NEW JERSEY HEALTH CARE QUALITY INSTITUTE

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

Newly Released Report: June 2, 2022
Updating Original Report of July 2020

As the identified issues in New Jersey's small group market continue to make quality and affordable health insurance for small employers and their employees more difficult to access, the Quality Institute has released a report updating its original report from July 2020 on this topic. Unfortunately, the status of the Small Group Market has continued to decline over the last two years and without some action, further decline is anticipated. This paper is released to bring attention to the issues and facilitate necessary consideration and action on this topic.

Issue:

- There is value in having a vibrant, regulated small group market in NJ. Most employers in NJ are small employers (defined as 2-50 full time employees). Having a small group market enables them to offer meaningful benefits to their employees as part of their employment package. Having access to benefits through the regulated market means that employees cannot be denied benefits or discriminated against because of their gender or health status. Additionally, there are important social and economic benefits in making sure that employees of small businesses and their dependents have on-going access to health care.
- Over the past decade, however, due to multiple changes in the health care system and the lack of action at the state or federal level to address those changes, there has been a steep decline in the New Jersey small group market, *with an enrollment decline of over 600,000 lives*.
- As more employers leave the small group market due to rising prices, the risk pool of those remaining in the declining market continues to contribute to *increasing costs and a dangerous downward spiral*.

Short-term efforts must be taken to stabilize the small group market and limit negative impacts on employers and consumers.
Long-term solutions aimed at overall affordability and transparency in the small group market and health care delivery system must be explored and enacted.

Background:

Small Group Market (SGM): Overview and Current State

Since passage of the Affordable Care Act (ACA), New Jersey has made significant reforms and investments in health insurance options, but these efforts have focused on the state's Medicaid program and individual market (which transitioned from a federally facilitated marketplace to a state operated one in November 2021) and ignored the SGM. This void has left small employers and their employees struggling to find affordable health benefits coverage which has

all the protections of the New Jersey regulated markets. For plan year 2022, SGM premiums increased at an alarming average rate increase of 10.4%[1].

While the ACA required larger employers (>50 FTE) to provide health insurance to their full time 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 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 potentially 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 affordable and provides meaningful benefits; 2) protect small employers and employees from discrimination based on gender or health status; and, 3) support small employers' commitment to offer health benefits to their employees, which is linked to overall health and wellbeing, and good for the state overall.

Impact of COVID-19 on the Small Group Market

The Covid-19 pandemic highlighted the need for people to have access to health benefits. The public health emergency, however, did not alter the downward enrollment trend in the SGM. Instead, more small employers moved to alternative coverage options outside the regulated SGM. Small employers' continued efforts to provide health benefits demonstrates the significance of these benefits in employee recruitment and retention, and the need for small employers to find a way to offer benefits, despite rising costs. Thus, the need to make significant changes to support the SGM is more important than ever, as small employers attempt to get back on their feet and retain their workforce.

Coverage Options in New Jersey's Small Group Market

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 (DOBI).*
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 set forth in Appendix A.*

[1] https://www.state.nj.us/dobi/pressreleases/pr210924.html

- While often a more affordable option for employers, selling plans in this market can lead to "adverse selection" where younger or healthier groups move to the lower cost plans. This trend results in declining enrollment in the SEHB program, leaving less healthy individuals left in the risk pool in SEHB. This type of selection "spiral" then continues the trend of rising premiums.

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 April 2021, enrollment had declined to about 300,000 lives, per analysis by the New Jersey Association of Health Plans (NJAHP). *(See Appendix B.)*
  - 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 Multiple Employer Welfare Arrangements (MEWAs), Professional Employer Organization (PEO), and self-funded or level funded plans, as well as increased enrollment in the individual marketplace (As of 2022, all major health benefits insurance carriers are selling self-funded products to small employers.)
  - 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**.[2]
  - 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 MEWA *(53,346)*
    - 9.1% had coverage through a PEO or other model, such as (Association Health Plans) AHPs *(46,822)*
- SGM premiums in New Jersey have **increased by 56% for a single individual and 89.6% for a family for the periods of 2005 – 2007 to 2018 – 2020 (data is reported over 3 years trend periods)**. [3]

[2] NJ does not track or report where small employers purchase health coverage outside of the SEHB. This information was collected from carriers and brokers and is not publicly reported. Data collection and reporting is needed to monitor and address market needs.

[3] See AHRQ MEPS data: https://meps.ahrq.gov/data_files/publications/cb25/cb25.pdf

For employers (with <50 employees) the average total single premium in 2005-07 was $4,840 and in 2018-20 was $7554. The average total for family coverage in 2005-07 was $11,832 and for 2018-20 was $22,433. Since 2020,

- 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 categories of expenses*[4]*:*
  - Professional: 22.9%
  - Outpatient: 18.7%
  - Inpatient: 18.7%
  - Rx: 14.6%
  - Other Medical: 8.6%
  - Commissions: 5.9%
  - Other Admin Expenses: 6.9%
  - Taxes: .2%
  - Profit: 3.5%

Individual Market and Its Impact on the Small Group Market:

- The growth in the individual market is a contributing factor to the decline of the small group market. The ACA changed the eligibility definition of a "small employer group" and in doing so, many smaller family-owned businesses were no longer eligible to purchase as a small employer group. This was often referred to as the elimination of the "groups of 1". Also, the ACA removed the ability for carriers to charge less for dependents under 31, which has the effect of moving those younger adult enrollees to IHC instead of SGM.

- The federal and later state subsidies in the individual market also played a role:
  - 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.
  - NJ's reinsurance program also helped to reduce premiums in the individual market but there was no comparable program for the SGM.
  - In 2020, New Jersey announced the New Jersey Health Plan Savings (NJHPS), subsidies for individuals to purchase on the new state-based exchange. In 2021 the program provided state-subsides, in addition to the federal Advanced Premium Tax Credits (APTC), for households with incomes up to 400% of the federal poverty level (FPL) to lower the costs of health benefits coverage. For 2022, the state modified the program and made subsides available for households up to 600% FPL[5].

SGM premiums have continued to rise with rates for 2022 increasing an alarming average of 10.4% as reported by NJ DOBI. https://www.state.nj.us/dobi/pressreleases/pr210924.html

[4] Based on Quarter 2, 2020 data from major carrier in New Jersey.

[5] https://www.state.nj.us/dobi/pressreleases/pr211217.html

- During the 2022 open enrollment period, approximately **311,692** New Jerseyans signed-up for health coverage through the individual market[6].
  - 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.

Due to these factors, purchasing individual coverage in New Jersey is a reasonable alternative to small group plans. However, there are, significant benefits to purchasing as an employer group including tax benefits (premiums are not income to the employee) and a broader choice of plan designs.

For Consideration: Potential Strategies to Address Health Care Affordability and Price Transparency for Small Employers and Consumers in New Jersey

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 and improve this market would benefit from more robust data collection about employees of small employers and where they get their health coverage. Regular data collection and analysis by DOBI, Treasury (through tax returns or additional filings), NJ Department of Labor, and information collected from 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 these State agencies, but it is not being shared across agencies, aggregated, and analyzed to inform decision making. These agencies should be convened to identify the data they currently hold, address any barriers to sharing the information across agencies, and create a strategic plan for its use and publication.

2. **Remove State requirement that a carrier must participate in the individual market if they want to sell in the small group market.**
   Currently, plans must sell in the individual market to sell in the SGM. This is a state requirement. The requirement was put in place during a period when it was necessary to then protect a struggling individual market, but the passage of the ACA and the creation of premium subsidies and the reinsurance program have negated the need for such a restriction. Removing this restriction will eliminate one barrier to competition in the SGM.

3. **Modernize the SGM to enable it to better compete with the Alternative Market.**

[6] https://www.cms.gov/newsroom/fact-sheets/marketplace-2022-open-enrollment-period-report-final-national-snapshot

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 69,633 lives now in self-funded/level-funded plans.[7] While MEWAs must comply with state underwriting rules and benefit design requirements, these plans do not. There are fair concerns about eliminating the alternative market options at this point. Currently, all the major carriers in the SGM are also selling alternative market options. If, however, reforms and state-based incentives were put into place to modernize and improve the affordability of the SGM, it would be able to better compete. Thereafter, it may make sense for the state to implement policy changes to further strengthen the market or restrict or phase out the sale of the self-funded/level-funded plans for groups under 50. 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 regulated market, which has the strongest state-based consumer protections.

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 small employers in providing insurance to their employees. 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 may require significant funds. However, this action would clearly demonstrate support for small employers, who have been unrecognized 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 review the age rating bands and geographic rating areas to potentially modify state methodology based on findings.**

   Guidelines for rating bands and geographic regions have not been updated since 2006, despite changes to the federal age bands and geographic population changes in New Jersey. The rate age-banding in NJ is currently at 1.9:1 while the Federal requirement is 3:1. This results in higher prices for the younger population and lower cost for older members. This rule does not encourage enrollment of the under 30 segment which is critical to sustain this market. If we were to allow a 3:1 age-rating, there would be a greater spread between the lowest and the highest age band resulting in more accurate pricing and increased enrollment.

   The state should review the geographic rating areas currently used, as competition in the health care system, changing demographics and population areas, and provider adequacy can make certain locations more expensive than others and thereby impact costs.

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

[7] See Appendix B, NJAHP 2020 Chart, New Jersey Sources of Coverage.

SGM plans are unable to use a closed formulary for their prescription coverage – even though it is a standard plan design element in the commercial market and other small employer markets throughout the country. While plans may have tiers of coverage with varying cost-sharing amounts and prior authorization requirements, these administrative structures end up limiting access but do so in a more confusing and administratively burdensome way for patients and providers. Allowing SGM plans to utilize a closed formulary would reduce drug costs and thereby reduce premium costs. This change would also reduce prior authorization disputes among plans, providers, and patients which could reduce administrative costs and provider dissatisfaction. Initial calculations from an industry source estimate that this could create a minimum savings of $10-$12 PMPM or 2% of SGM premiums. If this change was adopted, steps should be taken to ensure that appropriate consumer protections are in place, permitting exceptions to allow alternative brands when necessary.

7. **Allow plans to create a presumption of Medicare coverage in Small Group Certificate of Coverage.**
   Currently, there is no clear language in place that allows plans in the Small Group Market to implement a policy for which the plan can presume Medicare coverage for eligible enrollees. Under this policy, if an individual was eligible for Medicare to be their primary payer, the plan would be allowed to provide coverage as a secondary payer for all services that could be paid by Medicare, even if an individual is not enrolled in Medicare. Implementing this policy would encourage eligible enrollees to enroll in Medicare, reduce costs for plans in the SGM, all without reducing benefits. Consumer notice, confirmation, and opt-out procedures could all be included in this change to ensure that all employees are fully insured and protected.

8. **Require DOBI and the SEHB to review and adjust current minimum plan standards 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 make 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 limit consumer choice. Currently, carriers are required to meet two conflicting sets of standards, both designed to protect consumers. If DOBI was to revise 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 could design their plans to support longer-term stability of the market and promote choice for employers and employees.[8] DOBI and SEHB should rely on the ACA standards and therefore allow plan

[8] For example, the EPO Bronze Plan currently has a $3,000 deductible (which is the maximum), 50% coinsurance and a $9,100 MOOP. Its AV is just under 64%. If there were no NJ minimum standards around maximum allowable deductible and it increased to $9,100, the actuarial value (AV) would still be 60.2% and the plan would still be a

design flexibility to work within the CMS Actuarial Value (AV) construct which would result in lower priced products.[9]

9. **Design a "Best Evidence Plan" to be sold in the IHC, SGM, and other markets.** To meaningfully address our health care spending and overall health of New Jersey's residents, we need to fundamentally redesign what we purchase and prioritize in this sector. In 2020, the state launched the Office of Health Care Affordability and Transparency, which is focused on strategic initiatives to control the health care costs and spending in the state. It is recommended that this office, and its Health Care Affordability Advisory Group, focus on approaches that start with the essential health benefits in the ACA and expand them to build a new plan design that focuses on primary and preventive care, higher value best evidence care, and financially encourages patients to seek care at more appropriate settings based on acuity, while expanding access to care through relying on new technology, transparency on quality and prices, and supporting delivery models where providers are working to the top of their license. Such an approach, which aligns with the advice of the National Academies of Science, Engineering, and Medicine[10], would lead to the creation of a "Best Evidence Plan" for New Jersey. **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, is ready to work on this effort and would support the use of American Recovery Act funds to support this critical work. Partners in this work could include the Office of Health Care Affordability and Transparency, DOBI and other state agencies, IHC and SEHB boards, consumer organizations, providers, health plans, and brokers.

Appendix A: Alternative Markets in New Jersey

legitimate Bronze from an AV point of view. Increasing the deductible to $9,100 would produce a 6.2% rate decrease for a Bronze tier plan. While this product may not be attractive for some people, to others, it would be a lower priced option that they would choose. Having more choices and more competition will keep more lives in the market and bring down the overall risk and premiums. This may be an extreme example within the Bronze tier, however, it would also open many opportunities within the popular Silver tier.

[9] Another example is a popular plan design with level funded products - a $3,000 deductible with a $3,000 Maximum Out of Pocket (MOOP). This design would likely fit within a metallic tier, but not comply with NJ's minimum standards. Amending NJ's standards to align with the ACA would enable more flexibility in designing products to meet market demand and keep groups in the SGM.

[10] National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Care Services; Committee on Implementing High-Quality Primary Care

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 are not insurance and not guaranteed by the state insolvency fund.
- MEWAs impact New Jersey's small group market in that certain employers who might otherwise purchase health benefits plans through the SEHB program can alternatively obtain through a MEWA.
- MEWAs must comply with New Jersey insurance laws for both the individual and SEHB programs.
    - However, MEWAs are **not** insurers and **do not** pay New Jersey insurance premium taxes and are **exempt** from some reporting requirements.

There is only one MEWA, Association Master Trust (AMT), currently operating in New Jersey. As of June 2021, Affiliated Physicians and Employers Master Trust (APEMT) is no longer registered as a MEWA in the state and had filed for bankruptcy.

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.
- Because 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 and Level-Funded Plans[11]:

- 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.
- 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 thereby limiting their financial risk.
- **Level-Funded Plans** are a type of self-funded arrangement in which the employer makes a set payment each month to an insurer or third-party administrator which funds a reserve account for claims, administrative costs, and premiums for stop-loss coverage. When claims are lower than expected, surplus claims payments may be refunded at the end of the contract, which is why the product is attractive to healthier groups. These plans are not **guarantee issue,** meaning that an insurer does not have to offer them to the group the next year**.** Healthier groups can leave the SGM and purchase a Level-Funded Plan but groups with less favorable claims will have fewer options. Groups as small as 2 lives are purchasing these plans.

[11] See Kaiser Health News for more information and definitions on different insurance products. https://www.kff.org/report-section/ehbs-2020-section-10-plan-funding/

Health Care Sharing Ministries (HCSMs):

- HCSMs are organizations in which health care costs are shared among members who have common ethical or religious beliefs. Due to federal law, these plans are not prohibited in New Jersey. They are typically limited in coverage, exclude pre-existing conditions, and often do not provide comprehensive benefits.
- They do not meet the federal definition for health insurance, are not subject to ACA consumer protections, and are not regulated by the state. Under federal law, in order qualify as an HCSM and be allowed to be sold in New Jersey and other states, an organization must have been in operation and continuously sharing member health care costs since December 31, 1999.
- Some small businesses or their employees have resorted to joining these HCSMs. In December 2020, NJ DOBI issued a news release warning consumers about the dangers of HCSM plans.[12]

Appendix B: New Jersey Sources of Coverage 2020 – Analysis by NJ-Association of Health Plans

NJ Source of Coverage 2020 (created 4/20/21)	# of NJ Residents	% of NJ Residents
A. Commercial Markets Regulated by DOBI:		
Large employer (>50 employees)	637,847	7.18%
Small employer (1-50 employees)	300,197	3.38%
Self-Funded MEWAs	45,273	0.51%
Individual Market	310,650	3.50%
Student	27,000	0.30%
DOBI regulated total:	*1,320,967*	14.87%
B. Commercial Markets Not Regulated by DOBI:		
Self-funded plans (mostly large employers)	3,293,376	37.08%

[12] https://www.state.nj.us/dobi/pressreleases/pr201223.html

Self-funded, level funded (mostly small employers)	69,633	0.78%
Commercial non-regulated total:	*3,363,009*	37.08%
C. Government Not Regulated by DOBI:		
Medicare (Medicare, Medicare Adv, includes duals)	1,634,896	18.41%
NJFC/Medicaid <65 (removes Medicare duals)	1,425,917	16.05%
Federal VA	96,000	1.08%
Tricare	87,028	0.98%
NJ SHBP/SEHBP non-Medicare	590,524	6.65%
FEHBP < 65	150,000	1.69%
Government Total	*3,984,365*	44.86%
D. Uninsured:		
Uninsured	692,000	7.79%
E. Secondary coverage not accounted for above:		
People with secondary coverage not accounted for above	478,151	5.38%
TOTAL NJ POPULATION	**8,882,190**	

Source: New Jersey Association of Health Plans (Created 4/20/21)