

Short and Long-Term Strategies to Support Health Care Affordability and Price Transparency for Small Employers and Consumers in New Jersey

Issue:

- There has been a steep decline in the New Jersey small group market over the last decade, with an enrollment decline of 600,000 lives.
- While significant steps have been taken to improve affordability and access for those getting coverage through Medicaid and the individual marketplace, small group employers (those with 50 or fewer employees) struggle to provide quality and affordable coverage for their employees.
- As more individuals leave the small group market due to limited access or rising prices, the risk pool of those remaining in the declining market will continue to contribute to increasing costs and result in a dangerous downward spiral.

Short-term efforts must be taken to stabilize the current small group market and limit negative impacts on employers and consumers.

Additionally, long-term solutions aimed at overall affordability and transparency in the small group market and health care delivery system must be explored.

Background:

Small Group Market (SGM): Overview and Current State

New Jersey has made significant investments in health insurance options, however those have largely been focused on the state's Medicaid program, the individual Marketplace (which is currently transitioning from a federal operated platform to a state operated one), and coverage provided by large employers. This has left small group employers and their employees struggling to afford high-quality and actuarially sound health care coverage. While declining enrollment in this market was of concern before the COVID-19 pandemic, the increase in uninsured individuals and the yet-to-determined impact of this crisis on the health care delivery system has made this issue even more prominent. Previous economic recessions (such as in 2008) and major shifts in coverage (including the launch of the individual marketplace in 2012), have resulted in significant decline in SGM coverage. Initial analysis projects that employer-sponsored coverage in New Jersey could decline by as much as 960,000 lives due to impacts of the pandemic¹. Now more than ever, the state needs to ensure there are viable options for people to get high-quality and affordable coverage and that small employers and their employees are not left out of these efforts.

While the Affordable Care Act (ACA) required larger employers (>50 FTE) to provide health insurance to their employees, small employers (<50 FTE) are **not** subject to these federal requirements, nor are there state requirements that mandate the provision of coverage for employees of small employers. Many small employers are interested in identifying an affordable

¹ [Health Management Associates Estimates of COVID Impact on Coverage](#)

way to provide health care coverage for their employees as part of their benefit package, as this can enhance the attractiveness of an employment offer and increase employee retention. However, rising costs in this market and decreased enrollment have made the SGM less attractive to carriers, employers, and employees. Interventions to stabilize this market and slow-down and/or reverse its decline must be pursued to: 1) ensure all employees in New Jersey, including those of small employers, have access to coverage that is both affordable and high-quality and, 2) support small employers and encourage the investments they make to the state's economy.

Small group employers offer their employees coverage in two ways:

- 1) **Small Employer Health Benefits (SEHB) program:** The SEHB program allows small employers to purchase group coverage for their employees. This program allows employers to participate, regardless of the occupation of the group or the health status of the employees and allows them to renew coverage annually regardless of benefit utilization or health status of the covered lives. *For the purposes of this memo, when referring to the Small Group Market (SGM), we are referring to coverage provided through the SEHB program regulated by the Small Employer Health Benefits Program Board and the NJ Department of Banking & Insurance.*
- 2) **Alternative Markets:** Outside of the “traditional” markets to purchase health insurance, such as the individual market and the SEHB program, employers in New Jersey can also provide coverage through “alternative” markets that vary in benefits and employer risk sharing.

**Additional details about alternative markets in New Jersey are available in Appendix A.*

- While often more affordable for employers, plans in this market can promote adverse selection of healthier individuals into lower cost plans leading to declining enrollment in the SEHB program, leaving less healthy individuals in the risk pool in that market and further raising costs.

Key Facts and Figures about the Small Group Market:

- As of Quarter 1 2018, a total of **1,046,391** individuals were employed by small employers in New Jersey. With employee's dependents included, that number rises to **1,862,576**.
- In Quarter 3 of 2005, enrollment in the SGM peaked at approximately **981,000** covered lives. However, as of Quarter 4 of 2019, enrollment had declined to about **309,000** lives.
 - The average decline since its peak has been **11,145 members per quarter**.
 - Over the past year, the decline has averaged **7,828 members per quarter**.
- Primary reasons for the decline in the SGM, as identified through market data and a survey of brokers in the state, include:
 - Rising cost of premiums
 - Growing enrollment in alternative market plans, such as MEWAs, PEOs, and self-funded or level funded plans, as well as increased enrollment in the individual marketplace
 - Regulations around plans and employer participation in the market, including those focused on benefit design, dual participation by health plans in the small group and individual market, and group size

- Nearly **51%** (948,051) of the employees and their dependents employed by New Jersey small employers work for firms that **do not offer insurance**; another **21.6%** (164,614) are **either ineligible or choose not to enroll**.
 - Of the employees (and dependents) who had insurance through their employer:
 - 67% had coverage in the SGM (343,387)
 - 13.4% had coverage through a self-funded/level-funded plan (69,633)
 - 10.4% had coverage through a Multiple Employer Welfare Arrangement (MEWA) (53,346)
 - 9.1% had coverage through a Professional Employer Organization (PEO) or other model, such as (Association Health Plans) AHPs (46,822)
- SGM premiums in New Jersey have **increased by 38.5% since 2008**.
 - The price of premiums in the state's SGM has been consistently above the national average over the same time period.
 - Premium dollars for SGM plans are used for the following categories²:
 - Professional: 25.3%
 - Outpatient: 18.5%
 - Inpatient: 15.7%
 - Rx: 15.1%
 - Other Medical: 7.7%
 - Commissions: 6.4%
 - Other Admin Expenses: 5.9%
 - Taxes: 2.9%
 - Profit: 2.5%
- In addition to rising premiums, the growth in the individual market is a contributing factor to the decline of the small group market.
 - Federal subsidies and increased market competition keep consumer costs down in the individual market, making it more attractive for employees who struggle to afford their portion of coverage provided through their small employers and, as prices in the SGM rise due to declining enrollment, making SGM coverage less affordable for employers to provide in the first place.
 - In 2016, there were approximately **348,249** New Jerseyans with health coverage through the individual market, based on a monthly average measured over the year.
 - Just over half of those with individual market coverage (55%) have incomes above 400% of the Federal Poverty Level (FPL), with 42% above 500% FPL.

² Based on Quarter 2 2020 Data from Major Carrier in New Jersey

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1. Increase availability and transparency of data on where employees of small employers are getting health care coverage.

There is currently limited data about where individuals who leave the small group market go for coverage, and while assumptions about these lives can be made from different data sources, state-wide initiatives to stabilize this market would benefit from more robust data collection about employees of small employers and where they get their health care. Regular data collection and analysis by DOBI and/or Treasury of small employer tax returns or additional filings, information collected through licensed insurance producers, or other sources to track and publicly report aggregated data are necessary for policy and budget decisions. It is likely that this data is already collected by employers/carriers and reported to the State, it is just not being aggregated and analyzed to inform decision making. There are potential technological or administrative costs to the state to implement a new data analysis strategy. However, increased cost-savings for small employers that result from market improvements may outweigh any upfront investment.

2. Remove State requirement for health plans to sell in both the small group and the individual market.

Currently, plans must sell in both the individual market and the SGM in order to sell in either. This is a state requirement and not one promulgated by the passage of the ACA. The requirement was put in place during a period when it was necessary to then protect a struggling individual market, but since then, the passage of the ACA and the creation of federal subsidies to support the market, have negated the need for such a restriction. Currently, plans can circumvent this rule by pricing a plan in one market so high that they are effectively not selling an affordable product and not participating in both markets in a meaningful way. Removing this requirement may result in increased costs and decreased competition in the individual market. However, it may also increase competition in the SGM by allowing plans who left the market, or didn't participate due to this requirement, to enter/reenter. To date, at least one major plan left the SGM in part because it did not want to participate in the individual market.

3. Create small employer market with even playing field.

Self-funded/level-funded plans for small employers have drawn lives out of the SGM. Based on information from AHRQ and DOBI, there are approximately 68,633 lives now in self-funded/level-funded plans. While MEWAs must comply with state underwriting rules and benefit design requirements, these plans do not. There are fair concerns about eliminating this choice without doing something to make the SGM more affordable. If, however, reforms and state based incentives were put into place to improve the affordability of the SGM, it may make sense for the state to implement policy changes to further strengthen the market and restrict or phase out the sale of the self-funded/level-funded plans. Ultimately, sound insurance principles support having one market, where all purchasers play by the same

rules to avoid adverse selection and a downward spiral of the market, with state-based consumer protections in place. While consideration of the market's ability to absorb potential utilization shocks that could occur from this shift must be addressed, the reduced churn between standard and self-funded plans, potential increased consumer choice, and lower premiums could strongly benefit the market as a whole.

4. Provide a state-based tax credit to small employers (< 50 FTE) who offer plans that are fully compliant with New Jersey and ACA regulations.

This tax credit could assist employers who are not required to provide insurance to their employees but choose to provide coverage. The credit could vary over time depending on the availability of funds to support such a subsidy or can come from a designated fund or general funds. For reference, there are over 164,000 small employers in NJ who could benefit from such a credit. To make a meaningful impact on the market, this proposal could require significant funds. However, this action would clearly demonstrate support for small employers, who have been less recognized in efforts to improve affordability of coverage in the state. By limiting this tax credit to fully compliant plans, this could be an "equalizer" between the SGM plans and the alternative markets.

5. Request that the State does a review of rating bands and rating areas to potentially modify state methodology based on findings.

Guidelines for rating strata for plans in New Jersey have not been updated since 2006, despite changes to the federal age bans. The State's rating areas are not regularly updated. As a matter of fairness and to better reflect utilization, the State should review their methodology for these rate setting guidelines and modify accordingly to support the market, employers, and employees.

6. Remove the restrictions that prevent health benefit plans sold through the SGM from utilizing a prescription drug formulary.

SGM plans are unable to use a formulary for their prescription coverage. However, they can have tiers of coverage with varying cost-sharing amounts, which essentially limits the coverage and can be confusing for patients and pharmacies. Allowing SGM plans to utilize a formulary can reduce premium costs and is a standard plan feature in other commercial plans. This may also reduce the prior authorization disputes between plans and providers, which could reduce administrative costs and provider dissatisfaction. Initial calculations from an industry source estimate that this could create a savings of approximately \$10-\$12 PMPM or 2% of SGM premiums. If this change was adopted, steps would be taken to ensure that appropriate consumer protections are in place, permitting exceptions to allow alternative brands when necessary.

7. Require DOBI to review and adjust plan requirements annually to ensure carriers can provide plans that meet the actuarial value requirements for each ACA tier, can ensure consumer choice and affordability, and retain a relative level of consistency year over year for plans in the market.

Carriers are challenged to design actuarially sound plans in compliance with state regulations. The metallic tiered plans created through the ACA were designed with the intention of providing consumers with options for coverage that differ in premiums and cost-sharing amounts. However, regulations in NJ that limit total out-of-pocket costs makes certain plans, specifically bronze level plans, difficult to sell in the state. While these regulations were created with the intent of protecting consumers, they can actually limit consumer choice. If DOBI was to review various plan design levers and allow certain flexibility for plans, such as increased caps on ER co-pays, cost sharing based on site of service or physician type, or higher maximum plan deductibles, carriers can design their plans to support longer-term stability of the market and promote choice for employers and employees.

8. Add state-based subsidies for individuals to purchase insurance on the individual market.

Many employees of small employers will continue to get coverage through the individual market for various reasons (such as their employer not offering coverage through the SGM or concerns about affordability for SGM plans). As individuals transition from the small group market to the individual market, increasing the affordability of coverage on the marketplace is essential. There are approximately 48,000 individuals enrolled in the individual marketplace who are between 300-400% FPL and approximately 45,000 enrolled individuals between 400-500% FPL.

- Currently federal annual subsidies for those between 300-400% FPL range from:
 - \$0-\$3,828 for a family of one
 - \$1,200-\$4,176 for a family of two
 - \$3,420-\$6,036 for a family of three
 - \$5,160-\$7,908 for a family of four

Providing state-based subsidies could increase the size and health of the individual market, thereby driving down overall premium costs. If the state were to increase annual subsidies for those between 300-400% FPL by an average of \$2,000, the total cost to the state would be \$95,870,280. In later years, once the State Based Marketplace is established, the State may also want to create a subsidy for those above 400% and up to 600% FPL.

As a part of this effort, the states should also designate an entity to research the impact of merging the small group and individual market, providing state subsidies, the ability to use Individual Coverage Health Reimbursement Arrangements (ICHRAs) for premium costs, and state reinsurance options.,

9. Design a “Best Evidence Plan” to be sold in the IHC, SGM, and other markets.

To meaningfully address our health care spending and our overall health status, we need to fundamentally redesign what we purchase and prioritize in this sector. If we start with the essential health benefits in the ACA and then expand them to build a new plan design that focuses on primary and preventive care, higher value best evidence care, and encourages

patients to seek care at more appropriate settings based on acuity, while expanding access to care through relying on new technology and other providers working to the top of their license, we can design a “Best Evidence Plan”. **A “Best Evidence” (BE) Plan would recalibrate the current payment system to support more primary, preventative, palliative, and mental health care and would disincentivize low value care.** The BE Plan may require a waiver from HHS and DOBI to build on the ACA essential health benefits but avoid some state mandates and metallic tier actuarial values. The BE Plan could be utilized in the SGM as well and could be a national model for a high value Best Evidence Plan. The Quality Institute, in partnership with others, can apply for funding to begin work on this redesign. Partners in this work could include the new Office of Health Care Affordability and Transparency, DOBI, and the IHC and SEHB boards.

Appendix A: Alternative Markets in New Jersey

Multiple Employer Welfare Arrangements (MEWAs):

- Employees whose trade or business association belongs to a MEWA have access to group health benefits coverage through their association membership.
- MEWAs impact New Jersey’s small group market in that certain employers who might otherwise purchase health benefits plans through the SEHB program can obtain lower-cost group coverage through participation in associations that are members of a MEWA.
- MEWAs must comply with New Jersey insurance laws, including in both the standard IHC and SEHB programs.
 - However, MEWAs are **not** insurers and **do not** pay New Jersey insurance premium taxes and are **exempt** from some reporting requirements.

Two MEWAs currently operate in New Jersey: 1) Association Master Trust (AMT) and 2) Affiliated Physicians and Employers Health Plan (APEHP).

Professional Employer Organizations (PEOs):

- When a business contracts with a PEO, the PEO becomes a co-employer which allows the PEO to pool together employees of many other PEO client companies and provide additional and/or better benefits for the employees at a lower cost.
- PEOs can divert employees away from the standard SEHB program.
- Since health benefits plans offered through a PEO are **not** required to meet the same standards as the SEHB program or a MEWA, this can result in an unlevel playing field and provides an advantage to PEOs.



Self-Funded Plans:

- In a self-funded or self-insured arrangement, the employer assumes the financial risk for providing health benefits coverage to its employees.
- The employer pays claims on an incurred basis, rather than paying a set premium to a health insurance carrier.
- An employer can customize a plan to meet the health care needs of its workforce, **avoid** state health insurance regulations and benefit mandates, as well as save money by **not** having to pay state health insurance premium taxes.
- In order to protect against unpredicted or catastrophic claims, self-insured employers can purchase stop-loss insurance (aka reinsurance) which reimburses them for claims above a specified amount.