

State Support Essential for Federal Health Insurance Exchange

New Jersey Must Act to Ensure the Success of Health Care Reform

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The United States is in the midst of launching the most massive restructuring of health care since the introduction of Medicare in 1965. Most importantly, the Affordable Care Act (ACA) intends to extend health care insurance to about 30 million Americans who presently go without. In less than six months, eligible uninsured persons will be able to sign up for coverage that begins January 1, 2014. One group, consisting of 15 million poor adults¹, will be newly eligible for insurance via the expansion of Medicaid (only in states like New Jersey that opted in to this part of the ACA). The balance will obtain affordable insurance over the internet by signing on to a website created by their state governments or, in the case of 26 states including New Jersey, the federal government.

The fact that New Jersey will rely on a federal exchange to determine eligibility and the level of subsidized premiums to be paid under ACA does not relieve it of responsibility. It just means that it will receive minimal federal funding to discharge those responsibilities.

New Jersey is Still on the Hook

Major progress has been made to make health insurance affordable for all New Jerseyans under the ACA, but New Jersey must do much more if this goal is going to be achieved.

Instead of creating a state insurance exchange, or partnering with the federal government on a joint venture, the governor chose a federal exchange. The exchange is where moderate-income New Jersey families will shop for affordable quality private insurance. While the Obama

administration has made it clear it will do everything it can to properly administer the federal exchange, the state must do much of the work if the 600,000 eligible New Jerseyans² are to benefit from health care reform.

The governor's decision to opt for the federal exchange creates at least three major obligations for the state:

- There are *logistical* challenges, since the federal exchange must be integrated with an existing health care system that is primarily state-regulated.
- There are *financial* challenges, since the state exchange would have cost New Jersey nothing, yet the federal exchange cannot work unless the state commits funding and leadership.
- There are *consumer* challenges, in that New Jerseyans may pay more under a federal exchange absent vigorous state action.

While the governor's acceptance of the ACA's provision to expand Medicaid to an additional 300,000 eligible low-income adults³ is to be commended, the choice of a federal exchange creates major coordination and funding problems that can only be solved with additional state resources.

Given that this was the governor's decision, it is the executive branch's responsibility to provide the help and resources that the federal exchange requires to effectively assist uninsured and underinsured New Jerseyans. The governor's opposition to the ACA notwithstanding, a "hands-off" approach by the state is neither desirable nor feasible.

Challenge: Loss of Federal Outreach Funding

New Jersey must provide funding for outreach in order for health care reform to succeed.

About four of five Americans who could benefit from health care reform - through premium tax credits in the exchange or the expansion of Medicaid - don't know it.⁴ Many New Jerseyans also have other barriers - language, cultural, health and others - that will make maximizing enrollment even more difficult. An extensive and carefully tailored outreach campaign is essential to publicize the program, and assist New Jerseyans in figuring out the best plan and filling out the lengthy online application.

Even after the fact, it is important to note that had New Jersey chosen a state exchange, it would have been eligible for generous federal funds for outreach including "in-person assisters" who would help uninsured New Jerseyans apply for coverage.⁵ Instead, it is eligible only for federal

funding for “navigators” from a limited pool that will be split among 26 states. New Jersey can expect to receive only about \$1 million from this soon-to-be-announced funding.

This creates an enormous problem for New Jersey. The state will not be able to enroll nearly as many people as it should, and will therefore receive much less federal funding for medical assistance, which would have had a very positive economic impact. Without enhanced outreach, New Jersey will lose an estimated \$690 million in federal Medicaid funds each year, and 186,000 fewer New Jerseyans will likely benefit from health care reform.⁶

Recommendation

Based on the funding requests and experience of other states, the legislature should appropriate about \$12 million in state funds for outreach and navigators, evenly distributed between the Department of Banking and Insurance (for the exchange) and the Department of Human Services (for Medicaid, where federal funds will match state funds dollar for dollar - bringing the total funding for outreach to \$18 million). This expense is just a small portion of the major savings New Jersey will achieve by expanding Medicaid – a figure NJPP has conservatively estimated as \$2.5 billion through the next decade. This \$12 million should allow sufficient funding for publicity and contracts with the community-based organizations best equipped to reach those uninsured with major barriers to enrollment. About \$1 million in outreach funding generates about \$40 million in federal funding, so this is a worthwhile investment.⁷

Opportunity: One-Time Federal Funding Could Make the Federal Exchange More Effective

The state should use available federal dollars to take a more active role in the exchange.

Although the governor never explained why he chose a federal exchange, one of the reasons may have been that the state was not ready to implement its own exchange by the October 1, 2013 start for applications. However, the federal government has an operational challenge that is at least as daunting as the state government’s, compounded by the fact that it must develop different exchanges for each of 26 states. Successful operation of a federal exchange in New Jersey will be impossible without state support.

In some cases, state support is *mandated*. For example, the state must review insurance rates, and ensure that there are adequate provider networks in all health plans offered in the federal exchange. If the state already certifies that a health plan meets the criteria for participation in the exchange, the federal government will accept that certification.

Now, the federal government has gone a step further by making federal funds available to states that want to help make the federal exchange more effective. This funding could cover: selecting health plans for the exchange; helping to manage all consumer complaints; collecting and analyzing information on health plans and benefits; and helping to manage the decertification of

underperforming insurers. It makes complete sense for New Jersey to embrace these functions, since it already regulates all health plans, enforces insurance standards, and responds to consumer complaints. Taking this broader role could also avoid the market duplication and fragmentation caused by having two different government entities enforcing different sets of standards.

Recommendation

New Jersey should apply for this federal funding to perform these critical management activities as soon as possible since funding is time-limited. This would help to tailor the federal exchange to the needs of New Jersey and prepare the state to implement a state exchange in the future.

Opportunity: Federal Funding Still Available to Create State Exchange

New Jersey should actively work towards creating a state exchange in the future – before federal funds disappear.

Over the last two years New Jersey applied for and received \$8.9 million in federal exchange planning funds,⁸ much less than what many other states requested. For example, Maryland received \$27 million, while smaller states – like Idaho (\$20 million) and Iowa (\$41 million) sought and received more. Also, since New Jersey opted for a federal exchange, it was ineligible for much more generous “Level II” funding to implement the state exchange. For example, Maryland received an additional \$123 million in this round of funding, for a total of \$150 million. California received the highest total amount, nearly \$1 billion.⁹

Although New Jersey has decided to go with a federal exchange, it can still request to operate a state exchange after 2014, provided it meets certain deadlines. A state exchange should be seriously considered, given that it has the potential to meet the unique market and consumer needs of New Jersey. If the state is interested in operating a state exchange in 2015 or 2016, it must make those requests by November 18, 2013 and November 18, 2014, respectively.¹⁰ But if the state waits until 2016 to operate an exchange, there is a real possibility there'll be no federal funds left to implement it. Therefore it is critical that the state meet the November 18, 2013 deadline if it wants to implement a state exchange.

Recommendation

New Jersey should develop a proposal for a state exchange and share it with the public, stakeholders and the legislature for input. This should not be very difficult, since the state has already been planning for a state exchange - with \$8.9 million in federal funds - for the last two years. This proposal must be developed well before the November deadline in case the state decides that it wants to apply for available federal funding to start the state exchange in 2015.

Challenge: Potential Cost Increases

The state needs to step in to mitigate possible increases in individual market health insurance costs.

The control of health care costs has traditionally been left to the states (save for Medicare). The ACA doesn't change that, but provides more tools for states to keep costs in check. The state role is still very important because the federal exchange may result in even higher insurance costs, as compared to a state exchange, unless the state steps in.

The federal government made it clear they will not negotiate with insurers to obtain the best price for insurance premiums in plans offered in the exchange the first year. This would have been possible in a state exchange and was included in the legislation that passed the New Jersey legislature. Also, the federal exchange requires a 3.5 percent user fee from participating insurers to cover administrative costs.¹¹ (This is in addition to other ACA premium taxes that will be levied on the insurance industry). Insurers will likely pass the user fees along to consumers, resulting in higher premiums. This is a problem, because premiums are already at historic highs in New Jersey.

The state's current efforts to control costs have not prevented double-digit increases in premiums; as a result, New Jersey has the third highest individual market costs in the nation.¹² Since the early 1990s, the state has tried to control costs through what is called the Medical-Loss Ratio (MLR). The MLR places a 15 to 20 percent cap on insurers' administrative expenditures and profits; the remaining funds must be used for medical care to consumers. This excellent policy has not been enough to prevent major increases in insurance premiums.

Recommendation

As the MLR illustrates, most of the costs for health insurance premiums are for the actual medical care provided to the consumer. It will be critical, therefore, that the state does a better job in controlling those costs. Unfortunately, New Jersey's track record is not encouraging. For example, the governor signed legislation establishing Accountable Care Organizations over a year ago, but there are still no regulations to govern them. At the same time, there has been a proliferation of for-profit hospitals, with little oversight from the state. Inappropriate claims continue to be filed by certain medical providers, particularly those that are out-of-network, thereby increasing premiums for others. New Jersey needs to address these problems and adopt a tougher approach towards controlling costs.

The legislature should also grant DOBI the authority to approve all insurance rate increases in advance. About half the 50 states already have this authority. Some states that also have a MLR, like New York, have found this additional authority very helpful in requiring insurers to roll back excessive rate increases.

The legislature should also reserve some of the \$227 million in savings from the Medicaid expansion to provide supplemental assistance to some individuals eligible for premium tax credits in the exchange. While these tax credits can help to make insurance more affordable, they may not always be sufficient in New Jersey. The credits are the same for all states, determined on a sliding scale with an income up to 400 percent of the federal poverty level. But since New Jersey's cost of living is among the highest in the country, many New Jerseyans will be hard-pressed to afford even the subsidized premiums.

Another challenge will be that some parents will have to pay for their share of their premiums in the exchange and also pay for the premiums of their children in NJ FamilyCare – the total cost of which could be unaffordable. In those cases, the state should waive the cost of the premiums for the children.

Challenge: Fewer Options for Small Businesses

The state needs to provide additional support to small businesses, which will have fewer options in the first year of a federal exchange.

Under a state exchange, New Jersey could have offered a variety of plans to the employees of small businesses – a key intent of the Affordable Care Act. However, due to operational constraints, the federal government has scaled back its immediate rollout of the Small Health Business Options Program (SHOP) exchange for businesses (a different entity than the individual exchange). For the first year, the SHOP exchange will offer only one plan, giving employees no choice and making the SHOP exchange much less attractive to small employers.

Improving health coverage for employees in small businesses is critical to New Jersey's prosperity. The state established the Small Employer's Health (SEH) Plan in 1994 to ensure that small business owners could access small group health insurance and insure more individuals. But it hasn't worked. Since 2000, the number of small business employees with health coverage has decreased by 23 percent.¹³ Much like the individual health insurance that has become unaffordable for New Jerseyans to purchase at market rates, insurance has become unaffordable for many small businesses, so fewer of them provide this benefit. Less than half of New Jersey's small businesses provide any health coverage at all,¹⁴ which drives the state's uninsurance rate up and makes our small businesses less competitive with other businesses.

The SHOP exchange also creates coordination issues with the SEH Plan. They will have separate standards, procedures, and will be run by different levels of government - creating added confusion among small employers. This could further discourage them from providing health coverage to their employees.

Recommendation

Because the state, unlike the federal government, has existing relationships with small employers, it needs to reach out to them to explain the different options they have under the SEH

plan and SHOP. The state should also tap small employers for input if it decides to establish a state SHOP exchange, and consider merging the individual and small group employer market to simplify the insurance marketplace and spread any insurance risk over a larger pool of individuals. New Jersey needs to recognize that significant changes will be needed in the individual and small group markets to contain costs that could result from the federal exchange.

Challenge: Major Coordination Issues

The state needs to provide adequate funds and leadership to coordinate the federal exchange and state-run Medicaid as closely as possible.

With a state exchange, New Jersey would have created the information technology supporting the new eligibility system for the exchange and Medicaid together. Prior to ACA, the state was already planning to upgrade its antiquated informational system for Medicaid and other social support programs like food stamps; the state could have simply expanded the system to include individuals receiving premium tax credits via the exchange. That would have created an efficient and effective “one-stop-shopping” system for caseworkers and individuals to use. Instead, with the federal exchange, the federal government will operate its own eligibility system.

Later this year the federal government will be operating its eligibility system for the exchange and Medicaid, while the state will be operating its own eligibility system for Medicaid and other social programs. Under federal rules, which require a “no wrong door” approach, individuals must be able to apply for all three affordability programs (Medicaid, New Jersey FamilyCare, and the premium tax credits) with one application. The problem is that neither the state nor the federal eligibility system is even created yet, and it will be a challenge for the state to transfer all of the data electronically from individuals applying for Medicaid to the federal eligibility system in the exchange by October 1, 2013.

While individuals contacting the exchange will be provided information on Medicaid, workers in New Jersey’s county welfare agencies will not be trained to help those who are not eligible for Medicaid, but *are* eligible for premium subsidies. This is likely to create a major case management problem, particularly for the many families where the parents are eligible for the exchange but the child is eligible for Medicaid or New Jersey Family Care.

These changes are occurring at a time of very stressful transition for county welfare agencies. In addition to assisting the new category of childless adults for Medicaid expansion, eligibility standards and procedures for most other Medicaid consumers will be changed to conform to those established in the exchange for premium subsidies. And other major procedural changes for these offices - including client banking, which will allow any caseworker to assist in following up on a client – are happening at the same time. All these changes are not likely to be smoothly implemented by county offices given current funding.

Recommendation

The legislature must ensure that the Division of Medical Assistance and Health Services and the county welfare agencies have the funding for the training, staffing, office space and other resources to meet the operational and coordination demands of the state's new eligibility system, as well as the other important changes that are being implemented concurrently.

The federal exchange must be able to determine eligibility for Medicaid for persons not eligible for premium tax credits, rather than simply sending its assessment to the state to make the final determination. Given the limited resources at the county and state level, the state should allow the federal exchange to also determine Medicaid eligibility, which would be much more efficient and less costly than having the state do it.

The state should seek permission to automatically determine eligibility for Medicaid if a person is a food stamp recipient and meets all of the other eligibility criteria. A special effort must also be made by the county welfare agencies to provide case management to families where a parent is receiving health coverage in the federal exchange and the child is receiving Medicaid or FamilyCare.

New Jersey Policy Perspective

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Endnotes

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- ² Families USA, *Help Is At Hand: New Health Insurance Tax Credits in New Jersey*, March 27, 2013.
- ³ Genevieve M Kenney, et al
- ⁴ CVS Caremark, Press Release, June 1, 2012.
- ⁵ David Chandra, Center on Budget and Policy Priorities, *The Affordable Care Act: Exchange and Private Insurance Market Reforms*, PowerPoint, March 13, 2013.
- ⁶ NJPP analysis takes into account the amount of funds that would be generated with enhanced outreach and the actual cost of outreach based on data included in the Kaiser Commission on Medicaid and the Uninsured, *Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% of the FPL*, May 2010.
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- ⁸ Healthcare.gov.
- ⁹ Center on Budget and Policy Priorities, *Status of Health Insurance Exchange Implementation*, March 29, 2013.
- ¹⁰ Department of Health and Human Services, *Blueprint for Approval for State Based and State Partnership Exchange*
- ¹¹ David Chandra
- ¹² Kaiser Family Foundation, *Average per Person Premiums in the Individual Market*, 2010
- ¹³ New Jersey Department of Banking and Insurance website.
- ¹⁴ Kaiser Family Foundation, *Percent Of Private Sector Establishments That Offer Health Insurance To Employees By Firm Size*, 2011, This table shows that 46.7 percent of firms in New Jersey with less than 50 employees provide health care coverage.