RUTGERS

Center for State Health Policy

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

Preventing Adverse Risk Selection in New Jersey's Health Insurance Exchange and the Outside Individual and Small-Group Markets

Joel C. Cantor, Sc.D.

August 2012

Table of Contents

Acknowledgments

Dina Belloff, former senior research analyst at the Center for State Health Policy, contributed to an early draft of this report. In addition, the comments of Kate Greenwood of Seton Hall Law School on a draft of this report are gratefully acknowledged. Funding for this Policy Brief was provided by the New Jersey Department of Banking and Insurance (NJDOBI) under a grant from the US Department of Health and Human Services to assist New Jersey in planning for creation of a state-based health insurance exchange.

Preventing Adverse Risk Selection in New Jersey's Health Insurance Exchange and the Outside Individual and Small-Group Markets

Joel C. Cantor, Sc.D.

Executive Summary

The Patient Protection and Affordable Care Act (ACA) requires states to make changes to their individual (non-group) and small-group health insurance markets. Additionally, states are encouraged, though not required, to create health insurance exchanges in a way that support consumer choices. If a state does not create an exchange, the federal government will do so for it.

Experts are concerned that adverse selection will occur when health exchanges are formed and when coverage expands in 2014. Adverse selection happens when a disproportionate number of unhealthy individuals enroll in one health plan or market segment rather than another. It can raise premiums, driving out healthy individuals and increasing public subsidy costs.

With a guarantee of coverage for pre-existing conditions, an unhealthy person could wait to enroll in a comprehensive coverage plan and only do so when health needs require, making his or her coverage disproportionately more costly. Those who are healthy may choose to remain uninsured and incur a penalty that is lower than the cost of insurance they feel they do not need.

This Brief reviews recent trends in New Jersey non-group and small-group markets, including market reforms in the last 20 years and those required by the ACA. The author suggests some policy options that may help mitigate the potential for adverse risk selection and assure a stable health insurance market.

The ACA will lead to changes in to New Jersey health insurance markets, some of which increase the chances of adverse selection. Key changes include:

- New Jersey's Basic & Essential option — available to individuals since late 2003, which helped reverse rapid deterioration in the non-group market — will be phased out under ACA. Some individuals will be eligible for limited catastrophic coverage under the ACA (e.g., those under 30 years old) but others will be required to purchase standard plans with premiums above their Basic & Essential rates.

- The small-group market will change from up to 50 employees to up to 100 (and possibly higher) over the next several years. Larger firms participating in small-group exchanges could increase the chances of adverse selection.
- Self-funding of insurance with added stop-loss coverage may encourage more small firms with comparatively healthy workers to self-fund, taking them out of the market and risk calculations.
- The level of exchange enrollment is unknown. High enrollment would likely mitigate risk selection while low enrollment would likely worsen it.

The decisions that New Jersey policymakers make over the next year will greatly influence market stability in the state. Federal requirements for plans may be more stringent within than outside the exchanges. Experts believe the most important actions states can take to mitigate adverse risk selection against the exchange is to "level the playing field" between exchange and non-exchange markets. The degree to which New Jersey permits variation in plan design within and outside the exchange may affect the extent of risk selection. For example, if plans offered outside the exchange offer benefit packages and premiums that are more attractive to healthier individuals than plans within the exchange, adverse selection against exchange plans would likely occur.

Other policy decisions may also affect the degree to which exchange plans experience adverse selection. For example, the degree to which regulations relieve self-funded small-group insurance plans from financial risk could greatly influence the degree to which comparatively healthy groups remain outside the exchange. In addition, the way finance exchange operations are financed could affect premiums within the exchange relative to plans outside the exchange, possibly contributing to adverse selection against of exchange plans. Finally, a robust outreach and public education effort to maximize enrollment in exchange plans can help reduce the risk of adverse selection by encouraging the enrollment healthy individuals.

Preventing Adverse Risk Selection in New Jersey's Health Insurance Exchange and the Outside Individual and Small-Group Markets

Joel C. Cantor, Sc.D.

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 encourages them to create health insurance exchanges to support consumer choice and promote efficient and effective health insurance markets.[1] These reforms represent major changes for individuals and small groups purchasing health insurance in most states. The changes that will be experienced by New Jersey health insurance consumers will be somewhat less than those in other states because New Jersey already had enacted many of the major market reforms called for in the ACA. Nevertheless, health insurance market dynamics in New Jersey, and indeed in other states around the nation, will change as ACA reforms are implemented.

This Policy Brief addresses a major concern about the functioning of health insurance markets following the implementation of the ACA coverage expansions in 2014, the prospect that health plans offered through the new state exchanges will experience adverse risk selection. Adverse selection occurs when a disproportionate number of unhealthy individuals enroll in one health insurance plan or market segment. Policymakers are particularly concerned about the balance of risk selection between exchange and non-exchange health plans offered to individuals and small groups. Adverse selection among plans within health insurance markets is also of concern. As is discussed in detail below, new market rules guaranteeing access to coverage regardless of health status and limiting variability in pricing based on risk-related factors increase the possibility of adverse selection. In addition, less healthy individuals typically enroll in more comprehensive coverage that may cost more while healthy individuals tend to enroll in less comprehensive coverage that costs less and therefore more closely matches their own expected health care spending. Adverse selection can occur across plans within the exchange or between exchange and non-exchange plans. Both are of concern as adverse selection eventually leads to cycles of increases in premiums that drive out healthy enrollees

[1] The federal government will create a health insurance exchange for states that do not create their own.

making coverage unaffordable for remaining less healthy enrollees. Risk selection against the exchange can also increase the cost of public subsidies as premiums increase.

Analysts have suggested that adverse selection against health insurance exchanges is a very real possibility. In a national study, Trish et al. (2011) estimate that enrollees in exchanges may be higher risk than those currently enrolled in the private market. This study projects that new individual coverage enrollees will be older, less educated, and lower income than those currently enrolled in private insurance. Those who are eligible to enroll in the exchange but choose to remain uninsured are projected to be healthier and wealthier than those who enroll, indicating that subsidies and penalties for failing to enroll may provide insufficient incentives to overcome affordability barriers even at higher income levels. While the composition of enrollment in the exchange will vary by state, New Jersey-specific estimates suggest that the exchange population may have slightly worse health status than those in the current non-group market or the post-ACA non-group market outside the health benefits exchange.

Prior state initiatives also suggest that risk selection may be of concern in the ACA exchanges. States have attempted to create exchange-like health insurance purchasing cooperatives in the past and most have been subject to adverse risk selection (Jost 2010b). This occurred because the purchasing pools were generally unable to attract a large enough group of healthy enrollees. When groups can purchase insurance outside of the exchange, they may be able to find more competitive prices and policies than purchasing through the exchange. These experiences are relevant to the implementation of exchanges under the ACA to some extent, although lessons from purchasing pools may be limited because they have been offered in voluntary markets and generally without public subsidies.

The ACA includes provisions designed to minimize adverse risk selection across plans within the exchange and between the exchange and the outside market. However, even with these provisions, the way exchanges are designed and markets are regulated can have significant implications for risk selection. States may adopt any of several options to help mitigate the potential for adverse risk selection. Some of these may be helpful to New Jersey as it moves forward with plans to create a state-based health insurance exchange.

The section below describes features of the New Jersey insurance market regulatory context and requirements of the ACA that have potential ramifications for risk selection. This description is followed by discussion of policy options for New Jersey to consider with the aim of protecting its exchange from adverse selection and promoting stability in its health insurance markets. Whether or not New Jersey ultimately decides to create its own health insurance exchange or leave that task to the federal government, the broad scope of implementation decisions that New Jersey needs to make over the next year will greatly influence market stability.

Policy and Market Context

The ACA includes significant regulatory reforms for the individual and small-group health insurance markets, both within and outside of health insurance exchanges. These market reforms are designed to improve access to coverage and create more uniform premium pricing for enrollees. New Jersey instituted similar market reforms for individuals and small groups nearly 20 years ago that largely remain in place today. This section reviews recent trends in New Jersey's non-group and small-group markets, discusses the state's current regulatory approach, and provides an overview of changes required by the ACA.

New Jersey's Markets

New Jersey reforms in the 1990s implemented access and premium requirements similar to those prescribed by the ACA (Table 1). The ACA requires that state regulations must not "prevent the application" of the ACA, thus New Jersey rules that are less restrictive than the ACA will have to be changed by 2014 (Jost 2010b). In particular, policies will no longer be rated based on gender, so females will face somewhat lower premiums, while males will face somewhat higher premiums for individual policies. Small groups that are disproportionately female will see a reduction in their premiums. Non-group market rate bands will narrow somewhat (from 3.5 to 1 to 3 to 1), modestly lowering premiums for older individuals relative to younger enrollees. It appears that New Jersey may elect to make rate bands for the small-group market wider under ACA rules (i.e., move from the current 2 to 1 up to as high as 3 to 1) so premiums may vary more than current New Jersey regulations permit based on age and other factors allowed by the ACA.

Table 1: ACA and Current New Jersey Non-Group and Small-Group Access and Premium Rules

ACA Requirements[a]	Current New Jersey Requirements
Guaranteed issue and renewal	Guaranteed issue and renewal
Enrollment waiting periods limited to 90 days	No enrollment waiting periods[b]
No pre-existing condition exclusions	Limited pre-existing condition waiting periods[c]
No life-time or annual dollar limits	Limits permitted (annual)
Maximum premium variation in both non-group and small-group markets of 3 to 1, based on age, geography, family structure, and tobacco use[d]	Maximum premium variation: • 3.5 to 1 based on age and family structure for standard non-group plans • 3.5 to 1 based on geography, family structure, age, and sex for non-group limited benefit B&E plans[e] • 2 to 1 based geography, family structure, age, and sex for small-group plans

Sources: Jost 2010b; NAIC 2011; Baker 2011; NJDOBI 2011a, 2011b; Belloff and Cantor 2008

[a] Applies to all non-grandfathered plans. Prohibition on lifetime limits also applies to grandfathered individual and small-group plans, and the prohibition on pre-existing condition exclusions and annual limits applies to grandfathered small-group plans.

[b] Small groups may impose a 6 month waiting period on new employees.

[c] Waiting periods of 12 months for non-group coverage and 6 months for groups of 2 to 5 and groups up to 50 without prior creditable coverage.

[d] Variation by tobacco use limited to 1.5 to 1.

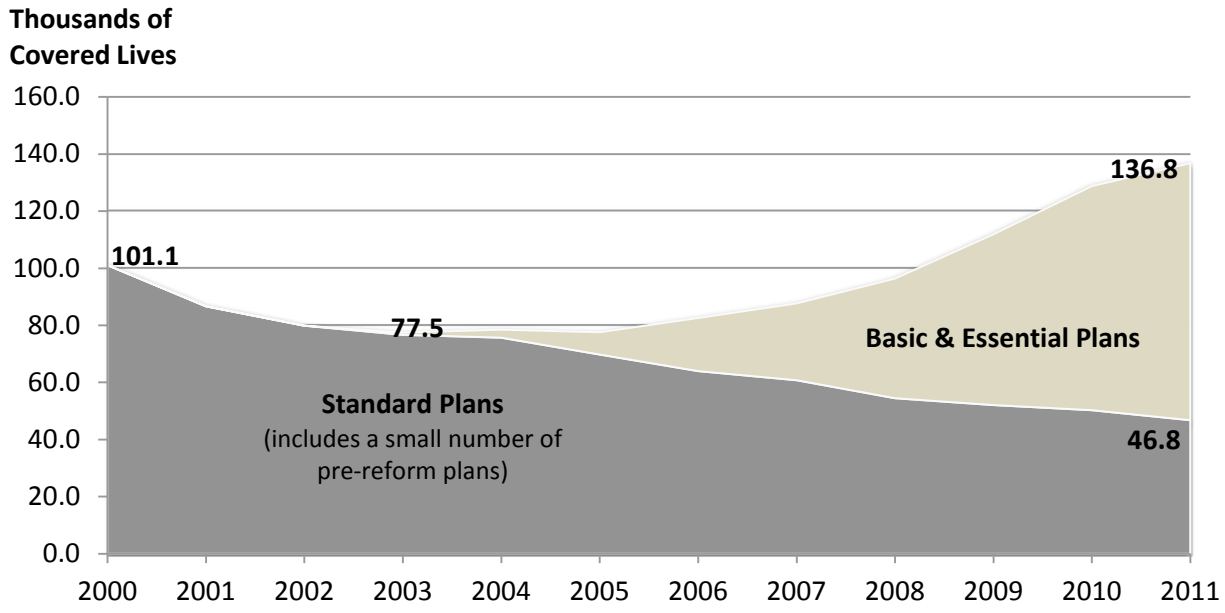
[e] B&E is Basic & Essential plans, described below.

The requirement that most individuals purchase coverage in 2014 or face penalties and the availability of premium tax credits for persons up to 400% of the federal poverty level are key differences between the ACA and current New Jersey health insurance markets. These features of the ACA are perhaps the most important means of averting adverse selection. In its voluntary non-group market, New Jersey's broad access and community rating rules enacted in 1992 with the creation of the Individual Health Coverage Program (IHCP) contributed to a steep decline in enrollment and an adverse risk selection spiral beginning in 1996 (Monheit et al. 2004). The availability of state-funded subsidies for low income non-group subscribers up to 250% of the federal poverty level until 1996 may have contributed to that market's stability until that time (Monheit et al. 2004; Swartz and Garnick 2000).

New Jersey's Basic & Essential (B&E) option, a reduced benefit option that became available in the individual market in March 2003, appears to have reversed the rapid enrollment decline in the state's non-group market, even as standard plan enrollment has continued to erode (Figure 1). New Jersey's B&E plan features annual dollar limits (NJDOBI 2011a) and is operating under a federal waiver of ACA rules proscribing such limits which will expire at the end of 2013. As of the first quarter of 2011, enrollment in B&E plans represented nearly two-thirds of total IHCP enrollment. Indications are that the B&E has attracted a healthier mix of risk into the New Jersey non-group market. Starting in 2014, "catastrophic plans" may be offered to individuals under age 30 or who receive affordability or hardship

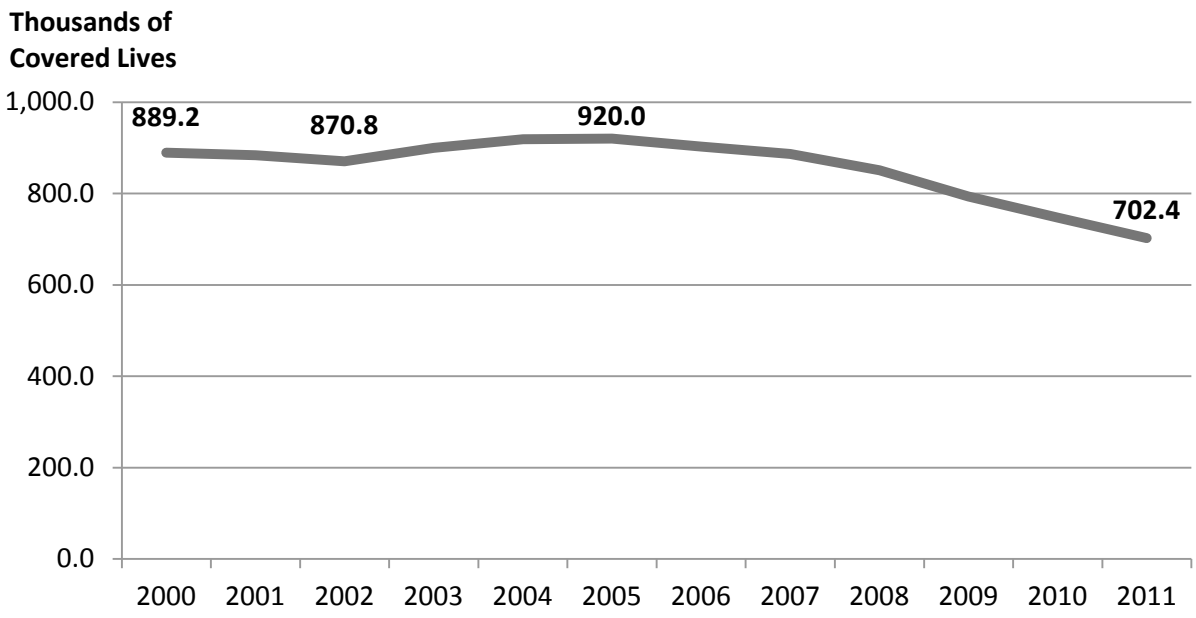
exemptions from the individual mandate. The catastrophic plans may have lower actuarial value than other qualified health plans.

Figure 1: New Jersey Non-Group Market Enrollment, Fourth Quarter 2000-2011



Source: New Jersey Department of Banking and Insurance, March 2012
http://www.state.nj.us/dobi/division_insurance/ihcseh/enroll/4q11historical.pdf

Figure 2: New Jersey Small-Group Market Enrollment, Fourth Quarter 2000-2011



Source: New Jersey Department of Banking and Insurance, March 2012
http://www.state.nj.us/dobi/division_insurance/ihcseh/enroll/4q11historical.pdf

In spite of its guaranteed issue and modified community rating rules, the New Jersey small group has not suffered the fate of the non-group market (Figure 2). After a long period of relative stability, New Jersey small-group market enrollment has declined since about 2007, although it is likely that this trend is attributable to the effects of the national recession (Holahan 2011).

New Jersey has implemented regulations in its small-group and non-group markets to limit the possibility of enrollees switching plans when they become sick. Persons enrolled in a non-group plan in New Jersey may switch coverage once a year during the individual market's open enrollment period in November, and small-group enrollees whose employers offer more than one plan may also only switch during their employer's annual open enrollment period. (NJDOBI 2010a, 2011b). The ACA requires that the exchange operate similarly, with annual enrollment periods, except in specific circumstances (e.g., loss of qualifying employer coverage or an inter-state move).

ACA-mandated changes in the size of groups purchasing in the small-group market may increase the possibility of risk selection against this market. Specifically, the ACA defines the small-group market to include employers with between two and 100 employees. Starting in 2014, the ACA offers states the option of increasing the maximum size threshold in the small-group market to 100 employees, but it requires them to do so by 2016. Many states, including New Jersey, currently define small groups as those up to 50 employees. Further, in 2017, states may open small-group exchanges to businesses of over 100 employees. Permitting larger firms to enroll through the exchange raises the prospect of adverse selection. Larger firms have more latitude to bear actuarial risk through self-funding, offering employers with lower-than-average risk the option of leaving the risk pool. This dynamic also applies to firms' decisions whether to retain "grandfathered" health plan status or to move into the exchange. Health insurance plans that have not substantially changed enrollee cost-sharing including deductibles and copayments, the scope of covered benefits, or premium contribution rates since March 23, 2010 are deemed "grandfathered" and exempt from many ACA insurance regulations, including rating rules.

One recent analysis by RAND suggests that decisions by employers to retain or drop grandfathered plan status could have large impacts on enrollment and premiums within the small-group exchange, known as the Small Business Health Options Program or SHOP exchange (Eibner et al. 2012). This study projects that SHOP enrollment could drop by about half and premiums increase as much as 9% if small employers do not abandon grandfathered status as most are expected to do by 2016. The RAND analysis also projects that the propensity of small firms to self-fund does not pose a great threat to the SHOP risk pool because few small firms self-fund. Other analysts, however, are less sanguine that self-funding does not threaten the SHOP risk pool as the ACA may significantly increase incentives for small firms to self-fund (Hall 2012).

Table 2 shows the current distribution of self-funding among New Jersey private sector employers as of 2010. While the rate at which New Jersey firms self-fund was lower than the national average among relatively small firms at that time, the self-funding rate was higher among very large firms (500 or more employees). It does not appear that firms in the 51 to 100 range were more likely to self-fund than those under 50, although stronger incentives to self-fund may have a greater impact among these firms. These data suggest that opening the SHOP to firms over 100 may increase the possibility of risk segregation among firms in the SHOP. Moreover, anticipated changes in the small-group coverage market could lead to greater self-funding even among small firms. Anecdotal information suggests that stop-loss carriers have recently begun assertively marketing products to small firms (Hall 2012; Insurance Journal 2012; Beeson 2012). The availability of advance funding, the practice of stop-loss carriers paying claims that have met deductibles as they are incurred, may further encourage small businesses to self-fund because it can ease employers' cash flow in case of large claims.

Table 2: Percent of Private-Sector Establishments That Offer Health Insurance That Self-Insure at Least One Plan, by Firm Size, New Jersey and United States, 2010

		Number of Employees				
	All Firms	**Under 50**	**50 or More**	**Under 100**	**100-499**	**500 or More**
New Jersey	24.9	10.2*	68.0	10.8*	20.4	88.3
U.S.	35.8	12.7	63.3	13.0	26.5	81.9

Source: Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2010 Medical Expenditure Panel. Survey-Insurance Component, Table IIA2a available at:
http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2010/tiia2a.pdf
*Estimate does not meet statistical precision standards and should be interpreted with caution.

Finally, subsidies available under the ACA and the enrollment mandate should reduce the risk of adverse selection in the New Jersey exchange, although some have argued that penalties for violating the individual mandate are too weak to fully achieve this aim (NAIC 2011). Some New Jersey health insurance stakeholders, especially insurance carriers and brokers, share the view that incentives to enroll under the mandate are likely to be too weak to guard against adverse selection (Cantor, Koller, et al. 2011). Using estimates from research on health insurance purchasing behavior, the Urban Institute projects that between 60% and 70% of the uninsured, depending on income and other factors, will purchase coverage under the ACA mandate (Buettgens, Holahan, and Carroll 2011).

Clearly, the degree of take up is likely to affect the extent of risk selection among plans within the exchange or between the exchange and outside markets. Consistent with the market circumstances noted above, it appears that the uninsured population in New Jersey that will be eligible to enroll in coverage through the exchange has somewhat worse average health status than the state's non-group market as of 2009, especially among adults age 35 to 64 (Cantor, Gaboda, et al. 2011). In addition, those who will receive federal subsidies for coverage are

estimated to be somewhat sicker than current non-group enrollees. High enrollment in New Jersey's exchange may mitigate some of this risk selection problem, but if enrollment is low then risk selection issues would be worse.

ACA Mechanisms for Mitigating Risk Selection

In addition to access and rating regulations, the ACA includes some provisions to mitigate the possibility of adverse selection. First, the ACA requires that employers and individuals enroll in the exchange in order to access federal tax credits and cost-sharing subsidies. Small businesses that begin offering health insurance coverage to employees through the exchange will be eligible for tax credits for two years. Individual subsidies based on income will also be available only for policies purchased through the exchange. These provisions of the ACA will mitigate adverse selection by attracting greater enrollment in the exchange.

The ACA also established annual open enrollment periods, a strategy that should discourage individuals from waiting until they have health expenses to enroll in a plan. It also sets some requirements for plans offered both inside and outside the exchange that will "level the playing field" and discourage risk selection. For example, plans offered outside the exchange must include the same essential health benefits as plans inside the exchange, and community rating rules apply both within and outside the exchange.

In addition, the ACA requires insurers to create a combined risk pool for individuals purchasing any given plan whether within or outside the exchange. Similarly, risk for small groups within the exchange must be pooled with small groups outside of the exchange when determining premiums for small groups. To the extent that states permit health insurers to operate exclusively outside the exchange, risk pooling between exchange and non-exchange plans would not occur. In addition, grandfathered plans are excluded from the joint risk pools.

Many of the rules included in the ACA to help mitigate adverse selection against the exchange were originally part of the 2006 Massachusetts health reform legislation, including the individual coverage mandate, the availability of subsidies only through the exchange (called the Connector in Massachusetts), and requirements that risk be pooled across the Connector and non-Connector markets (Silow-Carroll et al. 2011). Similarly, Utah's health insurance exchange requires that insurers establish a single risk pool for exchange and non-exchange products.

The ACA also includes risk adjustment mechanisms to offset costs to insurers experiencing adverse risk selection. States are required to employ a method for assessing plans with unusually low-risk enrollees to compensate plans with unusually high risk enrollees (Jost 2010a, 2010b). Unfortunately, many researchers believe that available risk-adjustment methods tend to estimate more favorable risk than actual experience would indicate (Baker 2011; Sturm 2011; Lueck 2010). Federal rules will require insurers to submit standardized information to support the risk-adjustment process, but some analysts argue that some states

(including New Jersey) will be at a disadvantage in calculating risk adjustments because they will not have direct access to detailed private claims records (Jost 2010a; Lueck 2010). Setting up a fair risk-adjustment mechanism is complex and must account for the state's specific population and continuous adjustments and reassessments are necessary (Sturm 2011).

The ACA also includes two temporary methods of adjusting for the potentially unequal distribution of risk. These temporary methods will be applied starting in January 2014. These mechanisms provide insurers with assurance that as enrollment in exchanges grows they will be protected. Later, it is anticipated that states develop enough experience to implement longer term risk-adjustment mechanisms (Jost 2010b). From 2014 to 2016, private health plans (including third-party administrators managing self-funded plans as well as grandfathered plans) will pay a fee to fund a reinsurance mechanism for high-cost enrollees in non-grandfathered non-group plans. Also, during the same time period, qualified health plans (i.e. those plans that are eligible to be sold within an exchange) will qualify for a "risk-corridor" program. This program will transfer revenue from qualified health plans that experience better-than-average risk to those enrolling less healthy individuals (Jost 2010b).

State Policy Options to Address Potential Sources of Adverse Selection

According to the National Association of Insurance Commissioners, "The most important thing that states can do [to mitigate adverse risk selection against the exchange] is to help facilitate a level playing field between participants inside and outside of the exchange" (NAIC 2011, 5). Federal requirements for plans are more stringent within than outside the exchanges. In particular, only federally "qualified health plans" (QHPs) may be offered in exchanges. In addition to meeting state regulations governing all individual and small-group insurance offerings (both in and outside the exchange), QHPs will also have to meet other requirements that could render them more costly than plans sold outside of the exchange (Jost 2010b).

Specifically, QHPs are required to offer an "adequate network" of providers (including "essential community providers" such as community health centers) and follow "fair" marketing standards. The ACA does not require states to apply these requirements to plans outside of the exchange. So, if certain specialists or other providers that appeal to older or sicker enrollees are more readily available in exchange provider networks, higher risk individuals may disproportionately enroll in exchange products (NAIC 2011). Of note, the availability of essential community providers in a network may attract less healthy enrollees, as these providers tend to have patients in with greater health problems (Lloyd and Gaboda 2011). Exchange plans must also follow marketing standards that do not encourage healthier

consumers to enroll or discourage less healthy consumers to enroll in a particular plan (NAIC 2011).

Insurers are not required by the ACA to participate in the exchange. Absent state regulations to the contrary, insurers may choose to limit participation to the non-exchange market, offering less comprehensive policies that are attractive to young and healthy populations. As noted, plans offered by insurers exclusively operating outside exchanges will not be pooled for rating purposes with plans inside the exchange, raising the specter of risk segmentation (Lueck 2010).

Plan Regulation Within and Outside the Exchange

New Jersey policymakers face a range of options for structuring market participation rules to "level the playing field" between the exchange and non-exchange markets. The first set of choices relates to the structure of the non-group and small-group markets outside the exchange. Options include:

- Eliminate the health plan market outside of the exchange, to the extent permitted by the ACA.
- Retain markets outside the exchange, but require plans in the non-exchange market to be qualified health plans (QHPs) (Jost 2010b; Lueck 2010).
- Allow non-qualified plans outside the exchange, but prohibit insurers not participating in the exchange from selling plans with comparatively low actuarial values, such as bronze level or catastrophic coverage, outside of the exchange (Jost 2010a).

Each of these options involves tradeoffs. Eliminating the market outside the exchange would mostly eliminate risk-selection concerns between exchange and non-exchange plans (selection stemming from self-funded plans and grandfathered plans which must be offered outside the exchange would still be possible), but this option would cause significant disruption to the existing coverage markets. Moreover, the exchange imposes other limitations that policymakers may find undesirable. In particular, undocumented immigrants are prohibited by the ACA from buying coverage in the exchange, even if they are not seeking subsidies. Nationally, an estimated 41% of undocumented immigrants have some form of health insurance (Passel and Cohn 2009). Since the undocumented are ineligible for public coverage, those with insurance obtain it in private markets. New Jersey has the fourth highest concentration of undocumented persons in the US, an estimated 6.2% of the state population, or 550,000 individuals (Passel and Cohn 2011). Thus, eliminating private insurance markets outside the exchange would likely add thousands of undocumented persons to the ranks of the uninsured in New Jersey. In addition, abortion coverage must be segregated from comprehensive plans within the exchange, making enrollment, premium collection, and plan administration complex. Plans outside the exchange may integrate abortion services.

Retaining markets outside the exchange, but limiting the market to QHPs would eliminate many possible drivers of selection against the exchange stemming from network adequacy, marketing, and essential community provider requirements. Regulations could also require carriers offering outside the exchange to affirmatively market at least one silver and one gold-level plan, avoiding the problem of carriers offering only plans attractive to the young and healthy outside the exchange. While clearly desirable from the perspective of avoiding selection, this option would add new regulatory burdens on plans outside the exchange.

The third option, allowing non-qualified plans outside the exchange but prohibiting carriers from selling only plans with comparatively less rich benefits, would be less disruptive to existing markets but would offer less protection from risk selection. Specifically, this option would not address drivers of risk selection stemming from differing regulations between exchange and non-exchange plans. Even if a requirement to offer fully qualified silver and gold level plans outside the exchange were imposed, allowing carriers to offer other plans could lead to risk selection.

To date, other states have sought to level the playing field in different ways. For example, Massachusetts requires insurers to offer the same health plan benefits design and premiums inside and outside the Connector, while Utah requires insurers to offer their most popular non-exchange plans in the exchange (Silow-Carroll et al. 2011). Like Massachusetts, the California exchange law requires that all plans offered in the non-exchange market must also be offered in the exchange. The state also requires "fair and affirmative" marketing of any plan offered in the exchange (Shewry 2010). California's exchange legislation allows the exchange board to develop a standardized product design; and if it does so, carriers in the non-exchange market must also offer those standardized plans (Silow-Carroll et al. 2011; Weinberg and Haase 2011; Shewry 2010). California allows catastrophic plans to be sold only within the exchange for persons eligible to purchase through the exchange, although persons not eligible to buy in the exchange may purchase catastrophic plans in the outside market (Silow-Carroll et al. 2011; Weinberg and Haase 2011; Shewry 2010). Oregon's June 2011 exchange legislation gives the Oregon Health Insurance exchange authority to "ensure fair competition of carriers in and outside the exchange" by creating standardized health benefit plan options both in and outside the exchange (76th Oregon Legislative Assembly 2011).

The extent to which New Jersey regulators permit variation in plan design, both within and outside the exchange, may also affect the degree of risk selection. Plan design remains a concern, even if plans outside the exchange must be certified as QHPs. As noted by the National Association of Insurance Commissioners, "Even within the same actuarial value, insurers would still be able to use cost sharing levels and the addition or limitation of certain benefits to differentiate their plans in order to entice or deter certain [less healthy] customers from enrolling" (NAIC 2011). As discussed above, plans offered in the New Jersey non-group market have been highly standardized but much more variability is permitted in the small-group

market, where riders are frequently used to tailor benefits for individual employers. Regulations imposing more standardization would make it easier for consumers to compare plans based on price, network composition, and other features and reduce the likelihood of risk selection, although they would, by definition, limit consumers' options. The benefits of plan standardization must be balanced by the desire to offer consumers more choices to meet their needs (Carey 2010). Regardless of how much standardization New Jersey policymakers permit, it appears to be particularly important that standardization rules apply equally to plans outside and inside the exchange.

In spite of regulations designed to prevent risk segmentation driven by plan design, permitting greater variability in plan design outside the exchange than within may lead to greater risk segmentation. In addition, as discussed further below, the extent to which insurers are required to offer identical plans within and outside the exchange can set the stage for more or less adverse selection. Exchange legislation in California acknowledged this possibility; its exchange legislation requires that insurers participating in the exchange offer at least one plan option in each of the four tiers of coverage and that the same products be sold outside of the exchange (Silow-Carroll et al. 2011; Shewry 2010).

Additional Issues in SHOP Exchange Design

As discussed above the small-group market poses unique challenges. Traditionally, small employers in New Jersey offer one or two plan options to employees. However, the ACA will allow employers to designate a level of coverage (actuarial tier) and then employees may choose any plan within that level. It appears that states may offer alternative options for structuring employer engagement in the SHOP exchange, including allowing employees to select from any available QHP or making only a single QHP available. Broader employee choice raises the prospect of adverse selection among plans. Higher risk enrollees may prefer certain provider networks or other benefit features, even within a given level of coverage (NAIC 2011; Carey 2010). In addition, if employers choose to offer a defined contribution (a fixed dollar amount) that employees use to purchase any insurance plan offered through the exchange, this could greatly increase the chance of adverse selection across plans and tiers of coverage within the exchange (NAIC 2011). (A separate Issue Brief addresses the defined contribution approach for the SHOP, see Chou et al. 2011).

New Jersey policymakers could consider several options to mitigate the possibility of risk selection stemming from the structure of the SHOP exchange, including:

- Limit larger groups access to the SHOP exchange, to the extent permitted by the ACA,
- Limit or closely regulate the availability of stop-loss coverage in the small-group market,
- Increase group minimum participation requirements and minimum contribution levels, and
- Carefully structure employee choice.

Small-Group Definition. As noted, the ACA requires SHOP exchanges to enroll small groups up to 50 employees starting in 2014 and 100 employees in 2016. States may open SHOP exchanges to the 100 threshold earlier, although that may increase the possibility of adverse selection among grandfathered or self-insured plans. Likewise, states may elect to allow large firms (over 100 employees) to enroll through the SHOP starting in 2017. As illustrated above, increasing the threshold above 100 may greatly expand the chances of risk selection as employers elect whether or not to self-fund or enter the exchange.

Stop-Loss Coverage. As discussed above, the health plans of small employers that elect to self-fund (i.e., bear financial risk) are exempt from many small-group insurance regulations. Groups with comparatively healthy workforces have financial incentives to self-fund to avoid premium rating rules, requirements related to essential health benefits, and other regulations. Traditionally, small firms have not self-funded in large numbers because of the risk involved. However, increased insurance regulations promulgated by the ACA may increase their incentive to do so. Typically, self-funded businesses purchase stop-loss coverage (also known as excess risk insurance) to limit their down-side liability. Anecdotal reports suggest that the ACA may have led some sellers of stop-loss products to market more aggressively or redesign their products to attract more small employers (Hall 2012), a pattern that appears to apply to New Jersey (Insurance Journal 2012; Beeson 2012). Practices such as advance funding stop-loss claims may further encourage even very small firms to self-fund by removing even short-term risk of high expenses. Stop-loss coverage is regulated by states (including New Jersey) but typically not as stringently as insured plans. Hall (2012) suggests that states should carefully monitor their stop-loss markets and revisit their regulations, offering several options. First, the minimum "attachment point" (i.e., deductible above which stop-loss coverage begins) might be raised. Currently, New Jersey requires minimum attachment points of $20,000 per insured individual and 125% of group expected claims (NJDOBI 2012). While this threshold is consistent with recommendations of the National Association of Insurance Commissioners, Hall (2012) suggests that this threshold is obsolete and should be reconsidered. He also suggests that states consider banning stop-loss coverage for very small firms or allowing the sale of stop-loss coverage only for employer plans that conform with ACA requirements (e.g., by offering all essential health benefits). There is some doubt about the permissibility of the latter approach under federal law.

Participation and Contribution Rules. Currently New Jersey has a 75% minimum participation rate in the small-group market (NJDOBI 2011b). Employees with coverage from other sources (e.g., Medicare, Medicaid, or a spouse's group plan) are counted toward that minimum, but those covered by the employers' self-funded plans are not. Permitting the offer of plans from more than one carrier raises the specter of risk selection. New Jersey policymakers could opt to

set limits on the number of carriers from which an employer may purchase plans. It may be especially important to restrict employers to purchasing all of their plans either within or outside the exchange but not a mix of the two.

Currently, New Jersey small businesses are required to contribute a minimum of only 10% of premium costs in the small-group market (NJDOBI 2011b). This rule encourages employers to offer coverage, but may compound risk segmentation in instances where employees have a wide range of plan choices. Policymakers may wish to revisit this minimum, particularly in light of the availability of federal subsidies for some small firms.

Structuring Employee Choice. As discussed elsewhere (Chou et al. 2011), there are tradeoffs between offering employees a broad range of plan options and preventing risk selection. In particular, it may be advisable to limit small groups to select plans only within or outside the exchange, but not a combination of the two. Rules limiting the number of coverage tiers that small employers may offer could also help prevent risk segmentation among plan types.

Other Exchange Design Considerations

New Jersey is also faced with decisions about regulations that could affect the balance of risk between exchange and non-exchange markets, including rules guiding:

- Exchange administrative charges, including broker fees and resources to fund navigators,
- Mandated benefits,
- Carefully structure open enrollment periods, and
- Enhanced risk adjustment strategies.

Exchange Administrative Fees. Exchanges will incur administrative expenses and federal grants to support these expenses are available only through 2014. State-operated exchanges will have to create on-going sources of support for administration after that date. If fees to support exchange operations are applied to plans purchased through the exchange but not the outside market then exchange plans would be comparatively more expensive, encouraging selection against the exchange (NAIC 2011). Spreading such fees across all state-regulated plans would have the virtue of lowering the burden on any given subscriber (assuming that carriers pass such fees to consumers in the form of higher premiums), and would not contribute to price differences between exchange and non-exchange plans. If the exchange infrastructure is seen as mainly benefiting those who enroll through the exchange, then broad-based fees may be seen as unfair to non-exchange buyers. However, if the exchange effectively increases consumer information and competition for all insurance buyers, then broad-based fees may be viewed as equitable. It is noteworthy that at least one state (Oregon) will require its exchange

internet clearinghouse and toll-free telephone hotline to provide information on plans both in and out of the exchange, including standardized comparisons of plan benefits and costs (76th Oregon Legislative Assembly 2011).

State policymakers can also address incentives for risk selection in structuring broker commissions. Broker commissions that are identical for plans sold inside and outside of the exchange would reduce the likelihood of brokers encouraging enrollment in a particular market (Jost 2010a; NAIC 2011; Lueck 2010). New Jersey regulators could require carriers to offer consistent broker commissions across exchange and non-exchange plans.

The ACA requires exchanges to engage navigators, although federal funds are not available for this function. As discussed above with regard to financing the exchange more generally, if the costs of navigators are funded exclusively through fees on plans sold within the exchange, then exchange plans would be more costly than equivalent plans outside the exchange, thereby encouraging selection against exchange plans.

Mandated Benefits. New Jersey will need to consider the plans to which it applies state-mandated benefits. This choice will be affected by how New Jersey elects to set essential health benefit standards. In any case, if benefit mandate requirements differ between exchange and non-exchange plans, adverse risk selection would likely occur against the market with the greater scope of required benefits.

Open Enrollment Periods. The ACA requires annual and certain special open enrollment periods as one way to stem risk selection, but states have discretion about related enrollment rules (NAIC 2011). To the extent permitted by the ACA, New Jersey might consider imposing penalties for re-enrollment following a specified period (e.g., over 60 days) of non-coverage, and limit the extent to which consumers are permitted to "buy up" to more generous coverage tiers. For example, states could limit consumers ability to raise their coverage level to one tier each year (e.g., from silver to gold). This would discourage individuals to hold only minimal coverage until they become ill. Of course, such policies must be balanced against encouraging consumer choice and promoting access to care.

Enhance Risk Adjustment. New Jersey might consider using prospective and retrospective risk adjustment rather than retrospective risk adjustment alone. Risk adjustment might be less complicated if health care records can be used in advance to properly price policies for the enrolled group (Baker 2011). Including prospective risk adjustment may make it easier for insurers to enter the market by stabilizing revenue in the event that the new insurance plans attract a disproportionate number of high risk enrollees (Jost 2010a). In addition, using both prospective and retrospective risk adjustment serves as a double check that insurers are being adequately assessed of their plan's risk profile.

Outreach, Enrollment, and Enforcement

Perhaps the most important hedge against risk selection is taking measures to assure high take-up of coverage among eligible populations. Groups with more health needs naturally have greater motive to buy coverage; making effective outreach, marketing, and establishing simple enrollment procedures essential. Many stakeholders worry that the penalty for not meeting minimum coverage requirement is too weak to promote high take up. Designing and implementing effective marketing messages and structuring an effective navigator program can add "carrots" to the "stick" of the penalty. Massachusetts invested significant effort to its outreach and enrollment efforts when implementing its insurance mandate (Michael, Koller, and Cantor 2012). The New Jersey media market is notably expensive and fragmented, underscoring the importance of early planning for marketing and outreach efforts.

Others have emphasized the importance of state enforcement of rules designed to avert adverse selection (NAIC 2011). Even rules imposed by the ACA, such as open enrollment periods, will only be effective if they are implemented vigorously.

Conclusions

The ACA includes significant new reforms to health insurance markets across the country in an effort to make insurance more affordable and accessible. New Jersey is better prepared to adopt these changes in some respects, having already implemented similar insurance market reform measures nearly 20 years ago. Still, the ACA sets up a new health insurance marketplace via state-based health insurance exchanges that will compete with existing state regulated markets, raising a new challenge. Risk selection against the exchange would raise premiums for low income individuals and eligible small businesses as well as increase the cost of federal tax subsidies. Moreover, risk segregation can also challenge the viability of plans or market segments that attract disproportionately high-cost patients. While the ACA offers some protections against adverse selection, ultimately the viability of the exchange and stability of insurance markets will depend to a great extent on decisions that states face.

Early research indicates that enrollees in the exchange generally, and in New Jersey specifically, may be at least somewhat less healthy than those currently enrolled in private insurance (Trish et al. 2011; Cantor, Gaboda, et al. 2011). Some experts wonder if the ACA's provisions will go far enough in preventing adverse risk selection between exchange and non-exchange plans and across plans and tiers within the exchange. Available analyses suggest that careful consideration of market rules that create a "level playing field" between the exchange and outside markets is essential.

New Jersey should draw lessons from its experience in the Individual Health Coverage Program (IHCP). Following a brief period of growth during a period when state subsidies were available, enrollment in standard health insurance plans in the IHCP has seen steady erosion.

Between 2000 and 2001, non-group standard plan enrollment dropped by more than half (see Figure 1 above). In an attempt to stem the decline of this market, policymakers created the Basic and Essential (B&E) program, in which enrollment has, in fact, grown substantially but led to a highly fragmented market. Under the ACA, the B&E plans will be phased out, offering an opportunity to structure a better-functioning market.

As policymakers consider their options for assuring a robust and stable exchange market, they must consider tradeoffs between establishing regulatory parity between plans within and outside the exchange and permitting flexibility in plan design and maximizing the breadth of choices available to consumers. The creation of exchanges and other requirements of the ACA make this a uniquely important moment for New Jersey policymakers.

References

76th Oregon Legislative Assembly. 2011. "Senate Bill 99." Oregon State Legislature. http://www.leg.state.or.us/11reg/measpdf/sb0001.dir/sb0099.intro.pdf.

Baker T. 2011. *Health Insurance, Risk, and Responsibility after the Patient Protection and Affordable Care Act*. Research Paper, no. 11-03. Philadelphia: University of Pennsylvania Law School, Institute for Law and Economics. http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1759366.

Beeson E. 2012. "Small Companies Look to Self-Insure Benefits, But State Warns About Stop-Loss Discrimination." Star-Ledger. http://www.nj.com/business/index.ssf/2012/04/post_177.html.

Belloff D, and J Cantor. 2008. *Private Insurance Coverage: A Case Study of the Small Group Market in New Jersey*. Albany, NY: The Nelson A. Rockefeller Institute of Government, Health Policy Research Center. http://www.rockinst.org/pdf/health_care/2008-08-private_insurance_coverage.pdf.

Buettgens M, J Holahan, and C Carroll. 2011. *Health Reform Across the States: Increased Insurance Coverage and Federal Spending on the Exchanges and Medicaid*. Washington, DC: Urban Institute. http://www.urban.org/UploadedPDF/412310-Health-Reform-Across-the-States.pdf.

Cantor JC, D Gaboda, J Nova, and K Lloyd. 2011. *Health Insurance Status in New Jersey After Implementation of the Affordable Care Act*. New Brunswick, NJ: Rutgers Center for State Health Policy. http://www.cshp.rutgers.edu/Downloads/8970.pdf.

Cantor JC, M Koller, S Brownlee, M Michael, D Belloff, and R Hughes. 2011. *Stakeholder Views about the Design of Health Insurance Exchanges for New Jersey: Volume I: Findings from Stakeholder Forum Discussions & Survey*. New Brunswick, NJ: Rutgers Center for State Health Policy. http://www.cshp.rutgers.edu/Downloads/8980.pdf.

Carey R. 2010. *Health Insurance Exchanges: Key Issues for State Implementation*. Washington, DC: AcademyHealth; Washington, DC: State Coverage Initiatives. http://www.rwjf.org/files/research/70388.pdf.

Chou J, M Koller, J Cantor, and D Belloff. 2011. *Examining a Defined Contribution Strategy in the SHOP Exchange*. New Brunswick, NJ: Rutgers Center for State Health Policy. http://www.cshp.rutgers.edu/Downloads/9130.pdf.

Eibner C, CC Price, R Vardavas, A Cordova, and F Girosi. 2012. "Small Firms' Actions in Two Areas, and Exchange Premium and Enrollment Impact." *Health Affairs (Millwood)* 31 (2): 324–31.

Hall MA. 2012. "Regulating Stop-Loss Coverage May Be Needed to Deter Self-Insuring Small Employers from Undermining Market Reforms." *Health Affairs (Millwood)* 31 (2): 316–23.

Holahan J. 2011. "The 2007-09 Recession and Health Insurance Coverage." *Health Affairs (Millwood)* 30 (1): 145–52.

Insurance Journal. 2012. "N.J. Examines Stop-Loss Insurance for Self-Insured Small Businesses." Insurance Journal. http://www.insurancejournal.com/news/east/2012/05/02/246035.htm.

Jost TS. 2010a. *Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues*. New York: Commonwealth Fund. http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2010/Sep/1444_Jost_hlt_ins_exchanges_ACA_eight_difficult_issues_v2.pdf.

———. 2010b. *Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues*. New York: Commonwealth Fund. http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2010/Jul/1426_Jost_hlt_insurance_exchanges_ACA.pdf.

Lloyd K, and D Gaboda. 2011. *Differences Among New Jersey Adults Using Private Doctors, Clinics, and with No Usual Source of Care*. Facts & Findings: 2009 New Jersey Family Health Survey. New Brunswick, NJ: Rutgers Center for State Health Policy. http://www.cshp.rutgers.edu/Downloads/9050.pdf.

Lueck S. 2010. *States Should Structure Insurance Exchanges to Minimize Adverse Selection*. Washington, DC: Center on Budget and Policy Priorities. http://www.cbpp.org/files/8-17-10health.pdf.

Michael M, M Koller, and JC Cantor. 2012. *Summary of Proceedings: Preparing the Public for Implementation of the Affordable Care Act–Opportunities and Challenges*. New Brunswick, NJ: Rutgers Center for State Health Policy. http://www.cshp.rutgers.edu/Downloads/9300.pdf.

Monheit AC, JC Cantor, M Koller, and KS Fox. 2004. "Community Rating and Sustainable Individual Health Insurance Markets in New Jersey." *Health Affairs (Millwood)* 23 (4): 167–75.

NAIC (National Association of Insurance Commissioners). 2011. *Adverse Selection Issues and Health Insurance Exchanges Under the Affordable Care Act*. Kansas City, MO: NAIC.

NJDOBI (New Jersey Department of Banking & Insurance). 2011a. "NJ Individual Health Coverage Program Buyer's Guide: How to Select a Health Plan - 2010 Edition." NJDOBI. Accessed June 16. http://www.state.nj.us/dobi/division_insurance/ihcseh/ihcguide/index.html.

———. 2011b. "NJ Small Employer Health Benefits Program Buyer's Guide: 2011 Edition." NJDOBI. Accessed June 16. http://www.state.nj.us/dobi/division_insurance/ihcseh/sehguide/index.html.

———. 2012. "What is 'Self-Insurance' and 'Stop Loss' or 'Excess Risk' Insurance?" NJDOBI. Accessed June 18. http://www.state.nj.us/dobi/division_insurance/ihcseh/sehguide/qanda_rates.html#selfinsuranceandstoploss.

Passel JS, and D Cohn. 2009. "A Portrait of Unauthorized Immigrants in the United States." Pew Research Center. http://pewresearch.org/pubs/1190/portrait-unauthorized-immigrants-states.

———. 2011. *Unauthorized Immigrant Population: National and State Trends, 2010*. Washington, DC: Pew Hispanic Center. http://www.pewhispanic.org/files/reports/133.pdf.

Shewry S. 2010. "Implementing ACA: California's Health Exchange." Presentation at The Commonwealth Fund's Webinar: Health Insurance Exchanges, New York, November. http://www.commonwealthfund.org/~/media/Files/Resources/2010/Exchanges%20Webinar/Shewry%20CA%20Exchange%20CMWF%2011%202010.ppt.

Silow-Carroll S, D Rodin, T Dehner, and J Bern. 2011. *States in Action*. Innovations in State Health Policy, February/March. New York: Commonwealth Fund. http://www.commonwealthfund.org/~/media/Files/Newsletters/States%20In%20Action/Feb_March_2011_StatesInAction_v2.pdf.

Sturm M. 2011. *Top 10 Actuarial Issues for a Health Exchange*. Seattle: Milliman. http://publications.milliman.com/publications/healthreform/pdfs/top-10-actuarial-issues.pdf.

Swartz K, and DW Garnick. 2000. "Lessons from New Jersey." *Journal of Health Politics, Policy and Law* 25 (1): 45–70.

Trish E, A Damico, G Claxton, L Levitt, and R Garfield. 2011. *A Profile of Health Insurance Exchange Enrollees*. Menlo Park, CA: Henry J. Kaiser Family Foundation. http://www.kff.org/healthreform/upload/8147.pdf.

Weinberg M, and LW Haase. 2011. *State-Based Coverage Solutions: The California Health Benefit Exchange*. New York: Commonwealth Fund. http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2011/May/1507_Weinberg_california_hlt_benefit_exchange_ib.pdf.

RUTGERS
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