk pools, and outlines key issues to consider in the decision whether to merge the markets.

Policy Context

Premiums in a combined non-group and small-group risk pool would depend on the respective average risk profile and size of each of the two now-separate markets. The risk composition of each of the markets, in turn, depends on market access and premium rating rules. In addition, premiums for any given enrollee depend on the rating and issue rules that currently apply, and any changes to those rules, as might accompany a merged market, will create “winners” and “losers”. Currently, New Jersey’s non-group and small-group markets are regulated somewhat differently, and the ACA will require changes to the structure of these rules. This section sets the stage for analysis of the implications of combining New Jersey’s non-group and small-group markets by reviewing current state regulations and changes that will be required by the ACA. This Brief considers the implications of merging risk pools in the two markets. It does not discuss the option of creating a single health benefit exchange for these markets without

¹ The federal government will create health benefit Exchanges for states that do not create their own.

merging the risk pools. Merging risk pools has broader implications than combining their administrative apparatus, as discussed below.

In the early 1990s, New Jersey enacted significant reforms in its individual and small-group markets, creating the Individual Health Coverage Program (IHCP) and Small Employer Health Benefit Program (SEHBP). These programs were created to expand the availability of health insurance to individuals and small groups by standardizing product offerings and creating easy access to information about the available products.² Regulatory changes required by the ACA, in many respects, are similar to the nearly two decade-old New Jersey reforms, although the ACA will require some modifications to New Jersey's regulatory structure. To start, the ACA defines small-groups as up to one hundred employees.³ Many states, including New Jersey, currently limit their small-group market to groups of up to 50 workers. This expansion of the small-group definition has implications for risk selection, as larger groups can better predict their future expenses and healthy groups may choose to self-insure while those with higher anticipated risk may be more likely purchase coverage in the exchange.

New Jersey non-group and small-group market regulations strictly limit the use by insurers of health status information in enrollment and coverage decisions, but these rules will become even stricter under the ACA. New Jersey's current non-group and small-group markets guarantee the issuance and renewability of coverage, but allow some pre-existing condition exclusions. Specifically, New Jersey allows limitations on coverage for pre-existing conditions of up to 12 months in the individual market and 6 months for some small businesses, including those with two to five employees and others that enroll after the annual open enrollment period and have no prior creditable coverage (New Jersey Department of Banking & Insurance 2011a, 2011b). Starting in 2014, the ACA will prohibit all pre-existing condition exclusions.⁴ New Jersey does not allow lifetime or annual dollar limits on coverage, but it does allow small groups to impose a six month waiting period before becoming eligible for health insurance coverage (New Jersey Department of Banking & Insurance 2011a, 2011b). This requirement will change when the ACA rules become effective in 2014 as the federal law does not allow waiting period of longer than 90 days.

Premium rating rules will also change under the ACA. Currently, New Jersey's individual market uses modified community rating and allows premiums to vary by 3.5 to 1 based on age for standard policies. New Jersey's individual market also offers Basic & Essential (B&E) policies with limited benefits that allow premiums to vary by 3.5 to 1 based on age, gender, and geography. The state's small group market has long used modified community rating allowing rates to vary by 2 to 1 based on age, gender, and geography. The ACA allows premiums to vary

² See http://www.state.nj.us/dobi/division_insurance/ihcseh/ihcrates.htm (IHCP) and http://www.state.nj.us/dobi/division_insurance/ihcseh/sehguide/index.html (SEHBP).

³ The ACA allows states to limit the small group market to 2 to 50 until 2016 when groups up to 100 must be included.

⁴ These provisions apply to all non-grandfathered plans.

based on age with a rate band of 3 to 1, and geographic region, or tobacco use with a rate band of 1.5 to 1, and prohibits rating based on health status in all individual and small group plans.⁵ New Jersey's rating mechanisms, while similar to what is allowed under the ACA will result in some changes for our individual and small group markets. In particular, policies will no longer be rated based on gender; thus, other factors equal, females will face somewhat lower premiums, while males will face somewhat higher premiums for individual B&E policies. Small groups that are made up of predominantly female employees would see a reduction in their premiums.

New Jersey imposes benefit requirements in its individual and small group markets, although these requirements vary. New Jersey's IHCP offers standardized policies with comprehensive benefit structures. However, beginning in 2003, B&E plans became available in New Jersey's individual market that include only nine benefits, with the option of riders to add some other benefits (New Jersey Department of Banking & Insurance 2011a). New Jersey's small-group market offers a standard set of policies, but insurers are allowed to offer a wide array of riders to add or subtract benefits to these plans, creating a great deal of variability in benefit offerings in this market (Belloff and Cantor 2008). The ACA takes a different approach to plan standardization, requiring plan options to fit within one of four actuarial value tiers. The state will retain the authority to regulate the extent of plan standardization, so long as plan standards are consistent with the actuarial tiers required by the ACA.

Under New Jersey law, B&E plans feature annual limits on specified services, which is not permitted under the ACA. Recognizing annual dollar limits are a feature of many existing plans and that removing these limits may significantly increase premiums, the federal government entertains requests for temporary waivers of ACA annual limits requirements. New Jersey requested and received such a waiver for its B&E plans this year and has filed for a request to extend the waiver. Nevertheless, the waiver will no longer be available as of December 31, 2013, and B&E plan annual limits will no longer be permitted.

Evidence on Potential Effects of Merging Risk Pools

Premiums in a merged non-group and small-group market would depend on the relative size of the two markets as well as their risk composition. The IHCP and SEHBP have experienced shifting enrollment over the years, for reasons that are examined elsewhere (Monheit et al. 2004; Hall 1999). In recent years, total enrollment in the small-group market has declined (Table 1), perhaps influenced by the poor state of the economy during this period. There has been a partially offsetting increase in IHCP enrollment, which has also seen a dramatic shift in its composition. Between the first quarters of 2008 and 2011, standard plan enrollment in the

⁵ These provisions apply to all non-grandfathered plans.

IHCP declined and B&E plan enrollment rose rapidly. By the first quarter of 2011, the B&E constituted nearly two-thirds of total IHCP enrollment.⁶ As a result of these trends, the SEHBP represents a declining share of total reform market enrollment in New Jersey.

Table 1: Recent Enrollment Trends in New Jersey Non-Group and Small-Group Markets

| First Quarter | Total IHCP & SEHBP | IHCP | | | | SEHBP | |
|---------------|--------------------|--------------------|----------|--------|-------------|---------|------------------|
| | | Total ^a | Standard | B&E | Percent B&E | Total | Percent of Total |
| 2008 | 977,995 | 90,360 | 59,117 | 30,850 | 34.1% | 887,635 | 90.8% |
| 2009 | 931,251 | 101,839 | 52,913 | 40,669 | 39.9% | 829,412 | 89.1% |
| 2010 | 894,152 | 117,185 | 52,058 | 64,917 | 55.4% | 776,967 | 86.9% |
| 2011 | 857,905 | 130,765 | 49,696 | 80,886 | 61.9% | 727,140 | 84.8% |

Source: http://www.state.nj.us/dobi/division_insurance/ihcseh/enroll/1q11historical.pdf.

Notes: IHCP is the Individual Health Coverage Program, SEHBP is the Small Employer Health Benefits Program, and B&E is Basic and Essential plans.

^a Includes a small number of pre-reform plans.

The implementation of the minimum coverage mandate, subsidies and other provisions of the ACA in 2014 will greatly influence the size and composition of New Jersey's coverage markets. Using data from 2009, the Center for State Health Policy (CSHP) projects that the number of persons with non-group coverage will grow by 171.5%, from an estimated 211,000 to 573,000 (Cantor et al. 2011).⁷ At the same time, enrollment in the small-group market (groups up to 50) is projected to decline by about 10% from 881,000 to 791,000.⁸ Thus, the proportion of small-group lives in a merged market would decline from 80.7% to 60.0% when 2014 ACA rules go into effect, increasing the influence of non-group covered lives on premiums in the combined market.

The CSHP also provides estimates of average health status within New Jersey's employer-sponsored and non-group risk pools with and without enrollment changes post-ACA reform. In the market before 2014 coverage expansions, CSHP estimates that the non-group enrollees are on average healthier than those with employer-sponsored coverage. Data were not available to support separate health status estimates for the small-group market, but risk in the small-group market is typically somewhat worse for larger groups with employer-sponsored

⁶ An earlier study (Monheit et al. 2004) suggested that IHCP enrollment declined during a period of tight labor markets in New Jersey. It may be the case that the current surge in B&E enrollment may reflect the weak labor market. If so, an improving economy may stem the growth of enrollment in these plans.

⁷ The baseline estimate of non-group enrollment is higher than data shown in Table 1 because the former includes student plans and because of differences in measurement. The post ACA-figure reflects 2014 ACA rules applied to 2009 data.

⁸ The baseline estimate of small-group enrollment is higher than data shown in Table 1 because of measurement differences. The post ACA-figure reflects 2014 ACA rules applied to 2009 data.

coverage. Further, CSHP estimates that average morbidity would remain fairly stable for those with employer-sponsored coverage after ACA implementation, while the risk profile in the non-group market would worsen somewhat as new individuals enroll in coverage under ACA rules.⁹ The population eligible for subsidies through the exchange is expected to exhibit the greatest increase in average risk following the implementation of the ACA enrollment mandate. On balance, these findings suggest that merging non-group and small-group risk pools within the exchange beginning in 2014 would not increase premiums for small employers. On the contrary, these findings suggest that premiums may increase for those with individual coverage following a merger.

These observations are contrary to at least one prior study of the impact of merging markets in New Jersey. This earlier actuarial research indicated that merging the non-group and small-group risk pools would reduce premiums for individuals while increasing them modestly for small groups (Belloff and Cantor 2008). However, this estimate pre-dated the recent rapid shift to limited-benefit B&E plans in the individual market (with their presumed more favorable risk profile) and did not take the effects of the ACA into consideration.

Evidence from Other States

Massachusetts merged non-group and small-group markets following its comprehensive 2006 reforms. Like the ACA, this merger was implemented in the context of a coverage mandate with subsidies for low and moderate income individuals. One study predicted that the Massachusetts merger would reduce premiums for individuals by about 15% and raise premiums for small groups by between 1% and 1.5% (Lischko 2007). The actual increase in premiums for small groups attributable to the merger, however, was more than twice that prediction, at 3.4% (Welch and Giesa 2010). The excess increase has been attributed in large part to an unanticipated manifestation of adverse selection, as an unexpectedly high number of individual subscribers enrolled for brief periods of time, used expensive services while enrolled, and then disenrolled.¹⁰

While measures were in place in Massachusetts to prevent adverse risk selection, including preexisting condition waiting periods and the individual enrollment mandate, these measures were apparently insufficient to prevent selection against the individual market. Once the markets were merged, insurers were required to treat all members of the merged market the same in rating and underwriting, including in the application of the preexisting illness

⁹ This finding is consistent with national research that suggests that enrollees in exchanges across the country will be higher risk than those currently enrolled in the private market (Trish et al. 2011).

¹⁰ Insurers in the merged market in Massachusetts are permitted to employ periods of preexisting illness exclusion to reduce this phenomenon. When the markets merged, terms of participation required insurers to use the same rating standards for all members of the merged market. Apparently unwilling to impose preexisting illness exclusions for small groups, insurers dropped them for individuals, permitting this “churning” behavior to manifest. *Id.* at 4.

exclusion. As they did not want to employ preexisting illness exclusions with small groups, the insurers could not employ them with individual purchasers. Individual purchasers, then, were free to enter and exit the insurance market freely (Welch and Giesa 2010). The individual mandate also failed to prevent individuals from jumping in and out of the market. The Massachusetts penalty in 2011 for failure to purchase health insurance ranges from \$228 to \$1,212 per person.¹¹ It appears that some consumers chose to expose themselves to the penalty rather than purchase health insurance.

A 2008 actuarial study of merging markets was also conducted for New York State, predicting that combining risk pools would reduce non-group premiums substantially (37%) while modestly increasing small group premiums (3%)(Gorman Actuarial, LLC, 2008). The applicability of this study to New Jersey is limited, however, because of important differences between New York and New Jersey markets and because it was conducted in the context of voluntary market participation. A more recent analysis by the United Hospital Fund of New York (UHF) of the impact of merging markets in New York takes into account the expansion of the non-group market that will take place in 2014 and considers merging the expanded non-group market with the small-group market (Newell and Gorman 2011). Using a range of assumptions about the composition of risk in New York markets, this analysis first predicts that expanding that state's non-group market following the implementation of ACA coverage expansions will reduce premiums between 13% and 41%. It is important to note, however, that New York's current non-group market is similar to New Jersey's market of standard plans in the IHCP and, like that market segment here, has been experiencing erosion of enrollment, presumably due to extensive adverse selection. While New York offers a subsidized plan (known as Healthy NY) to low income individuals and sole proprietors, it does not offer limited benefit products like the B&E plan in New Jersey. Thus, predictions of major beneficial premium effects of the enrollment mandate and subsidies under the ACA are not surprising, but they cannot be directly extrapolated to New Jersey.

Perhaps more relevant to the New Jersey context, UHF simulated the effect of merging the expanded individual market with the existing small-group market in New York. They find that these risk pools (including small-groups up to 50 employees) following the ACA coverage expansions would increase small-group premiums by between 3% and 13% while reducing non-group premiums from 13% to 41%, depending on assumptions about differences in average health and the extent of new enrollment in the individual market.

The experience of combining individual and small-group risk pools in Massachusetts, and studies of potential mergers in New Jersey and New York are at variance with CSHP

¹¹ The penalty is lower for children, and there are other exceptions. See Massachusetts Department of Revenue, TR 10-25: Individual Mandate Penalties for Tax Year 2011, available at http://www.mass.gov/?pageID=dorterminal&L=7&L0=Home&L1=Businesses&L2=Help+%26+Resources&L3=Legal+Library&L4=Technical+Information+Releases&L5=TIRs+-+By+Year%28s%29&L6=2010+Releases&sid=Ador&b=terminalcontent&f=dor_rul_reg_tir_tir_10_25&csid=Ador.

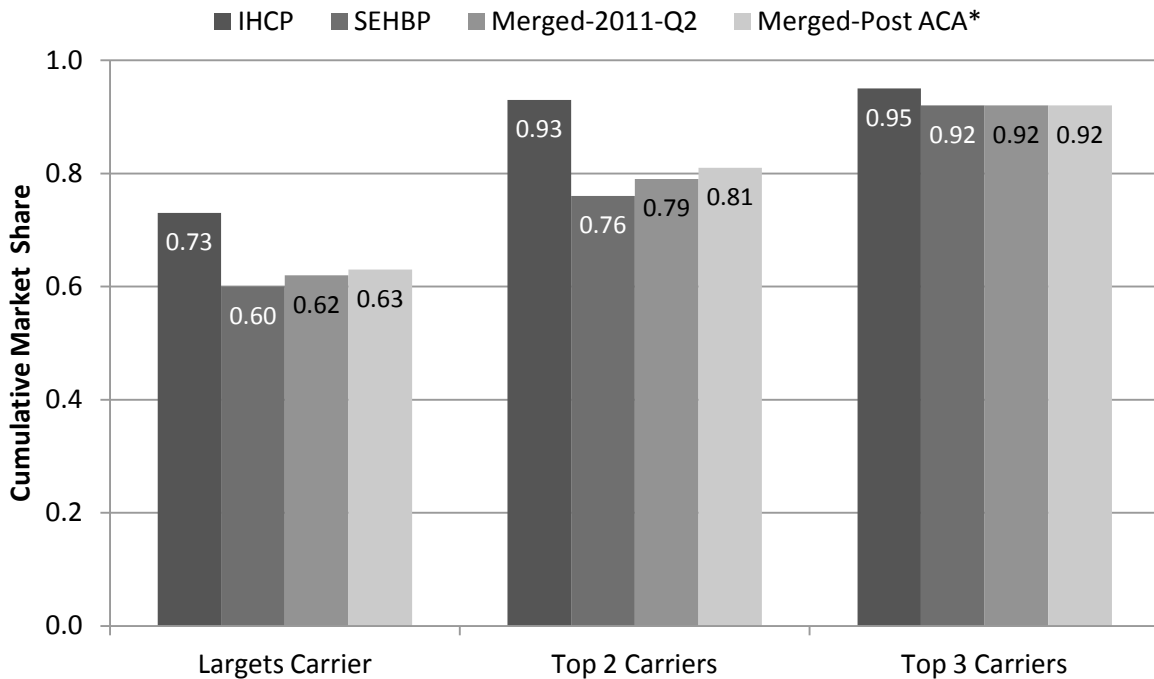
analyses of current market circumstances in New Jersey (Cantor et al. 2011). This difference can be attributed to the recent rapid growth of B&E plans along with recent declines in SEHBP enrollment. These changes have almost certainly altered the morbidity profile of these markets, with attendant consequences for predicted premiums following a market merger.

Other Considerations

Potential Benefits of a Larger Market. Theoretically, merging the individual and small-group markets may bring economies of scale in health plan management and regulation by increasing the aggregate number of covered lives. New Jersey's individual and small-group markets are already fairly large (133,864 and 714,106 covered lives, respectively), so it is unlikely that a merged market would lead to greater operational economies. Combining regulations and oversight in the two markets could lead to modest savings for carriers and regulators, although the administrative needs of serving non-group enrollees differ from those of groups regardless of whether the market is combined or not. Expansion of coverage in 2014 will increase the combined number of covered lives only modestly (by less than 3%) according to CSHP estimates (Cantor et al. 2011). As discussed above, added covered lives in 2014 will be in the individual market. Thus, there are no clear new economies resulting from combining the markets along with ACA implementation.

Analysts have suggested that a larger pool of enrollees in a merged market might attract more insurers and competition, which would be especially important in states with low enrollment in these markets (Jost 2010b). The SEHBP and especially the IHCP are fairly concentrated markets. Figure 1 shows that the largest carrier (Horizon Blue Cross Blue Shield affiliated companies) holds a nearly three-fourths market share in the IHCP and 60% in the SEHBP. In the IHCP, two carriers dominate while three are active in the SEHBP. If a combined market were to attract more active participation from other carriers, consumers may benefit from increased competition. However, unless new carriers aggressively pursue enrollment in the market, merging markets alone will not stimulate competition. The same four carriers occupy the top market-share ranks in the current IHCP and SEHBP markets. Thus, as shown in Figure 1, concentration in a combined market would be roughly the same as in the pre-merger SEHBP, and adding new enrollees in 2014 will not spur more competition.

Figure 1: New Jersey Non-Group and Small-Group Market Shares, Second Quarter 2011 and Reweighted for Projected Post-ACA Enrollment



Sources: Market share data from NJ Department of Banking & Insurance (see www.state.nj.us/dobi/division_insurance/ihcseh/ihcsehenroll.html), and post-ACA projections from the Center for State Health Policy (Cantor et al. 2011).

*Reflects projected growth in IHCP enrollment relative to the SEHBP, but assumes that market shares of carriers within these markets would remain constant.

A Bigger Small-Group Market. The ACA requires that states allow small groups of up to 100 to enroll in the Exchange beginning in 2016 and allows states to include these mid-sized groups as early as 2014. New Jersey’s current small group market includes groups of up to 50. A larger small group market may have the benefit of increasing the number of Exchange participants, further stabilizing health insurance premiums and providing a broader base to spread the impact of merging in the individual market. On the other hand, the chances of risk selection against the Exchange may be greater with larger groups which have more predictable risk and healthier groups may opt-out of the risk pool by self-funding (Jost 2010a).

Plan Standardization. Under the ACA, New Jersey may choose to standardize plan offering in the Exchange by defining standard benefit packages and plan designs that may be offered by insurers. Similarly, the state may allow the Exchange to actively select a limited number of plan options that will be sold through the Exchange based on benefits offered and plan value for enrollees. New Jersey currently offers standardized plans in its individual market (New Jersey Department of Banking & Insurance 2011a). These plans vary based on cost sharing

requirements and delivery systems (HMO, PPO, and indemnity). Standard plans offer no benefit riders, and only limited riders are available for B&E plans. An extensive number of riders are available in New Jersey's small-group market, making products in this market much less standardized (New Jersey Department of Banking & Insurance 2011b). Plans were more standardized in the early years of the SEHBP, but market demands have led to much less standardization over the years (Belloff and Cantor 2008).

Plan standardization is intended to provide clearer choices to consumer and to encourage competition based on premiums as opposed to benefit design. Markets with more benefit permutations may also be more vulnerable to risk segmentation, especially when it occurs in the individual market. Combining markets would require New Jersey to change the level of plan standardization for either the non-group or small-group purchasers (or both). Moving away from standardization in the IHCP may increase the chances of risk selection and reduce price competition, while moving toward standardization in the SEHBP would reduce choices available to businesses.

New Jersey also has the option of promoting an employee-choice model within its Exchange. This model is characterized by employers making defined contributions to worker premiums and employees selecting from among plan options within the Exchange (Chou et al. 2011). If New Jersey embraces the employee-choice approach, then the dynamics of purchasing in the small-group market will approach those of non-group purchasers. For instance, under this model, plan standardization may become more important for small-group enrollees than it is under the current employer choice model.

Distributional Consequences & Rate Bands. As noted above, rating regulations and pre-existing condition waiting period regulations vary by market segment in New Jersey. The ACA will require changes to these regulations, which will affect the relative premiums paid by various population groups. For example, women with small group or B&E plans will, in general, face lower premiums relative to their male counterparts. Combining markets will require harmonization of all regulations, which may, in turn, have distributive effects beyond those required by the ACA. For example, the ACA requires that the current 3.5 to 1 rating bands in New Jersey's individual market be reduced to 3 to 1, but the state's current 2 to 1 small group rate bands remain permissible under the ACA. Combining the risk pools would require making these bands identical, thereby causing more changes in premiums than otherwise would be required. Such a change in rate bands would yield winners and losers. For example, if the small-group market moves to wider rate bands, groups with older workers will see higher premiums while those with disproportionately young workers will have lower premiums. When the IHCP moves to slightly narrower rate bands, older enrollees may find premiums to decline somewhat while younger enrollees may face a premium increase. However, in both cases, the implications

for premiums will depend on how the average market premium behaves in light of the enrollment composition of a merged market and how it changes over time.

Conclusions

New Jersey has long considered merging its individual and small-group markets in order to stabilize premiums and improve enrollment in the individual market (Belloff and Cantor 2008). One of the foremost considerations in this decision is how combining the markets would affect premiums in the non-group and small-group markets. Contrary to prior studies in New Jersey and other states, analysis in this Brief of the composition of current markets in New Jersey suggests that a merger would not reduce premiums for non-group enrollees, and may even lead to higher rates for individuals. Thus, a merger could lead to reduced affordability in this market segment.

Other arguments for combining these markets – achieving economies of scale and attracting greater health plan competition – may also not apply in New Jersey. The IHCP and SEHBP markets already appear large enough to make them viable marketplaces (the addition of new covered lives following implementation of the ACA will increase the size of New Jersey's individual market further). Moreover, while New Jersey's markets are fairly concentrated today, they are served by the same carriers and merging them is thus unlikely to increase competition. Insurers and brokers have long asserted that small groups differ from individual purchasers of health insurance in many important ways, and the administrative needs of individuals will differ from those of small groups regardless of whether the markets are merged or not. Thus, administrative efficiencies from combining the risk pools may be small.

Combining the markets would require harmonization of rating rules and plan designs, which might prove disruptive to market participants. The degree to which plans are standardized in non-group and small-group markets in New Jersey varies a great deal, which means that the purchasing options in these markets would need to be aligned. Standardized plans are most often advocated for individual purchasers but appear less attractive to group purchasers. Customers in the current employer-choice model of purchasing in the small-group market may object to having their plan options reduced to a small number of standard plans. On the other hand, if New Jersey creates an employee-choice model for the small-group market, more standardization may be desirable.

Merging the risk pools would also require altering rate band structures. Some changes will be required by the ACA (e.g., moving from 3.5 to 1 rating for B&E plans to 3 to 1), but differences between rate bands in the non-group and small-group markets remain permissible under the ACA. If these markets are combined, rate bands would have to be made consistent. This change would lead to higher premiums for some purchasers while lowering them for others.

The ACA requires numerous changes in the structure and regulations of health insurance markets, most of which will be implemented in 2014. These changes increase the uncertainty around the probable impacts of combining non-group and small-group risk pools. In its health benefit Exchange authorizing legislation, California decided against merging its individual and small group markets initially, rather it decided to continue studying the potential for merging the markets in 2018 once the ACA is fully implemented and the state has a few years of experience to consider (Shewry 2010; Weinberg and Haase 2011). In 2018, California will have a better idea of the risk composition of the two markets and can better determine the potential costs and benefits of merging them.

This Brief suggests that many of the common arguments for merging the non-group and small-group risk pools – such as making individual coverage more affordable, achieving administrative efficiencies, and attracting greater health plan competition – may not apply in New Jersey’s current market and regulatory context. However, these observations are made with considerable uncertainty about the composition of market enrollment with the implementation of ACA coverage expansions and before many key policy decisions have been made.

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