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Center for State Health Policy

A Unit of the Institute for Health, Health Care Policy and Aging Research

Envisioning Repeal of the Affordable Care Act: Lessons from New Jersey Experiments in the Individual Coverage Market

Joel C. Cantor, Sc.D.
Alan C. Monheit, Ph.D.
Margaret Koller, M.S.
John S. Palatucci, M.P.A.

July 2020

Author Affiliations

Rutgers Center for State Health Policy
Joel C. Cantor, Sc.D., Distinguished Professor & Director
Margaret Koller, M.S., Executive Director

Rutgers School of Public Health
Alan C. Monheit, Ph.D., Professor of Health Economics
John S. Palatucci, M.P.A., Graduate Research Assistant

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Acknowledgments

The research discussed in this report was funded by the Robert Wood Johnson Foundation. The views expressed in this report do not necessarily reflect those of the Foundation. The authors are grateful to former CSHP colleague Susan Brownlee who contributed to survey development and data collection.

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Executive Summary

Efforts by the Trump administration and Congress to undermine the Affordable Care Act have been partially successful, but key coverage provisions of the law remain in place. This report considers the fate of individual health insurance markets if full repeal was achieved. Specifically, we examine what would happen if the widely popular pre-existing condition and premium rating rules were retained, but the individual mandate, premium tax credits, and comprehensive qualified health plan rules were repealed. Our analysis is particularly relevant since the penalty for the individual mandate was eliminated by the Tax Cuts and Jobs Act of 2017, and as the Supreme Court is poised to hear another challenge to the constitutionality of the ACA in the fall of 2020.

We review the experience of New Jersey which in the 1990s was among a small group of states that imposed stringent pre-existing condition and rating regulations but without a mandate, subsidies, or certain plan standards. Our analysis of regulatory data and a survey of insurers reveals that many insured individuals would be considerably worse off if key features of the ACA were repealed. In particular, persons purchasing comprehensive plans in the pre-ACA market would be especially disadvantaged by the repeal of additional elements of the ACA, even accounting for subsidies. Further, repeal of ACA provisions would result in sharply higher premiums, likely leading many of those who gained coverage under the law to return to the ranks of the uninsured.

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Introduction

Coverage provisions of the Patient Protection Affordable Care Act (ACA) of 2010 (42 U.S.C. § 18001 et seq.) have been the principal targets of the Trump administration and congressional Republican "repeal and replace" efforts (Oberlander 2017; Thompson, Gusmano, and Shinohara 2018). Through legislative and administrative actions to incrementally undermine the ACA, significant portions of the Act have already been rolled back (Marmor and Gusmano 2018; Morone and Blumenthal 2018). The Trump administration stopped funding cost-sharing subsidies for plans sold through the marketplaces, shortened the marketplace enrollment period, restricted the use of special enrollment periods for people missing open enrollment, and significantly cut resources for public education and outreach efforts. It also promulgated rules broadening the availability of "association health plans" and easing restrictions on limited duration health plans that are exempt from ACA pre-existing condition rules and could offer fewer benefits than ACA qualified health plans (Keith 2018; Pollitz et al. 2018).

Collectively, these actions by the administration undermine the sustainability and affordability of the ACA insurance reforms. High-risk individuals are unlikely to be deterred by limited enrollment periods and reduced outreach, but the number of young and healthy individuals enrolling is likely to decline, exacerbating risk selection and putting upward pressure on premiums. Likewise, the expanded availability of association and limited duration plans that are not as comprehensive as ACA plans and which may impose preexisting condition restrictions will likely steer healthy enrollees away from compliant plans and drive up premiums.

For its part, through the enactment of the 2017 Tax Cuts and Jobs Act (P.L. 115-97), Congress eliminated the federal individual mandate penalty beginning in 2019. This last move gave rise to lawsuits by Texas and 20 states asserting that the individual mandate is no longer constitutional and without it, the remaining provisions of the ACA are unsustainable. Finally, the US Justice Department ruled that it would no longer defend the Texas case and has filed a brief supporting striking down the ACA (SCUS, n.d.). The petition led by Texas, culminating in the

current US Supreme Court case "California v. Texas," remains an existential threat to the ACA with an expected Supreme Court decision in 2021 (Keith 2020).

Congressional efforts to repeal other features of the ACA have to date not been successful. Among the most potentially consequential of such measures were proposals to impose stringent spending caps and other restrictions on the Medicaid program. Instead, the Trump administration has taken other steps to support states seeking to limit access to Medicaid. Notably, it has encouraged states to submit demonstration waiver requests to impose work requirements and other restrictions on non-disabled Medicaid beneficiaries, which would lead to significant disruption and disenrollment (Hahn et al. 2018).

Following the 2018 mid-term election which gave control of the House of Representatives to Democrats, Congress and the White House moved on to other legislative priorities, tabling efforts to repeal what they still derisively refer to as Obamacare. New developments including the emergence of the COVID-19 pandemic, the rise of a vigorous racial justice movement, and the approaching 2020 federal election have coalesced to push efforts to undermine the ACA off the front pages and social media news feeds. Nevertheless, the impending Supreme Court challenge threatening the loss of health insurance for millions and pre-existing condition protections for many more during a national health crisis will keep the debate over the ACA both deeply consequential and politically salient.

In this report we consider what would happen if the repeal movement achieved more of its aims. Specifically, we consider the fate of non-group health insurance markets[1] that retain popular features of the ACA, namely limitations on pre-existing condition exclusions and restrictions on demographic variations in premiums,[2] but eliminate the federal penalty for non-compliance with the individual coverage mandate, federal premium and cost sharing subsidies, and comprehensive qualified health plan rules.

Prior to the ACA, a number of states pursued insurance availability and affordability objectives akin to those of the ACA for their individual and small group insurance market, but without mandates or major subsidies (Buchmueller and DiNardo 2002; Chollet 2000, 2004; Hall 2000a, 2000b; LoSasso and Lurie 2009; Monheit and Schone 2004). These examples provide us with an opportunity to consider what would happen to the non-group market under the ACA without its mandate and subsidy provisions. We do so by focusing on one such state with a history of progressive insurance reforms, New Jersey, and drawing on rich data from regulators and a survey of insurance companies participating in New Jersey's non-group market.

New Jersey is particularly well suited to illustrate the implications of a partial repeal of the ACA. Beginning in the 1990s, it was among a handful of states that sought to make non-group

[1] The non-group market, also referred to as the individual market, serves those without access to employer-sponsored insurance or public coverage. It includes plans sold in the subsidized ACA marketplaces and plans sold directly by insurers to consumers outside the marketplace.

[2] For polling data on the popularity of key ACA insurance provisions, see Bialik and Geiger (2016) and KFF (2012).

health insurance widely available through access and rating regulations that favored older individuals and those with pre-existing conditions (Cantor and Monheit 2016). As previously documented, New Jersey's regulatory approach led to adverse risk selection, rising premiums, and declining enrollment (Monheit et al. 2004). In fact, the experience in New Jersey's non-group market before the ACA was cited in oral arguments before the Supreme Court in NFIB et al. v. Sebelius (132 S. Ct. 2555, 2012) in defense of the individual coverage mandate (Cantor and Monheit 2016). As discussed further below, New Jersey has also taken steps to enact key provisions of the ACA – including adopting an individual mandate penalty – into *state* law in anticipation of a further weakening or a full repeal of the federal law.

The remainder of this report begins with background drawn from prior studies of health insurance market transitions following ACA implementation. We then turn to the New Jersey context, first detailing actions to taken by the State to promote accessible non-group coverage prior to the ACA, then providing a summary of the State's initiatives taken in light of the aforementioned federal policy actions undermining the ACA. This policy context sets the stage for our presentation of an in-depth empirical analysis of the transition of the New Jersey non-group market from the pre-ACA to the ACA era. We find that the transition to the ACA had significant implications for the well-being of people covered by non-group health insurance, improving the welfare of many (but not all) individuals who depend on the non-group market in New Jersey. Last, we draw implications from these results for a hypothetical future coverage market without significant subsidies and the federal mandate, but with popular regulations banning pre-existing condition exclusions and limiting premium variations. We also discuss the limits of recent New Jersey reforms intended to compensate for a federal ACA rollback. We conclude that such a market would represent a significant reversal of progress made in the equitability and affordability of coverage since ACA implementation.

Prior Research

Most prior studies on insurance transitions to coverage under the ACA focus on aggregate shifts, such as the changes in the number of uninsured, insurer participation, and average premiums. However, a few studies have examined the impact of ACA implementation on the well-being of non-group health insurance purchasers. For example, one study of national Blue Cross Blue Shield claims examined the experience of enrollees who transitioned from non-group plans in force prior to 2014 to ACA-compliant plans. This study revealed that transitioning enrollees had a much lower prevalence of chronic conditions and lower care utilization and spending compared to new enrollees in the ACA qualified plans in 2014 and 2015 (BCBSA 2016). This result may simply reflect the elimination of underwriting and rating regulations that favored younger and healthier enrollees in most states before the ACA. Although this study suggests that individuals transitioning from pre-ACA non-group coverage to ACA plans were entering a sicker risk pool and

therefore may have faced higher premiums, it does not directly examine changes in premiums or benefits (e.g., deductibles, covered services, or limits) of plans held by transitioning individuals.

Following full ACA implementation, ACA-compliant non-group plans experienced large premium increases and poor financial performance, raising the question of whether these plans' experiences were indicative of significant adverse selection. However, Claxton and Levitt (2016) point out that extensive attention paid to insurers announcing financial losses in the marketplace failed to recognize others reporting more favorable results. The authors point out that major features of the ACA, including the mandate and subsidies, make predicting the risk profile of enrollees transitioning into these plans difficult. Some plans set premiums expecting healthier pools than they achieved, while others erred by expecting sicker pools. As elaborated below, this was clearly the case in New Jersey after initial ACA implementation. Other researchers posit that declining insurer participation may overstate problems in the marketplaces, as exiting insurance companies generally offered plans with higher premiums and very low market shares compared to competitors that remained in the marketplaces (Holahan, Blumberg, and Wengle 2016). These studies suggest that the early years of the ACA were characterized by somewhat cloudy actuarial "crystal balls", requiring adjustments in future years. But these studies provide few insights into how the welfare of individual policyholders may have changed in the transition.

In fact, rapidly rising premiums of marketplace benchmark silver plans in the early years of the ACA has been cited frequently as evidence of adverse selection and rising costs to consumers (Clements 2016), but this observation fails to account for consumer plan switching behavior or the availability of premium tax credits. A study of premiums in California's ACA marketplace showed that enrollment-weighted premiums (i.e., accounting for switching) were 11.6 percent to 15.2 percent less than unweighted average premiums in 2014 to 2016, with enrollment-weighted premium growth rates across these years about two percentage points less than unweighted average premiums (Gabel et al. 2017). Another California study of non-group market risk pool composition showed a stable market with more favorable average risk in 2015 compared to 2014 (Goldman, Bertko, and Watkins 2015). Underscoring the importance of consumer plan switching, a study of enrollees in federally facilitated marketplaces showed that 43 percent of 2015 enrollees selected a new plan in 2016 and that the 85 percent of enrollees receiving tax credits experienced average net premium increases of just four percent, about half the rate of increase of pre-subsidy enrollment-weighted premiums (ASPE 2016).

The research reported here goes beyond this prior literature, focusing on welfare changes for specific cohorts of individuals transitioning from pre-ACA to ACA-compliant plans in New Jersey. The following section provides important policy context for understanding these empirical results.

The New Jersey Context before the ACA

Table 1 summarizes the evolution of selected features of the New Jersey non-group market regulations in the more than two decades prior to enactment of the ACA. In 1992, following the repeal of the state's all-payer hospital rate-setting system which subsidized New Jersey's non-group market insurer of last resort (the state's Blue Cross Blue Shield plan), the state required insurers to provide comprehensive, standardized benefit plans with pure community rating and limited pre-existing condition waiting periods. Soon after the law's implementation, the market showed signs of an adverse selection spiral (Monheit et al. 2004). In an effort to stabilize the non-group market, in 2003 the legislature required a limited benefit product called the Basic and Essential (B&E) plan be offered. Following this reform, comprehensive plans continued to suffer enrollment losses and with sharply rising premiums while the B&E proved to be very popular.

Table 1: Selected Regulatory Provisions Applying to the New Jersey Non-group Health Insurance Market, 1993–2017

Legal Provision	NJ Standard Plans	NJ Basic & Essential Plans	ACA Qualified Health Plans
Statutory authority	NJ Pub. L. 1992, c. 161 NJ Pub. L. 2008, c. 38	NJ Pub. L. 2001, c. 368	US Pub. L. 111-148
Effective dates	1993 & 2009	2003	2014
Issuance and underwriting	Guaranteed issue with 12-month pre-existing condition waiting period		Guaranteed issue, no waiting period
Rating	Pure community rating Starting in 2009: Modified community rating (MCR) with 3.5:1 variation by age and territory, five-year cap on increases for grandfathered plans[a]	Modified community rating (MCR) with 3.1 variation by age, gender, and territory	MCR with 3:1 variation by age[b]
Products	Comprehensive standardized plans	Limited-benefit plans	Qualified health plans with ten essential health benefits. Standardized by "metal level"

[a] Lesser of medical trend or 15% for insureds holding plans purchased prior to statue effective date.
[b] New Jersey uses a single rating area for the individual market under the ACA.

By statute, the B&E plan offered fairly comprehensive hospitalization coverage, but only very limited outpatient benefits, including only $500 per covered person for out-of-hospital diagnostic testing and $700 per covered person for ambulatory physician visits. The B&E also waived coverage of most state mandated benefits which further kept premiums down. Unlike standard plans offered in the non-group market since the early 1990s, insurance companies were permitted to vary B&E premiums by a ratio of up to 3-to-1 by age, gender and sub-state rating region. Starting in 2009, the legislature also allowed premium variation of 3.5-to-1 by age and region for the comprehensive standard plans, although the impact of this change was muted by capping premium increases for those who purchased plans prior to this legislative change.

In 2014, the ACA substantially altered New Jersey's non-group market rules. In addition to the coverage mandate and substantial federal subsidies, the ACA eliminated the state's pre-existing condition waiting period and changed rating rules to a 3-to-1 ratio based only on age.[3] New Jersey's pre-ACA standard plans required little modification to comply with ACA essential health benefit rules, but the B&E plan design fell well short of ACA requirements. While the federal government and New Jersey regulators permitted continued marketing of ACA non-compliant plans after 2013, New Jersey insurers elected not to do so, and B&E subscribers were required to switch to ACA qualified health plans when their 2013 contract ended (Hempstead 2017).

Additional ACA changes also encouraged robust insurer competition by providing consumers with ready access to information on the costs and actuarial value of coverage. While previous New Jersey reforms required plan standardization and the state published detailed rate comparison tables, the on-line ACA marketplace more easily enabled consumer comparison shopping (after the initial technical issues were resolved).

A CO-OP entered the New Jersey non-group market in 2014 and an additional commercial plan entered in 2015 (although both subsequently exited the market). While insurers had to set 2014 premiums under a great deal of uncertainty about risk pool composition, they made those decisions within the context of new insurers entering the market and a growing pool of price-sensitive consumers. In 2013 the New Jersey non-group market was dominated by one insurer, with an 80 percent market share, but by the third quarter 2014, that insurer's share dropped to around half, with six insurers actively participating in the market, including three selling through the ACA marketplace (DOBI, n.d.).

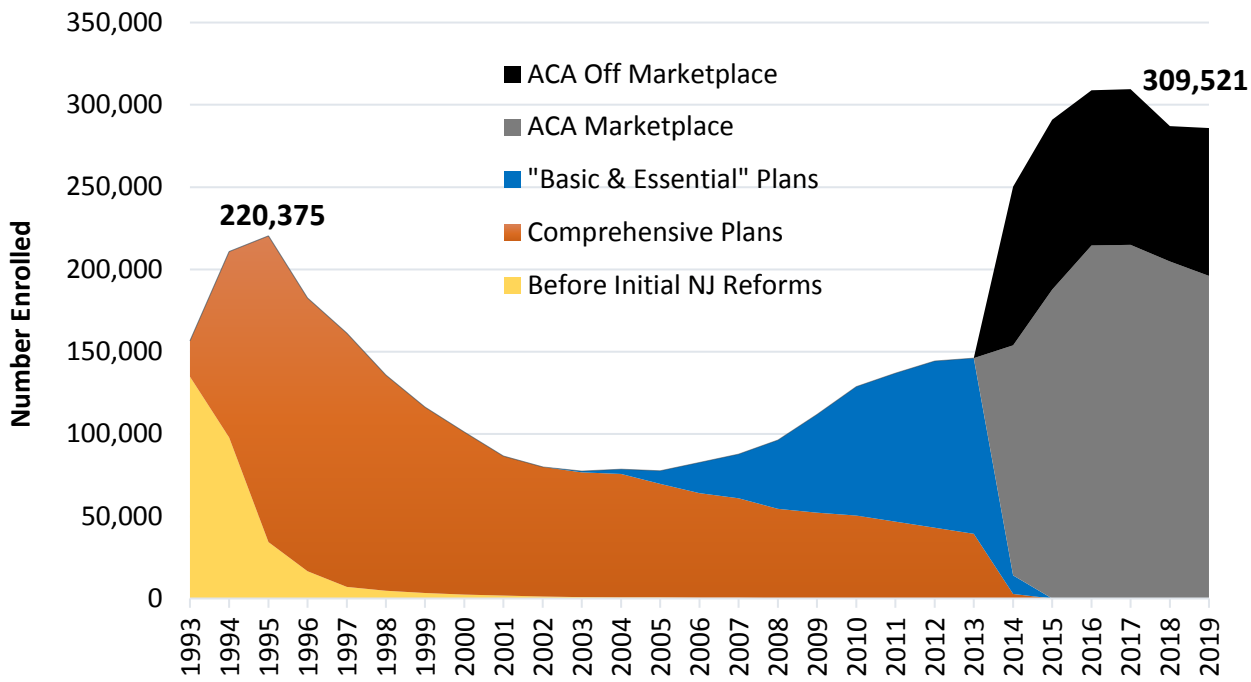
While New Jersey non-group reforms of the early 1990s initially appeared to meet their goals (Swartz and Garnick 1999, 2000), they proved unsustainable (Monheit et al. 2004). Between 1995 and 2013 the state's non-group market appeared to experience significant adverse selection, with enrollment declining by about eight percent per year and premiums rising rapidly

[3] New Jersey is a single state-wide rating area so there is no premium variation by region within the state, and the state did not adopt rating by smoking status.

(Cantor and Monheit 2016; DOBI, n.d.; Monheit et al. 2004). Following the 2003 state legislation that introduced limited benefit B&E plans with age-gender modified community rating, the overall market enrollment trend reversed. By 2013, B&E enrollment represented nearly three-fourths (73 percent) of the non-group market. Additional state legislation in 2008 that introduced age-based rating in standard (non-B&E) plans did not appear to have a discernable effect on the enrollment trend. In contrast, the transition to ACA qualified health plans and the implementation of marketplace subsidies and the individual mandate were accompanied by a rapid increase in covered lives. By the fourth quarter of 2017, 214,900 individuals were enrolled through the federal marketplace, with most receiving subsidies, and 94,612 purchased plans directly from insurance insurers which precluded subsidy payment, together representing a near doubling (89.6 percent) of enrollment from the fourth quarter of 2013 (DOBI, n.d.).

Figure 1 summarizes aggregate individual market enrollment trends in the New Jersey from the period of its reforms if the 1990s, through subsequent state legislative changes (see Table 1) and into the first five years following ACA implementation. The trend shows the sharp decline in comprehensive plans following enactment of early New Jersey reforms and the rise of enrollment in B&E products. New Jersey quickly phased out the B&E following ACA implementation and maintains comparatively high enrollment in ACA-compliant plans sold both on and off the ACA marketplace.

Figure 1: New Jersey Individual Health Insurance Enrollment
By Plan Regulatory Category, 1993–2019



Source: NJ Department of Banking and Insurance, http://www.state.nj.us/dobi/division_insurance/index.htm
Note: Data shown are for the fourth quarter of each year, except 2019 which is based on first quarter data.

New Jersey Actions in Anticipation of ACA Repeal

Actions taken by New Jersey policymakers in response to attempts to weaken the ACA by the Trump administration and Congress underscore the need to understand the fate of coverage markets in the state should the ACA be repealed or struck down by the Supreme Court. New Jersey has taken a series of steps to support provisions of the ACA for its residents by shifting governing law from the federal government to the state. Under the Health Insurance Market Preservation Act in 2019, New Jersey was the first state to enact a penalty for non-compliance with the health insurance enrollment mandate following its repeal at the national level under the 2017 federal tax reform law (NJDOT 2020). This was followed in 2018 by the establishment of a reinsurance pool under a federal Section 1332 ACA State Innovation Waiver (KFF 2020). Further, in 2019, New Jersey took steps to create its own on-line health insurance exchange, transitioning the state from the healthcare.gov platform (Stainton 2019). This development enables the state to override federal limitations on the annual enrollment period, strengthen consumer education and support tools, and facilitate coordination with the Medicaid enrollment process among other advantages (NJOG 2019). Furthering the state's effort to preserve the ACA, Governor Phil Murphy signed a package of nine additional bills in January 2020 removing obsolete state insurance regulations from the books and codifying additional provisions of the ACA in New Jersey law (Stainton 2020).

Of key importance, however, New Jersey has not enacted measures to replace federal funding of ACA premium tax credits and cost-sharing reductions in the event of a repeal. It would also not be in a position to replace federal funding for the ACA Medicaid expansion. Should the ACA fall, New Jersey's insurance markets would once again have strong structural regulations, including provisions guaranteeing access for people with pre-existing conditions and assuring comprehensive benefits, but without critically important subsidy mechanisms to assure affordable access to coverage and mitigate adverse risk selection in the market.

Transition of the New Jersey Non-Group Market under the ACA

Data and Methods

Our study uses data for 2013 through 2015 reported in a survey of the top three health insurers participating in the New Jersey non-group market in 2013. Data for 2014 and 2015 were also collected from the one additional insurer that entered the non-group market in 2014. Collectively, these insurers covered 98 percent of insured lives in New Jersey's non-group market in 2014 and 2015.[4] The survey is supplemented with publicly available data from the New Jersey Department of Banking and Insurance (DOBI) and the federal healthcare marketplace.

[4] The survey instrument is available from the authors.

The survey collected aggregate statistics from the three insurers for cohorts of individuals covered in 2013. Each insurer reported data for their plans with the highest enrollment in 2013 in each of three product types: standard Preferred Provider Organizations (PPO), standard Health Maintenance Organizations (HMO), and Basic & Essential (B&E) plans, including one B&E with riders and one without (when offered). For analysis, data on B&E plans with and without riders were combined. For each of these 2013 plans, which we refer to as "index plans", the insurance carriers reported data on the disposition of enrollees who remained insured in the non-group market with them in 2014 and 2015, including those enrollees who left the insurer in 2014 but returned in 2015. The survey also obtained information from all four surveyed insurers about enrollees in their non-group products in 2014 and 2015 who were not enrolled in a 2013 index plan. We refer to these individuals as "new enrollees".

For each 2013 index plan enrollee cohort, insurers provided data on the share of enrollees in 2014 and 2015 that: (a) remained in their 2013 plan (permitted in 2014 only), (b) migrated to a federal *marketplace* plan, (c) migrated to a *direct-purchase* (off-marketplace) plan, or (d) were no longer enrolled in a non-group product offered by that insurer. Within the groups that were retained by the insurer, data were provided on enrollee distributions by age group, ACA plan metal level, and the share with Advanced Premium Tax Credits (APTC) or Cost Sharing Reductions (CSR), when applicable. Data on age, plan metal level, and cost-sharing status were also obtained for *new enrollees* (i.e., not migrating from a 2013 plan) in 2014 and 2015. Details on premiums and selected benefit provisions for 2013, 2014 and 2015 plans were obtained from the New Jersey DOBI, Healthcare.gov, or the participating insurers. The findings presented in the following show enrollment-weighted distributions combined across insurers.

Results

Health Plan Enrollees before the ACA. We begin by examining enrollment and the age composition in the New Jersey non-group market at baseline, i.e., in study index plans and the entire non-group market in 2013 (Table 2). Index plans accounted for 86.2 percent of all covered lives, with the highest percentage for B&E enrollees (94.9 percent) and the lowest for HMO enrollees (57.0 percent). Age distributions of enrollees in 2013 index plans in all three product types closely reflect their respective distributions among all covered lives as reported to regulators. It is notable that over half of HMO enrollees, both in index plans and market wide, were age 55 or older, while B&E enrollment was comparatively young. In the 2013 market as a whole, 52.5 percent of enrollees were female, including 56.3 percent of enrollees in PPOs, 55.2 percent of in HMOs, and 51.2 percent in B&E plans.

Table 2: Enrollment and Age Distributions in the New Jersey Non-group Market Overall[a] and Index Plans, 2013

	All Plans		PPO		HMO		Basic & Essential	
Age Group, %	Market	Index	Market	Index	Market	Index	Market	Index
Under 25	24.8	25.8	25.5	24.7	17.2	17.9	25.4	26.4
25–34	15.8	16.6	10.9	10.1	2.8	2.6	18.4	18.6
35–44	12.8	13.3	10.8	10.8	4.9	5.3	14.1	14.4
45–54	20.1	20.7	22.2	23.9	16.1	18.3	20.0	20.3
55 and older	26.4	23.6	30.7	30.5	58.9	56.0	22.1	20.4
Enrollment, N	145,442	125,366	27,948	17,913	10,616	6,050	106,878	101,403
Index, %		86.2		64.1		57.0		94.9

Sources: NJ DOBI IHCP Annual Report 2013 (market) and NJ Insurance Carrier Survey (index plans).
Notes: PPO = Preferred Provider Organization, HMO = Health Maintenance Organization.
[a] Excludes 612 individuals enrolled in indemnity plans available prior to 1993.

Transitions from Pre-ACA Baseline Plans to ACA Plans. Table 3 shows the disposition of 2013 index plan enrollees following full implementation of the ACA in 2014 and 2015. In 2014, about half of PPO and HMO index plan enrollees stayed in a non-group plan sponsored by their 2013 insurer, while only one-in-three B&E subscribers was retained by their 2013 insurer. For all three product types, retention rates increased in 2015, including 2013 enrollees who left their insurer in 2014 but subsequently returned. These shifts likely reflect premium differences across plans and their changes over time.[5]

In 2014, fairly small proportions of index plan enrollees remained in their 2013 plan (they were permitted to do so until the end of their enrollment year) or migrated to plans sold on the ACA marketplace. Instead, the majority of 2013 enrollees who were retained by their insurer migrated to the direct-purchase market. Migration into marketplace and direct-purchase plans in 2015 rose, with many of those who left their insurer in 2014 returning in 2015. The greatest increase in marketplace enrollment between 2014 and 2015 occurred among B&E index plan enrollees.

In spite of the significant changes in changes in market offerings with ACA implementation, the market demonstrated significant inertia, with large numbers of enrollees staying with (or returning to) their pre-ACA carrier. The transition of persons from the B&E plan is an exception to this pattern. This group, having purchased low cost plans pre-ACA, is undoubtedly very sensitive to premium changes, and may have more actively shopped for

[5] In light of the considerable actuarial uncertainty of a market in transition, premiums offered in the New Jersey market varied widely across insurers in 2014 but variation was considerably less in 2015. For example, the lowest premium silver plan offered by the dominant insurer in the marketplace was 15 percent higher than the least expensive silver option in the 2014 but less than one percent higher than the lowest cost silver plan in 2015. Likewise, the dominant insurer's bronze plan was 25 percent costlier than the lowest premium offering in 2014 but was the lowest cost bronze offered in 2015 (CMS, n.d.).

coverage. Further, B&E enrollees who were ACA subsidy-eligible had new affordable options with richer benefits than the B&E, providing an incentive for them to change plans.

Changes in Enrollee Age Distributions. Table 3 also shows age distributions of migrating enrollees. The share of enrollees ages 55 or older was higher among migrants to marketplace plans from all three index plan types than to the direct-purchase market. While HMO index plan enrollees were more likely to be age 55 or older, this is especially the case among those who migrated to the marketplace where the share of enrollees age 55 and older was 80 percent in 2014 and 73 percent in 2015. In contrast, about half of B&E index plan enrollees migrating to direct purchase market were under age 35. The age distributions for PPO index plan enrollees fell between the extremes of the HMO and B&E enrollees. *As older and possibly sicker enrollees favored marketplace plans after ACA implementation, direct purchased plans benefited from favorable selection.*

Table 3: Disposition and Age Distributions of 2013 Index Plan Migrants in 2014 and 2015

	Enrollment		2013 Age Distribution, %		
PPO Index Plans	N	%	<35	35-54	55+
2014 Migration					
Remained in 2013 plan	1,170	6.5	35.3	35.3	29.4
Marketplace	974	5.4	20.1	39.9	39.9
Direct purchase	6,329	35.3	33.1	37.1	29.7
Not retained	9,440	52.7	37.2	32.5	30.3
Total	17,913	100.0	34.7	34.7	30.5
2015 Migration					
Marketplace	1,352	7.6	22.3	40.2	37.5
Direct purchase	8,474	47.5	33.1	37.6	29.3
Not retained or returned	8,023	44.9	38.3	30.9	30.9
Total	17,849	100.0	34.6	34.8	30.6
HMO index plans					
2014 Migration					
Remained in 2013 plan	511	8.4	16.8	23.1	60.0
Marketplace	523	8.6	6.5	13.2	80.3
Direct purchase	2,049	33.9	21.4	28.3	50.4
Not retained	2,967	49.0	23.0	22.2	54.8
Total	6,050	100.0	20.5	23.6	56.0

Continued on next page

Table 3: Disposition and Age Distributions of 2013 Index Plan Migrants in 2014 and 2015 (continued)

	Enrollment		2013 Age Distribution, %		
PPO Index Plans	N	%	<35	35-54	55+
2015 Migration					
Marketplace	750	12.5	10.1	17.2	72.7
Direct purchase	2,979	49.5	20.7	28.3	51.1
Not retained or returned	2,291	38.1	23.8	19.6	56.5
Total	6,020	100.0	20.5	23.6	55.8
B&E index plans					
2014 Migration					
Remained in 2013 plan	7,933	7.8	44.2	36.7	19.1
Marketplace	7,487	7.4	26.9	37.0	36.1
Direct purchase	17,327	17.1	50.1	37.2	12.7
Not retained	68,656	67.7	45.9	33.4	20.8
Total	101,403	100.0	45.1	34.6	20.4
2015 Migration					
Marketplace	16,039	15.9	31.1	37.4	31.4
Direct purchase	32,882	32.5	48.4	37.8	13.8
Not retained or returned	52,242	51.6	47.2	31.7	21.2
Total	101,163	100.0	45.0	34.6	20.4

Changes in Plan Values and Subsidy Status. Distributions of plan metal levels, mean actuarial values, and subsidy status of the migrant cohorts are shown in Table 4. Patterns in the follow-up years 2014 and 2015 differ somewhat across index plan types and whether enrollment was through the marketplace or direct purchase. Reflecting the marketplace overall (CMS 2017), around 70 percent of enrollees migrating from PPO index plans to the marketplace purchased silver plans. In contrast, B&E migrants to marketplace plans were somewhat more likely than average to purchase silver plans while HMO migrants were somewhat more likely to purchase gold plans. The share of PPO and HMO index plan migrants to silver marketplace plans who received APTC was similar to the share for all marketplace enrollees (86 percent in 2014 and 83 percent in 2015), although the number receiving CSRs was lower than the marketplace average (about 52 percent in 2014 and 2015) (CMS 2017). B&E migrants to the marketplace were more likely to receive CSRs than either PPO or HMO migrants. Outside the marketplace, PPO migrants were disproportionately likely to purchase silver plans and the largest share of B&E migrants purchased bronze plans. A slightly greater share of HMO migrants to direct purchase plans bought gold plans compared to PPO migrants.

Migration patterns and subsidy eligibility confirm that B&E enrollees are a price-sensitive market segment including many with incomes low enough to make them eligible for subsidies. In contrast, standard HMO and PPO plan migrants had somewhat higher incomes (as evidenced by comparative low rate of CSR eligibility) and HMO migrants evinced a high demand for broader benefits. Still, a substantial portion of enrollees migrated to plans that made them eligible for premium and cost-sharing subsidies, suggesting welfare gains.

Table 4: Distribution of Enrollment in Direct Purchase and Marketplace Plans by Metal Level, Mean Actuarial Value, and Subsidy Status among 2013 Index Plan Migrants in 2014 and 2015

	2014				2015			
	Direct	Marketplace			Direct	Marketplace		
PPO Index Plans	% Dist.	% Dist.	% APTC	% CSR	%. Dist.	% Dist.	% APTC	% CSR
Platinum	3.1	2.4	88.0	--	3.2	3.1	66.7	--
Gold	8.3	27.6	71.2	--	9.2	26.5	67.9	--
Silver	87.4	69.4	80.9	38.2	86.2	68.6	81.8	31.7
Bronze	1.0	0.5	60.0	--	1.1	1.7	52.2	--
Catastrophic	0.2	0.1	--	--	0.2	0.1	--	--
All plans	100.0	100.0	78.2	--	100.0	100.0	77.2	--
Mean actuarial value, %	71.3	73.2	--	--	71.4	74.2	--	--
HMO index plans								
Platinum	3.7	2.4	38.5	--	2.8	1.6	61.5	--
Gold	28.8	37.7	87.0	--	24.9	33.2	86.9	--
Silver	66.7	58.8	87.2	34.8	71.4	63.7	88.9	28.8
Bronze	0.7	1.1	30.0	--	0.8	1.4	81.8	--
Catastrophic	<0.1	0.0	--	--	<0.1	0.0	--	--
All plans	100.0	100.0	85.5	--	100.0	100.0	87.7	--
Mean actuarial value, %	73.5	74.1	--	--	73.2	73.5	--	--
B&E index plans								
Platinum	0.3	0.1	83.3	--	0.2	0.5	66.7	--
Gold	4.9	15.3	83.1	--	4.5	11.2	81.5	--
Silver	25.2	78.1	90.6	49.9	29.4	75.8	89.2	37.7
Bronze	68.1	5.9	69.7	--	62.4	11.8	63.4	--
Catastrophic	1.4	0.7	--	--	3.6	0.6	--	--
All plans	100.0	100.0	87.6	--	100.0	100.0	84.6	--
Mean actuarial value, %	63.7	70.9	--	--	64.0	70.0	--	--

Notes: APTC = Advance Premium Tax Credits; CSR = Cost Sharing Reduction; -- indicates not applicable.

Changes in Premiums and Cost Sharing. Table 5 shows changes in premiums and cost sharing features of plan migrants. The premiums in the table do not account for APTCs, and those with subsidies would pay less than amounts shown. PPO plan features shown are for in-network providers. Both PPO and HMO index plan migrants for the two illustrative age categories (ages 30 and 50) experienced premium reductions of between 15 percent and 66 percent in their transition to ACA qualified health plans. Gross (before subsidy) premiums fell somewhat more for the younger enrollees and reductions were similar for marketplace and direct-purchase plans. Both PPO and HMO migrants also faced lower primary care copayments. PPO migrants also transitioned to plans with deductibles between 15 percent and 34 percent lower than their 2013 plan. PPO enrollees had somewhat higher maximum out-of-pocket (MOOP) thresholds in their transition to ACA plans, while HMO enrollees had no MOOP limit in 2013 but did in their ACA plans. In spite of much lower premiums and primary care cost sharing, both PPO and HMO migrants faced increased specialist cost sharing in their ACA plans, markedly so for HMO migrants.

As discussed above, pre-ACA B&E plans had very limited benefits beyond inpatient hospital care, although they also had no deductible or provider copays or co-insurance. These plans also lacked MOOP limits, which are required for ACA qualified health plans. B&E plan migrants experienced increased premiums of between 6 percent and 38 percent in their transition to ACA plans and they faced significant deductibles in their new plans. Cost sharing for primary care and specialty visits were also imposed on the B&E migrants, with particularly high cost sharing for specialty care.

With some exceptions, migrants from the comparatively comprehensive HMO and PPO plans experienced substantial cost reductions as they moved to ACA-compliant plans. Resulting savings were even greater for those receiving APTC or CSR subsidies. However, for high-utilizers of specialty care, these savings were partially offset by increases in specialty cost sharing. The question of welfare impacts for those migrating from B&E plans is more complex, with higher premiums (before subsidies) and cost sharing, but with much more comprehensive benefits.

Table 5: Mean Monthly Premiums and Cost Sharing Features of 2013 Index Plan Migrants in 2014 and 2015[a]

		2014				2015			
	2013	Marketplace		Direct		Marketplace		Direct	
PPO Index Plans	Mean	Mean	% Ch[b]	Mean	% Ch[b]	Mean	% Ch[b]	Mean	% Ch[b]
Monthly premium, $									
Age 30	625	397	-36.5	441	-29.5	370	-40.7	380	-39.1
Age 50	817	624	-23.6	693	-15.2	583	-28.7	597	-26.9
Medical deductible, $	2,600	1,829	-29.6	2,219	-14.6	1,704	-34.4	1,979	-23.9
Primary care copayment, $[c]	31	24	-21.9	28	-9.5	23	-27.3	25	-18.6
Specialist copayment, $[d]	46	48	4.5	51	12.6	44	-3.4	48	5.2
Out-of-pocket maximum, $	5,200	5,669	9.0	6,393	22.9	5,252	1.0	5,470	5.2
HMO index plans									
Monthly premium, $									
Age 30	1,080	401	-62.9	424	-60.7	369	-65.8	376	-65.1
Age 50	1,110	630	-43.2	667	-39.9	581	-47.7	592	-46.6
Medical deductible, $	0	1,722	--	1,626	--	1,634	--	1,612	--
Primary care copayment, $[c]	32	24	-25.8	26	-17.1	22	-29.6	24	-24.3
Specialist copayment, $[d]	32	46	43.6	52	64.4	44	37.4	48	50.1
Out-of-pocket maximum, $	None	5,299	--	5,886	--	5,081	--	5,517	--

Continued on next page

Table 5: Mean Monthly Premiums and Cost Sharing Features of 2013 Index Plan Migrants in 2014 and 2015[a] (continued)

		2014				2015			
	2013	Marketplace		Direct		Marketplace		Direct	
PPO Index Plans	Mean	Mean	% Ch[b]	Mean	% Ch[b]	Mean	% Ch[b]	Mean	% Ch[b]
B&E index plans									
Monthly premium, $									
Age 30	303	375	23.8	358	18.2	339	11.9	322	6.4
Age 50	427	590	37.9	563	31.7	534	24.9	514	20.2
Medical deductible, $	0	1,978	--	2,534	--	1,876	--	2,345	--
Primary care copayment, $	--	26	--	30	--	26	--	27	--
% with copayment	0.0	100.0	--	94.2	--	99.9	--	98.3	--
Primary care coinsurance, %	--	--	--	50.0	--	--[e]	--	--[e]	--
% with coinsurance	0.0	0.0	--	5.8	--	0.1	--	1.7	--
Specialist copayment, $	--	50	--	49	--	47	--	43.1	--
% with copayment	*0.0*	*80.5*	--	*32.0*	--	*73.8*	--	*37.1*	--
Specialist coinsurance, %	--	35.7	--	50.0	--	34.5	--	50.0	--
% with coinsurance	*0.0*	*19.5*	--	*68.0*	--	*26.2*	--	*62.9*	--
Out-of-pocket maximum, $	None	6,014	--	6,643	--	5,723	--	6,087	--

Note: -- indicates not applicable.

[a] Means weighted by enrollment in each plan and carrier, dollars adjusted to 2015 using the Consumer Price Index-Medical Care average for US cities.

[b] Percent change compared to 2013 mean level.

[c] All plans in 2014 had primary care copayments, and in 2015 fewer than 0.3% of plans had co-insurance (not shown).

[d] Over 99% of plans in both years had a specialty care copayment, the remainder had co-insurance (not shown).

[e] Data not shown due to small number of individuals with coinsurance.

New Enrollees in the Non-Group Market. Tables 6 to 8 describe persons who were not in one of the 2013 index plans and who purchased non-group coverage from one of the four study insurers in 2014 and 2015.[6] Table 6 shows that a much larger share of new enrollees purchased via the marketplace in both study years than index plan migrants (shown in Table 3). Further, new entrants were on average younger than migrants. However, like the index plan migrants, enrollees on the marketplace were older on average than those buying in the direct-purchase market.

The distribution of enrollment according to plan metal levels and the proportions receiving APTC and CSR assistance (Table 7) is about the same as reported in Healthcare.gov statistics for the marketplace as a whole (ASPE 2016; CMS 2017). In both 2014 and 2015 these enrollees disproportionally purchased silver plans, especially within the marketplace. More than eight in ten buying on the marketplace received subsidies. Premiums and benefit features of new entrants (Table 8) reflect the metal level and average actuarial values in the prior table. *Collectively, these data suggest that many new enrollees had been previously priced out of the non-group market or found even the low-cost B&E plans a poor value.*

Table 6: Disposition and Age Distributions of New Enrollees in 2014 and 2015 Plans

	Enrollment		2013 Age Distribution, %		
Year and Market	N	%	<35	35-54	55+
2014					
Marketplace	131,897	71.6	31.5	38.2	30.3
Direct purchase	52,371	28.4	49.5	31.8	18.7
Total	184,268	100.0	36.6	36.4	27.0
2015					
Marketplace	143,503	79.8	35.0	37.2	27.8
Direct purchase	36,234	20.2	51.5	30.7	17.8
Total	179,737	100.0	38.4	35.9	25.8

[6] Marketplace coverage in New Jersey for 2014 was offered only by the study insurers, in 2015 one non-study insurer entered the marketplace but achieved a market share of only 1 percent.

Table 7: Distribution of Enrollment in Direct Purchase and Marketplace Plans by Metal Level, Mean Actuarial Value, and Subsidy Status among New Enrollees in 2014 and 2015

	2014				2015			
	Direct	Marketplace			Direct	Marketplace		
Metal Level	% Dist.	% Dist.	% APTC	% CSR	%. Dist.	% Dist.	% APTC	% CSR
Platinum	11.0	3.2	70.0	--	8.1	3.5	58.0	--
Gold	17.9	14.4	69.9	--	17.9	8.0	62.2	--
Silver	53.3	70.9	89.0	51.6	53.3	69.7	87.4	51.2
Bronze	12.4	10.6	65.7	--	15.7	18.2	77.3	--
Catastrophic	5.4	0.9	--	--	5.0	0.8	--	--
All plans	100.0	100.0	82.6	--	100.0	100.0	81.8	--
Mean actuarial value, %	72.9	71.0	--	--	71.9	69.7	--	--

Notes: APTC is Advance Premium Tax Credits; CSR is Cost Sharing Reduction; -- indicates not applicable.

Table 8: Mean Monthly Premiums and Benefit Features of New Enrollees in 2014 and 2015 Plans[a]

	2014		2015	
	Marketplace	Direct	Marketplace	Direct
Plan Feature	Mean	Mean	Mean	Mean
Monthly premium, $				
Age 30	331	377	304	360
Age 50	521	593	479	567
Medical deductible, $	1,685	2,064	1,962	1,999
Primary care copayment, $[b]	40	28	24	25
Specialist copayment, $	67	49	44	43
% with copayment	*70.4*	*94.9*	*47.1*	*86.5*
Specialist coinsurance, %	30.7	50.0	40.2	40.1
% with coinsurance	*29.6*	*5.1*	*52.9*	*13.5*
Out-of-pocket maximum, $	5,367	5,877	5,660	5,451

[a] Means weighted by enrollment in each plan and carrier, dollars adjusted to 2015 using the Consumer Price Index-Medical Care average for US cities.

[b] All plans had primary care copayments in 2014 and over 99% had copayments in 2015, those with coinsurance not shown.

Discussion

New Jersey was one of a small group of states that pursued regulatory strategies to make non-group health insurance widely available and affordable, especially for women, older enrollees and those with pre-existing conditions. These regulations are similar to ACA requirements, with the important exception that they were not accompanied by an enrollment mandate or significant subsidies. Advocates seeking to repeal and replace the ACA succeeded in stopping the enforcement of the federal individual mandate starting in 2019, have advanced strategies to allow the offer of plans that fall short of ACA standards, and have proposed ending or modifying premium tax credits and cost-sharing subsidies (Marmor and Gusmano 2018; Morone and Blumenthal 2018; Pollitz et al. 2018). In response to these federal actions, New Jersey took bold steps to preserve the structure of the ACA under New Jersey law, but to date has not taken steps to replace the substantial government funding under the ACA subsidizing. If anti-ACA forces ultimately succeed, non-group insurance markets across the country will be like New Jersey's before enactment of President Obama's signature reform, making understanding New Jersey's effort to establish an inclusive non-group market and how that changed under ACA particularly germane.

Prior to the ACA, the New Jersey non-group health insurance market experienced significant challenges. Following community rating and plan access reforms of the early 1990s, the market evinced significant adverse selection, with rapidly rising premiums and declining enrollment (Monheit et al. 2004). The introduction of a limited-benefit B&E plan with age-gender rating in 2003 ended the market's overall enrollment decline, but left about three-fourths of non-group covered lives with significant financial exposure. The ACA reversed these trends with the enrollment mandate, and significant subsidies, and elimination of the limited benefit plan option, leading to more than a doubling of total market enrollment from its low point in 2004 (DOBI, n.d.). *Our findings suggest that a reversal of the ACA would lead not only to reduction in the number of covered lives in the New Jersey health insurance market, but also to significant reductions in welfare for many in the New Jersey.*

Using data from New Jersey insurers, regulators, and the ACA marketplace, this study builds on prior research by tracking how the state's non-group market changed from 2013, before ACA implementation, through 2015. Following cohorts of New Jersey non-group enrollees who stayed with their insurer through the ACA transition, we found that those who held ACA-like comprehensive plans in 2013 paid substantially lower premiums, even without accounting for premium subsidies. They also had lower cost sharing in many cases (not accounting for cost-sharing reductions), but higher for some others. Specifically, 2013 migrants from standard HMO or PPO plans saw their premiums decline by 24 percent to 41 percent in 2014-15. Their new plans also had substantially lower primary care copayment levels and PPO migrants saw deductibles decline by 15 percent to 34 percent. The pre-ACA HMOs had no maximum out-of-pocket limits,

a protection that was added under the ACA. On the other hand, HMO enrollees faced annual deductibles in their ACA plans of roughly $1,600 while there was no deductible in their 2013 plans, and most migrants from both plan types also faced increased specialist copayment levels. It is also noteworthy that the opportunity to enroll in plans with out-of-network benefits declined, with only one PPO offered in the New Jersey non-group market in 2014 and none in 2015.

It is more difficult to assess whether Basic and Essential plan enrollees were made better or worse off in the transition to ACA coverage. B&E rating rules favored males and younger enrollees, compared to either pre-ACA New Jersey standard plans or plans offered under the ACA. Moreover, the opportunity to opt for the very limited benefits of the B&E ended with ACA implementation. Although those under age 30 and certain others were eligible for ACA catastrophic plans, our findings suggest that B&E enrollees did not view catastrophic plans as a strong substitute for their pre-ACA limited benefit plans. Although their premiums are comparable, B&E plans cover more "up-front" costs (e.g., no deductible) while leaving large financial exposure for those with high medical costs on the back-end. By contrast, the catastrophic plan benefit design is roughly the opposite, with high front-end cost exposure but good coverage for those with high expenses (e.g., unlike the catastrophic plan the B&E had no MOOP).

B&E migrants opting to buy off outside of the marketplace (who likely did so because they were not eligible for the ACA subsidies), disproportionately purchased bronze plans, but even so, they experienced premium hikes of 6 percent to 38 percent. They also faced deductibles of about $2,000 and copayments for primary care and specialty visits, which were not required by B&E plans although the number of covered visits were capped. All ACA plans had MOOP limits, which averaged about $6,000 for B&E migrants. B&E migrants with low demand for coverage and who were not ACA subsidy eligible most likely felt worse off in 2014, on the other hand, those with unexpected high medical expenses were no doubt better off.

The large share of "new enrollees" (i.e., not in the study migrant cohorts) that purchased on the ACA marketplace and received APTCs and CSRs, may suggest that these individuals were made better off. Many were likely uninsured prior to 2014 and the ACA arguably provided them with access to affordable coverage. On the other hand, if individuals purchased coverage mainly to avoid the ACA tax penalty and perceived themselves as having little need for health insurance, they may not feel better off as a result of acquiring coverage.

Our study also suggests that the overall non-group market in New Jersey was made substantially more sustainable by the ACA. Enrollment rose sharply in 2014 and the decline in premiums for those transitioning from pre-ACA standard plans is evidence of a more favorable risk pool, as is the younger age distribution of ACA enrollment compared to pre-reform standard plan enrollment. Further, consumer protections are greater under the ACA, including required maximum out-of-pocket limits. There likely are additional social benefits. In particular, with more

individuals insured with comparatively comprehensive benefits, health care providers may have experienced reduced bad-debt or charity care. On a cautionary note, our data also show that the New Jersey marketplace attracted disproportionately older enrollees compared to the direct purchase market, consistent with national evidence on selection into marketplaces (Graves and Nikpay 2017). These findings underscore the importance public policies protecting the marketplace from the effects of adverse selection. In the case of New Jersey and several additional states, the implementation of a state-specific individual mandate penalties in is an important step in that direction. Still, if states cannot replace premium and cost-sharing subsidies in the wake of an ACA repeal, the future of health insurance markets will be greatly imperiled.

Limitations

Our study is based on a single state, and we did not have access to information about consumer preferences, health status, or other characteristics. Further, our richest information is only about consumers who stayed with their non-group insurer in the transition to the ACA. We have no way of knowing the disposition of those who left their 2013 insurer. Given that total enrollment shifts were associated with relative premiums among insurers in the non-group market, we expect that many price-sensitive individuals switched insurers. But some may have elected to go without coverage.

In spite of these limitations, our analysis reveals that the ACA appears to have made many individuals better off in New Jersey. If Congress and the Trump administration succeed in further dismantling ACA coverage provisions, in the absence of added protections at the state level, millions of across the country would likely experience a reversal of the favorable transitions we document in this study. New Jersey consumers may be insulated from the impact of actions by Congress and the Trump administration to reverse the ACA compared to residents of other states. In June 2018, New Jersey became the first state to enact a state-level individual mandate in response to Congress ending enforcement of the ACA mandate (NJ P.L. 2018, c.31), it also joined the ranks of states authorizing a reinsurance pool to help keep its market stable (NJ P.L. 2018, c.24). To the extent other states fail to take similar steps, reversal of the gains New Jersey saw transitioning to the ACA could well foretell significant harm to non-group enrollees across the country.

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Center for State Health Policy

Center for State Health Policy
Rutgers, The State University of New Jersey
112 Paterson Street, 5th Floor
New Brunswick, NJ 08901

p. 848-932-3105 f. 732-932-0069
cshp_info@ifh.rutgers.edu
www.cshp.rutgers.edu