



NJ For Health Care

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AARP New Jersey
Alliance for Disabled in Action, Inc
Alliance for Retired Americans
Alliance for the Betterment of
Citizens with Disabilities
Bergen Peace and Justice
BlueWave New Jersey
Camden Churches Organized
for People
Cathedral CDC Social Services
Catholic Charities,
Diocese of Trenton
CDI Head Start Serving
Middlesex County
Communications Workers of
America, District 1
Communications Workers of
America, Local 1034
Communications Workers of
America, Local 1037
Elder Rights Alliance
Family Voices NJ
First Presbyterian Church,
Woodbridge NJ
First United Methodist Church
of Beach Haven Terrace
Garden State Equality
Garden State Spine and
Pain Institute
Gray Panthers of South Jersey
Health Care For All -
New Jersey
Health Professionals and Allied
Employees, AFT, AFL-CIO
Hispanic Directors Association
of New Jersey
JClarkMedia.com
La Casa de Don Pedro
Lutheran Office of Governmental
Ministries
National Association of
Social Workers NJ Chapter
National Organization for Women
New Jersey
New Jersey Appleseed Public
Interest Law Center
New Jersey Catholic Conference
New Jersey Citizen Action
New Jersey Citizen Action
Education Fund
New Jersey Health Care
Quality Institute
New Jersey Policy Perspective
New Jersey Public Interest
Research Group
New Jersey State Conference -
NAACP
New Jersey - West Hudson Valley
Council Union For Reform Judaism
New Jersey Working Families Alliance
Next Step
South Jersey NOW -
Alice Paul Chapter
Spanish American Social Cultural
Association (SASCA)
Statewide Parent Advocacy Network
The Workman's Circle/Arbeter Ring
Branch 1091
The Workmen's Circle/Arbeter Ring
Women's Fund of New Jersey

Robert W. Schwaneberg
Policy Advisor to the Governor for Health Care
Office of Gov. Chris Christie
PO Box 001
Trenton, New Jersey 08625-0001

Re: Establishing a High Risk Pool for New Jersey

Dear Mr. Schwaneberg,

On behalf of the New Jersey Citizen Action Education Fund, NJ Consumer Voices for Coverage and the entire NJ For Health Care Coalition, I am writing to thank you for meeting with representatives of our coalition to discuss the state's options in establishing a temporary high risk health insurance pool under the Patient Protection and Affordable Care Act (PPACA).

We are pleased that New Jersey has submitted a letter of intent to the U.S. Department of Health and Human Services (HHS), establishing New Jersey's interest in accessing these new federal funds to help more New Jerseyans access affordable health coverage. We believe it is in the best interest of New Jersey residents for the state to establish this program. Like you, we understand that given New Jersey's unique position as a guaranteed-issue state with an individual health coverage program (IHC) and the PPACA's program eligibility requirements, the establishment of a high risk insurance pool creates a number of challenges in design and implementation.

After numerous discussions and consultation with representatives of our coalition and academic experts, we have prepared the following discussion of options that could be pursued by policy makers in developing and implementing a high risk pool for New Jersey. As you know states are still waiting for guidance from the Department of Health and Senior Services, guidance which may impact any of these options. .

A High Risk Pool for New Jersey -- Key Issues for Consideration

The 6 month crowd-out provision restricting the high risk pool to individuals with pre-existing conditions who have been without coverage for at least 6 months. As a guaranteed issue state, New Jersey must be careful not to exclude or unfairly penalize people who have responsibly obtained coverage through the State's IHC.

The requirement that in order to obtain coverage through the high risk pool one must be a citizen or national of the United States or lawfully present in the United States. This excludes undocumented immigrants, currently eligible for the IHC, from the high risk pool.

The requirement to provide evidence of high risk. The application and the statute provide three alternative methods of establishing high risk. The first two include proof of denial of coverage and proof of coverage offered only with an exclusionary rider. These would be very rare instances in New Jersey and are therefore not relevant. The third method is to show proof of “certain medical conditions specified by the State and approved by HHS”. A simple way to utilize this method would be to create a list of conditions that evidence high risk and limit membership to applicants who can establish that they have had such a condition. Many states have established such lists. Examples from New Hampshire, Texas, and Nebraska are provided in the appendix.

In order to determine if our state High Risk Pool program meets the affordability requirements, we must define a “standard rate”. The application intends the high risk pool to be affordable, and the Patient Protection and Affordable Care Act provides federal funding to subsidize coverage to assure affordability. The benchmark for affordability is the “standard rate.” The standard rate is defined in the application by reference to the *individual market*. One way to derive a standard rate, therefore, would be to use the premiums charged in the IHC for coverage similar to that in the High Risk Pool program. The High Risk Pool program could achieve compliance with the standard rate by meeting that benchmark with a combination of premium and subsidy drawn from the \$141 million available to the program. As the premiums in the IHC are quite high, that benchmark could be achievable.

Using New Jersey’s Existing FamilyCare Buy-In Program

We understand there is interest in using NJ’s FamilyCare program. This approach, if approved by HHS, has several advantages. First, it would presumably permit coverage more cheaply than “going to the market” as the statutory provision creating the Buy In program pays per month to a managed care organization under NJ FamilyCare for a child of comparable age whose family income is between 200% and 350% of the poverty level, plus a reasonable processing fee. NJSA 30:4J-12(5)(j). Second, this approach would differentiate the program quite clearly from existing IHC coverage, thereby blunting claims of unfairness from high-risk members of IHC plans who could argue that they meet the high-risk definition and only fail the crowd-out test because they “did the right thing” by already purchasing IHC coverage.

However, based on our understanding of the PPACA, there are obstacles that could eliminate this approach as an option for New Jersey. The current NJ FamilyCare legislation permits the Commissioner to set up a Buy In program only for children. *See* NJSA 30:4J-12(5)(j). We are also concerned that even if the the first problem could be solved by amending the statute to permit adult enrollment, plans may be reluctant to agree to participate in this market. NJ had some difficulty finding any plan to participate in the children’s buy in because of its low rate. Were this problem to be solved by permitting the rate to float, or by permitting plans to bid for the coverage, the rates would presumably approach that of the IHC market, and the cost advantage would be lost. Such an outcome would also be contrary to the intent of the Buy-In

program. In addition, the NJ FamilyCare provider network is generally regarded as “fragile;” that is, there is a limited number of participating providers, and their participation may be threatened if they see this program as asking them to do more for less.

This approach would require legislation, and would entail some substantial negotiation with insurers before they would agree to participate at any price. They almost certainly will not participate at the current NJ FamilyCare Plan D price. On the other hand, this option would be something new and would help New Jersey plan for the influx of new, higher-income people that the federal health reform law will add to Medicaid.

Creating a New IHC Category

A new product could be added to the IHC program by simply lifting the PPACA criteria for the High Risk Pool program and applying it as the eligibility criteria for membership in this new program. The premiums would almost certainly be higher than comparable existing IHC products, at least in the beginning, as plans would know that each and every one of the applicants is high-risk. In current IHC products, most, but probably not all, of the members are high-risk. Presumably the “standard rate” condition could be met by determining how deep the subsidy would have to be to compensate for this higher risk profile, and applications could be limited to the number of persons who could be supported by adequate subsidies, given the federal funding available. It is our view that adding a new subsidized plan to the IHC would at least require new regulations, and might require legislation.

This alternative also has problems. First, the high cost-sharing in many of the current IHC plans would render them inappropriate choices with the 65% actuarial value rule. One of the more expensive choices would have to be selected, which would reduce the number of covered lives reachable with available subsidies. Second, there is the fairness problem related to current IHC members, discussed above. Third, administering the anti-crowd out and legal residency requirements would be new for the IHC, and would require some planning and preparation.

The IHC option is much more easily accomplished. It could use some lightly-modified version of a plan currently in the IHC. It does not add much, however, from a public policy perspective, as it would continue what some think of as the intersection of two failed models: high risk pools, and an expensive, high cost individual market.

Reinsurance: Application to One of the Above Two Options

Either of the above options would benefit to some degree if the subsidy were applied not directly, on a per-member basis, but rather through a reinsurance mechanism. Reinsurance is said to amplify the effect of subsidy. Insurers, particularly in the non-group market, tend to react to high-cost members over-cautiously – that is, it is asserted that insurance rating tends to overstate the risk presented by a population that is likely to include high-risk members, as raters tend to be very conservative. Such over-reaction leads to higher rates.

The use of reinsurance is intended to moderate this effect. It is estimated that the application of \$1 in subsidy through reinsurance can reduce premiums by more than \$1, as the reinsurance does

two things: it literally subsidizes (as does direct per-person subsidy), and it gives insurers' actuaries comfort that an insurer is less exposed to extraordinary costs in any particular case. The Healthy New York example is often regarded as evidence of this multiplier effect, although there were confounding variables (including, significantly, benefits packages different from those in the comparator plans).

If reinsurance works as described above, there are three values in using it. First, it might amplify the federal subsidies, getting more "bang for the buck." Second, insurers themselves might be interested in participating in the reinsurance, as it serves to smooth out their risks. That is, they might be willing to supplement from their own funds the federal subsidy if they believed that the funds would be returned in an efficient and beneficial fashion. Third, reinsurance serves to minimize the possibility that insurers would "cherry pick" or "lemon drop", as reinsurance concentrates subsidies in high-cost cases. The goal would be that insurers would be less likely to maneuver to obtain the better of the risks in the High Risk Pool if they believed that a reinsurance system would compensate them for serving well the worse-off of the members of the High Risk Pool.

The reinsurance mechanism could be applied to either the FamilyCare buy-in program or the IHC plan addition. It might be appropriate to discuss with insurers and Medicaid their interest in trying this mechanism in one or the other of the plans; as Medicaid must plan for an influx of new Medicaid members, a reinsurance program might be a pilot of interest. Risk adjustment of several sorts will be a part of the Exchange process in the Patient Protection and Affordable Care Act, *see* PPACA §§ 1341-43. The Department of Health and Human Services might be interested enough in having New Jersey engage in some piloting of reinsurance in this setting and thus look more favorably on New Jersey's application than they might otherwise.

Direct Subsidy

Another approach could provide HRP coverage that meets the PPACA's § 1101 HRP provisions, by using a direct subsidy in the New Jersey's Individual Health Coverage ("IHC") program. *See* NJSA 17A:27B-2 *et seq.* Under this method, a NJ state agency would act as the "program." The NJ program would qualify applicants, identify plans in the IHC that meet the requirements of § 1101 of PPACA, and facilitate the qualified applicant's purchase of coverage, including the provision of subsidy toward the premium. One of the advantages of this approach is that it would better prepare the state for the Exchange required in 2014 since a similar subsidy approach will be required.

The NJ program would be an aggregator/exchange that would do a number of things:

Qualify applicants with the PPACA requirements:

1. Citizenship/lawful residence;
2. Satisfaction of 6-month crowd out period;
3. Satisfaction of "pre-existing condition," perhaps, as discussed, by reference to a list of conditions.

Identify plans in the IHC that meet the federal requirements:

1. 65% actuarial value;

2. Satisfaction of out of pocket limitation;
3. Limitation on rating
4. Does not impose preexisting condition¹

Link qualified applicants to qualified plans:

1. Steer applicants to appropriate plans;
2. Allocate subsidy amount to applicant's premium account through some transfer. The transfer could take place in two ways.
 - As with, *e.g.*, § 8 stand-alone housing certificates, by splitting the premium into two pieces, both of which would be due to the insurance company chosen by the applicant. If, for example, the premium were \$1,000 per month, and the subsidy were \$400 per month, the applicant would be responsible for paying \$600 each month, and the program would be responsible for paying \$400 per month; or
 - As with, *e.g.*, FamilyCare Plan D, the program would pay the entire premium to the chosen insurer, and bill the applicant for the applicant's cost share. If the monthly premium were \$1000/month, for example, the program would pay the insurer \$1000 each month, and bill the applicant for her \$600 monthly cost share.

Key to this approach is that the agency selected to administer the program is able to meet all federal and state program requirements. For example, the agency would have to determine if the individual in fact has one of the preexisting conditions specified by the state. Therefore the state may want to select an agency that has experience determining whether a person has a medical disability and has an effective outreach program. The agency also should have an existing Management Information System that could be used to accept applications and supportive documents over the internet and monitor the subsidies. Experience in determining citizenship status would also be very helpful.

This option would be a relatively simple way to link to insurance people with a demonstrated need for coverage (by virtue of their pre-existing condition) but who have not purchased due to cost. Because NJ is a guaranteed issue state, cost is a key issue. The subsidy available for each of the three years is approximately \$47 million (\$141 million /3 years). This may provide a subsidy of about \$4700 per person if we assume an enrollment of 10,000. By way of comparison, the current annual rate for a single person purchasing Aetna's HMO coverage with a \$30 copay is \$14,382, and for a single person purchasing Horizon's HMO coverage with a \$15 copay is \$10,601.88. The subsidy would be significant, and it is likely that a fair number of people who currently wish to purchase but are deterred by price could be brought in with a \$4700/year subsidy.

Subsidizing the Current IHC Market

¹ A possible barrier is that NJ plans in the IHC program are permitted to use preexisting illness exclusions. If the PPACA and the HHS application mean what they say, none of these products would be appropriate for a HRP vehicle so we have requested clarification on this matter.

An alternative to the options described above would be to request the DHHS permit New Jersey to use the High Risk Pool funding to subsidize and maintain (until 2014) the existing IHC. Admittedly, the plan outlined below fits very poorly into the application forwarded by Health and Human Services, but in the interest of completeness we are including it here.

New Jersey could propose to use the High Risk Pool funding to draw currently uninsured, high-risk people into the IHC, and to fold them after their first year into the general IHC market. The subsidies would be divided into pools that one hand would subsidize new members and the other would subsidize the overall pool.

The High Risk Pool in the IHC would incorporate a structure similar to creating a new IHC Category described above: the creation of a new IHC plan with crowd-out, medical condition requirements, residency requirements, etc. In 2011, new members would be admitted to the new High Risk Pool plan, subsidized (through reinsurance or otherwise) as is described above. In 2012, additional new members, similarly qualified as high-risk, uninsured, etc., would be admitted to the IHC's High Risk Pool. Those members who have been in the High Risk Pool for a year, however, would be folded into the existing IHC; that is, they would be directed to the existing IHC plans. These plans would be less expensive than they are now, as some of the federal money (perhaps supplemented by plan-paid reinsurance funds) would go to the subsidization of the *existing* IHC products. In 2013, there would be a similar welcoming of new members into the High Risk Pool, and a similar shift of members who'd had a year in the High Risk Pool into existing IHC plans. The benefits of this program include increased equity to current IHC participants, as they would share in the federal subsidy and a more general spreading (and therefore a richer piloting) of the reinsurance-directed subsidy funding.

Under this option, implementation issues include:

1. Securing federal approval for the idea of splitting the federal funding in Y2 and Y3 between reinsurance in the separate High Risk Pool and the general IHC.
2. Setting the portion of federal funding to the IHC at a level proportionate to the claims or covered members transferring from the High Risk Pool. Some matching reinsurance funds to permit robust premium reduction in the existing IHC plans would have to come from another source – for example, the participating insurers.
3. The transferring members would of course be eligible for federal funding – they were qualified when they entered the High Risk Pool.
4. The existing members of the IHC would not benefit from federal funds; rather, they would benefit from funds from another source (although some modeling of how an honest allocation of funding to meet this condition would be required).
5. The Department of Health and Human Services might support this approach because it helps to ease in the risk adjustment system required by the Patient Protections and Affordable Care Act section 1341 for 2014-2016, and might provide some lessons for future use.
6. The plans might support this design because their contributions would flow back to them, and they have to participate in a similar plan beginning in 2014 anyway.

7. The plans, however, might observe that their contribution to the reinsurance must come from income, and that it will therefore not serve as an effective subsidy as does outside funding.
8. An obvious benefit of this program would be that it would extend benefits to those who “did the right thing” and purchased insurance.
9. A problem with this approach is that it does little to fix the deteriorating state of the IHC. However, we are looking forward to a well designed exchange that will address this problem in 2014.

We appreciated how complex many of these issues are for New Jersey. We look forward to meeting with you again and other members of the Administration to discuss these issues and ideas and to working together for the benefit of all New Jerseyans. Please feel free to call us with any questions or if you would like additional information.

We look forward to hearing from you

Sincerely,



Evelyn Liebman
Director of Organizing & Advocacy
New Jersey Citizen Action Education Fund



Crystal Snedden
Health Care Campaign Coordinator
New Jersey Citizen Action Education Fund

Cc: The Honorable Thomas B. Considine, NJ Department of Banking and Insurance
The Honorable Jennifer Velez, NJ Department of Human Services
The Honorable Poonam Alaigh, MD, MSHCPM, FACP, Commissioner NJ Department of Health & Senior Services
The Honorable Senate President Stephen Sweeney
The Honorable Senate Majority Leader Barbara Buono
The Honorable Senate Minority Leader Thomas Kean, Jr.
The Honorable Assembly Speaker Sheila Oliver
The Honorable Assembly Republican Leader Alex DeCroce
The Honorable Senator Loretta Weinberg, Chair, Health, Human Services and Senior Citizens Committee
The Honorable Senator Joseph Vitale, Vice – Chair, Health, Human Services and Senior Citizens Committee
The Honorable Assemblyman Herb Conoway, Chair, Health & Senior Services Committee