Committee Meeting

of

SENATE COMMERCE COMMITTEE, AND SENATE HEALTH, HUMAN SERVICES AND SENIOR CITIZENS COMMITTEE

"The Committee will receive testimony on the status of Federal healthcare reform implementation in New Jersey"

LOCATION: Committee Room 4
State House Annex
Trenton, New Jersey

DATE: March 3, 2011
2:00 p.m.

MEMBERS OF COMMITTEE PRESENT:

Senator Nia H. Gill, Co-Chair
Senator Loretta Weinberg, Co-Chair
Senator Robert M. Gordon
Senator Fred H. Madden Jr.
Senator Joseph F. Vitale
Senator Jim Whelan
Senator Dawn Marie Addiego
Senator Diane B. Allen
Senator Gerald Cardinale
Senator Thomas H. Kean Jr.
Senator Robert W. Singer

ALSO PRESENT:

Elizabeth J. Boyd
Philip R. Gennace
Eleanor H. Seel
Committee Aides
Office of Legislative Services

Sarah Lechner
Jason Redd
Senate Majority
Committee Aides

Laurine Purola
Christina Velazquez
Senate Republican
Committee Aides

Meeting Recorded and Transcribed by
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New Jersey State Legislature

SENATE COMMERCE COMMITTEE

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COMMITTEE NOTICE

TO: MEMBERS OF THE SENATE COMMERCE COMMITTEE

FROM: SENATOR NIA H. GILL, ESQ., CHAIR

SUBJECT: **COMMITTEE MEETING - MARCH 3, 2011**

The public may address comments and questions to Philip R. Gennace, Committee Aide, or make bill status and scheduling inquiries to Joanne W. Gillespie, Secretary, at (609)984-0445, fax (609)777-2998, or e-mail: OLSAideSCM@njleg.org. Written and electronic comments, questions and testimony submitted to the committee by the public, as well as recordings and transcripts, if any, of oral testimony, are government records and will be available to the public upon request.

The Senate Commerce Committee will hold a joint public hearing with the Senate Health, Human Services and Senior Citizens Committee on Thursday, March 3, 2011 at 2:00 PM in Committee Room 4, First Floor, State House Annex, Trenton, New Jersey.

The committees will receive testimony from invited guests and written testimony from the public on the status of federal healthcare reform implementation in New Jersey, including preparations for a health insurance exchange and measures to be taken for the required expansion of Medicaid.

Issued 2/24/11

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SENATOR NIA H. GILL (Co-Chair): Good afternoon.

Welcome to the joint Committee of Commerce, and Health and Senior Services. This Committee will be chaired by myself and, of course, the distinguished Loretta Weinberg.

As we all know, the Federal healthcare reform is now law. So today we are not going to debate the merits of healthcare reform; we are going to discuss the implementation of this law and how the State should best proceed.

Today's meeting will be divided into two aspects: the Federal health reform law, Medicaid expansion, and the creation of the statewide health insurance exchange. I want the Committee and the public to be aware that throughout today's meeting, many of our invited guests will use the term *consumer* when referring to those who purchase insurance. I would like to clarify that, in this context, consumer means both individual and employers.

I turn the mike over to Senator Weinberg.

SENATOR LORETTA WEINBERG (Co-Chair): Well, I'm going to take advantage.

We did have a Health Committee meeting just preceding this, so obviously it's the Health Committee that's the most well attended. (laughter)

SENATOR GILL: That's because the Commerce Committee was further away.

SENATOR WEINBERG: Yes, right, okay. Well, hopefully they're traveling--

SENATOR GILL: Takes us a little time to find our way. (laughter)

SENATOR VITALE: That's true. And as Vice Chairman, I want to welcome you.

SENATOR GILL: Thank you very much.

SENATOR WEINBERG: Just to add to what the Chair of the Commerce Committee, Senator Gill, said, the states are responsible for meeting the Federal requirements which are outlined in the law. And they include creating temporary high-risk pools; establishing a standard medical loss ratio; and the requirement that children remain covered on their parents' health plans until the age of 23 -- although I think in our state we already do that -- I think it's 26, actually; broader provisions of health reform, such as the Medicaid expansion insurance mandates -- even though we have not been following that right here in New Jersey -- and the health benefit exchanges.

So we hope to hear from our invited guests what is happening here so that we can't wake up early one morning and find out that New Jersey has not been responsive to what the Federal mandates are.

Does somebody have a list of the speakers available here?

SENATOR GILL: And while we get a list of the speakers, of course we would like the ranking -- so as not to say the senior -- most senior -- Republican to make an opening statement if he would like.

Senator Singer? You have none?

Is there anyone on the Republican side who would like to make an opening statement at all? (no response)

See how bipartisan we are in the Commerce Committee?

Okay, then we will start with the first witness, Mr. Dave Knowlton.

Thank you very much, sir.

D A V I D L. K N O W L T O N: Thank you, Senator, Madam Chair; Senator Weinberg.

Senator Gill asked me to do a presentation on an overview of the elements of reform, particularly surrounding the exchange; and that's what I'm going to do. I have handed out my material to you so that you can follow on along if you'd like, because to take on the challenge of presenting all the information about an exchange would take a very long time to do that -- it's very nuanced, it's very complicated.

I'm not going to take a position on anything; I'm going to try to describe how it works at a very high level. I also understand from your staff, Senator, that the Department will be following me and they have some specifics about how New Jersey is specifically responding.

SENATOR GILL: Yes, they will.

MR. KNOWLTON: Okay.

So let's get into it. What is an exchange? An exchange is really a virtual marketplace where the consumer can compare insurance costs and benefits side-by-side and make purchases of insurance. People will be subsidized; you will need to have information on what those subsidies look like. You may actually have something online so that people can actually see how their subsidies would play out within the exchange.

The exchange is the place that people who do not have insurance will be going to get insurance under the new law, if they don't have it through other means.

There are four principles of exchanges; I like to call them the four *A*s. And I would hope that legislators would keep in their mind these principles as they examine the exchange information that will come before you.

Availability. Is access granted geographically? Can people get the care they need? Is care available?

Is it adequate? Are there adequate numbers of networks, benefits, and providers?

Is it affordable? The fact that there may be subsidized premiums doesn't mean that the there may not be cost shifting within the benefit itself. Is it affordable?

And finally, is it administratively simple? Is it able to be understood? Are people going to be able to make good decisions as they look at information and choices?

What the exchange requires is adherence to qualified health plan rules -- that certification, recertification, and decertification -- how would that work?

Essential health benefits -- meeting the Federal guidelines which includes all the things you would think: hospital emergency, prescription drugs, behavioral health, rehab, maternity, etc.

It requires a toll-free call center. It requires the maintenance of a website with plan information in a standardized format, and it's one of the first things that -- deliverables -- that you have to provide -- you have to provide people.

And it requires an online calculator to determine the actual cost of coverage. Now, this is actually a picture of an online calculator that the

Kaiser Family Foundation actually uses right now. You can get that online at their website. And to show you what a calculation looks like, showing not only the premium that you would pay if you were not on this income -- this is a premium unsubsidized; and this is what you'd pay subsidized, about 10 percent of that premium.

I think there's a lot of potential to a national insurance exchange. Though economies of scale can be gained, and some increase insurance market efficiency, it's also an opportunity for greater market oversight. This transparency -- getting some transparency into the system and new opportunities for insurance market competition, which has long been an objective of reform and of the exchange.

So let's go over some of the key issues. And I, again, apologize; you kind of need your seatbelts to go through this so quickly. Some key issues -- exchange functions and authority: Should there be active or passive oversight? Should you just say, "Okay, whatever plan wants to come in, can come in," or should you have strict rules of who can get into the exchange? Because remember: This is where consumers -- Senator Gill, you were correct -- consumers, being both employers and individuals, are going to be buying policies.

Who can participate in the exchange? Can everybody participate? Is this an all-comers can participate, or can only certain select people who meet certain select criteria participate? Are you going to set the rules governing insurance that's sold inside and outside of the exchange? Will company *A*, if they sell within the exchange, have to adhere to different rules in the products that they sell outside the exchange? There's

been debate in some states of making them the same; I don't know anyone who does yet.

Concerns about risk selection -- and I'll talk a little bit more about that later -- but if plans are subject to tremendous adverse selection because they're in the exchange, they will follow the downward spiral of -- death spiral -- of insurance and they won't survive. You have to be able to know that you can manage adverse selection and risk.

Should the exchange be the exclusive source for certain markets -- for the poor, for people transitioning from Medicaid -- so that they would be the only place to buy these services; or should they be just an alternative source for some markets?

The premise of why they put an exchange into the-- Well, the practical answer why they put an exchange in was because Massachusetts did, and it worked. But the reason that the exchange, in theory, is in is because health insurance markets haven't worked very well. You go out and buy auto insurance, you can go see some basic coverages and say, "What's it going to cost me?" and make a decision. Health care is a good deal more complicated, and whether you get the adequate coverage that you need is not quite as easy to figure out.

In addition, exchanges can really be designed to create oversight and structure to insurance markets that make some good determinations.

One of the most exciting areas of the exchange is its role in addressing the costs of care. They can be given the authority to negotiate with plans over price. Some states have chosen not to do that; and some states they might do that. They can look at standardized benefit packages to promote price comparisons by both the employers and consumers. They

can look at fixed employee contributions to promote lower cost -- requiring a fixed contribution. The public plan could catalyze private plans to become more cost efficient if the exchange has an alternative that's a public plan or a quasi-public plan. The public plan would be something like Medicaid for everyone. A quasi-public plan might be something like access to the State health benefits program or something like it, administered externally to the State but sponsored by the State.

And finally, greater insurance transparency will promote more informed consumer choice and give incentives for efficiency because you would be able to track what's happening. The exchange is intended to be very transparent.

Getting people into the exchange in enrollment is always a challenge. And the exchange is going to have to have ways to facilitate enrolling people. They're going to need reliable information on options and all processes within the exchange. They're going to need help centralizing how you would choose plans, and how to determine a subsidy. Let me explain: If someone is insured by their employer, they have a standard plan. Let's say it's a woman. She becomes pregnant; she decides she's going to leave her job for a period of time, longer than just family leave. That alters her income. She is now eligible for a different level of subsidy than she was when she was in her employer's plan. Then let's say she's been out for a couple of years; she goes back in again to the workplace. The subsidy equation shifts again. So if we don't figure a way to make it very easy for people to understand, this is going to be a nightmare -- trying to figure out who's entitled to what subsidy at what level, in terms of the program.

How are people going to make payments can be determined by the exchange. They can centralize that if they wish. Payments could go through the exchange if you thought it was the right way to go.

And tracking enrollment and disenrollment -- to minimize the coverage gaps that I talked about.

Exchanges don't have to just be about how they get people enrolled, they could also be involved in requiring people to report on quality, investigate complaints. They can be a gateway for Medicaid and SCHIP. And one of the things, as you can imagine -- people who have lower-end jobs may move in and out and need transition. The transition between the exchange and Medicaid, the exchange and SCHIP, is going to be a big issue.

They will allow participating plans to be evaluated, and they can establish and publish comparative standards so people can get comparative information, much as the Senate Health Committee pushed when they pushed for patient safety reporting, cardiac reporting, other levels of reporting in the state.

Now, all the comments I just made are what exchanges are doing generically. Frankly, New Jersey's way ahead of the game. If you look at the President's health reform, New Jersey is way ahead. We, for example, have no penalty for pre-existing conditions and we haven't had for a long time. We have guaranteed issue and guaranteed renewal. We have no medical underwriting permitted in our individual and small group markets. The Kids First (*sic*) law that was passed -- Senator Vitale's bill -- got all kids covered in New Jersey. We have medical loss standards right now that exceed the Federal standards, not only the level but a stricter

enforcement of what can be included in those standards; we have no benefit caps except in one program, the basic and essential policy which we have a Federal waiver for; and no rescission. If you followed what happened in California, rescission is when someone says, "Oh, I find out that you've got breast cancer, but you neglected to tell me that you were a cigarette smoker 20 years ago, so we're not going to cover you for your breast cancer." It's a moot point in New Jersey because of our guaranteed issue and renewal. So we don't have the problem that California had with rescission.

I would also add that we have-- I don't want to put this as -- ahead of the game; someone said behind the game. But we have 33, I think, 33 mandated benefits in New Jersey. Some of those are a problem and drive up the cost of health care, but some of those are benefits that other states are going to have to put in their policies when the Obama reforms come forward, because we already have them. One that comes to mind is an Ob/Gyn acting as a primary care physician. It is a New Jersey law; it will be mandated under Federal reform.

So let me talk briefly about process, and then I'll comment briefly on what I see as some of the concerns. Your initial decision point is, what really do you want to do? Do you want to form a State exchange? You don't have to. Do you want to form a State exchange and, if you do, if you want it to be a State-based exchange, do you want to run it? Or do you want it to be a not-for-profit company that's going to run this, some not-for-profit group? A for-profit cannot run it, but a not-for-profit can. Do you want to do it, or do you want somebody else to do it?

Or do you want to form a regional exchange? And if you want to do that, do you want to create your own, or do you want to join another

regional exchange? If you look at the way healthcare benefits are purchased in New Jersey, people live in New Jersey and work in New York; people live in Pennsylvania and work in New Jersey, and vice versa. So having-- There is certainly an argument that making it very easy for people to move across state lines and stay within easy coverage in their network, and so forth, makes some sense. It adds to the complexity of the insurance issue, and makes it a difficult decision.

The other alternative is to do nothing -- there's no requirement that the State have an exchange. If the State did not have an exchange, the Feds would create one for you, and you'd be adhering to the Federal rules. If my-- One of the brief editorial comments I'll make is I hope you won't choose that option. New Jersey is already, as I mentioned earlier, far ahead in their regulation of insurance -- on many of the things that the Obama reforms intend to get at, New Jersey has already done. And the interface between Medicaid and this level of insurance in the individual and small group exchange markets will be important, and there needs to be a specific New Jersey flavor, in my judgment, to those markets.

So what's the exchange responsible for? They're responsible for marketing, network adequacy, quality improvement, and reporting uniform enrollment; provider directories including a significant amount of data in and out of network; and timely consumer data for cost sharing -- what's involved in cost sharing. And that's a very-- Having been involved a little bit in the out-of-network debate, that's a very difficult thing to come up with: How can we get a consumer timely information on what that consumer's out-of-pocket costs will be at a provider at a given point in

time? And now we're talking about doing that determination when they're trying to buy a policy. It's pretty complicated.

An exchange has to have an expert board of directors, the ability to maintain transparency in some way, relationships with State agencies and private agencies -- probably less an issue in New Jersey -- and the ability to protect and promote health care delivery, health plans, and, most importantly, the consumer.

Now, let's talk a little bit about the consumer issues, because that's where the rubber hits the road a little bit. The exchange is -- as Senator Gill pointed out -- the exchange is a consumer vehicle in that consumers here are both small businesses and individuals. The consumer issue, as I see it, it really has to be independent from insurers in some capacity. It has to be sensitive to health literacy. We make a lot of determinations that people we think need to understand about their health and about their care, and we neglect the fact that some people don't understand. The example of the diabetic who was taught to inject an orange to learn how to give himself insulin injections, comes back a week later and has been dutifully injecting his orange and not giving the injection to himself, is a real-life story. And so health literacy is a big issue.

Cultural sensitivity. People are going to want to know the cultural sensitivity of the plans that are within the exchange. Can we make that information available? Language: Cultural sensitivity is more than racial issues; it's more than specific cultures; it's also, can you go to the doctor at night? Can you go to the doctor on a Saturday? Do they speak your language? I believe that any state will have to have some ombudsman or ombudsman function to see this through in a meaningful way, and two

states have tried initial efforts with just using an ombudsman and, ultimately, had to engage local community navigators. These are local, usually advocacy groups who are helping people navigate through the exchange.

They need a subsidy algorithm or a calculator like I showed you earlier; and especially important in this state is Medicaid coordination -- Medicaid and SCHIP.

One thing I worry about with consumers is the quantifiables squeezing out the relevant -- that we report on a lot of data because we can gather that data, but it's not data that's especially meaningful to people. Some of our health reports recently reported everybody is sort of about the average -- everybody's about average. It doesn't give you -- yes, we can record it very carefully -- but it isn't telling us information we can make decisions on.

And I think, ultimately, the exchange will fail if it doesn't enable us to put a bright light on plans that are doing good -- that are doing good for consumers in making good choices.

There are a bunch of other decisions that need to be made -- I'm not going to go through these. You're going to be having this debate again and again, I'm sure, and I'll be glad to come back and answer the questions. But this gives you an idea of some of the other choices that are in your documents that I handed to you. There are a bunch of choices that you have to address in looking at this legislation.

So where do you start? Well, you've got a good start. You have enabling legislation already in the hopper, as I understand it. You have technical resources available to you that can help you with it. And let

me give you your bogey: There's a deadline for the Federal Health and Human Services to evaluate your proposal by January 1 of 2013. Exchange has to be up and working by 2014. Drilling down a little bit, this is the timelines: the RFP in July 2011; have to submit by 2012; 2013, start selling health insurance through the exchange; fully operational by 2014; and the big, big, big problem, for most states: self-sustaining by 2015.

Now, are there current working models? Sure there are. Exchanges exist in Massachusetts, which actually did the first one called the *Connector.* And in Utah, most recently, one was created specifically in response to Federal reform in California. And I won't go through all the details -- the Massachusetts program known as the Connector -- they have an individual mandate in Massachusetts; about 95 percent of Massachusetts citizens are covered now under their program. Cost remains a problem in Massachusetts -- cost is still very high. Plans cannot be sold through their Connector, as they call it, without approval by the state.

Utah is a much more open system, open to any plan that wants to participate. The state only defines the minimum benefits that have to be provided. And they have about 85 percent of their residents covered in the Utah program.

California is brand new. It was the first exchange in response to the Affordable Care Act. They have broad powers to negotiate on behalf of the public; we don't quite know how that's going to roll out because they're too new. It is thought it's going to look like the Connector in Massachusetts, and they have no individual mandate yet. The translation is, I think they may be going to rely on the Feds for their individual mandate.

So what I'd like to do in the remaining couple of minutes is talk about some concerns I have, and things that I think may be problematic that you ought to pay attention to in the Connector and in reform. The first, I mentioned earlier, is adverse selection. If people can move in and out, based on whether they're sick, and the price depends on what happens as sicker people get in the plans, you'll have the problem we have in the individual market: that people get sick, the price goes up, so people who are a little healthier leave; the price goes up some more, so more people who were not quite as sick, but still sick, leave, leaving only the real sick in the plan. That's the downward spiral. So you really have to be able to address adverse selection, and that's not an easy task, as I think the folks from DOBI who will follow me will be speaking about.

One of the big problems in adverse selection is pre-existing conditions. New Jersey -- another editorial comment -- I promised Senator Gill I'd identify my editorial comments -- another editorial comment is that I think the Obama reforms made a mistake with their pre-existing condition regulations, because I think New Jersey did it right. New Jersey has a waiting period for pre-existing conditions, which means that somebody will not casually go bare on insurance assuming, "Well, I'm not going to get sick." Under the Obama reforms, you can sign up immediately -- it's immediate issue by 2014 for adults, for kids now -- but kids don't get sick as often as adults. So you could show up at-- Go bare, pay a minor penalty in the early years, up to two-and-a-half percent of your income in the later years, and if you're young, and you're healthy, you're going to say, "I'll pay the penalty." At the maximum you'll pay $2,500 at the real outside, and that's not even, probably, in the individual market, four months' premium -

- and it's $2,500 a year, so you can do the math. What they do instead, then, is they wait, and if they fall off a dock, or hit their head, or get sick, get cancer or something else, they show up and sign up immediately because there's no waiting period. That's going to be a big problem. It also will preempt, as I understand it -- I'll be interested in what the DOBI people say -- but as I understand it, New Jersey law would be preempted on that matter, and that's going to be a problem for us. So you're going to have to address that in some way.

I also believe, by the way, the Feds have got to address it because it will cause a downward spiral in insurance if they don't.

Crowd out is when people say, "I'm going to use the plan on the inside, in the exchange, rather than continue to provide a plan as an employer." So I say to my employee Catherine, "Let me give you a check for the amount of the premium," and I'm out of it from now on. That's called crowd out, and there is a fear that you'll crowd out good coverage that some people have now. How you protect against that is a big issue in health reform and in the design of the exchanges consistent with what's going on in Federal law.

Physician availability. You will not have enough primary care in New Jersey now if you were to implement this today. There is not enough primary care capacity now. Let me give you an anecdote: You're now sitting in Mercer County. In the past three months, seven doctors in Mercer County went to concierge medicine, where you pay an *X* amount of money in order to get your care. Seven practices went to concierge medicine. So everybody says, "I don't know what your feelings are on that," but everybody kind of said, "Well, that's too bad; they shouldn't do

that." The real reality is they move from covering about 1,600 people a year in their practice -- and that's a pretty low estimate -- to covering 600 a year. So you have 7,000 people in Mercer County now without primary care, and seven fewer providers to provide that care. Huge problem -- huge problem in New Jersey, it was a huge problem in Massachusetts. It inundated the emergency rooms because they couldn't -- people just getting routine care -- not because they wanted to, but because primary care was not available. It will become an even increased problem with Medicaid. So another problem that really needs to be addressed in New Jersey.

I mentioned-- I won't reiterate the issue of literacy.

Interfacing the individual and small group market is going to be a challenge. You're going to have to do it in a responsible way, or you may say, "Let's just merge it." That's going to be a decision point you're going to have to think through.

I can't say too much about this next thing: the undocumented. New Jersey has a significant amount of undocumented. When we were doing the reform work with Senator Vitale, we were eighth in the nation in undocumented residents. President Obama has been very clear that no Federal dollars will be used to cover undocumented residents. I don't know what will happen as we parse back charity care, because we're now covering people with insurance cards instead. But I can tell you that hospitals, even though the Feds will not cover it, hospitals still have to provide care under the EMTALA Law. And New Jersey's EMTALA law far exceeds the Federal EMTALA law. The Federal EMTALA law is a lot more lenient; New Jersey law is a lot more strict. So you're going to have real challenges in dealing

with the undocumented, and I don't see a clear solution to that immediately on the horizon.

Last issue I've seen concerns is an issue that the Legislature attempted to address in the Assembly; I understand it did pass a limited bill and it's over here now for consideration in the Senate -- and that's on out-of-network costs. It's going to be impossible to maintain this system if people can charge people in the exchange out-of-network charges of eight, nine, or 10 times Medicare and get paid that; it will break the bank. I am a great fan of market forces working in health care, but if you don't let them work and they're unfettered in price, it will break the bank. So you have to pay attention to it. The out-of-network issue is a crisis with respect to health reform. You have to pay attention to it.

I also-- I trust that you are all a little more knowledgeable about this than I am, but just let me take my quick stab at it -- on the issue of politics here; and there are political issues here. The first most obvious is funding -- who's going to pay for this? Are you going to have it subsidized by people playing in the exchange (indiscernible) with plans? Are you going to prevent them from passing that on? Are you going to allow it to be considered in a medical loss ratio? These are all very big issues. What is the base of exchange operations going to be, as I mentioned earlier? Is it going to be a not-for-profit? Is it going to be in the State? If it's in the State, is it going to be a new entity like one of the authorities, or is it going to be in DOBI or Health or Human Services? The out-of-network issue, I don't have to tell you, is a political issue. If you don't think it is, wait until you take up your bill, coming soon.

And what participation requirements do you plan for providers? What requirements to participate? For example: If you're in one plan in the exchange, do you have to be in all of them? What are the rules going to be? And what requirements for the plans? If you have an exchange offer, do you have to offer all the plans available in the exchange? If you have plans, and you have still maintained the individual and small group markets, do you have to continue to do that?

So if you want to look at it graphically, on one side you have really individual health underwriting, pre-existing condition limits allowed, high deductable plans, etc. -- much of which we're going to do away with in health reform, but there will be things right at that edge. And on the other side you have government prescribed prices, benefits; it's the only market; universally comprehensive benefit plan. And you have each side saying, "I don't want to do it that way." So politically, that's where the challenge will be. Everybody's going to be searching -- and I'm not going to walk through these individually -- but as you can see, it moves from less regulation to more regulation, and I'll let you read the materials that are in front of you to see the particular issues there. But you move from having anybody play to only a few play.

So I'd like to leave you with a few points of just summarizing this -- a few reminders. Remember -- this is one of my favorite New Jerseyans -- remember, number one: Subsidies vary with personal circumstance. People will move in and out of subsidy. That is going to be an enormous problem, and I would suggest to you that it can't be managed without computers. So this is going to have to be web-based solutions of some kind, because people will be moving too rapidly.

There is a strong foundation of insurance market reform and regulation in New Jersey. It's something to be proud of, it's something you should build upon. You should not try and reinvent the wheel. We already far exceed Federal standards in New Jersey.

Exclusivity enhances the value of the exchange. If you say -- if it's the *GUMs* -- the great unwashed masses -- everybody can play, you will not play as well. You will not have the leverage that the exchange is meant to give.

Setting benefits standards is critical for adequate coverage and informed choice. New Jersey has a good record there; you should be proud of it, and I think you should be willing to step up to that plate.

The cost curve rules. If you can't bend it, this won't work. So it won't work here, and it won't work federally. Cost curve absolutely rules. It has to bend, and the treatment trap is right behind it. The treatment trap is that we overtreat -- that we're overtreating, and in New Jersey, as you know, the real horror here is end-of-life care which we overtreat to the tune of being number one in the nation.

If there is no primary care, there is no access. There cannot be access without primary care. There is not an easy solution to primary care. It's going to require outreach to nursing; it's going to require outreach to other extenders to be able to maintain the primary care that your citizenry will need as this reform moves forward.

You're going to have to create the exchange to be trusted in a meaningful way. And the price of success will be somebody staying on top of it. There will need to be oversight and vigilance.

And I'll leave you with a comment that Hillary Rodham Clinton made, when she was doing her health reform, that always stuck with me, when she said, "Don't forget the fear." There's a significant difference between the concerned, cost-conscious consumer and the panicked patient in pain. And so there is a need to be sensitive as we design these beautiful systems. There's a need to be sensitive to the patient who's looking at their computer screen and trying to make an informed choice about the options for he or she and their family. And I think the point was well made this morning in the release from the AARP, with health leading the number one concern of their constituency. What you're dealing with is not, in this exchange issue and the reform issue, is not only approaching 18 percent of the domestic gross product; but it's also something that everybody lives with that really matters to people.

So I thank you. I'm honored that you asked me to share this with you, Senator Gill. And I'll be happy to answer any questions if I can.

SENATOR GILL: Thank you very much.

Any questions from anyone?

Senator Vitale.

SENATOR VITALE: Thank you, David. Thanks for that presentation, and I'm happy to hear that you'll be back again, because we won't fix this in two hours -- or learn all about it. It's pretty extensive.

I do want to talk about three things: one is the most recent comment about primary care and access. I mean, it's an issue now, and it's going to be a greater issue with the 1.3 million uninsured New Jerseyans -- maybe a little bit less -- gaining access to health insurance and demanding care. We have done some things over the past few years to expand the

ability for advanced practice nurses to practice not just independently, but also to increase the scope of their practice -- to diagnose and to prescribe drugs for their patients. So that's a good step in the right direction. And it will take longer than 2014 for us, even if we were to start today, to aggressively recruit and retain, through any number of means, medical students in New Jersey. It will take at least 10 years to see the fruits of that labor. So you're right. What are some of your -- what would be some of your ideas going forward -- starting today, even recognizing the reforms you've already put in place with loan forgiveness for nurses and for doctors, and for expanding the scope of practice for LPNs -- what else should we do?

MR. KNOWLTON: Well, there's no question that you're going to have to look to nursing in a big way; and you're going to have to move-- It's also a public relations problem. You're going to have to move the public's confidence in that care. The basis of it-- I can tell you, as a health quality person and a researcher, that the quality is excellent and there's no reason to be worried about it, but it can't become second-class care. If people perceive it as that, they won't use it.

I foresee a lot more clinic use. What has been an anathema to many states -- of the retail clinics -- is going to become a reality, and I think one that should be embraced but managed; where Walgreens and Rite Aid and Walmart are looking at retail clinic environments in states. They're going to become really needed because you can use one provider more efficiently in a clinic setting. Hospitals are going to be asked to step up. But we need to plan for this now. I think the big thing, Senator Vitale, is that we do the planning now -- that we don't wait until this hits us in 2014;

2014 is a nanosecond away in terms of health planning. And in terms of implementation of regulations to do all this, it takes a long time.

SENATOR VITALE: True.

Next, I want to ask you a little bit about the Medicaid expansion and what has to take place -- what will happen in 2014? Currently, New Jersey has set up a 60-40 match in Medicaid, so it's 40 of the State dollars, 60 Federal dollars for match. And that's good; it used to be 50-50, and they've increased that a little bit over the past couple of years, but certainly a pretty significant burden on our treasury to support the cost -- the State-borne cost -- of Medicaid. What I've read is that by the first year the Federal government will cover the cost of all the Medicaid dollars up to 100 percent of those costs for a period of time, and then we'll gradually go back down to level off at around 88 percent of Federal dollars and 12 percent State -- which is now 40 percent, which is a big savings for our State. Of course, we have to consider that we're going to increase the number of people enrolled in Medicaid and so it might balance itself out.

If you could explain -- and I'm still trying to get my head around this equation -- that it will be-- Reimbursement will apply at certain levels for those who are already in Medicaid?

SENATOR GILL: Senator, we're trying to do this in two parts. But we do have a second segment -- is devoted directly to Medicaid.

SENATOR VITALE: Okay.

SENATOR GILL: So if you would be kind enough to reserve that question.

SENATOR VITALE: For the Medicaid folks?

SENATOR GILL: Yes.

SENATOR VITALE: Sure, no problem at all.

SENATOR GILL: Any other further questions from any Senators?

Senator Cardinale.

SENATOR CARDINALE: Thank you, Madam Chair.

You addressed shortages of personnel, particularly of primary care physicians. Is New Jersey unique with respect to that shortage?

MR. KNOWLTON: No. Primary care shortages are a problem around the nation. New Jersey has a very high shortage, comparatively, but it is not unique at all.

SENATOR CARDINALE: To what do you attribute our being in a worse position than, perhaps, some other states?

MR. KNOWLTON: Yes, we are in a worse position than some other states. Primary care-- I hope I'm getting your question, Senator. The primary care crisis is a national crisis; it is not a New Jersey crisis, it's a national crisis.

SENATOR CARDINALE: But I think you just told me that it's worse in New Jersey than in some other states.

MR. KNOWLTON: It is, it is.

SENATOR CARDINALE: To what do you attribute that difference?

MR. KNOWLTON: It's not exactly something that I've looked at carefully, so I'm just giving you my judgment. I think it's population density, so that the amount of primary care that we need in our geographic confines, with the population density we have, has to be that much richer -- number one. And number two, a lot of our medical students that we train

here, leave -- they go elsewhere. And that would be my guess. But I haven't looked at it rigorously, Senator, so I'm not an expert on it.

SENATOR CARDINALE: Is primary care the only area of physician shortages that we have?

MR. KNOWLTON: No.

SENATOR CARDINALE: We have physician shortages in many areas?

MR. KNOWLTON: Yes.

SENATOR CARDINALE: Obstetrics?

MR. KNOWLTON: Again, not an expert. That's my understanding -- yes.

SENATOR WEINBERG: The answer is yes to that.

SENATOR CARDINALE: Neurosurgery?

MR. KNOWLTON: Neurology-- I could give you a list of a number of them.

SENATOR GILL: Senator, I know we're talking about the time constraint, but he said he doesn't have all the--

SENATOR CARDINALE: Yes, I--

SENATOR GILL: You can make the statement, and we'll all agree.

SENATOR CARDINALE: No, I'm not interested in making a statement; I'm interested in developing some information--

SENATOR GILL: Okay.

SENATOR CARDINALE: --which I think could be useful for us.

In your presentation you suggested that we might have to rely on non-physician-trained personnel to do some of the functions that physicians today do -- I don't know if it was you or if it was Senator Vitale who talked about that -- as diagnostic functions. Do you believe that the population of New Jersey is receptive to having non-physicians do their diagnostic work-ups?

MR. KNOWLTON: I believe portions of them are, Senator. It's part of the issue I talked about -- that we're going to have to educate the public. But yes, I think so. I think portions are; I certainly am. And I think that it's been a factor in the military forever. So certain people are used to it, and certain people are not. But it is an absolute imperative under reform, because if you decided today you were going to fund whatever funding was available, and you were going to give long redemption and whatever to get everybody all re-enrolled and get your enrollments up in medical school, you still have a 10-year window. So it's a problem that's not going to go easily away. There has to be some sort of extenders to accomplish the result.

SENATOR CARDINALE: The question that occurs to me then is, if diagnostic procedures can be acceptably done by non-physicians, why should we have medical schools? Why don't we disband our medical schools and have an expansion of nursing facilities or some other kind of profession, whatever we might call it?

MR. KNOWLTON: Well, there's an awful lot, Senator, that -- a diagnosis that a nurse could do, and there's a lot of diagnoses that a nurse would not attempt that is outside the scope of the practice.

SENATOR CARDINALE: I would suggest to you that that's correct. The problem is when the patient is ill, we don't know which patient can be successfully diagnosed by a nurse, and which patient may really require a more professional diagnosis. So traditionally we have required that those diagnoses be done by a physician, because we know that the physician is in a better position, generally, than other personnel -- whether it be physicians assistants, nurses, or anyone else. I'll agree with you that many cases can be handled by lesser-educated personnel. But the problem is we don't know in advance which those are, and so people are going to be misdiagnosed if we denigrate the professional training of those who are going to do this procedure.

MR. KNOWLTON: I won't belabor it. I would just reply that I would love to talk to you about it. I think there is an opportunity to do both. I think it's a question of expanding responsibly. We've had this type of expansion in dentistry, optometry, podiatry, osteopathy in the history of the country, and I think we're ready for the next stage. But it has to be done, exactly as those professions were, in a responsible manner. But we need to address it or we'll have a problem.

SENATOR GILL: Thank you.

Senator Whelan.

SENATOR WHELAN: Thank you, Senator Gill.

You gave us some statistics: Massachusetts is 95 percent and Utah is 85 percent. Do you know what New Jersey is?

MR. KNOWLTON: No, I do not.

SENATOR WHELAN: Okay. When you talked about the RFP in July 2011 -- presumably that's being put out by the State to start this process -- on your timeline sheets, July 2011, RFP.

MR. KNOWLTON: I have to-- I have to go back to what you're referring to.

That's the RFP for information technology of the web structure. We have to have an RFP out--

SENATOR WHELAN: Okay, who's putting the RFP--

MR. KNOWLTON: We're putting the RFP -- the State has to put out an RFP.

SENATOR WHELAN: The State.

MR. KNOWLTON: The State, yes.

SENATOR WHELAN: That's what I'm saying.

MR. KNOWLTON: Yes, that's--

SENATOR WHELAN: So the State--

MR. KNOWLTON: I didn't know what you were looking at.

SENATOR WHELAN: Now-- Okay.

I'd like to ask: I have a sense, from your presentation, from the consumer's point of view -- either individual or employer, group, whatever -- how it kind of works. From the insurance company's point of view, what's their incentive and why do they want to be part of the exchange instead of just being out there on their own, especially the larger ones? They say, "Why do I need this? I'm BlueCross BlueShield," whatever.

MR. KNOWLTON: Senator, let me answer that two ways: One way to answer it is, the insurance industry has stepped up in the State in the past. Kids First never would have happened if insurers hadn't

stepped up to participate on a very public purpose basis. But that being said, they were also getting access to a lot of covered lives. If the exchange is designed in a way that's responsible and doesn't hurt them, but is responsible also and doesn't hurt the consumer so both sides--

You point out a very excellent point: It has to be a balance or it won't work. Because the insurers can certainly say, "No, thank you." The providers can say, "No, thank you." And the consumers can say, "No, thank you." So you've got to balance it so that it works. And that it will be a challenge -- exactly.

SENATOR WHELAN: But explain again-- If I'm one of the big guys, why do I want to go into an exchange where I'm laid side by side with other companies that may be undercutting me or whatever? Don't I want to just use my bulk to say, "I'm the 800-pound gorilla, and I'm not going to be part of the exchange."

MR. KNOWLTON: Well, I think they'd want to be for the reason I said: that they would gain access to covered lives. But let's take, for point of argument, that they didn't, and everybody stayed home. Well, then New Jersey may want to say that participation in an exchange is tied to providing insurance in the State of New Jersey, because we need the exchange to be covered. You can regulate it all-- As I started in my presentation, Senator, I said you can regulate it at any level here, and it is a balancing act. You've got to balance the interests of a variety of stakeholders that very often have different views. Your point is very well taken with the plans. But if everybody stays home then you've got a problem; you've got to tweak the exchange and change the rules.

SENATOR CARDINALE: Thank you.

SENATOR GILL: Senator Allen.

SENATOR ALLEN: My question is really a follow-up, talking about if everybody stays home. When we first got SCHIP, that's what everybody did -- they stayed home. And it took years and so many different trial balloons as to how we could bring them in, and so many different things that we tried. I worry that we're going to run up against the same sort of thing, and as you said if that's what happens, we're in big trouble.

MR. KNOWLTON: You're exactly right, Senator Allen. The enrollment issues challenges are significant. However, I would suggest that-- My personal belief is that New Jersey has learned from its SCHIP experiences. This recent Kids First work that we did really got enrollments rapidly, much more rapidly--

SENATOR ALLEN: Twelve years later--

MR. KNOWLTON: Yes, after a lot of experience, I admit.

And also the Department of Human Services now is much better oriented to getting enrollment. I don't know how that will work in the exchange; it may be that Human Services is better resourced to assist in enrollment and the crossover. When Human Services is up here later, you may want to ask about the interface between Medicaid and the exchange.

What happens when somebody is making beds at one of the casinos in Atlantic City, and covered by Local 54 HEREIU, suddenly loses their job in a layoff; now is subsidized and has to dump into the exchange with almost 100 percent subsidy; and then suddenly gets reemployed -- what happens with Medicaid and how are you going to interface those things? Those are big issues.

So it's not only enrollment, it's interface to make the system work.

SENATOR WEINBERG: It's the infrastructure.

SENATOR ALLEN: Thank you.

SENATOR GILL: Any further questions?

One quick one.

SENATOR VITALE: Thank you, Chairwoman.

Dave, we-- As part of the Federal reform, obviously there's the mandate that all shall have health insurance and purchase it. And, you know, just the work that we did over the years -- we met with lots of experts, and talked about that particular dynamic and how it relates to the cost of insurance when everyone is in, versus when everyone has the option of being in. That's one of the main sticking points, of course, that a lot of the lawsuits are now based upon nationally -- by some of the governors who protest, and it's about the mandate mostly. Can you explain, just in your opinion, why it is that it's necessary to have the mandate?

MR. KNOWLTON: It doesn't work without a mandate. Because insurance is about spread of risk, and you have to spread the risk. You have to have a bunch of homes that aren't going to burn down to pay for the one that does. You have to have a bunch of drivers who never have an accident to pay for the people who do. And health insurance is one of the few places that everybody feels they don't get their money's worth if they didn't use it. You don't complain about your life insurance, "Gee, I didn't get to make a life insurance claim this year." So the problem is, if everybody isn't in, it gets absolutely destroyed. I worry about that in the Obama reforms.

I -- editorial comment -- I think the reform you suggested, Senator, in your Phase 2, that would have allowed for automatic enrollment if you remained uninsured, was a more practical way than penalizing people -- minimum penalties that will cause people to adversely select out. You cannot pay for the sick -- you cannot pay for the sick without the help of the healthy. It's impossible.

SENATOR GILL: Thank you very much for your testimony today. Thank you very much.

MR. KNOWLTON: Thank you for the opportunity.

SENATOR GILL: And we will hear from the Department of Banking and Insurance, Neil Sullivan; a five-minute presentation.

ASST. COMMISSIONER NEIL SULLIVAN: Good afternoon. My name is Neil Sullivan; I'm Assistant Commissioner for Life and Health in the Department of Banking Insurance. And I have primary responsibility for the insurance reform aspects of the Affordable Care Act.

So a lot of ground to cover in five minutes -- that's a challenge; but let me give it my best shot.

The Department of Banking and Insurance-- The two major issues that the Department has been dealing with have been the Pre-Existing Condition program and the planning for the exchange. So a little bit of what's happened in the past, a little of what's been going forward.

We are part of an interagency task force working very closely with other agencies of the State that are affected by healthcare reform; working very closely with Valerie Harr, who you will be hearing testimony from. We have also been coordinating closely with other states and other

national associations to try to stay plugged into what's been going on, on a national level, with respect to healthcare reform.

The Department of Banking and Insurance has applied for and obtained from the Federal government grants for the implementation of the insurance reform aspects of the Affordable Care Act. We applied for and obtained a $1 million grant with respect to improving our rate review capabilities. We applied for and received a $1 million grant with respect to planning for the establishment of the exchanges. We applied for and received a grant that totaled approximately $900,000 to use for enhancement of consumer protection functions of the Department. We also entered into a contract through the Individual Health Coverage Program Board -- which is in, but not of the Department of Banking and Insurance -- to run what was originally called the High Risk Pool in the State of New Jersey -- what has come to be called the Pre-Existing Condition program.

And I'll spend a few minutes talking about that, because that's an important initiative. There's been made available $141 million in Federal funds under the Affordable Care Act, and we put a good deal of time and attention into looking at that and deciding how to implement that in the best interest of the residents of the State of New Jersey.

The rules established by the Federal government for eligibility are challenging for a state like New Jersey. To be eligible for the Pre-Existing Condition program, an individual has to have been uninsured for six months; an individual has to have a pre-existing condition; and an individual has to be here on a documented basis. The challenge for New Jersey is that we are one of only five states that already has guaranteed issue

in the individual insurance market, where it is already unlawful for insurers to reject an individual who applies for coverage on the basis of their health status, or to rate them up on the basis of their health status. Pre-existing condition programs, or high-risk rules, have traditionally been used in states where there is medical underwriting and, therefore, there are people who are shut out of the market because of their health status. That has not been true in the State of New Jersey. So a good part of the early implementation was in working with HHS to get them to accept some tweaks to the program that would make this work for the State of New Jersey. We have the option: We could either establish a plan for the state and in the state, or we could default to the Federal government and allow them to establish a high-risk pool in the State of New Jersey. And many states elected that option; close to half of the states elected that option. But we didn't see that as the best option for the State of New Jersey. A key issue is our guaranteed issue status and how to make sure that this money is used to provide the most coverage to the most individuals in the state.

A lot of talk has been in the press about disappointing enrollment in the high-risk pools -- not just in New Jersey, but nationally. And so I'd really like to address that. We established, through the Individual Health Coverage Program, initially working with Horizon BlueCross BlueShield of New Jersey -- Horizon was the first carrier to step up to the plate to work with the State to use our individual insurance program to make these plans available.

We had to convince HHS that the requirement that the plans be offered at a standard rate don't mean that the prevailing rates that apply in the State of New Jersey -- because we're guaranteed issue, our individual

health coverage is already sold at a premium-- Because of that guaranteed issue there is adverse selection, as Dave Knowlton referred, so the prices are higher. So we need to track people in the State of New Jersey into a higher-risk pool. We need the ability to offer it at a lower rate.

Health status has not been the barrier to coverage in the individual market in New Jersey; affordability has been the barrier. And we work with HHS and they allowed us to establish these plans. Although they're richer benefits, they don't exclude pre-existing conditions from day one. They are 30 percent less expensive than the prevailing plans in the State of New Jersey.

As of the end of January, our enrollment in the Pre-Existing Condition program was 256 insured lives. And so there's been talk about the expectations for the plans, and the fact that the enrollment is low. There are five states that are guaranteed-issue in the United States. When HHS released data -- the most recent data on enrollment in the high-risk pool, on a national basis for every state, was released as of the end of December. Numbers were really skewed because they were as of the end of December for state-based high-risk pools; as of the end of January for the Federal. So they had an additional month in their enrollment figures. Nevertheless, New Jersey's enrollment was higher than the enrollment in 34 states and the District and Columbia. So we are, despite our guaranteed-issue status, and despite the fact that in many states this program could be more attractive to many more citizens, we are in that top tier. Among the five guaranteed-issue states in the State of New Jersey (*sic*), two of them, Vermont and Massachusetts, had no enrollment. So we're pretty proud

about the way that the high-risk pool, the Pre-Existing Condition program, has been implemented in the State of New Jersey.

Beginning in March, a second carrier will be available under this program. AmeriHealth has agreed and we have entered into a contract with HHS to bring in AmeriHealth, so their individual plans will also be made available to persons who qualify for the Pre-Existing Condition program. And we're hopeful that that will further help to enhance enrollment in that program.

On September 23, many of the market reforms of the Affordable Care Act came into effect for plans with anniversaries on or after September 23. The Department, prior to that effective date, issued guidance to the industry on how to bring plans into conformance with the requirements of the Affordable Care Act. As Dave Knowlton mentioned, many of the requirements that are in the Affordable Care Act are already State law in the State of New Jersey, but others are not: the requirement that preventative services be offered without cost sharing; the prohibition on annual and lifetime limits, with the prohibition on annual limits coming in on a graduated basis between now and 2014.

One of the challenges for New Jersey is that we have a State law that establishes a basic and essential plan. That plan is the most popular plan in the individual insurance market. That plan covers 75,000 New Jersey residents. So under New Jersey State law, insurance carriers are required to offer several things: they're required to offer three comprehensive plans that have no annual limits, that have no lifetime limits; and they're required to offer a basic and essential plan which is a much less expensive plan, but does include internal annual limits on certain

services that could be considered to be essential benefits under the Affordable Care Act. They have limits on wellness benefits, on physician visits, on in-hospital diagnostic tests.

SENATOR GILL: Mr. Sullivan, I wondered: We could actually -- I know you have a wealth of information -- address this to the exchange.

ASSISTANT COMMISSIONER SULLIVAN: Okay; be happy to do that.

SENATOR GILL: Thank you.

ASSISTANT COMMISSIONER SULLIVAN: We applied for, as I mentioned, and received a $1 million planning grant for the establishment of an exchange in the State of New Jersey. Mr. Knowlton did, I thought, a very good job of describing many of the variables in the establishment of exchange, many of the challenges in the establishment of the exchange. So we have been using that planning grant money and intend to use it for several purposes. The most immediate purpose is stakeholder engagement. We have contracted with Rutgers Center for State Health Policy to run forums talking to different constituents that will be affected by the running of an exchange in 2014, to get their take, their opinions on many of those variable that are involved in establishing an exchange. So there have been forums that have been run under Rutgers with provider groups; there are forums that are planned throughout the month of March and into the middle of April with consumer groups, with employer groups, with health plans, and with brokers to get their input. That's the first part of the planning process -- is to find out what people think about those variables in the establishment of the exchange.

SENATOR WEINBERG: And how much of the $1 million was spent on that?

ASSISTANT COMMISSIONER SULLIVAN: That contract is for a little less than $250,000.

We also intend to use the planning grant to engage consultants to work on some of the issues, many of which Mr. Knowlton mentioned, that require some technical expertise: a lot of those issues with respect to adverse selection; a lot of those issues with respect to changes to the Medicaid program; a lot of those issues with respect to what are different options for-- Dave described some of the problems with people whose eligibility changes as you cross the magic threshold from 133 percent of Federal poverty level, and therefore the Federal responsibility -- threshold with respect to Medicaid eligibility, and move into the tax subsidy eligibility. To see how to coordinate the coverages between Medicaid and private plans in the best way.

So we have drafted a request for proposal; we are looking for consulting expertise on a lot of those design issues around those issues; around pros and cons of different governance models; around different financing models. As Dave mentioned, in 2015 there will no longer be Federal funds available for the establishment of the exchange and a New Jersey State-run exchange will have to be self-supporting.

SENATOR WEINBERG: Let me interrupt again for a moment, if I may.

Mr. Knowlton talked somewhat about the need for computers, or infrastructure, in order to be able to carry out any of these programs. Are you investing in that at all?

ASSISTANT COMMISSIONER SULLIVAN: Absolutely. So let me talk about the grants that have been accessed, the grants that are available in the future.

I mentioned the consulting services: One of the initial issues is an information technology gap analysis. We have certain capabilities in the State of New Jersey, primarily in the Medicaid operation, to perform eligibility and enrollment tasks. That will need to be built out to also have the exchange perform those tasks with respect to individuals who are not Medicaid eligible, but are subsidy eligible, and would be using the exchange. So the initial part is to scope out that gap analysis to determine exactly what are the additional software and hardware needs to perform those infrastructure functions, so that in future grant opportunity we can apply for the funds to execute on that and to have that information technology infrastructure out there.

There are a number of challenges around that, one of them being that HHS has not yet defined the technical specifications that will be required. So we can start the planning now, but we can't finish it.

There are also expectations that there will be, sort of, developed through our Federal grants, some of the modules that may be necessary; and so that states will be able to access those modules -- as opposed to 50 different states building some of these pieces -- which will be, by definition, uniform throughout the United States.

SENATOR GILL: So to facilitate our time, please, if you have questions raise your hand and--

SENATOR WEINBERG: Go ahead.

SENATOR GILL: --we can participate.

Senator Cardinale.

SENATOR CARDINALE: Yes.

I think you said something that challenges my knowledge of what I thought we had in New Jersey with respect to pre-existing conditions. Did I hear you correctly? If Mr. *X*, who is uninsured, finds himself diagnosed as needing a heart transplant, can Mr. *X* go out and get a guaranteed issue policy in New Jersey?

ASSISTANT COMMISSIONER SULLIVAN: Under this Pre-Existing Condition program that I described, if Mr. *X* has been uninsured for a period of six months, and Mr. *X* has a pre-existing condition, he could buy a plan that will, from the first day, cover that pre-existing condition.

SENATOR CARDINALE: Is that what all of your 256 people in this plan have done? Are all of these folks people who have developed a serious illness?

ASSISTANT COMMISSIONER SULLIVAN: The requirement that was imposed by the Federal government is that they have a chronic condition. So not necessarily serious, but certainly serious would count.

SENATOR CARDINALE: Can it be an acute condition?

ASSISTANT COMMISSIONER SULLIVAN: We've been in discussions with HHS. They originally imposed the chronic condition upon us. We were looking to get the eligibility as broad as possible, and they required that we only apply this for chronic conditions. More recently we have seen HHS put out guidance, with respect to their own pools, that appear to be broader than that. So we are in discussions with HHS on that very issue.

SENATOR CARDINALE: The question occurs to me that you're applying for grants and you're spending certain funds based on the Federal law. I know, and I guess we all know, that a Federal judge has declared this law unconstitutional. Is it wise for us to be spending funds, making plans for something, which has already been declared by a Federal District Court to be unconstitutional?

SENATOR GILL: And I'm assuming that you can't answer that (laughter). And the further question--

ASSISTANT COMMISSIONER SULLIVAN: Thank you, Madam Chair.

SENATOR GILL: That clearly is not within your expertise. Perhaps it could be a question proper to the Governor, or some other person.

But factually--

SENATOR CARDINALE: Madam Chair, let me rephrase my question.

SENATOR GILL: You know, Senator Cardinale, I always give you all of the time you need. But we do have other people to testify, and I think our more esoteric questions can't be engaged here, because we have a whole list of people. So--

SENATOR CARDINALE: But I believe I can rephrase my question to overcome your objection to the question.

SENATOR GILL: Of it being esoteric, or the question itself? (laughter)

SENATOR CARDINALE: The question itself.

SENATOR GILL: We will--

SENATOR CARDINALE: Because I think it's an important question.

SENATOR GILL: You don't have to edit-- Ask the question, but in deference to the people who are here to testify, try to get that--

SENATOR CARDINALE: I realize I asked him--

SENATOR GILL: Ask your question, Senator.

SENATOR CARDINALE: --and you properly have corrected. I asked him to express an opinion with respect to something that he may not have the expertise to opine.

But let me ask you a different question: Are there any other areas where the Department is currently expending significant money gearing up for the implementation of any other law which has been declared unconstitutional by a Federal judge?

SENATOR GILL: That--

SENATOR CARDINALE: True or not?

SENATOR GILL: That-- We're trying to keep this so that we can get some information based--

SENATOR WEINBERG: And let me add, because I don't know what the Department is expending, so far it seems to me that they are expending money they're getting from the Federal government that is earmarked for this. Am I correct?

ASSISTANT COMMISSIONER SULLIVAN: That's absolutely true. None of these expenditures I have described have included State dollars.

SENATOR CARDINALE: But Senator--

SENATOR WEINBERG: Yes.

SENATOR CARDINALE: --the Federal government doesn't have any money that it hasn't first taken from taxpayers--

SENATOR WEINBERG: Wait a minute; you know--

SENATOR CARDINALE: And New Jersey taxpayers pay the most.

SENATOR GILL: Senator, in all--

SENATOR WEINBERG: Call your Congressman.

SENATOR GILL: --due deference, we're going to move on.

Are there any other questions from any other Senator?

Senator Vitale -- yes.

SENATOR VITALE: Thank you, Neil.

Can you describe -- and I may have missed this -- the number of grants that you have, that the Department has applied for, whether it's DOBI or other departments in the State?

ASSISTANT COMMISSIONER SULLIVAN: I'm not aware of all of the grants outside of DOBI. We do have discussions with other agencies, but I wouldn't be comfortable -- I really haven't been tracking those. I can certainly describe the ones that the Department has applied for.

SENATOR VITALE: Just how many -- how many DOBI--

ASSISTANT COMMISSIONER SULLIVAN: Sure. Valerie can describe what-- So for the Department it was the $1 million Exchange Planning Grant; it was the $1 million Rate Review Grant; it was the $900,000 Consumer Assistance Grant.

SENATOR VITALE: For the high-risk pool.

Thank you very much.

SENATOR GILL: Thank you.

Any further questions? (no response)

Thank you very much for your testimony.

ASSISTANT COMMISSIONER SULLIVAN: Thank you.

SENATOR GILL: Thank you.

SENATOR WEINBERG: Thank you. We would like to call Valerie Harr, the State Director of Medicaid.

V A L E R I E H A R R: Good afternoon, Chairwoman Weinberg, Chairwoman Gill, and members of the Senate Health, Human Services, and Senior Services Committee, and Commerce Committee. My name is Valerie Harr; I'm the Director of the Division of Medical Assistance and Health Services in the Department of Human Services, and I have the responsibility of overseeing the CHIP, NJ FamilyCare, and Medicaid programs.

I will be speaking specifically today about the Affordable Care Act and the impact on the Medicaid and FamilyCare programs.

Since the Affordable Care Act has many provisions impacting Medicaid, we've been working over the past 11 months to assess the various provisions to begin responsible, appropriate implementation in compliance with those provisions.

The Division has built a tracking system for and management of the over 50 provisions of the Affordable Care Act that do impact the Medicaid program. That includes program integrity, Medicaid and CHIP eligibility, Medicaid and CHIP benefits, quality and access, long-term care, and demonstration projects.

An example of the mandates associated with the Affordable Care Act: There was a change to the pharmaceutical and manufacturing rebates that are provided to the Medicaid program and retroactive to January 1, 2010. The Affordable Care Act increased the minimum rebate percentage from 15.1 percent to 23.1 percent of the average manufacture prices, and 11 percent to 13 percent for generic drugs. So we've been required to collect those rebates, as well as collect rebates on the pharmaceutical dispensing among our four participating HMOs. So we're in compliance with that provision and are collecting those increased rebates.

We're also in the process of establishing a recovery audit contractor to identify provider improper payments, overpayments, and underpayments. We submitted a State plan amendment in December 2010, and we anticipate having the recovery audit contractor in place by April 2011, which is another requirement under Affordable Care Act.

Additionally, we've applied to CMS to cover our 57,000 low-income general assistance adults to get Federal financial support for that program. We applied for a State plan amendment and, unfortunately, in the past few weeks, the Centers for Medicare and Medicaid Services did not approve that State plan amendment because, as you may know, this program does not include an inpatient or outpatient hospital benefit.

So we're continuing to work--

SENATOR WEINBERG: I'm sorry, just-- If the program doesn't-- What did you say?

MS. HARR: It does not include a hospital benefit for the general assistance population.

SENATOR WEINBERG: So therefore, what did we lose in Federal funding for that?

MS. HARR: It's not-- We haven't gained-- We don't-- It's currently a State-funded program. Historically, that's what it's been, and we're trying to get Federal support -- Federal matching funds -- for that program. They disallowed the State plan amendment, but they're continuing to work with us for us to seek another way to get Federal financial support for that program, probably through a waiver approach. So we're in active conversations with them.

In 2014, the Affordable Care Act makes major changes to the Medicaid landscape. Currently, the Department of Human Services Division of Medical Assistance and Health Services covers approximately 1.3 million residents of New Jersey. Effective January 2014, Medicaid program eligibility will increase across the board to 133 percent of the poverty level. This will be for parents, childless adults, and children. New Jersey already covers parents and children up to that level, so the majority of the new enrollees in 2014 will be childless adults or adults without dependent children.

Using the census data, we estimate that an additional 380,000 people will become eligible for Medicaid. The enrollment expansion will be 100 percent federally funded for the first two years.

The Affordable Care Act also changes the way income is calculated for Medicaid eligibility. It will be modified to a calculation called *modified adjusted gross income*. It's an IRS calculation. We are awaiting CMS regulations and guidance on exactly how that new calculation will work.

So with the anticipation of that new level of individuals entering the Medicaid program, we're starting to think about and create the vision of what the Medicaid program should look like, in anticipation of 2014. We're looking at making data-driven decision making, relying more heavily on health information technology, looking at patient-centered medical homes, health behavior incentives, and increased access to home- and community-based services -- all in anticipation of sort of that new Medicaid landscape.

The Affordable Care Act will require Medicaid payment rates to primary care physicians to be no less than 100 percent of Medicare starting in 2013 -- and I know you had some discussion about primary care access -- And so in 2013 and 2014, we will be required to increase primary care reimbursement to 100 percent of Medicare. The fact that this increase is only funded by the Federal government for two years is of concern to the State, and how to maintain an adequate network beginning in 2014, and then knowing that in 2015 the responsibility of that increased provider reimbursement will need to be shared by the State.

New Jersey, unfortunately, has the distinction of ranking among the bottom, nationally, in reimbursement rates for Medicaid, so it will be considerable cost for New Jersey to maintain that increased provider reimbursement rate.

With the expansion of Medicaid to the--

SENATOR WEINBERG: I'm sorry. Again, I'd just like to get this straight--

MS. HARR: Sure.

SENATOR WEINBERG: --in terms of the discussion we had a little earlier about the loss of primary care physicians.

We know that Medicare rates are pretty low now. So what percentage of Medicare rates does Medicaid pay to primary care physicians?

MS. HAAR: Medicaid's primary care rates are currently about 34 percent of Medicare. So in 2013 and 2014, we will have to increase our Medicaid primary care rates from 34 percent of Medicare to 100 percent of Medicare.

SENATOR WEINBERG: Which might have answered the earlier question about one of the reasons we're losing primary care physicians. Thank you; go on.

MS. HARR: So the Affordable Care Act provides enhanced funding for states to pursue medical homes, and New Jersey legislation had been enacted requiring the Medicaid programs begin a pilot demonstration around medical homes. So I'm pleased to let you know that we're actively working with our contracted managed care organizations to implement a medical home pilot, and last week we issued memorandums of understanding with our four contracted HMOs to begin implementing that medical home demonstration.

We also have many technology initiatives underway that will help us get to 2014 and, again, I think as you heard some of the discussion about the IT requirements under the Affordable Care Act, I think the Medicaid program is-- We're in a very good position. We're in the midst of building a new eligibility system that would be utilized by all 21 county welfare agencies. The system could be used as a building block for a health insurance exchange. We're also in the process of procuring a new fiscal

agent -- that's our Medicaid Management Information System -- that processes all of the claims to our providers. And we recently submitted a Medicaid health information technology plan to CMS to promote the use of health information technology and electronic medical records. And under that, in the fall of 2011 we will be making incentive payments to providers that are adopting electronic medical records. That is 100 percent federally funded by CMS, but the funds will flow through the Medicaid agency.

SENATOR WEINBERG: Is there a limit on that Federal funding -- a limit of time?

MS. HARR: Yes, I think it's through -- I could confirm this for you -- but I think it's through 2016. There will be several stages -- several installments, of that funding. The providers need to show meaningful use and meet certain criteria to continue to receive those incentive payments.

SENATOR GILL: And with the medical records, does the State have to build an infrastructure to make sure that we have a high degree of privacy, where you can't-- In other words, someone cannot hack into the medical records, and who can see the medical records, and things like that?

MS. HARR: Right, absolutely. There are privacy requirements. We are working in coordination with the Director of the State HIT office in the Governor's Office, as well as the Office of the National Coordinator. And yes, there would be -- and we would make sure that we respect and meet those privacy requirements.

We continue to be mindful of the Affordable Care Act and the impact on Medicaid, making sure we're in compliance with the enacted

provisions and regulations, while balancing the current challenges and opportunities for the Medicaid program.

So again, I thank you for the opportunity to speak, and I'd be happy to take any additional questions.

SENATOR GILL: Thank you very much.

Any questions? Oh, I cannot believe it.

Senator Cardinale. (laughter)

She doesn't know anything about Federal law.

SENATOR CARDINALE: You're planning to triple -- as I understand it -- your reimbursement in, is it two years from now?

MS. HARR: In 2013 and 2014.

SENATOR CARDINALE: Okay. Where are you going to get the money?

MS. HARR: Right. So in 2013 and 2014, because of the concern about all the people who would be newly eligible under the Affordable Care Act, that's 100-- The difference between where we are now and where we would need to be is funded by the Federal government. But the problem is, after those two years, if the State wants to sustain that level of reimbursement, the State must share in the cost. So it is a very good question; it's something we will all have to, I think, be challenged and decide.

SENATOR CARDINALE: So that absent a major Federal appropriation, that we can't really rely on today because that appropriation hasn't been voted on by the Congress for two or three years hence, this Affordable Care Act is going to triple New Jersey's obligation under the Medicare program. Is that an appropriate assessment?

SENATOR GILL: I don't think that-- Are you qualified to answer that question?

MS. HARR: Correct. I don't know the long-term -- the financing -- of the Federal Act.

SENATOR GILL: Thank you.

SENATOR CARDINALE: Someone's going to have to pay for it.

SENATOR GILL: We'll find out for you, Senator Cardinale.

SENATOR CARDINALE: Thank you.

SENATOR GILL: That's one of those esoteric questions.

Senator Vitale.

SENATOR VITALE: Thank you, Senator Gill.

Thank you, Valerie, for coming.

I want to stay on the Medicaid discussion for a moment, and there was a question I wanted to ask earlier that's more appropriate to ask you, and that's -- just help me out with this, because I'm not good with math; they threw me off the Budget Committee -- those who are currently in the Medicaid programs, when the Federal Act is fully implemented, those who are already in will maintain a certain rate of reimbursement to the State; those who are newly eligible after will get the higher match? Is that correct?

MS. HARR: Yes, correct.

SENATOR VITALE: So for example: There are how many people in Medicaid today?

MS. HARR: One-point-three million Medicaid and CHIP -- 1.3 million.

SENATOR VITALE: Right. And so in 2014, we continue to get this-- What do we have, 60-40 match with Medicaid?

MS. HARR: Medicaid, it's 50-50 Medicaid--

SENATOR VITALE: Right.

MS. HARR: --after we lose the enhanced ARRA stimulus funding, it's 50-50. It's 35 percent State share, 65 percent Federal for CHIP.

SENATOR VITALE: So those numbers stay the same for those already enrolled in Medicaid, right? So then I guess the question is -- and it's tricky, I guess. After 2014, those who become eligible -- not who are eligible for, but not yet enrolled -- those who become eligible after 2014 we will get 100 percent match for the first couple of years from the Feds.

MS. HARR: Right. That's the newly eligible; that's the 380,000 people who I'm talking about, yes.

SENATOR VITALE: Right. And after-- And in the third year, the match -- well, gradually goes down to where's it's 88 percent match Federal, 12 percent State.

MS. HARR: Correct.

SENATOR VITALE: As opposed to 50-50 today. So we don't know what the-- We'll have to do this study, we don't know what the cost effect will be when we certainly go up in coverage -- go up in reimbursement, rather, from the Feds; which is a good thing, because we're only paying 12 percent, not 50 percent. We're also increasing the number of people who are in the program. So I don't know how that's going to balance out in terms of dollars and cents.

So there will be two populations that we will be reimbursed for, right? Those who are already in and should have been in before, and those who are newly eligible after.

MS. HARR: Right. Eligible but not enrolled, versus a new category of eligibility: childless adults are not categorically eligible for Medicaid today. They will be in 2014.

SENATOR VITALE: Right. And we'll get the high max then.

MS. HARR: Yes. I did want to point out -- I heard your earlier comment that for those individuals -- the parents, over 133 percent of the poverty level -- the State would have an option to-- Those individuals could move into an exchange and be eligible for a subsidy, or State Medicaid program could offer a basic -- continue to cover them -- offer a basic health plan and take the Federal subsidy. I don't know all the details. I think there are definite pros and cons to that, but really I think that what happens is you draw a line in the sand around -- at 133 percent of poverty -- going forward, in terms of the Medicaid program, and the sort of categorical eligibility goes away.

SENATOR VITALE: Setting aside -- last question -- setting aside the overall cost of all of this, if we were to incrementally expand eligibility in Medicaid now, today, starting next month and going forward to 2014, for childless adults and parents who were no longer eligible for FamilyCare, and began to enroll them in Medicaid, once 2014 came would we get a higher match for them?

MS. HARR: Correct. If we expanded coverage today, it would be 50 percent State share, 50 percent Federal share. But you would be held harmless in 2014 and get the full Federal funding.

SENATOR VITALE: So somebody who is better at math than me could sit down and figure out what it is that-- And I think that we will benefit if we make the investment now, because we'll see an enhanced investment or an enhanced match after 2014. Yes, we have to make a greater investment now in spending Medicaid, but once 2014 hits we get held harmless on those individuals, and then it gets a little bit lower at 88 percent; as opposed if we do nothing with them now, we don't expand now, and then we stay at 50-50 match, when 2014 comes they're going to remain at 50-50 because they were eligible but not enrolled -- is that right? Do they stay at 50-50?

MS. HARR: No. So the childless adults that we're talking about are not eligible today.

SENATOR VITALE: But I don't mean childless adults; I mean those who are not currently enrolled.

MS. HARR: So we have individuals eligible for Medicaid today; for whatever reason they have elected not to enroll. We would get 50 percent match on them today; we would get a 50 percent match on them in 2014.

SENATOR VITALE: What population will we get a higher match on -- if we enrolled them today -- in 2014, if we increased enrollment? Is there a population?

MS. HARR: That we would get a higher match now?

SENATOR VITALE: Later.

MS. HARR: That's the childless adult population. If we expanded today, we would get a regular Federal matching rate. So we

would have to have 50-- You know, half State, half Federal; but in 2014 it would be all Federal.

SENATOR VITALE: One hundred percent.

MS. HARR: Hundred percent.

SENATOR VITALE: Thank you.

SENATOR CARDINALE: Madam Chair, I have a point of order.

SENATOR GILL: Yes.

SENATOR CARDINALE: Senator Vitale has asked some very important questions. And he's asked these very important questions about what's going to happen in 2014. The witness has information which I think is good for us to generate. But when I ask questions about what's going to happen in 2014, the Chair seems to feel that this witness does not have the information to answer my questions. I do not understand that procedure.

SENATOR GILL: Well, let me explain. The questions asked by Senator Vitale are based on the information and the numbers presented in her discussion and the laws as they exist. You asked a question based upon a hypothesis of information that was not presented here.

SENATOR CARDINALE: That's not correct. Maybe you misunderstood my question.

SENATOR GILL: Well, we're not-- I misunderstood your question, but what we will do is that we will come back to her at another point; we'll finish these others. Would you be available to stay?

MS. HARR: Yes.

SENATOR ALLEN: Senator, if I could-- I think we would appreciate it if we could just deal with that question now while she's here.

SENATOR GILL: What is the question?

SENATOR CARDINALE: It's a very simple question. This witness told us--

SENATOR GILL: What's the-- Okay.

SENATOR CARDINALE: This witness told us--

SENATOR GILL: What is the question?

SENATOR CARDINALE: She gave us information, and my question is based on information that she gave us.

SENATOR GILL: Ask the question.

SENATOR CARDINALE: You've told us-- It's a repeat question; I think you know what the question is, but let me repeat it. You have told us that our 34 percent reimbursement rate is going to go to 100 percent reimbursement rate -- that's tripling.

MS. HARR: Yes.

SENATOR CARDINALE: Roughly tripling of our reimbursement rate. Now, that is a tripling of New Jersey's expenditure with respect to this program. My question was: How much is that going to cost New Jersey, and how is that proposed to be financed under this Act that is termed *affordable health care?*

MS. HARR: Okay--

SENATOR GILL: Which is a different question, but we'll let this-- This one is better formed.. Go ahead.

MS. HARR: Okay.

SENATOR CARDINALE: I understand--

SENATOR GILL: Listen, you could--

SENATOR CARDINALE: Well, I understand-- You have to understand, I'm not a lawyer so I don't-- I understand lawyers second-guessing my question.

SENATOR GILL: No, I understand doctors just want to get a second opinion.

MS. HARR: So right now, as the Affordable Care Act is written, is that in 2013 and 2014 we must triple our primary care Medicaid reimbursement rates up to the Medicare rate. That's estimated to cost us -- cost -- several hundred million dollars each year. Those first two years, as the Act is written now, is that the Federal government would pay for that increased reimbursement level. But after those two years, again as the Act is written today, if a state wants to maintain their reimbursement levels up to that level they have to provide the state matching funds. So I think that, just to restate, you said where-- We would have to address where would the State funds come from if the State chose to maintain that higher level of reimbursement after that enhanced Federal funding expires.

SENATOR CARDINALE: And let me opine, Madam Chair. It can't come from anywhere but the taxpayers of the State of New Jersey. And that's the point I am trying to get across.

SENATOR GILL: And you--

SENATOR CARDINALE: That affordable health care is a word that may not be very affordable for the taxpayers of the State of New Jersey, given the circumstances that this Act also brings with it. It's not affordable; it's probably breaking the bank.

SENATOR GILL: Thank you very much, Senator Cardinale.

And thank you.

I'm going to call a panel together: Ward Sanders from New Jersey Association of Health Plans; New Jersey Hospital Association; I don't know if Fred Jacobs is here or -- you didn't identify yourself; and the Employers Association of New Jersey -- John Sarno.

So you know we have some background, so we'd like you to zero in.

WARDELL SANDERS: Sure.

I'll start. Ward Sanders with the New Jersey Association of Health Plans. My organization represents the major health plans in the state that insure or administer benefits for about 7 million New Jersey residents.

And we thank the Chairwomen for inviting us to testify today.

I will issue one little caveat, and that is: from the invitation yesterday I haven't had a chance to really vet these comments with my plan members. I've done my best to sort of identify areas of common interest and common thought around exchanges and around Medicaid expansion.

First, on the exchanges: Just to be clear, Health Plans believes that -- the ultimate goal here, that we have, is really the same as the legislation -- is to make sure that residents have access to high quality and affordable coverage. The exchanges, we believe, are a mechanism or a tool to get to that and we're supportive of the notion of an exchange.

It's just important to remember that exchanges are really just one vehicle or mechanism of a distribution channel for accessing coverage. Health Plans does have the business and technical expertise to aid the State in creating a workable exchange, and we will clearly work with the State and

legislators to do our best to contribute to that process, and we want to partner with the State.

We do believe that states are best positioned to create -- and are advised to create -- local exchanges that are state-based. While there is an ability for the Federal government to step in, in the absence of State action, we don't believe that it's really in anyone's interest to have the Federal government step in and create a solution from outside the state for what New Jersey should do. We feel very strongly that the State is best positioned to do that; and that the Federal government will be evaluating our progress on January 1, 2013, and that we will need to act with some alacrity to make sure that we meet the requirements of that to move forward the State-based program.

We will have -- as Mr. Knowlton and others have pointed out -- a number of key decision points. So I was going to mention, just at a very high level, some of the concerns or positions that we have, really, on the architecture of this exchange.

First, with respect to governance: We believe that the exchange needs to be independent and transparent, and largely devoid of political influences. We would recommend a broad constituency of stakeholders involved in the governance of this with consumers, employers, health plans, and other organizations and persons with experience in this area to help run this.

The second point is with respect to efficiency. We really -- this is a very important point to us -- we really want to make sure that there's not overlapping regulatory responsibilities. So for example: Currently the New Jersey Department of Banking and Insurance reviews policy forms, and

rates, and solvency requirements. What we really don't want to see happen is an exchange that has a separate regulatory responsibility in these areas, so that on one hand the exchange is telling us that we have to do *X*, but the Department of Banking and Insurance, meanwhile, is telling us we have to *Y*. There are plenty of roles for the exchange to play, but we do not want to see an overlapping responsibility with potentially conflicting regulatory requirements.

In a similar vein, there are elements that are going to be required of this regarding, for example, quality standards. We would really like to see national standards be used, rather than sort of home-grown standards. For example, the NCQA does a very nice job with national standards for national plans that have to, state-by-state, tailor 50 different mechanisms to measure metrics on quality -- it's a little challenging. We don't believe that there-- While there are substantial costs that are associated with that, the complexity and so forth -- and without an incremental value -- is an important point. So to the extent that there are national standards that can be used in some of these areas for measurement, we would request that they be used.

Third, on product offerings: We would like to ensure a broad range of consumer choices. The requirements of the Federal law are pretty strict. An issuer has to be licensed in good standing; has to offer at least one of the metallic plans -- a silver or gold plan; and charge the same premium whether it's in or outside of the exchange; and they have to sell a qualified health plan that's certified by the exchange. We believe that any plan that -- that there should be a vibrant market, and that the market should be competitive, and folks should be -- if they meet the requirements

-- be permitted to sell in the exchange without restriction. Also we believe the carrier should be able to offer products outside the exchange if necessary.

So I think that will be necessary for folks who are undocumented, as undocumented will not be permitted, I don't think, to purchase through the exchange. You know, New Jersey has had a similar experience in the early '90s with the reform--

SENATOR GILL: We're not going to go back in history at 4:30, 5 o'clock. So we'll keep it on--

MR. SANDERS: Okay.

And two other very quick points -- to make sure that I'm consistent with the timeframe here -- is that we would like to keep the individual in small group markets distinct and a large group market distinct from the exchange as well.

I had a number of points on Medicaid exchanges, but -- I'm sorry, on the Medicaid expansion, but the Medicaid Director did a really good job of explaining that. I will say that there's clearly a chasm between the folks who are eligible for subsidies and those who can afford coverage. And we are ready to partner with the State to try and assist where subsidies are provided to help those folks be able to afford coverage.

And again, just on the undocumented: We will-- I think our uninsured rates -- someone was asking what that is -- it's about 1.3 million to 1.4 million residents. It's about, I think, about 15 percent of our population. We will continue to have an uninsured population because we have a fair number of undocumented--

SENATOR GILL: What is it that-- Okay. So we kind of get that.

Do you have any other points?

MR. SANDERS: No, I'll close with that.

SENATOR GILL: Okay, thank you very much. And thank you for your testimony.

Next, please -- identify yourself.

N E I L E I C H E R: Good afternoon. My name is Neil Eicher from the New Jersey Hospital Association. I promise I will be brief.

Like the Committee, we're trying to get our heads around the post-reform era. As such, the Association -- we created eight separate work groups to kind of handle the Affordable Care Act over the next few years, and, as such, we'll be producing policy papers. We produced one on health insurance exchanges last year and, through the Chairs, I would be happy to submit it to the Senate Commerce and to the Senate Health Committee.

We tried to bring in some national expertise for the Committee hearing, but on short notice we were unable. However, we remain available as a resource to bring in whatever representatives from the Federal government to speak on this issue in months and years to come.

Specifically on the exchanges: I just wanted to highlight two recommendations that we offer in our white paper. The first has to deal with enrollment. We believe that hospitals, as a point of service facility, should play an integral role in enrollment for Medicaid and the exchange -- either some form of direct enrollment, some automatic enrollment or, if that's not possible, at least some real-time connection through HIT mechanisms with the State -- to be able to do some sort of income

verification and automatically enroll these people in insurance so that we don't send them out after treatment and they are uninsured, and then come back as uninsured. We want to do whatever we can to assist the State in the enrollment process.

And secondly, I will say with respect to adequate networks: We want to make sure that -- even though people have an insurance card, it's not successful unless they have access to care. So we want to ensure that there are adequate primary care and specialty networks for these newly insured people.

Thank you.

SENATOR GILL: Thank you very much.

Next witness, please.

J O H N J. S A R N O, ESQ.: Yes, John Sarno.

UNIDENTIFIED MEMBER OF AUDIENCE: (Indiscernible)

MR. SARNO: Okay, I'm going to move up.

SENATOR GILL: And as you move up, I'll call Christine Stearns from the NJBIA.

MR. SARNO: John Sarno, Employers Association of New Jersey. I've e-mailed a statement, so I'll just briefly comment on two related features in connection with the exchange.

One, Dave Knowlton mentioned-- He referred to it as crowding out -- that is, employers simply getting out of the game, getting out of the healthcare game. And related to that is purchasing power -- the type of purchasing power that the exchange may have.

So let's talk about crowding out really quickly. There's no requirement-- The Affordable Care Act does not require any employer to

provide insurance to any employee. In fact, when you look at the incentives, and you look at the subsidies, and some of the modest penalties in the bill, there's actually an incentive for employers not to sponsor health care. Why do I say that? Well, if you're an employer -- a small employer, 50 or less employees -- there's going to be no penalty for either discontinuing insurance or not providing it in the first instance. And that, of course, is our small market in New Jersey right now, which insures about 800,000 people, right? No penalty.

If you're over 50 employees -- employers over 50 -- then there's no penalty for-- There's no penalty either if you provide what's called a *free choice voucher* to your employee. And what that is, is basically what it sounds like: It's a voucher that -- the employee goes into the exchange and it helps that person purchase insurance. So if the employer decides to do that, no penalty. The only penalty, and it's modest, for an employer -- mid-size or larger -- that discontinues insurance or gets out of insurance entirely is if the employee gets a subsidy. Now, what does this mean? That means that conceivably we're going to have a market in New Jersey that migrates from a small group plan to an individual *market*, I should say. And that's going to have an enormous impact on the exchange, what it looks like, how it operates.

Now, David said that -- he implied -- that crowding out is a negative thing. Well, I-- It's not necessarily a negative thing, because employers and businesses generally will focus on what they do best: They can get out of the health and welfare business, focus on what they do best -- which is to be competitive. So we're looking at an exchange and a process which could have a tremendous competitive impact on business in the state.

I just want to be clear about that: This is not just regulation in health care and what's affordable, what's not. If we do this right, we can have a tremendous competitive business environment. We can decouple; in other words, we can have true portability in New Jersey, where an employee doesn't have to worry about their employer providing the insurance. They'll have it on their own, and they can take that insurance from -- wherever they go.

So that's a tremendous positive, it's a tremendous opportunity that, quite frankly, hasn't been addressed in any statement thus far.

The other thing -- and I'll end with this -- is the purchasing power. What is this exchange going to do? Right now, the small employer market in New Jersey has 800,000 people, right? We just said that. If I was a corporation with 800,000 employees, that gives me enormous, enormous bargaining power. And you know what? I'm going to self-insure, although the incentives for self-insurance will no longer be there in 2014. So let's say I go to a carrier -- right? -- and I negotiate with that carrier. And that's why the insurance premium for a large corporation is substantially smaller than what a small employer pays in New Jersey -- because they have bargaining power.

So the question, the decision point: is the insurance exchange going to be able to bargain directly with a carrier? Because they're going to have 800,000, a million, 2 million lives. So is it going to be a passive exchange, a website where people just shop? Or will the State of New Jersey use that power to negotiate with a carrier to bring reductions to the small employer?

So those are the two comments that I'll leave you with, and if you have any questions I'll be happy to answer them.

SENATOR GILL: Ms. Stearns.

CHRISTINE A. STEARNS, ESQ.: Thank you, and thank you for giving me the opportunity to speak today. I will try to be brief.

You have written comments from me that I believe have been distributed to you. And I'm here to be a resource if you have any questions. I know this will be an ongoing dialogue that New Jersey will be engaged in as we go forward in the next couple of years.

There are just a couple of quick points I'd like to make. First, I would like to express my appreciation to Chairwoman Gill for her comments as she opened this, to say that when we say *consumer* we don't just mean individuals, we also mean small business. Because I think that is a very important point that -- remembering that small businesses are very key to the discussion of how we put the exchange together and how it's designed, and are a key component to their success in the future.

And I know that many of you have listened to me for many years talk about the importance of ensuring that health insurance remains affordable or within the reach of small businesses in New Jersey. In recent years, as the economy has taken a downturn and insurance premiums continue to climb, health insurance has become out of reach for many small employers and we've seen a significant drop in the number of people who are covered in the small employer market.

So for many of them, they look to the exchange not becoming a choice fast enough for them, and are really hoping it provides a meaningful alternative for something that is more affordable.

So that choices that the State is going to make -- in terms of what size employers are permitted initially into that marketplace; whether individuals and small employers are put altogether in terms of the pricing, and what impact that will have on cost; what the State does with adding on to the package of what is considered essential benefits, and whether we add what are currently mandates in New Jersey which will impact the cost of the benefits -- are all really sort of key decisions that we make, and I think something that we should all think about very carefully in terms what it will do to continue to put health insurance within reach for small employers.

So with that I will conclude my remarks, because I know the hour is getting late.

SENATOR GILL: Thank you very much, both of you.

Now we will have the next panel: New Jersey Citizen Action, Ev Liebman; and New Jersey Policy Perspective, Ray Castro.

Oh, you can move up; we don't bite -- just sounds like we do.

E V L I E B M A N: Good afternoon, Chairwoman Gill, Chairwoman Weinberg, and members of the Committee. Thank you so much for holding this important hearing and giving us the opportunity to speak today; and for those of you who are still here, for being here still.

Citizen Action, as you may know, is the State's largest independent citizen watchdog organization. And we also lead a large consumer healthcare coalition representing approximately 70 organizations that collectively represent around 2 million residents here in New Jersey. And it is on behalf of Citizen Action and that coalition that I'm here to speak today.

We believe that the establishment of New Jersey's health insurance exchange is of the utmost importance to New Jersey consumers -- healthcare consumers, patients -- and, in fact, many regard it as the heart of Federal health reform. And that mechanism, that at least holds the promise of bringing us the greatest benefits, particularly to low and moderate income families who by far will get the most benefits from the exchange -- both in terms of access to coverage and access to subsidies -- as well as small business owners, and really as to our State as a whole and to all taxpayers, in that it will be, if it's done well, a mechanism that can reduce costs.

But fundamentally -- and I'll go over some of the issues that you've heard about and give you our views on some of them, as well as expand on some of them -- we believe that an exchange must work for us as consumers and patients; that it must provide us the best coverage at the best price, and protect and negotiate on our behalf; be independent of conflicts or free of conflicts, whether those conflicts come from the industry or politics.

It's interesting and important that the establishment of the exchange is the only provision under the Affordable Care Act that requires states to include stakeholders in the planning process. We know that the State, as you've heard, has gotten a $1 million planning grant, in part to have that stakeholder process, and we are looking forward to being involved with that and hearing more from the State about their plan to solicit and incorporate our views.

So I think David Knowlton gave a really terrific overview of the myriad of issues that are involved; I won't go through all of them, but I do

want to highlight some of the ones that we think are most important to consumers.

The first is, is that we do believe New Jersey's exchange, like in Massachusetts and in California, should be what we are referring to as an *active purchaser*. We will provide the Committee with more detailed written testimony, but one of the things I have provided today is a report that was released by the Robert Wood Johnson Foundation, along with the Urban Institute, just two days ago about health insurance exchanges and Medicaid, and how they will impact the State. In New Jersey what they tell us from that report is that--

SENATOR GILL: Do we have the report?

MS. LIEBMAN: You do have the report -- yes.

SENATOR GILL: Okay, so do you want to highlight what's important in the report to you--

MS. LIEBMAN: Yes.

SENATOR GILL: --or do you want--

MS. LIEBMAN: I just want to point out a couple of statistics from the report--

SENATOR GILL: Okay, please do.

MS. LIEBMAN: --in terms of illustrating how large the exchange will be, and in the context of a market and the value to consumers.

Their estimate is that the exchange will serve almost 600,000 non-elderly healthcare consumers; 28 percent of these consumers will be under 200 percent of the Federal poverty level; 18 percent will be between 200 and 300 percent; 10 percent will be between 300 and 400 percent; and

43 percent will be above 400 percent. So what we are going to see in the exchange is a majority of consumers who are low- and moderate-income, and who will have access probably for the very first time to affordable coverage.

Those who access insurance through the exchange will also be accessing the subsidies through the exchange -- a major component of that affordability equation. The Robert Wood Johnson report estimates that for this population they will be able to access up to $700 million in subsidies to offset the cost and make insurance more affordable. So it gives you a sense of the size of this pool, the strength of its ability to use its purchasing power, to negotiate with carriers for the best possible products at the best possible price. And for that reason we believe that New Jersey's exchange -- and we hope we will be here again to talk about various legislative proposals -- should designate our exchange in New Jersey as an active purchaser; that it uses our marketing power to our benefit as taxpayers and consumers to get the best possible product.

And what that does is it puts those of us who aren't fortunate enough, necessarily, to work for a very large corporation or the State of New Jersey on a level playing field. Because those large, self-insured plans -- the State of New Jersey, right now, very much uses their purchasing power to negotiate the best health coverage and best health services for their employees. And that is what New Jersey taxpayers, New Jersey residents who can't access insurance through that system, should have as well.

SENATOR WEINBERG: We're--

MS. LIEBMAN: Yes?

SENATOR WEINBERG: If you could kind of get to the bottom line of your suggestions here, and move to Ray so we can hear from him, too.

MS. LIEBMAN: Sure, okay.

I just wanted to point out that that is the opposite of the Utah model or the take-all-comers, very passive approach, which some also dub the *craig'slist* approach to health insurance exchanges, where you just throw up a website and let anybody post anything and let the consumer fend for him or herself.

I want to just speak briefly about what David talked about in terms of adverse selection -- the idea that we--

SENATOR GILL: We've heard about adverse selection. If you want to add--

MS. LIEBMAN: I just wanted to give you some examples of the types of market rules that we should be considering to prevent adverse--

SENATOR GILL: Okay, but we don't have to go through the whole explanation of adverse selection.

MS. LIEBMAN: No, no, no.

SENATOR GILL: Okay.

MS. LIEBMAN: So some of the types of things that other states have considered, and that we think New Jersey needs to consider to prevent adverse selection or cherry-picking, are things like requiring insurers that sell insurance outside the exchange to comply with all the requirements applicable to plans sold inside the exchange; prohibiting insurers that participate in the exchange from establishing separate affiliates to sell only outside the exchange; prohibiting insurers from using marketing practices or

benefit structures intended to attract healthy applicants to plans outside the exchange, while discouraging unhealthy applicants; and prohibiting brokers from collecting higher commissions for plans that are sold outside the exchange, thereby discouraging them from directing consumers into the exchange.

We also believe that we need to give serious consideration to combining our individual and small group markets. We believe, and many health economists agree, that health insurance markets work best when risk is shared across large numbers of subscribers.

We also believe that at a minimum the Department of Banking and Insurance, which I think is the most likely agency, should be preparing and making public up-to-date actuarial analyses so we can make the best decision about how and if to merge these two pools, so that we get the best bang for our buck and better serve both small business owners and consumers.

We believe that we should have an independent public exchange, not a not-for-profit corporation. The main reason that we think it should be an independent public body is that the exchange should be open to open meeting laws, public disclosure laws, the Sunshine Act; that their agendas, their meeting notes, should be public; and that the public has an opportunity to also interact with the board.

We think that the board needs to be independent. We also think that healthcare consumers should have a seat at the board, but that any entity that has a financial interest in the exchange should not sit on that board; and we do not think that any appointed officials,

commissioners, other State regulators should sit on the board but should serve in an advisory capacity.

We also--

SENATOR WEINBERG: Excuse me, you-- We heard Neil Sullivan testify about the $250,000 grant that went to Rutgers to engage stakeholders. Have you been involved with that at all?

MS. LIEBMAN: I'm aware that they have been retained to conduct a process to get stakeholder input. Citizen Action has not yet been contacted in any way to participate in that process.

SENATOR WEINBERG: Okay. It is getting really late, so we have to wind this up. We would like to hear from Mr. Castro.

SENATOR CARDINALE: Madam Chair, I have one quick question for this witness.

SENATOR GILL: That's not up to you; I'm not holding my hand up to you (referring to her raised hand); that was the sun (laughter).

SENATOR WEINBERG: The sun is coming right into-- (laughter)

SENATOR GILL: Of course.

SENATOR CARDINALE: I would never accuse you of violence.

MS. LIEBMAN: Just two more quick points--

SENATOR WEINBERG: Did you say you have a question?

SENATOR CARDINALE: I have a question.

SENATOR WEINBERG: Go ahead.

SENATOR GILL: The Senator has a question.

SENATOR CARDINALE: You tell us you want a public entity as this exchange. And we have had -- it's not recent -- but we have had a great deal of experience with a public entity in auto insurance called the JUA; it turned out to be a disaster. But you add an element to it. You say you want this public entity to have, essentially, no competition from entities which are outside. Do you really believe that monopoly leads to lower prices? America was built on competition, and competition leads to lower prices. Why is it, if you think this exchange is good, you are afraid to have private entities competing with it?

MS. LIEBMAN: Senator, perhaps I misspoke. When I was referring to a public agency, I was referring to that entity that would govern the exchange and manage the exchange. I wasn't speaking to the carriers that would operate within the exchange. What we anticipate is that there will be, hopefully, vibrant competition--

SENATOR CARDINALE: I understood that.

MS. LIEBMAN: Oh, I'm sorry.

SENATOR CARDINALE: If I appeared not to, I fully understand that you are referring not to the insurance companies being public entities.

MS. LIEBMAN: Well, I don't think it would serve New Jersey consumers or small businesses to have multiple exchanges run by multiple governing authorities.

SENATOR CARDINALE: But you suggested specifically that any company outside the exchange that was selling a similar product to what would be sold in the exchange, would have to be guided by all the rules and regulations that governed the companies in the exchange,

therefore eliminating any possibility of competition. Competition drives prices down. What happened to auto insurance in New Jersey when we allowed more competition? We no longer have a problem of affordability and availability for our constituents, because eight or nine years ago we got smart and we allowed competition. Why do you want, in health insurance, to prevent competition?

MS. LIEBMAN: My suggestion was that that was one type of market rule that could be examined in the context of avoiding adverse selection. It may not be a market rule that fits for New Jersey, based on our market and based on the level of competition, but these are the types of policy options or policy alternatives that should be examined. And we do believe there should be market rules, that work beyond those that are already in the Affordable Care Act, to manage adverse selection so that the exchange succeeds.

SENATOR CARDINALE: I don't really understand your answer, but I'm not going to pursue it because the hour is late.

SENATOR WEINBERG: At 10 minutes to five you don't ask to understand your answer.

SENATOR CARDINALE: I understand, I understand. I'll stop.

MS. LIEBMAN: Just two quick points, and then I will turn it over to--

SENATOR WEINBERG: Okay, please -- we really have to finish this now and I would like to move to Mr. Castro. So we have a copy of the report that you referred to, so if you would just sum up now.

MS. LIEBMAN: Just one other point -- expand a little bit on what David Knowlton raised in terms of cultural competency.

SENATOR GILL: We don't need-- I'm not-- An expansion on what someone else said-- Is there anything else new you want to add?

MS. LIEBMAN: Yes. What I wanted to suggest is that, in the system of navigation, that New Jersey should encourage, if not mandate, a public-private partnership with community-based organizations who are often trusted and better able to help residents of their communities access the exchange, understand the insurance products, as opposed to a system that simply relies on the exchange itself or a system of brokers.

SENATOR GILL: Thank you very much.

As you begin to speak, sir, I will call our last witness -- and I'm sorry, my eyeglasses weren't clean -- Independent Pharmacy Alliance, John Covello, can come up.

You can start your testimony, sir.

RAYMOND CASTRO: Oh, okay, thanks.

SENATOR GILL: Thank you very much for your testimony.

MR. CASTRO: Thanks. I'll be very, very brief because that (indiscernible) did cover a number of my points.

We, as you know -- Medicaid is one of our nation's most successful programs, and it's not surprising that ACA built upon the success of Medicaid. My estimate is similar to the Department's in terms of over 300,000 individuals who are going to be enrolled in Medicaid by 2019. I also estimate that in the first year alone about 62 percent of them will be enrolled -- that's over 200,000 people. So you can understand the tremendous pressure that the exchange is going to be under, and Medicaid

is going to be in, in the first year. So we really have to be prepared this year in order to get to that level.

As also was pointed out, we're talking about childless adults. This is basically a new group for Medicaid. The only way that you can get -- if you're a childless adult, is if you apply for welfare in our state, General Assistance.

And so childless adults are very diverse: we're talking about people who are mentally ill and homeless; and we're also talking about people who have been middle class their entire life and may have a college degree, and who have become unemployed and suddenly are going to be going into Medicaid. It's a new group, and it's a much more mainstream group than we've had in the past. And that's an opportunity, I think, to mainstream Medicaid and to reduce the stigma in the program.

And then I think one of the other things that the Legislature could do is that we should really lump all these programs together in one name -- like New Jersey Cares. Instead of having a Medicaid program, a New Jersey FamilyCares Program, and exchange program, we should call it one program.

There are two things this year that I think are very important: one is the information technology. We're very happy with the progress the State is making in that area. We believe there are a lot of decisions that have to be made; I guess the question is how easy is the application process going to be? For example, in Wisconsin all you have to do is enter your Social Security number and it literally fills out the application for you, and then asks you if the information is correct. Also in Wisconsin, the same

application process determines eligibility for food stamps and other programs. Those are decisions that we'll have to make in our State as well.

The other area was the issue that was raised Senator Vitale in terms of what can we do now to expedite the process towards reform. We are allowed to expand eligibility starting this year at a 50 percent match. That will greatly reduce the demand for services starting in 2014.

SENATOR GILL: We've gone through that.

MR. CASTRO: Okay, all right.

The other issue is, with respect to the Federal funding that we will get for this program, I know there were a number of concerns with aid to taxpayers. I think it needs to be pointed out, as Valerie pointed out, they are applying for a waiver for General Assistance. Medical costs in GA cost about $190 million -- that's all State funded. For the first time we have an opportunity to draw down a lot of debt. That's going to be a windfall to New Jersey, to the taxpayer, before this program is even started. So I think that needs to be taken into account.

The other issue which is going to be important is the benefits that are going to be provided in Medicaid. This new-- Under the Federal rules for childless adults, you can set the benefits lower than the benefits that others in the Medicaid program would have. We would be very concerned about that; we think that would be very inequitable. These individuals are going to have the same incomes as anybody else in Medicaid. We believe that they should have the same benefits.

Thank you.

SENATOR GILL: Thank you.

SENATOR CARDINALE: I have a question for this witness, Madam Chair.

SENATOR GILL: I think you piqued his interest.

Senator Cardinale.

SENATOR CARDINALE: I just can't let that stand. (laughter)

You say this is a windfall for New Jersey because it's going to be paid with Federal funds.

MR. CASTRO: Existing State benefits under the GA program would be paid with State (*sic*) funds.

SENATOR CARDINALE: Every state is covered by the Federal law. Every state is going to have to be treated somewhat equally by the Federal government. So this expansion of cost -- you think it's a windfall for us because we're going to get a grant from the Federal government? Have you ever looked at the numbers -- what we get in benefit for what we pay in taxes to the Federal government? New Jerseyans are going to pay a disproportionate share of this cost from other states. I think you are based on a totally and completely erroneous premise to say that this is a windfall. This is a disaster for New Jersey taxpayers.

MR. CASTRO: I'll have-- Can I respond to that?

SENATOR GILL: I don't think that that calls for--

SENATOR VITALE: I have a question.

SENATOR GILL: Is that a question? Is it a disaster or is it a windfall? The Senator thinks it's a disaster.

SENATOR CARDINALE: I think it's a disaster. I'm disagreeing with his statement.

SENATOR GILL: You say it's a windfall, and I will say beauty is in the eye of the beholder. (laughter)

So if you have anything else to add other than that--

Thank you very much for your testimony -- thank you both.

And please move up, Mr.--

SENATOR WEINBERG: Covello.

SENATOR GILL: --Covello.

SENATOR WEINBERG: Just before--

SENATOR GILL: Oh, I'm sorry.

SENATOR WEINBERG: --you go ahead, John, I know Mr. Sullivan is still in the audience -- yes, from DOBI -- and Valerie Harr from Medicaid. I would like, on behalf of both Committees, to get from each of you a list of legislation that you think needs to be passed in this session of the Legislature, okay? Is that--

UNIDENTIFIED MEMBER OF AUDIENCE: (off mike) We will respond to the (indiscernible).

SENATOR WEINBERG: Yes, what you think we need to be addressing in terms of legislative initiatives during this particular legislative session.

SENATOR GILL: In this session -- before November.

SENATOR WEINBERG: Yes, the 2010 and 2011 legislative--

SENATOR GILL: We wouldn't like it in January, because technically you would be complying with (indiscernible).

SENATOR WEINBERG: This year.

SENATOR GILL: But if you have a date--

SENATOR WEINBERG: Well, in time to get it passed if it needs to be passed this year. So it would be nice to have this by June -- by the end of the budget session.

SENATOR GILL: Mr. Covello, aren't you glad you're not responsible for that?

J O H N C O V E L L O: I certainly am, Madam Chair; as a former staffer I know the last witness should be brief and cover only what hasn't been covered. And I will do both.

I want to thank both the Chairs for inviting me to testify as one of the provider groups in this, and recognition that-- Really, the main thing for the Committee-- Pharmacy services are going to be an important part of the development of this exchange, and our national group -- National Pharmacy Association -- has developed some basic principles for legislation to build on the model (indiscernible) that NAIC has done. And really it's -- (indiscernible). I just want to draw attention to, as the process moves forward and legislation will have to be enacted, things that need to be added and covered in that.

As the two Chairs have sponsored bills at the State level, it's important to recognize the Federal ACA act does provide for some level of pharmacy benefit manager with oversight and responsibility to the Federal government -- in terms of reports and information, and a lot of things that have been covered in the bills that the two Chairs have dealt with for over a decade in New Jersey. And obviously we're going to look forward to working to make sure those provisions are covered in the bill.

Another important part is that the law requires that these qualified plans -- part of the requirement is-- An important thing is that it

will have to recognize and include a clear statement that our practices of any willing providers for pharmacy services be included, as this is developed, so that it's open access, and it meets all the adequacy of standards, and accessibility, and quality of these plans. So that it would really have to reflect that in the practices act -- dealing at all providers' levels and primarily insuring that there isn't requirements of mandatory mail order. And also the treatment -- as we've dealt with and seen in other areas in the state -- who's defining what's considered specialty drugs, and make sure that it is still covered and provided at the pharmacy -- local -- for access.

The only other point that's really important as it moves forward -- and I think this sort of builds on what Mr. Knowlton said -- is it's going to change a lot of the paradigms -- and it's been done iteratively. Additional services, that now we are licensed to allow pharmacies to provide -- like therapy management, and MTM, and other services -- are going to have to be defined in this and provided for this. A lot of this is, with the fact we're going to have so many new people providing access to this care, it doesn't always have to be done in a primary setting. And obviously that is something that State and other payment programs -- Medicaid is looking at, Medicare provides for this -- will have to be built upon that.

So really, we just welcome the opportunity as part of the end of the continuum, that I know oftentimes can get overlooked. And certainly by including us early and recognizing that we play an important role -- we wanted you to know that we're ready to speak up through the process to make sure this component is also covered as to what's going to be necessary for these individuals.

And I'd be happy to answer any questions you may have.

SENATOR GILL: There are no questions because Senator Cardinale had to leave. (laughter)

I would like to thank everyone for testifying. And this will be an ongoing -- not the testimony -- but the work will be ongoing. So that we want to make sure -- both Chairs -- that we get it right, and I know both Committees.

So although we have had abbreviated testimony, the Committee aide Sarah will take any further information and will be one of the point persons with respect to the exchange -- that's my bill and Senator Vitale's bill. And we hope to get Senator Cardinale on at one point. (laughter) And that will be in Commerce Committee. And Jay, of course, is for Health with Senator Weinberg, and that Committee will have jurisdiction over the Medicaid portion. So Commerce is the exchange -- that's Sarah; Medicaid is the health -- Jay in Senator Weinberg's--

SENATOR WEINBERG: Jay Redd.

SENATOR GILL: Jay Redd. I gave him--

SENATOR WEINBERG: We have a few Jasons.

SENATOR GILL: Oh, okay.

And so forward any suggestions, any ideas -- no complaints (laughter), they don't take any complaints -- and we will work through this to make sure that it is what it should be.

And thank you all very much for your testimony and presence here today. Thank you.

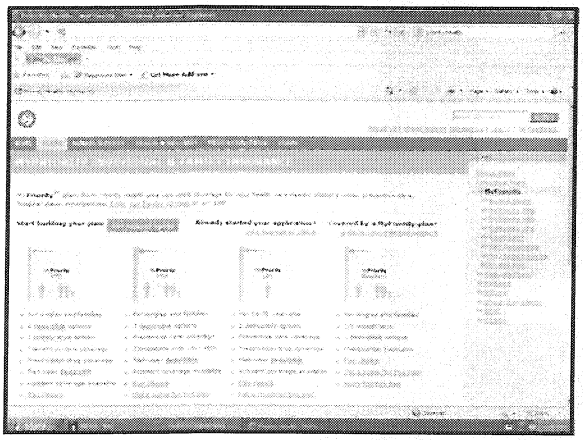
(MEETING CONCLUDED)

APPENDIX

WWW.NJHCQI.ORG

What is an Exchange?

A virtual marketplace where the consumer can compare insurance cost and benefits side by side.



Exchange Core Principles

- ☐ Availability (Access geographically)
- ☐ Adequacy (network/benefits/Providers)
- ☐ Affordability
- ☐ Administrative Simplicity

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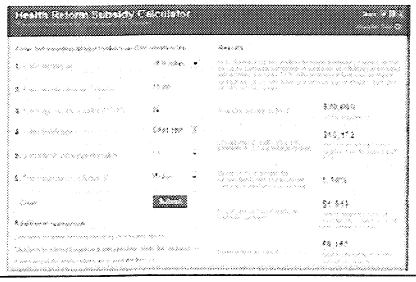
What does it require?

- ☐ Qualified health plan rules
- ☐ Essential health benefits meeting federal guidelines
- ☐ Toll free call center
- ☐ Maintenance of website with plan information in standardized format
- ☐ On-line calculator to determine actual cost of coverage



National Insurance Exchange Potential

- ☐ Economies of scale and insurance market efficiency
- ☐ Market oversight
- ☐ Transparency
- ☐ New insurance market competition

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Insurance Exchange: Key Issues

- ☐ Exchange functions and authority: active or passive oversight?
- ☐ Who may participate in the exchange?
- ☐ How to set rules governing insurance sold inside and outside the exchange?
- ☐ Concerns about risk selection
- ☐ Should the exchange become exclusive source or alternative source for some markets?

Why have an exchange?

- ☐ Health Insurance markets are not well organized today;
- ☐ Exchanges can be designed to provide structure and oversight to insurance markets.

Exchange role in addressing costs of care

- ☐ Exchange can be given authority to negotiate with plans over price;
- ☐ Standardized benefit packages promote price comparisons;
- ☐ Fixed employer contributions promote lower-cost plans;
- ☐ Public plan could catalyze private plans to be more cost efficient;
- ☐ Greater insurance transparency will promote more informed consumer choices, incentives for efficiency.

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To facilitate enrollment, the Exchange can centralize:

- ☐ Reliable information on options and all processes;
- ☐ Choosing plans;
- ☐ Subsidy determination;
- ☐ Making payments;
- ☐ Tracking enrollment and disenrollment to minimize coverage gaps.

What else can the Exchange do?

- ☐ Require reporting on quality
- ☐ Investigate complaints
- ☐ Gateway to Medicaid, SCHIP
- ☐ Participating Plan evaluation
- ☐ Establish & Publish "standard comparative information" for consumers

New Jersey is clearly ahead of the game!

- ☐ No penalty for pre-existing conditions
- ☐ Guaranteed issue and renewal
- ☐ No medical underwriting
- ☐ KidsFirst
- ☐ Medical Loss Ratio
- ☐ No Benefit caps
- ☐ No Rescission

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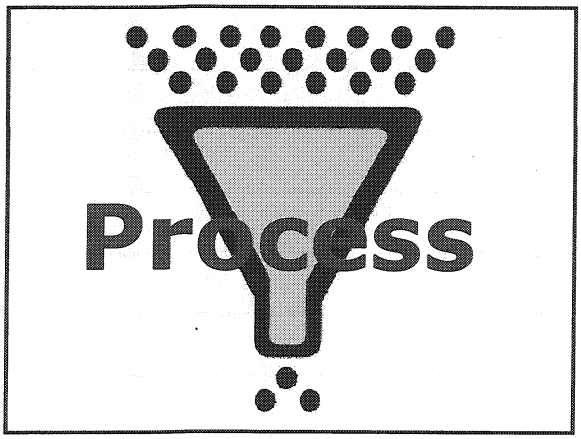
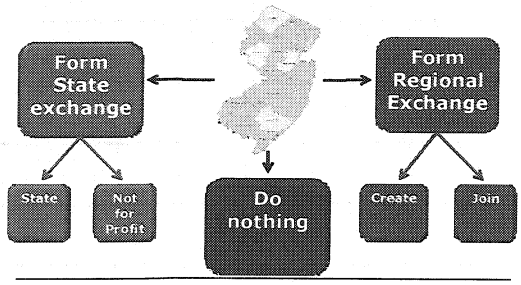
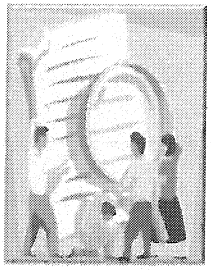


Initial Decision Point:



Exchange Responsibilities

- ☐ Marketing
- ☐ Network adequacy
- ☐ Quality improvement and reporting
- ☐ Uniform enrollment procedures
- ☐ Provider directories including significant data on in/out of network providers
- ☐ Timely consumer data on cost sharing



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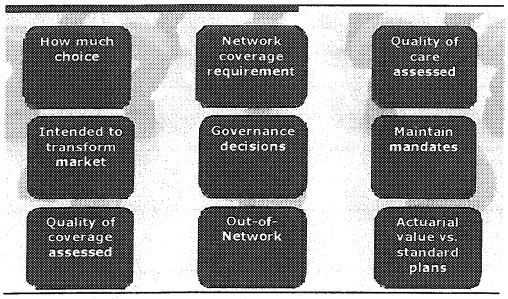
Exchange entity must have:

- ☐ Balanced expert Board of Directors
- ☐ Ability to maintain transparency
- ☐ Relationships with other State and private agencies
- ☐ Ability to protect and promote health care delivery, health plans and most importantly, the consumer

Consumer Issues

- ✓ Independent from insurers
- ✓ Sensitive to health literacy
- ✓ Culturally sensitive
- ✓ Ombudsman
- ✓ Local community navigators
- ✓ Subsidy algorithm / calculator
- ✓ Medicaid coordination
- ✓ Quantifiable squeezing out relevant
- ✓ Bright lights for good plans

Other Decisions:



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So where do we start?

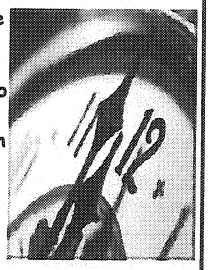
- Pass enabling legislation for Exchange
  - 3 Bills already submitted
    - S2597 (Gill)
    - S2553 (Vitale/Gordon)
    - S1288 (Van Drew)
- Technical Resources
  - OLS
  - National Conference of State Legislatures
  - National Academy of Social Insurance (has Toolkit with language)
  - National Association of Insurance Commissioners

Deadline

Federal HHS to evaluate each States' progress before January 1, 2013. Exchange up and working by 2014.

Timeline

- July 2011 – RFP for IT/website infrastructure
- Jan. 2012 to Dec. 2012 – State must submit application to HHS
- Nov. 2013 – Start selling health insurance through the exchange
- Jan. 2014 – Exchange fully operational
- Jan. 2015 – Exchange self-sustaining



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Current Working Models

Exchanges Exist in Massachusetts and Utah and one was recently created in California.

Massachusetts

- Exchange is known as the *Connector*
- The state serves as an active purchaser of insurance and solicits bids, negotiates prices and benefits
- Plans cannot be sold through *Connector* without seal of approval by the State
- Individual mandate
- 95.6% of Massachusetts residents covered *(Census Bureau, 2010)*

Utah

- Open to any plan that wants to participate
- State only defines minimum benefits that must be offered
- No individual mandate
- 85.2% of Utah residents covered *(Census Bureau, 2010)*

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California

- ☐ Sept 2010 – First Exchange in response to Affordable Care Act
- ☐ Broad powers to "negotiate on behalf of the public" and decide on health plan offering selections
- ☐ Incorporates Medicaid, thought to eventually look like Mass. *Connector*
- ☐ No individual mandate yet

Concerns

- Adverse Selection
- Pre-Existing Conditions
- "Crowd Out"
- Physician availability
- Literacy
- Individual & small group market
- Undocumented
- Out of Network

Politics

- ☐ Funding the administration of the Exchange
- ☐ Base of exchange operations
- ☐ Out-of-Network
- ☐ Participation requirements
  - Providers
  - Plans

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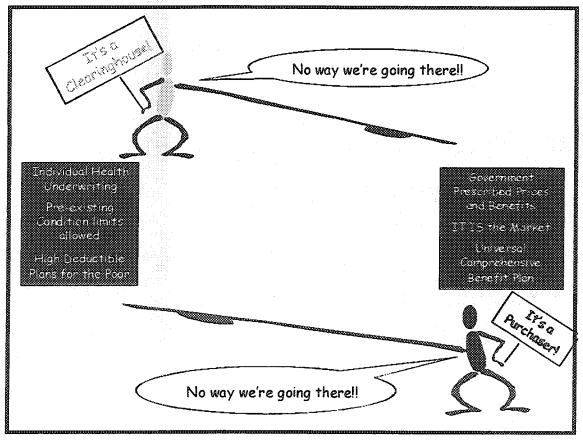

Searching Shades of Grey for a Workable Exchange

- Any Licensed Carrier
- Carriers Set Prices
- Any Insured Benefit Plan meeting exchange minimum standards

- All plans meet exchange standards
- Risk-Adjusted Plan Payment?
- Carriers must offer plans in each Benefit tier ("Bronze-Silver-Gold")

- Selective Contracting
- Price Negotiation + Risk Adjuster
- Standard Core Benefit Tiers

Increasing Regulation

Remember

Subsidies vary with personal circumstance
There's a strong foundation of insurance market reform and regulation in New Jersey
Exclusivity enhances the value of the Exchange
Setting benefit standards is critical for adequate coverage and informed choice
Cost Curve Rules
Treatment Trap right behind
No Primary Care = No Access
Exchange must be trusted
Price of success = vigilance
Don't Forget The Fear

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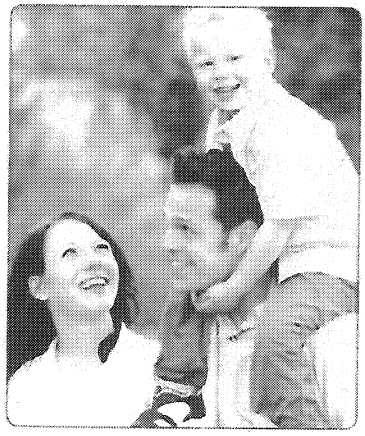
Is there one group responsible for assuring health care quality for New Jerseyans?

The New Jersey Health Care Quality Institute: Harnessing the power to assure quality

The New Jersey Health Care Quality Institute is recognized in the State and the region as an innovator, advocate, and leader for improved health care quality.

The problem: New Jerseyans are paying ever-increasing costs for health care, yet the state remains at the bottom of the list when it comes to quality of care and preventing medical errors.

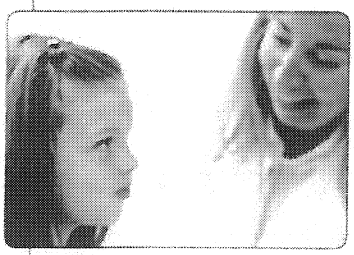
The solution: While many talk about costs and offer band-aid measures, NJHCQI is the first non-profit, impartial, and non-partisan organization working to make system-wide changes to improve patient safety and the quality of care.



Founded in 1997 and partially funded by a grant from the Robert Wood Johnson Foundation, the NJHCQI brings together all key stakeholders to make real and measurable improvements to our state's health care system. Its purpose is to "undertake projects that will ensure that quality, accountability, and cost containment are all closely linked to the delivery of health care services in New Jersey."

Step One for NJHCQI has been to foster the collaboration of all stakeholders in the state's health care delivery system, giving purchasers and health care consumers the critical ability to link quality, accountability and cost containment.

These linkages are made by publishing the results of objective research, comparative data on providers, and other pertinent educational information. This allows purchasers and consumers to adopt value-based purchasing practices and make highly informed decisions, based on the merits of various health care programs, treatments, and services.



The New Jersey Health Care Quality Institute – Quality Powered!

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John J. Sarno, Esq.
President & General Counsel

March 3, 2011

Statement to the N.J. Senate Committees on Commerce and Health

My name is John Sarno, president of the Employers Association of New Jersey (EANJ), a nonprofit trade association comprised of New Jersey employers. I have been asked to share my views with the Committee on the implementation of the Affordable Care Act, specifically on an insurance exchange, and I am happy to do so.

EANJ does not engage in lobbying. Since 1916, it has provided advice, counsel and training to employers on labor, employment and health care issues. I am a labor lawyer by background and also teach labor and health care law at Fairleigh Dickinson University.

We continue to make an extensive study of the Affordable Care Act and to translate the law to employers in practical ways. New Jersey's economy continues to feel the sharp aftermath of the two year-plus recession and even though the economic decline may be statistically over, the state's employers are still wary about hiring. And while February's small employer hiring numbers are cause for tempered optimism, one of the biggest concerns for small employers is the escalating costs of health care.

From March through October 2010, EANJ convened ten groups of employers in five regions of the state. 458 private sector employers that employ 41,200 employees in New Jersey attended, about a third of the EANJ's membership. The meetings resulted in a real time cross section of the state's employers.

B3x

Among the top concerns expressed by these employers were increased health care costs (78%); maintaining the productivity of the existing workforce (62%); the mismatch of skills of current and future workers (39%); and finding the money to make capital investments (32%). Most employers are continuing the cost cutting measures that got them through the recession. Many jobs remain vacant, although as noted there appears to have been some rehiring in February. However, Increasing health care premiums have eaten into whatever wage savings employers have been able to muster.

Increasing health care costs have also eaten into paychecks. Employers passed health-insurance costs onto employees at a sharply higher rate in 2010, reflecting an acceleration of a trend that has been on the rise for years. As firms struggle to remain competitive, more of them are reducing benefits they offer workers or making workers pay more for them.

The cost of health care premiums in New Jersey have already rose nearly five times faster than wages since 1998, according to Families USA, a Washington-based nonprofit group. Their report issued in 2008, found premiums in New Jersey rose 71 percent while earnings increased just 15 percent between 2000 and 2007. New Jersey is ranked 28th among states in the rate of growth in premiums compared with earnings.

The number of individuals insured by small employer plans peaked in 1999 at 937,784 but has since declined to about 800,000. Layoffs are the major cause of this decline, but regardless of how business friendly New Jersey becomes, fewer employers are going to provide workers with health care coverage under the strain of increasing premiums.

In fact, during EANJ's meetings, slightly more than one in ten employers stated that they will consider discontinuing coverage this year because of costs.

Recently, President Obama acknowledged during a meeting with state governors at the White House that states might need more flexibility in implementing the Affordable Care Act. He highlighted a part of the law that would allow states to tailor their own solutions to healthcare reform in 2017 if they fulfilled the same goals as the federal law. He supported a measure put forward in Congress to move that date up to 2014.

"If your state can create a plan that covers as many people as affordably and comprehensively as the Affordable Care Act does - without increasing the deficit - you can implement that plan," Obama told the governors. "And we'll work with you to do it," he added.

States are charged with carrying out many of the reforms, including establishing exchanges where individuals and small employers can buy health insurance in 2014.

To date, New Jersey has accepted all of the federal money that has been offered to implement the law.

K4x

For example, New Jersey received federal money to set up a reinsurance program that covers individuals who are not eligible for Medicare but who cannot otherwise get insurance. The program has been reimbursed over $30 million by the federal government the first year.

New Jersey has also accepted funds to plan for the creation of an exchange, which under federal law must be a self-sustaining enterprise.

The Affordable Care Act enables a state insurance exchange can accomplish at least four important goals:

1. Offering consumers a choice of health plans and focusing competition on price. Exchanges offer enrollees a choice of private health insurance plans. Covered services and cost sharing (i.e., deductibles, coinsurance or copayments, and out-of-pocket limits) would be organized or standardized in ways that make comparisons across plans easier for consumers. The aim is to focus competition among plans on the price of coverage and minimize the tendency for plans to vary benefits in order to attract healthier than average enrollees.

2. Providing information to consumers. In conjunction with offering a choice of plans, an exchange is intended to provide consumers with transparent information about plan provisions such as premium costs and covered benefits, as well as a plan's performance in encouraging wellness, managing chronic illnesses, and improving consumer satisfaction. The exchange could also serve a customer assistance function—typical for large employers—to assist consumers who encounter billing or access problems with their plans.

3. Creating an administrative mechanism for enrollment. For people who obtain private insurance coverage through work, the employer typically facilitates enrollment in a plan and the payment of the premium. This is especially true in larger businesses. An exchange could serve a similar function for people without access to that kind of assistance, including people buying insurance on their own or who work for small businesses. The exchange could also be used to determine eligibility for and administer income-related subsidies.

4. Moving towards portability of coverage. Coverage through an exchange can be de-linked from employment, helping to make health insurance more portable for people moving from job to job. Exchanges also could coordinate enrollment shifts between Medicaid and subsidized private coverage for people with very low and potentially changing incomes.

Another function of an exchange could also be to facilitate changes in the rules governing how insurers sell coverage. Although these types of changes can be implemented simply by changing insurance laws and do not necessarily require the creation of exchanges, some argue that exchanges can make these insurance market reforms more effective by monitoring marketing practices and administering a uniform system for enrolling in a health insurance plan.

In important ways, New Jersey already has a small employer health benefits law that tracks the federal law. Like the Affordable Care Act, state law requires guaranteed issued policies

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regardless of pre-existing conditions. Basic coverage must be provided on a modified community rated basis, meaning that everyone within a band can purchase insurance for the same price regardless of medical condition. In return, the law requires employers to cover 75% of all eligible employees and carriers must meet medical loss ratios. To increase rates, an insurance carrier must submit a certified actuarial report but premium increases are automatic if the basic criteria are met.

Assuming that New Jersey will have flexibility in implementing the Affordable Care Act, what would a reformed small employer market look like? A key feature would be the insurance exchange or some other pooling arrangement, the success of which would be dependent upon insuring as many people as possible to leverage purchasing power. Private carriers will sell within the exchange. People who cannot afford to buy insurance will receive a subsidy. Employers who do not offer insurance to their employees will contribute to the subsidy either directly or indirectly, with exemptions for small business.

New Jersey employers have stated that the primary reason for offering coverage is to attract and retain qualified workers. *Rutgers Center for State Health Policy* (2004). Most employers that do not offer health insurance indicate that the cost is too high. *Id.* Research indicates that even a 30% reduction in premiums would cause only about 15% of currently uninsured small employers to offer coverage. *See* The Commonwealth Fund, Task Force for the Future of Health Insurance (2002).

The mechanics of the exchange are not controversial and since New Jersey already has in place a regulatory infrastructure, the physical creation of the exchange can be accomplished efficiently. But as noted, the success of the exchange depends on enrolling sufficient critical mass. The Affordable Care Act relies, in part, on the personal mandate to accomplish this end. Massachusetts has also enacted a personal mandate so we may look to that state for an example of the perils of implementing health care reform.

Massachusetts enacted its reform in 2006. Its insurance regulations were similar to New Jersey's and the 2006 law was, in many ways, the model for the Affordable Care Act, including the personal mandate to purchase insurance and the creation of an insurance exchange. Coverage increased from about 88% to 96% the first year but the cost of insurance still increased, more so for small employers. When insurance companies announced premium increases in 2010 up to 30%, Governor Deval Patrick authorized a price-fixing inquiry.

Carriers in Massachusetts argued that hospitals and big medical practices held too much bargaining power and therefore they had no choice but to pay them monopoly rates for medical care. The premium increases were necessary to stay in business, they said.
In January, 2011, the Patrick administration introduced a bill to create an 18-member board to regulate how much providers should be paid for what service. Some have called this an attempt to impose price controls, a regulatory strategy to mitigate price inflation.

Hex

The Massachusetts health care law, like the Affordable Care Act relies on tax breaks, subsidies, penalties, the personal mandate and the insurance exchange to expand care and create consumer purchasing power. Two federal courts have found the Affordable Care Act unconstitutional, although three courts have upheld the law. But whether the Supreme Court of the United States upholds or invalidates the law, New Jersey will still have a health insurance system that is unsustainable over the long haul.

The Affordable Care Act has many complex moving parts, each dependent on the other. Should the personal mandate be invalidated, the challenge for New Jersey will be deciding how to develop the critical mass of employers for a viable insurance exchange. If the mandate is upheld, the Act's incentives will encourage smaller employers to discontinue insurance coverage for employees.

This is a critical time for New Jersey's economy. Employers are weighing whether to hire next year or buy new equipment, or both. Projected health care increases could be as high as 25% in a run up to the reforms under the Affordable Care Act that become law next year. Without productivity gains, many businesses, particularly smaller business, are highly vulnerable.

The state has about 250,000 small employers (defined as 500 or less employees) and 8 of 10 New Jersey residents work for a small employer. About three of four New Jersey residents are covered under an employer-sponsored health care plan, although only about half by a small employer.

The recession has taken a toll on employer-sponsored health care in the state. In the first quarter of 2010, the small employer group market had about 775,000 covered lives, down 16.5% from 2000, as small employers have dropped coverage.

Other responses from the EANJ focus employer groups were:

- Percentage that will consider changing health care coverage within the next year: 68%
- Percentage that will consider eliminating health care coverage next year: 12%
- Percentage that will consider paying penalty in 2014 rather than offer health care coverage: 48%
- Percentage that will invest in employee wellness in 2014: 22%
- Percentage that think the Affordable Care Act will reduce health care premiums: 8%
- Percentage that think the Affordable Care Act will be amended within the next 2 years: 38%

As noted above, slightly more than one in ten employers state that they will consider discontinuing coverage next year because of costs. Almost half state that they would consider paying the penalty for employers with 50 or more employees that discontinue coverage.

As one participant, a senior manager at an optical instrument manufacturer employing 90 employees put it:

"Pension and health benefits traditionally have been annoying distractions from core business functions and increasingly have become very expensive cost centers. I don't think that I will lose much sleep about shifting my employee benefits obligations, as long as employees can get decent coverage in the exchange, at reasonable cost and I save money after paying federal penalties."

The participant above is commenting on a cost-benefit simulation that shows the cost of continuing to pay 80% of health care premiums for employees against discontinuing coverage and paying an annual penalty based on full-time headcount, minus the first 30, when at least one employee receives a subsidy to purchase their own insurance. In the simulation, the employer reaps a substantial savings for discontinuing coverage.

Moreover, standardized coverage will be available on the insurance exchange. Consumer protection requirements and coverage mandates will ensure that employees will be able to receive basic coverage equivalent to most employer-sponsored plans.

On October 21, 2010, Philip Bredesen, the governor of Tennessee published an op-ed in the *Wall Street Journal* entitled "ObamaCare's Incentive to Drop Insurance" which was discussed by several of the groups. In the piece, the governor concluded that "the economics of dropping coverage is about to become very attractive to many employers" by conducting a simulation substantial similar to the one referenced above. Letters that followed reflected opinions in the offered in the groups.

As noted above, slightly more than half (52%) of employers implicitly stated that they would *not* consider discontinuing coverage in 2014. This comports with a 2010 Towers Watson report that notes that 57% of employers are confident that they will be offering health care benefits five years for now. However, it is clear that employers assume that competitive pressures will result in both voluntary and involuntary terminations of older workers with replacement by younger, cheaper and relatively healthier employees who are expected not to be big consumers of health care in the short term. Should there not be a return to a "normal" replacement rate, as another participant noted, "it's hard to see how the status quo is sustainable."

In any event, in 2014 both current and new employees will be subject to the personal mandate. Thus, to the extent that most employers are more or less equal in their ability to hire new talent, the playing field becomes more equal regarding health care. In other words, employer sponsored health care may not be as an important inducement in recruiting and hiring when all

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new hires are legally obliged to carry their own insurance. This is particularly true with entry level jobs and certainly the case in a "buyers market."

Many participants explained that their current health care programs are "legacy costs." Many began providing health care insurance to remain union free, when insurance was inexpensive and when proprietary knowledge to perform firm-specific jobs required a generous benefits package to recruit and retain employees. Over the last decade, technology has de-skilled some jobs and has diluted the importance of proprietary knowledge for others. Labor unions are no longer a threat for most firms and as noted above, health care costs have skyrocketed.

Policy makers have often opined that employers will continue to offer coverage to compete for talent. However, the transformation of jobs and work over the last two decades, together with immigration and wage patterns, has created a more fungible job market. Thus, some participants reported that they anticipated recruiting and retention costs to be less expensive, which would include less generous benefits packages or, in the case of health care, none at all.

In short, New Jersey must plan for the migration of insured individuals from the small group market to the individual market. Indeed, the insurance may want to encourage this outcome. As employers get out of the health and welfare business they can focus more intensely on their core competencies. Employees can buy their own portable insurance in the exchange. Employers can choose to offset the costs with a free choice voucher or with some other tax exempt plan or employees will receive a subsidy. In either case, portable health care would be de-coupled from employment – a win-win.

Finally, with a critical mass of participants, the exchange must decide whether and how it will use its purchasing power. A large corporation with thousands of employees pays far less in insurance premiums than a small employer. The reason is because of purchasing power. I would suggest that the New Jersey Insurance Exchange have the authority to drive a hard bargain with the insurance carriers for the benefit of participants.

Thank you. I will be happy to take any questions that you might have.

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MEMORANDUM

TO: Members of the Senate Commerce Committee and Senate Health, Human Services and Senior Citizens Committee

FROM: Christine A. Stearns

DATE: March 3, 2011

RE: Federal Healthcare Reform Implementation in New Jersey

On behalf of the New Jersey Business & Industry Association (NJBIA), I appreciate the opportunity to participate in today's joint hearing. We appreciate ensuring that the perspective of small business is included in the discussion on this important topic.

In our Annual Business Outlook Survey, the cost of purchasing health insurance has been the top concern for NJBIA's membership for twenty-five years, with the exception of last year when the overall cost of doing business edged it out for the top spot.

Cost Control is Critical

It is also well known that the Patient Protection and Affordable Care Act's (PPACA) provisions were intensely debated. I will not attempt to recap that debate but I will highlight one concern that is particularly relevant as the State of New Jersey, and our businesses, begin to implement the provisions of the law--cost control.

So as New Jersey implements PPACA, it is important to be mindful that employers large and small are struggling with double-digit premium rate increases. And, several provisions of the act could force premiums to rise even more. Health insurance premiums exceeded $5,000 for individual employees and $13,000 for family coverage (2010 Kaiser/HRET Survey of Employer-Sponsored Health Benefits). These rates are double what employers paid just ten years ago.

Rising costs, combined with the recession, are resulting in a sharp drop in the number of people covered in New Jersey's small employer market. There are more than 130,000 fewer people covered now than there were in January 2008, a decline that began in 2006.

Unfortunately, the federal healthcare reform law offers little relief.

Many proponents of federal healthcare reform have touted the Small Business Health Care Tax Credit as a major benefit for small business. The maximum credit is worth 35 percent of the premium, but a business has to have ten or fewer employees with average wages under $25,000 a year to qualify. In a high wage state like New Jersey, it's unlikely that many businesses will benefit from the tax credit, certainly not the way those in other lower cost states will.

102 West State Street, Trenton, NJ 08608-1199 • 609-393-7707 • www.njbia.org

Health Insurance Exchange Design

A Health Insurance Exchange is a mechanism for organizing the health insurance marketplace to help consumers and small businesses shop for coverage in a way that permits easy comparison of available plan options based on price, benefits and services, and quality. It is believed that by pooling people together, reducing transaction costs, and increasing transparency coverage will be more affordable.

The State has several key decisions to make about how the Exchange will be designed that are of great interest to small employers, including:

- **Small Business Cutoff**: New Jersey will have to determine whether to elect the option to use 50 employees as the cutoff until 2016 or to allow businesses with 51-100 employees to participate in the Exchange. Beginning in 2017, state must allow employers with up to 100 employees and may elect to allow larger employers.
- "**Essential Benefits**": While states are permitted to offer benefits in additional to the "essential health benefits" defined by HHS, the state would be responsible for defraying the cost of any additional required benefits. With the numerous existing health benefits mandates laws that currently exist in New Jersey, this will require a careful review.
- **Exchange Configuration**: New Jersey must determine if the Exchange will be administered by a governmental agency or non-profit entity established by the state. The nature of the Exchange and its broad range of responsibilities may best be served by an entity that is accountable to the public yet carried out by a professional staff that can effectively implement the law.

NJBIA appreciates your consideration of our view.

Health Reform Across the States: Increased Insurance Coverage and Federal Spending on the Exchanges and Medicaid

Timely Analysis of Immediate Health Policy Issues

March 2011

Matthew Buettgens, John Holahan and Caitlin Carroll

Summary

With the enactment of the Health Care and Education Reconciliation Act of 2010 on March 30, 2010, the Patient Protection and Affordable Care Act (ACA) became law, fundamentally changing health insurance and access to health care in the United States. Using the Urban Institute's Health Insurance Policy Simulation Model (HIPSM), we estimate important effects of the ACA at the state level: the increase in insurance coverage, coverage and subsidies in the new nongroup health benefit exchanges, Medicaid enrollment and costs under the expansion and total new federal spending on Medicaid and subsidies. We provide results by state, by region and by two useful groups of states. Key results are also displayed on maps. For ease of comparison, we simulate the ACA as if fully implemented in 2011 and contrast the results with HIPSM's prereform baseline results for 2011. These results complement an earlier policy brief that analyzed the national impact of health reform as if implemented in 2010.[1]

We estimate that:

- Full implementation of the ACA would lead to a 10.3 percentage point decrease in the national uninsurance rate for the nonelderly, roughly equivalent to 28 million fewer uninsured Americans. Although every state would enjoy a decline in uninsurance, the magnitude of the decrease varies significantly by state, ranging from a 1.1 percentage point decrease in Massachusetts to a 16.9 percentage point decrease in Texas.
- State-level income distributions and employer-sponsored insurance (ESI) eligibility levels affect the impact of health reform. States where lower income levels allow for higher Medicaid and exchange subsidy eligibility would see a greater decline in uninsurance rates. Likewise, states with low ESI eligibility would see a larger decrease in uninsurance than states with high ESI eligibility.
- The percent of nonelderly covered through nongroup health exchanges would vary by state. Massachusetts has the lowest coverage through nongroup exchanges at 5.4 percent, while North Dakota covers 13.9 percent of its population through the nongroup exchange, with a national average of 8.9 percent. We also observe regional differences, ranging from 7.1 percent in New England to 10.3 percent of the nonelderly in West North Central states. The variation reflects differences in income distribution and the level of ESI coverage.
- Under the ACA, exchange subsidies would total approximately $33 billion, with the majority going to those below 200 percent of the federal poverty level (FPL). Subsidies per nonelderly person, a useful measure for comparing subsidy amounts between states, are highest in the Pacific states and lowest in New England.
- Nationally, there would be 4.9 million new Medicaid enrollees who are eligible for Medicaid under current law, accounting for 8.3 percent of total new Medicaid enrollment under the ACA. Regionally, newly enrolled current eligibles make up the smallest share of total Medicaid enrollment in New England, 5.4 percent and the largest share in the mountain states, 10.5 percent. States with the highest ratio of ESI eligible residents see the lowest percentages of their total Medicaid enrollment made up by newly enrolled current eligibles, as do states with a high proportion of residents under 138 percent of the FPL.
- There would be 12.3 million newly eligible Medicaid enrollees nationwide, representing approximately a fifth of total enrollment.[2] This enrollment is driven by newly eligible adult nonparents, who account for 10.0 million of the newly eligible Medicaid enrollees. Children and adult parents make up a smaller proportion of newly eligible Medicaid enrollees. Due to the Children's Health Insurance Program (CHIP), children are already covered through a high-income threshold, so fewer gain eligibility with the general Medicaid expansion.
- Newly eligible Medicaid enrollees are less expensive, on average, than current enrollees. Although new eligibles make up about 20 percent of total enrollees, they only account for 15.4 percent of costs. This is because the newly eligible adults would be, on average, cheaper to cover than currently enrolled adults. Without reform, most states do not have an income eligibility threshold for adult nonparents, and many of those that do have

Robert Wood Johnson Foundation

State Coverage Initiatives
Robert Wood Johnson Foundation

Urban Institute

closed their enrollment. Therefore, the adult nonparents currently enrolled gained eligibility through disability and medical need.

- There would be $82.3 billion in new federal spending on Medicaid and exchange subsidies flowing to the states. There would be considerable state variation since factors affecting both the exchanges and Medicaid are involved. West Virginia would receive $498 in new federal spending for every nonelderly person in the state, while Iowa would receive only $171. A full analysis of the economic impact of the ACA on states would have to include the distributional effects of Medicare payment cuts, new taxes on payroll and unearned income and taxes on insurers, drugs and medical device manufacturers.

Introduction

With the enactment of the Health Care and Education Reconciliation Act of 2010 on March 30, 2010, the Patient Protection and Affordable Care Act became law, fundamentally changing health insurance and access to health care in the United States. This brief provides state-level estimates of three important aspects of reform. First, while all states would see an increase in insurance coverage under the ACA, the current insurance markets in the various states differ considerably. Thus, the coverage effects of the ACA would vary significantly between states. We present state-level estimates of the percent of the nonelderly who would be uninsured without health reform and the uninsured rate among the nonelderly under the ACA. The effect of health reform on insurance coverage within a state is the difference of these two, the percentage point decline in the uninsured rate. We examine state and regional patterns in this decline.

Second, we examine coverage and subsidy costs in the new nongroup health benefit exchanges. We provide state estimates of the number of nonelderly covered in the exchanges and how the distribution of exchange coverage would vary by income group. The share of exchange coverage for those below 400 percent of the federal poverty level is particularly significant because the large majority of these would receive subsidies. This share is a result of several factors, such as the availability of ESI in addition to the distribution of income in a state. We then present income-based premium and cost-sharing subsidies in total dollars, in dollars per nonelderly person and in dollars per person with subsidized coverage. Subsidy dollars per nonelderly person provides a measure of the level of federal subsidies flowing into a state, controlling for differences in state population. The amount of subsidy dollars per subsidized person allows comparisons between states of how much an average subsidized person would cost.

Third, we present estimates of Medicaid/CHIP enrollment and costs under the Medicaid expansion, giving separate figures for adult nonparents, adult parents, children and those made newly eligible by the expansion. For each estimate, we provide results by state, region and two groups of states. Key results are also displayed on maps.

Lastly, we consider the Medicaid costs of new enrollees and estimate the share paid by the federal government. We combine this with the total exchange subsidies to estimate the total federal dollars flowing to the states.

The results presented here complement state-by-state estimates of Medicaid coverage and spending released in 2010.[3] That work dealt exclusively with Medicaid and used two take-up rate scenarios to forecast Medicaid enrollment for 2014 to 2019. This report presents 2011 estimates, as described in the Methods section below. We present state-level results from a full HIPSM simulation of the ACA. Medicaid enrollment is not based on fixed *a priori* take-up rates as in the earlier work but is simulated as described below in Methods. We focus on new federal dollars paid to states for exchange subsidies as well as Medicaid rather than on total Medicaid spending.

Methods

To estimate the effects of health reform and the individual mandate, we use the Urban Institute's Health Insurance Policy Simulation Model.[4] HIPSM simulates the decisions of businesses and individuals in response to policy changes, such as Medicaid expansions, new health insurance options, subsidies for the purchase of health insurance and insurance market reforms. The model provides estimates of changes in government and private spending, premiums, rates of employer offers of coverage and health insurance coverage resulting from specific reforms.[5]

We simulate the main coverage provisions of the ACA as if they were fully implemented in 2011 and compare results to the HIPSM baseline results for 2011 prior to implementation of these reforms. This approach differs from that of the Congressional Budget Office or the CMS actuaries who by necessity provide 10-year estimates. Our approach permits more direct comparisons of reform with the prereform baseline and of various reform scenarios with each other. The key coverage provisions of the ACA and their implications for coverage and costs were summarized in an earlier policy brief providing a nationwide analysis of the ACA based in 2010.[6]

To simulate state-level results, we made the following enhancements to the model not reflected in earlier documentation:

- Two years of CPS data (survey years 2009 and 2010) were pooled together

to increase state sample size. Results for large states are based on a larger number of surveyed households than results for small states and thus have greater accuracy. Note that the CPS oversamples small states, so the number of observations is not necessarily proportional to state size. Our standard for state-level estimates was at least 100 unweighted observations; most are based on far larger numbers.

- Medical expenditures were adjusted to reflect state-level differences in health care pricing and utilization as measured in the National Health Expenditure Accounts.[7]
- Private health insurance premiums reflect both the state-level differences in expenditures from the previous item and state-specific differences in the risk pools of enrollees for a given type of insurance.
- The ACA was inspired in its general form by the comprehensive health reforms enacted in Massachusetts. The HIPSM results for Massachusetts without the ACA take into account some important provisions of that state's health reform law, though we did not comprehensively model it.

There are significant differences between insurance markets in the various states, particularly in the individual and small group markets. We did not model 51 different regulatory regimes with their various rules for premium rating, benefit package requirements and so on. The distribution of premiums in a given state is influenced both by the underlying levels of health care pricing and utilization and by the market conditions in that state. As noted, we take into account the former. For most states, the resulting distribution of average premiums is similar to that published in sources such as the MEPS-Insurance Component. However, some differences appear to be driven by differences in the structure of insurance plans and other market factors in certain states.

Modeling the private insurance market and typical plan structures available in a given state is a significant effort. We are starting to supplement the baseline used in this brief with special baselines focused on certain states. An important example was a simulation in 2009 of numerous health reform options for New York.[8] State-level estimates from the national version of HIPSM should not be considered a substitute for versions tailored to a specific state in answering technical state policy questions, particularly regarding implementation of the new health insurance exchanges.

We calibrate the behavior of our model so that a standard expansion of Medicaid and CHIP achieves take-up rates consistent with the empirical literature.[9] These baseline take-up rates for the uninsured are between 60 and 70 percent, depending on person type and income group. The ACA contains important provisions that would increase take-up. States are required to establish a web site capable of determining eligibility for Medicaid and automatically enrolling eligibles. Hospitals would be able to make presumptive eligibility determinations. There would be other new requirements for simplifying enrollment and renewal of Medicaid and CHIP. We estimate a take-up rate of about 73 percent for the uninsured who are newly eligible. This rate is higher than the baseline rate due to outreach and enrollment simplification provisions in the ACA, as well as a modest indirect effect of the individual mandate as observed in health reform in Massachusetts. Our Medicaid take-up is consistent with the enhanced outreach scenario in Holahan and Headen.[10]

To estimate modified adjusted gross income (MAGI) as defined in the ACA, we deduct the following from gross income: Social security, SSI, workers' compensation, veterans' benefits, child support and public assistance. We also impute child care expenses for families and deduct them up to the $5,000 cap defined in the tax law. Some other deductions which are part of MAGI, such as those for some types of pension benefits, cannot be computed and would be difficult to reliably impute based on CPS data. These additional deductions are unlikely to affect our results materially.

Finally, we emphasize that the estimates in this paper assume a uniform implementation of the ACA. There are many important implementation decisions within a state's authority. Few of these decisions have been made; when they are, we will be able to incorporate them into future estimates. Also, there is value in comparing the effects of a consistent policy across states.

Results

State Characteristics Relevant to the ACA

Several groupings of states will be useful in our analysis. The first is based on the state distributions of modified adjusted gross income as defined in the ACA. Since these are of independent interest and, as far as we know, have not been published elsewhere, we include a full table with cutoffs at 138 and 400 percent of the FPL (Table 1). These cutoffs are the eligibility levels for the Medicaid expansion and exchange subsidies respectively. There are distinct regional patterns. For example, in New England, nearly half of the nonelderly are at 400 percent of the FPL or above. Twenty-one percent are in the Medicaid eligibility range and 31 percent are between 138 and 400 percent of the FPL. Compare this with East South Central states, where 34 percent are below 138 percent of poverty, 38 percent between 138 and 400 percent and 28 percent above 400 percent.

Using cluster analysis, we separate states into four groups that have proven useful in analyzing our results. *Lowest impact* states are those in which about half of nonelderly adults are at or above 400 percent of the FPL. These states have a significantly lower share of the nonelderly in the Medicaid and exchange subsidy income groups (Table 1a), so these programs would be expected to have a somewhat lower impact. These states are Connecticut, Maryland, Massachusetts, New Hampshire and New Jersey (Figure 1). *Moderate impact* states

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have about 40 percent of nonelderly adults at or above 400 percent of the FPL and 30 to 40 percent between 138 and 400 percent of the FPL. These are Colorado, Delaware, D.C., Illinois, Minnesota, North Dakota, Pennsylvania, Rhode Island, Vermont, Virginia and Washington. *High subsidy impact* states have more nonelderly adults between 138 and 400 percent of the FPL than in either of the other two categories and have less than a third below 138 percent of the FPL. Thus, they have a particularly large population that could potentially be affected by exchange subsidies. These are Alaska, Florida, Idaho, Iowa, Kansas, Maine, Michigan, Missouri, Montana, Nebraska, Nevada, Ohio, Oklahoma, Oregon, South Dakota, Utah, Wisconsin and Wyoming. Finally, *High Medicaid impact* states have about a third of all nonelderly adults below 138 percent of the FPL, a higher proportion than the other groups. These also generally have a larger-than-average share in the 138 to 400 percent range as well. These are Alabama, Arizona, Arkansas, California, Georgia, Hawaii, Indiana, Kentucky, Louisiana, Mississippi, New Mexico, New York, North Carolina, South Carolina, Tennessee, Texas and West Virginia.

Also, we identify states as having *low or high ESI eligibility* depending on whether less than 60 percent of nonelderly adults are eligible for ESI, that is, are potential policyholders (Figure 1). Those ineligible for ESI are either not in the work force or hold jobs—particularly part-time jobs—which would not have ESI as a benefit even if other workers in the firm were offered ESI. Low ESI eligibility states are Alabama, Alaska, Arizona, Arkansas, California, Colorado, Florida, Georgia, Idaho, Kentucky, Louisiana, Maine, Michigan, Mississippi, Montana, New Jersey, New Mexico, New York, North Carolina, Oregon, Rhode Island, South Carolina, Tennessee, Texas, Utah, Washington, West Virginia and Wyoming. High ESI eligibility states are Connecticut, Delaware, D.C., Hawaii, Illinois, Indiana, Iowa, Kansas, Maryland, Massachusetts, Minnesota, Missouri, Nebraska, Nevada, New Hampshire, North Dakota, Ohio, Oklahoma, Pennsylvania, South Dakota, Vermont, Virginia and Wisconsin. Figure 1 overlays income and ESI eligibility groups. An interesting pattern emerges. High ESI eligibility states generally occur either in a cluster of low- and moderate-impact states along the Eastern seaboard or in a cluster of moderate-impact and high subsidy impact states in the Midwest.

Insurance Coverage

Nationally, the ACA would decrease the number of uninsured nonelderly persons by just under 28 million, a decrease of 10.3 percentage points (Table 2). There would, however, be considerable variation by state. Massachusetts would see little change (a decrease of 1.1 percentage points) because the ACA was to a large extent based on the health reforms already operating in Massachusetts. As a result of these reforms, the state had a low uninsured rate to begin with. The states with the largest decreases would be Texas and New Mexico (16.9 and 16.0 percentage points, respectively). These states currently have much higher than average uninsured rates (29 and 28 percent, compared with a national average of 19 percent).

There are clear regional patterns in how health insurance coverage would change under the ACA. New England states would see an average decrease in the uninsured rate of only 4.3 percentage points, while West South Central states would see an average decrease of 15.8 percentage points and South Atlantic states a decrease of 12.3 percentage points. Figure 2 maps these differences. Massachusetts, the only state that has already enacted comprehensive health reform, stands out as the only state with a decrease in uninsurance under 2 percentage points. There is a large band of states which would see the greatest gains in insurance coverage under reform across the Southwestern and Southeastern states. North of this grouping, the Midwest and Northeast would experience more modest decreases in uninsurance, along with Washington and California.

There are also significant differences across income clusters as well as between ESI eligibility clusters (Table 2a). High Medicaid-impact and high subsidy-range states would see a much larger decrease in the uninsured rate than the other two groups (11.6 and 10.6 percentage points, respectively). Lowest impact states would see a decrease of only 6.2 percentage points. Low ESI eligibility states would see a decrease of 11.4 percentage points, in contrast with 8.0 percentage points for high ESI eligibility states. Health reform has the most effect in states with the lowest availability of ESI.

The Nongroup Exchanges

Nationally, 8.9 percent of the nonelderly would be covered through the nongroup health exchanges (Table 3). State by state, the percentage varies from 5.4 percent in Massachusetts to 13.9 percent in North Dakota. Groups of states that would have similar changes in rates of insurance coverage often have very different rates of exchange enrollment. For example, Georgia and Montana would experience large changes in insurance under reform, with 12.6 and 12.7 percentage point increases, respectively. However, while Georgia will cover only 7.1 percent of its population through the nongroup exchange, Montana covers 13.1 percent.

There are regional patterns in nongroup exchange enrollment. New England and East South Central states would have the lowest proportion of the nonelderly covered in their nongroup exchanges, with 7.1 and 7.7 percent, respectively. Mapping the percentages of the nonelderly with exchange coverage, we see the regions with the highest shares are West North Central, Mountain and Pacific. High rates of exchange coverage are also found in Florida, some Middle Atlantic states and some New England states. West North Central states would have the highest, 10.3 percent, closely followed by Mountain and Pacific states, both with 9.8 percent. The lowest rates are in Massachusetts, West

25x

Virginia and Hawaii. Massachusetts has very high ESI availability and a lower than average share of people in the exchange premium subsidy income range. West Virginia has a large proportion of nonelderly adults eligible for Medicaid under the expansion. The gain in coverage under reform for West Virginians is due more to the Medicaid expansion in this state than on average.

In Table 3, we also show the income distribution of those enrolled in the exchange. The share of enrollees above 400 percent of the FPL is particularly significant; it gives a good indication of how much of the exchange risk pool is not subsidized. The exchanges would likely be an attractive option for those already enrolled in nongroup coverage, and many currently uninsured who are not offered ESI would take exchange coverage to comply with the mandate even if their income is too high to qualify for subsidies.[11] There is a little unsubsidized coverage of persons below 400 percent of the FPL, mostly those using employee choice vouchers. Regionally, the share above 400 percent varies from 41.8 percent in New England to 23.1 percent in the East South Central states.

High subsidy impact states, not surprisingly, would have the highest percentage of the nonelderly enrolled in nongroup exchanges, 9.7 percent (Table 3a). Lowest impact states would have only 7.3 percent of the nonelderly in the exchanges, due in part to the fact that these states have the lowest share of residents in the subsidy-eligible income group. High Medicaid impact and moderate impact states would be closer to average, with 8.6 and 9.2 percent, respectively. The percent of those in the exchange above 400 percent of the FPL would vary from 30.1 percent for high subsidy impact states to 42.3 percent for lowest impact states.

In Table 4, we show the amount of premium and cost-sharing subsidies that would be paid to low-income exchange enrollees in each state. Nationally, $29 billion would be paid in premium subsidies and $4.3 billion in cost-sharing subsidies. Since subsidy amounts are computed using a sliding scale of percent-of-income thresholds, most of the spending is on the lowest eligible income groups. Sixty-three percent of premium subsidy dollars would go to those below 200 percent of the FPL and 29 percent to those between 200 and 300 percent of the FPL.[12] Similarly, 91 percent of cost-sharing subsidy dollars would go to those below 200 percent of the FPL.

In Table 5, we show the total exchange subsidies that would be received by residents of each state, that is, the sum of premium and cost-sharing subsidies from Table 4. Due to the differences in state populations, these totals are unsuitable for comparisons between states. For that purpose we give two averages. First, the subsidy amount per nonelderly person measures the per capita subsidy dollars that would flow into a state. Second, the subsidy amount per person covered by a subsidized policy shows how many subsidy dollars would be received by a typical low-income person in a state's exchanges.

The lowest subsidies per nonelderly person would be in New England and the Middle Atlantic states and the highest subsidies per nonelderly person would be among West South Central, Mountain and Pacific states. This variation is largely a result of the share covered by exchanges (Table 3) and the income distribution within the subsidy eligibility range, that is, 138 to 400 percent of the FPL. For example, the Mountain region has the same share of exchange coverage as the Pacific region, but its subsidies per nonelderly person would be only $128, as opposed to $135 in the Pacific. The Pacific region has a larger share of exchange coverage below 200 percent of the FPL than the Mountain region (Table 3). As we have seen in Table 4, the bulk of subsidies go to those in this income group. A map of average subsidies per nonelderly person shows the high and low regions that we have identified. Florida and Vermont appear as isolated high subsidy states.[13]

Subsidy amounts per subsidized person are more uniform across states. Subsidy income thresholds vary by income, so differences in the income distribution between 138 and 400 percent of the FPL would be an important factor in these average subsidy amounts. State differences in underlying medical costs and premiums are an equally important factor. Since the federal government pays the difference between a benchmark premium and a percentage of income, states with higher medical costs and premiums will be eligible for higher subsidies, all else being equal. A third factor is ESI availability. There are significant state differences in who would be barred from subsidies due to an affordable ESI offer. These three factors interact and in some ways balance each other, dampening the differences between states.

Among income groups, high subsidy impact and high Medicaid impact states would have the highest subsidies per nonelderly person ($136 and $127 respective) and lowest impact states the lowest ($81). High ESI eligibility states would also have significantly lower subsidy dollars per nonelderly person ($115 versus $129). Differences in subsidy amounts per subsidized person are too small to give a significant pattern for either income or ESI eligibility clusters.

The Medicaid Expansion

Table 6 provides a state-by-state overview of enrollment in Medicaid and CHIP. Nationally, about a fifth of enrollees would be newly eligible under the Medicaid expansion. The rest were previously eligible—and the large majority were enrolled before reform. Because of the high income eligibility thresholds for children in the CHIP program in most states, few children would gain eligibility (Table 7). Less than 100,000 of the 12.3 million newly eligible enrollees would be children. These children are mostly in states with Medicaid/CHIP income thresholds for children at 200 percent of the FPL or less (not shown in tables).[14] Even for states with thresholds far above 138 percent of the FPL, the difference in income definition under the ACA would gain eligibility for a small number of children. Eligibility thresholds for adult parents

are generally lower than for children, so more would gain eligibility. Few states have general income eligibility thresholds for adult nonparents and enrollment is closed in many of these. Most adult nonparents currently enrolled in Medicaid obtained eligibility through special programs (e.g., disability or medically needy). Thus, the large majority of newly eligible Medicaid enrollees are adult nonparents (10.0 million out of 12.3 million).

For state comparisons, we will focus on the percent of Medicaid/CHIP enrollees who are made newly eligible by the expansion as well as percentages of newly enrolled current eligibles. This gives information about the mix of enrollees in public coverage and has important implications for costs, as we shall see. There are two kinds of factors to distinguish. First, current eligibility rules in the various states and, second, factors that make new eligibles more or less likely to enroll in Medicaid versus other insurance coverage options, including remaining uninsured. Current Medicaid and CHIP eligibility rules are complex and vary greatly for children, parents and adult nonparents. Also, the ACA standardizes the definition of income, modified AGI as defined in the law, to be used in the eligibility test. The states with the 20 lowest percentages of enrollees who are newly eligible are nearly all—except for Pennsylvania and Michigan—among the 25 states with the highest eligibility thresholds for parents in 2009.[15] A few states have fairly generous Medicaid thresholds for adult nonparents as well, namely Arizona, Delaware, New York, Vermont and Hawaii.

Some states offer more limited coverage than standard Medicaid benefits to adults through Section 1115 waivers. Those who have such coverage and have MAGI below 138 percent of the FPL would qualify for the newly eligible federal match rate. For this reason, we count these as newly eligible. The state with the lowest share of new eligibles among enrollees is Vermont. That state offers full Medicaid benefits to parents up to 191 percent of the FPL and to childless adults up to 160 percent. The second lowest is Massachusetts, which has already enacted comprehensive health reform. Pennsylvania has a more limited coverage program up to 213 percent of the FPL. Enrollment was closed by 2009, but there are enough existing enrollees to place that state among the 20 lowest. In fact, the 11 states with the lowest percentages all have programs with relatively high thresholds available to adult nonparents.

Regionally, New England and the Middle Atlantic have the lowest percentages of new eligibles among enrollees (11.5 and 12.4 percent) and the South Atlantic and West South Central states have the highest (28.8 and 25.7 percent). The Southern and Western regions are fairly uniformly low in their thresholds for adult parents and few have any general income eligibility programs for adult nonparents. Thus, higher than average shares of their Medicaid/CHIP enrollees are new eligibles. Exceptions such as Arizona and Washington stand out (Figure 5).

Unsurprisingly, regions with the most aggressive Medicaid enrollment outreach have the lowest percentages of newly enrolled current eligibles. New enrollment of current eligibles is lowest in eastern regions, with the lowest proportion in New England at 5.4 percent. At the other end of the spectrum, Mountain and West North Central states would see a large percentage of their Medicaid enrollment made up by residents who are eligible under current law. Individual states, however, do not necessarily conform to a regional pattern. Middle Atlantic states stand out as an example as this region contains the states with both extremes of enrollment (D.C. with 2.5 percent and New Jersey with 13.4 percent, respectively). There is little variation in new enrollment of current eligibles by income and ESI clusters, although there is a noticeable pattern. The percent of newly enrolled current eligibles increases with income levels (8.0 to 9.0 percent) and decreases with higher ESI eligibility (8.4 to 8.0 percent).

There is also a pattern across income clusters in new eligible enrollment. The share of enrollees who are new eligibles is only 15.7 percent for the lowest impact states. It is 17.7 percent for moderate impact states and 20.0 percent for high Medicaid impact states. High subsidy impact states have a noticeably higher share: 25.1 percent. This is due to generally low prereform eligibility for adults in this cluster. Additionally, the share of new eligibles in high subsidy impact states is higher than that in high Medicaid impact states due to the presence of California, Arizona and New York in the latter.

In Table 8, we show the Medicaid/CHIP spending on acute care for the nonelderly by state. Note that while nearly a fifth of enrollees would be newly eligible (Table 6), only 15.4 percent of costs would be incurred by the newly eligible. Nearly all of the newly eligible would be adults (Table 7), and these would be significantly cheaper to cover than current adult enrollees. The reason is that most current adult enrollees gain eligibility through such pathways as disability or medically needy that are closely associated with high health care costs.[16] For most states, the percent of costs incurred by new eligibles is less than the percent of newly eligible enrollees. There are exceptions, though. In states with Medicaid or Section 1115 Waiver programs for childless adults, many of those who would be newly-eligible in other states are already enrolled. The remainder would not necessarily be less expensive to cover on average.[17]

Total New Federal Spending on States

We now estimate the total federal spending on Medicaid and exchange subsidies that would go to each state (Table 9). We first show the total costs of new Medicaid enrollees and then estimate the share paid by the federal government. For newly eligible enrollees, we used a federal match rate of 90 percent. In the law, this is initially 100 percent but phases down over time to 90 percent. Some states have Section 1115 waiver programs for adults with benefits more limited than standard Medicaid. Under the ACA,

those with MAGI under 138 percent of the FPL would be enrolled in standard Medicaid and counted as new eligibles. For new enrollees who were eligible before reform, the current match rates were used. These vary by state. For Section 1115 enrollees in seven states—Arizona, Delaware, Hawaii, Maine, Massachusetts, New York and Vermont—an enhanced match of 90 percent was used.[18] These are likely to be underestimates because we use the Medicaid rates for children as well. Some would be covered under separate CHIP programs at a higher match rate. However, only the expenses of the newly enrolled and newly eligible are included here, and the vast majority of these are adults. Very few children would gain eligibility through the expansion because existing CHIP income thresholds are higher, though the change in the income definition to MAGI would gain eligibility for a few. Total exchange subsidies are repeated from Table 5.

Two estimates in Table 9 are directly comparable across states: the percent of Medicaid costs for new enrollees reimbursed by the federal government and the total federal Medicaid and subsidy dollars per nonelderly person. The percent reimbursed varies from about 70 percent in Minnesota and Washington to nearly 90 percent. It cannot be higher than 90 percent given our methodology. Minnesota and Washington have low federal medical assistance percentage (FMAP) rates (50 and 50.94 percent respectively), a low percentage of Medicaid enrollees who are newly eligible (7.5 and 10.3 percent) and Medicaid programs open to low-income adults, both parents and nonparents. In contrast, four states with very high percentages—Kentucky, Louisiana, Mississippi and West Virginia—have high FMAP rates (70 to 76 percent), high percentages of enrollees who are newly eligible (22 to 29 percent) and no Medicaid programs for adult nonparents. Regionally, the lowest federal match rates would be in New England, the Middle Atlantic and the Pacific (79 to 80 percent) and the highest would be in East South Central and South Atlantic regions (87 to 88 percent).

The regions at the extremes of new federal Medicaid and subsidy dollars per nonelderly person are the same as for federal match rates. Namely, the lowest per capita federal dollars would go to New England, West North Central and Pacific states ($223 to $267), and the highest would go to the East and West South Central regions ($382 and $391). The state with the highest per capita federal dollars would be West Virginia ($498). That state has a high current FMAP rate (74 percent) and a high percentage of new eligibles among Medicaid enrollees (27.4). West Virginia has high shares of people in both the Medicaid and exchange subsidy eligibility ranges (Table 1).

The state with the lowest per capita federal dollars would be Iowa ($171). Nearly 40 percent of the nonelderly in this state would have MAGI above 400 percent of the FPL and would thus be ineligible for Medicaid and subsidies. Iowa also has a low FMAP rate (63 percent) and extended Medicaid eligibility with standard benefits for adult parents up to 116 percent of the FPL.

The states which would receive the highest per capita new federal dollars are concentrated in the East South Central and West South Central regions and the contiguous states of West Virginia and Florida (Figure 6). Additionally, Maine and Wyoming both receive per capita subsidies noticeably different from their respective regional patterns. Many of the New England states would be below $275 as well as a cluster of Mountain and West North Central states from Nevada through Nebraska. Washington, Minnesota, Iowa and Connecticut stand out as isolated low per capita dollar states. We have seen how Washington differs from its neighbors regarding Medicaid (Figure 5).

The lowest and moderate impact states have noticeably lower federal reimbursement percentages and per capita new federal dollars than the high subsidy and high Medicaid impact states (Table 9a). There is little difference in the reimbursement rates for high and low ESI states, but there is a difference in new federal dollars per capita.

Summary

Uninsurance rates would decrease in all 50 states and in Washington, D.C. Under the ACA, every state contributes to a national decline of 28 million nonelderly uninsured persons. Factors such as current insurance markets and demographic makeup play an important role in shaping the effects of the ACA reform, as the considerable state variation from the national average shows. Massachusetts, for example, has already enacted comprehensive health reform and therefore sees only a small decrease in its uninsured population. Low state ESI eligibility amplifies the effects of the ACA, as does a state income distribution that results in a high eligibility rate for Medicaid and exchange subsidies.

Enrollment in the nongroup health exchanges depends on current employer-sponsored insurance eligibility as well as state income distributions. A high enrollment in the nongroup exchange tends to correspond with low Medicaid eligibility and vice versa. This can be seen in West Virginia, which has a larger than average proportion of nonelderly persons eligible for Medicaid and as a result the proportion eligible for exchange subsidies is smaller. Nongroup enrollment is also decreased where there are high levels of ESI eligibility in a state because persons with an affordable ESI offer cannot receive subsidies in the exchanges. A main driver of nongroup enrollment is the percent of the nonelderly who are eligible for exchange subsidies. This pattern is reflected in the Mountain states, many of which are in the high subsidy impact and have high levels of nongroup exchange enrollment.

Nongroup exchange subsidies are sensitive to coverage levels, income distributions and state

specific medical costs. Income distribution within states is also an important determinant of subsidy amounts, as is the availability of ESI. Since a large proportion of exchange subsidies go to those below 200 percent of the FPL, a larger share of exchange coverage of this income group will also lead to increased subsidies. Looking at subsidies per subsidized person, or the average cost of a subsidized person, the interaction between level of exchange enrollment and percent of exchange enrollment below 200 percent of the FPL does not fully explain the regional variation. Factors such as medical costs and premium levels can change subsidies per subsidized person and contribute to the different levels among states.

The Medicaid expansion, which mainly affects adult nonparents, on average attracts cheaper and healthier enrollees. Of the 12.3 million newly eligible enrollees, 10.0 million of them are adult nonparents. These new enrollees have lower associated costs because, on average, they do not have the same health issues that allowed adult nonparents to enroll previously. Adult parents see a relatively small but substantial (2.2 million) increase in Medicaid coverage due to the new ACA income eligibility definitions as well as increased income thresholds. Children are largely unaffected by the Medicaid expansion due to the high income eligibility threshold associated with CHIP. In addition to the new eligibles, all states would experience increased enrollment of the currently eligible. State income clusters and ESI eligibility are important determinants of new enrollment of current eligibles. There is a consistent decline in the percent of newly enrolled current eligibles as income levels decline and as ESI eligibility increases.

State variation in the proportion of newly eligible Medicaid enrollees is affected by current Medicaid programs for adults. The regional similarities in Medicaid/CHIP eligibility rules are generally reflected in the proportion of newly eligible enrollees in those regions. However, states that currently have programs targeting adult nonparents tend to be exceptions. In the Southwest, for example, eligibility thresholds for adults tend to be low, so they would have a large number of new eligibles. Arizona, however, has a relatively high threshold for adult parents and a program for adult nonparents. This leads to a small proportion of newly eligible enrollees in that state.

There would be $82.3 billion total new federal Medicaid and exchange subsidy dollars flowing to the states. State differences in this amount reflect the factors discussed above for both the exchanges and Medicaid, as well as differences in current FMAP rates. Even after adjusting for population, differences across states are considerable. West Virginia would receive $498 in new federal spending for every nonelderly person in the state, while Iowa would receive only $171. States with the highest new spending per capita would be heavily concentrated in the South, while states with the lowest spending would be mainly in the Northeast and Midwest.

Table 1. Distribution of the Nonelderly Population by State and Modified Adjusted Gross Income (Thousands)

	≤138% FPL		138-400% FPL		400%+ FPL		Total
	N	%	N	%	N	%	N
New England:	**2,567**	**21.1%**	**3,770**	**31.0%**	**5,829**	**47.9%**	**12,167**
Connecticut	600	19.8%	857	28.3%	1,574	51.9%	3,031
Maine	278	25.0%	425	38.2%	409	36.8%	1,112
Massachusetts	1,165	21.4%	1,612	29.7%	2,656	48.9%	5,434
New Hampshire	181	15.9%	367	32.1%	596	52.1%	1,145
Rhode Island	239	26.2%	291	31.9%	383	41.9%	914
Vermont	103	19.4%	217	40.9%	211	39.7%	531
Middle Atlantic:	**10,501**	**25.3%**	**14,040**	**33.9%**	**16,897**	**40.8%**	**41,438**
Delaware	189	25.1%	265	35.0%	301	39.9%	755
District of Columbia	160	29.5%	151	27.7%	233	42.8%	544
Maryland	1,043	20.6%	1,585	31.3%	2,437	48.1%	5,066
New Jersey	1,635	21.3%	2,418	31.5%	3,617	47.2%	7,670
New York	5,039	29.6%	5,753	33.7%	6,255	36.7%	17,047
Pennsylvania	2,434	23.5%	3,869	37.4%	4,053	39.1%	10,355
East North Central:	**10,904**	**27.1%**	**15,125**	**37.5%**	**14,279**	**35.4%**	**40,309**
Illinois	3,032	26.5%	4,133	36.1%	4,270	37.3%	11,434
Indiana	1,601	29.3%	2,090	38.3%	1,769	32.4%	5,460
Michigan	2,505	29.0%	3,093	35.8%	3,046	35.2%	8,645
Ohio	2,721	27.4%	3,824	38.5%	3,398	34.2%	9,944
Wisconsin	1,044	21.6%	1,984	41.1%	1,797	37.2%	4,825
West North Central:	**4,281**	**24.6%**	**6,590**	**37.8%**	**6,546**	**37.6%**	**17,416**
Iowa	594	22.8%	1,034	39.6%	984	37.7%	2,613
Kansas	633	26.7%	934	39.5%	800	33.8%	2,367
Minnesota	971	21.6%	1,608	35.8%	1,914	42.6%	4,492
Missouri	1,453	28.3%	1,870	36.4%	1,816	35.3%	5,139
Nebraska	354	22.6%	623	39.8%	587	37.5%	1,564
North Dakota	112	20.5%	216	39.5%	219	40.0%	548
South Dakota	164	23.7%	303	43.8%	225	32.5%	693
South Atlantic:	**12,907**	**28.9%**	**16,305**	**36.5%**	**15,401**	**34.5%**	**44,614**
Florida	4,518	29.5%	5,691	37.2%	5,096	33.3%	15,305
Georgia	2,682	30.4%	3,213	36.4%	2,933	33.2%	8,828
North Carolina	2,542	30.8%	2,964	35.9%	2,746	33.3%	8,252
South Carolina	1,152	30.0%	1,527	39.8%	1,157	30.2%	3,836
Virginia	1,505	21.8%	2,347	34.0%	3,057	44.2%	6,909
West Virginia	508	34.3%	562	37.9%	413	27.8%	1,484
East South Central:	**5,354**	**34.2%**	**5,883**	**37.5%**	**4,431**	**28.3%**	**15,668**
Alabama	1,309	32.4%	1,524	37.8%	1,202	29.8%	4,035
Kentucky	1,230	33.4%	1,364	37.0%	1,089	29.6%	3,683
Mississippi	1,022	40.2%	943	37.0%	580	22.8%	2,544
Tennessee	1,794	33.2%	2,052	38.0%	1,559	28.8%	5,406
West South Central:	**10,581**	**32.8%**	**11,988**	**37.2%**	**9,658**	**30.0%**	**32,227**
Arkansas	850	34.6%	1,031	41.9%	577	23.5%	2,457
Louisiana	1,302	33.7%	1,302	33.7%	1,257	32.6%	3,861
Oklahoma	852	27.3%	1,231	39.4%	1,042	33.4%	3,125
Texas	7,577	33.3%	8,425	37.0%	6,782	29.8%	22,783
Mountain:	**5,536**	**27.9%**	**7,523**	**38.0%**	**6,750**	**34.1%**	**19,810**
Arizona	2,024	34.0%	2,046	34.4%	1,882	31.6%	5,952
Colorado	994	22.1%	1,595	35.4%	1,921	42.6%	4,510
Idaho	342	25.5%	628	46.8%	370	27.6%	1,340
Montana	220	26.0%	332	39.2%	295	34.8%	847
Nevada	604	25.7%	997	42.4%	752	31.9%	2,353
New Mexico	692	37.6%	623	33.9%	524	28.5%	1,839
Utah	567	22.7%	1,113	44.6%	817	32.7%	2,496
Wyoming	93	19.6%	190	40.2%	191	40.3%	473
Pacific:	**13,348**	**29.6%**	**15,802**	**35.0%**	**15,963**	**35.4%**	**45,114**
Alaska	158	25.6%	256	41.4%	204	33.0%	618
California	10,624	31.1%	11,739	34.4%	11,790	34.5%	34,154
Hawaii	341	31.0%	434	39.4%	327	29.6%	1,103
Oregon	926	27.6%	1,262	37.6%	1,166	34.8%	3,354
Washington	1,299	22.1%	2,111	35.9%	2,477	42.1%	5,886
Total	**75,979**	**28.3%**	**97,028**	**36.1%**	**95,755**	**35.6%**	**268,762**

Source: Urban Institute analysis, HIPSM 2011.

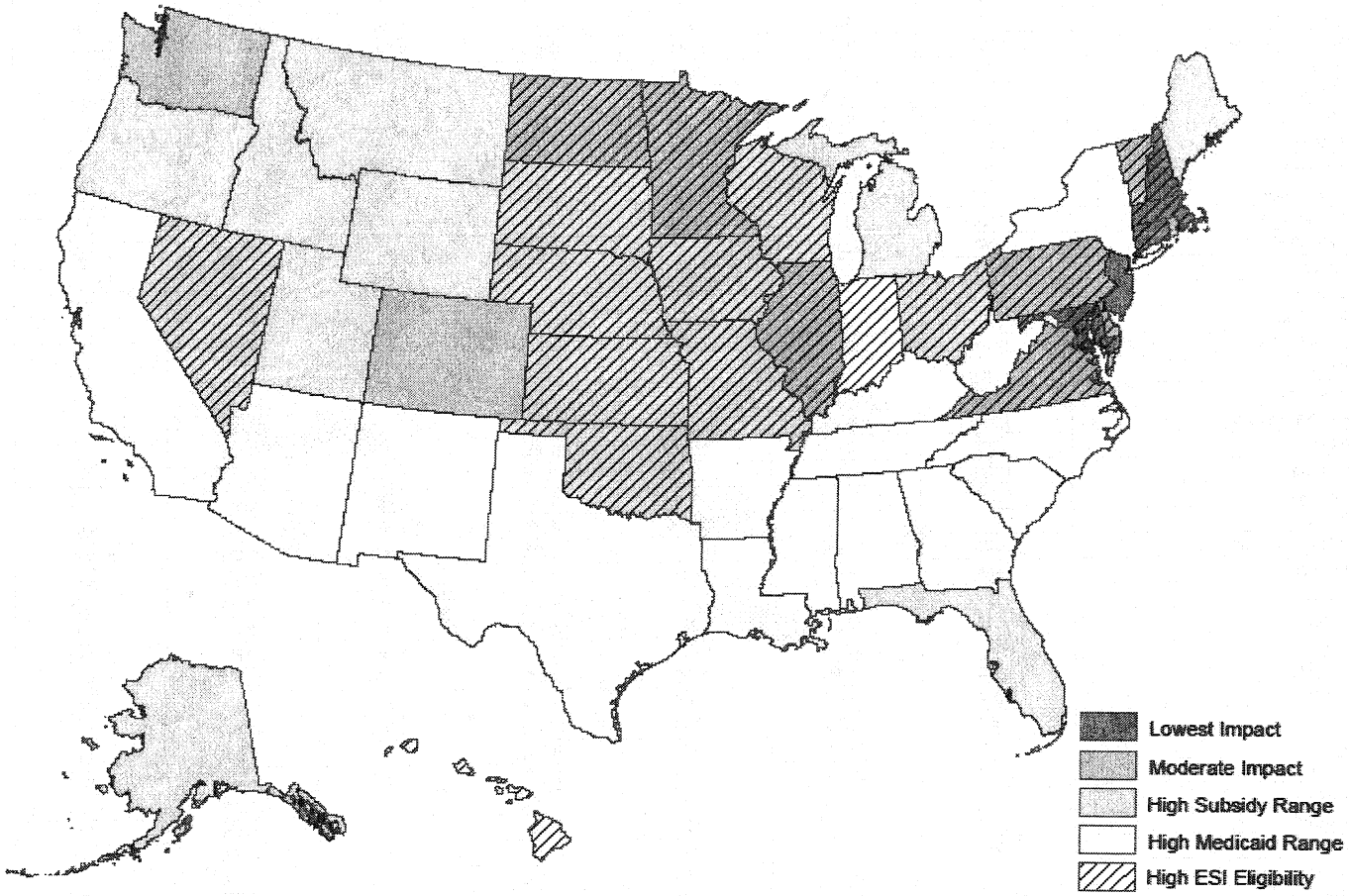
30x

Table 1a. Distribution of the Nonelderly Population by Modified Adjusted Gross Income (Thousands)

	<138% FPL		138-400% FPL		400%+ FPL		Total
	N	%	N	%	N	%	N
Income Cluster							
Lowest Impact	4,625	20.7%	6,840	30.6%	10,881	48.7%	22,346
Moderate Impact	11,039	23.5%	16,802	35.8%	19,037	40.6%	46,878
High Subsidy Impact	18,027	27.0%	25,792	38.6%	22,995	34.4%	66,814
High Medicaid Impact	42,289	31.9%	47,594	35.9%	42,842	32.3%	132,725
Eligibility Cluster							
High ESI	21,858	24.4%	32,555	36.4%	35,018	39.2%	89,431
Low ESI	54,121	30.2%	64,473	36.0%	60,737	33.9%	179,331

Source: Urban Institute analysis, HIPSM 2011.

Figure 1: Map of Income Clusters with ESI Eligibility



31x

Table 2. Change in Nonelderly Uninsured Under the ACA

Population (thousands)	Total nonelderly	Before Reform: Total nonelderly uninsured		After Reform: Total nonelderly uninsured		Change: Total nonelderly uninsured	
		N	%	N	%	N	Pct Pts
New England:	**12,167**	**1,083**	**8.9%**	**556**	**4.6%**	**-527**	**-4.3%**
Connecticut	3,031	397	13.1%	197	6.5%	-200	-6.6%
Maine	1,112	147	13.2%	66	5.9%	-81	-7.3%
Massachusetts	5,434	216	4.0%	158	2.9%	-58	-1.1%
New Hampshire	1,145	136	11.9%	50	4.3%	-87	-7.6%
Rhode Island	914	124	13.6%	53	5.8%	-71	-7.8%
Vermont	531	62	11.7%	32	6.1%	-30	-5.6%
Middle Atlantic:	**41,438**	**6,416**	**15.5%**	**3,270**	**7.9%**	**-3,146**	**-7.6%**
Delaware	755	116	15.4%	64	8.5%	-53	-7.0%
District of Columbia	544	67	12.2%	35	6.5%	-31	-5.8%
Maryland	5,066	743	14.7%	363	7.2%	-380	-7.5%
New Jersey	7,670	1,342	17.5%	683	8.9%	-659	-8.6%
New York	17,047	2,814	16.5%	1,599	9.4%	-1,215	-7.1%
Pennsylvania	10,355	1,334	12.9%	526	5.1%	-808	-7.8%
East North Central:	**40,309**	**6,210**	**15.4%**	**2,515**	**6.2%**	**-3,695**	**-9.2%**
Illinois	11,434	1,814	15.9%	768	6.7%	-1,046	-9.1%
Indiana	5,460	870	15.9%	326	6.0%	-544	-10.0%
Michigan	8,645	1,363	15.8%	613	7.1%	-750	-8.7%
Ohio	9,944	1,591	16.0%	562	5.7%	-1,028	-10.3%
Wisconsin	4,825	572	11.9%	246	5.1%	-327	-6.8%
West North Central:	**17,416**	**2,340**	**13.4%**	**1,037**	**6.0%**	**-1,303**	**-7.5%**
Iowa	2,613	296	11.3%	171	6.6%	-125	-4.8%
Kansas	2,367	365	15.4%	167	7.1%	-198	-8.4%
Minnesota	4,492	461	10.3%	234	5.2%	-227	-5.0%
Missouri	5,139	803	15.6%	284	5.5%	-520	-10.1%
Nebraska	1,564	229	14.7%	106	6.8%	-123	-7.9%
North Dakota	548	75	13.6%	33	6.1%	-41	-7.5%
South Dakota	693	110	15.9%	41	5.9%	-69	-10.0%
South Atlantic:	**44,614**	**9,650**	**21.6%**	**4,173**	**9.4%**	**-5,477**	**-12.3%**
Florida	15,305	3,979	26.0%	1,741	11.4%	-2,238	-14.6%
Georgia	8,828	2,006	22.7%	892	10.1%	-1,114	-12.6%
North Carolina	8,252	1,596	19.3%	734	8.9%	-861	-10.4%
South Carolina	3,836	768	20.0%	289	7.5%	-479	-12.5%
Virginia	6,909	1,033	14.9%	439	6.3%	-594	-8.6%
West Virginia	1,484	268	18.0%	77	5.2%	-190	-12.8%
East South Central:	**15,668**	**2,983**	**19.0%**	**1,168**	**7.5%**	**-1,815**	**-11.6%**
Alabama	4,035	707	17.5%	266	6.6%	-440	-10.9%
Kentucky	3,683	735	20.0%	251	6.8%	-484	-13.1%
Mississippi	2,544	539	21.2%	214	8.4%	-325	-12.8%
Tennessee	5,406	1,003	18.5%	437	8.1%	-566	-10.5%
West South Central:	**32,227**	**8,747**	**27.1%**	**3,664**	**11.4%**	**-5,083**	**-15.8%**
Arkansas	2,457	558	22.7%	201	8.2%	-357	-14.5%
Louisiana	3,861	822	21.3%	292	7.6%	-530	-13.7%
Oklahoma	3,125	608	19.5%	260	8.3%	-348	-11.1%
Texas	22,783	6,758	29.7%	2,911	12.8%	-3,847	-16.9%
Mountain:	**19,810**	**4,172**	**21.1%**	**2,088**	**10.5%**	**-2,084**	**-10.5%**
Arizona	5,952	1,328	22.3%	802	13.5%	-526	-8.8%
Colorado	4,510	829	18.4%	372	8.2%	-457	-10.1%
Idaho	1,340	244	18.2%	110	8.2%	-134	-10.0%
Montana	847	182	21.5%	74	8.8%	-108	-12.7%
Nevada	2,353	557	23.7%	274	11.7%	-283	-12.0%
New Mexico	1,839	515	28.0%	220	12.0%	-295	-16.0%
Utah	2,496	433	17.3%	201	8.0%	-232	-9.3%
Wyoming	473	84	17.7%	35	7.3%	-49	-10.4%
Pacific:	**45,114**	**9,299**	**20.6%**	**4,818**	**10.7%**	**-4,482**	**-9.9%**
Alaska	618	130	21.1%	53	8.5%	-78	-12.5%
California	34,154	7,561	22.1%	3,930	11.5%	-3,631	-10.6%
Hawaii	1,103	104	9.5%	53	4.8%	-51	-4.7%
Oregon	3,354	683	20.4%	303	9.0%	-380	-11.3%
Washington	5,886	821	13.9%	480	8.2%	-341	-5.8%
Total	**268,762**	**50,900**	**18.9%**	**23,289**	**8.7%**	**-27,611**	**-10.3%**

Source: Urban Institute analysis, HIPSM 2011.
Note: We simulate the provisions of the Affordable Care Act fully implemented in 2011.

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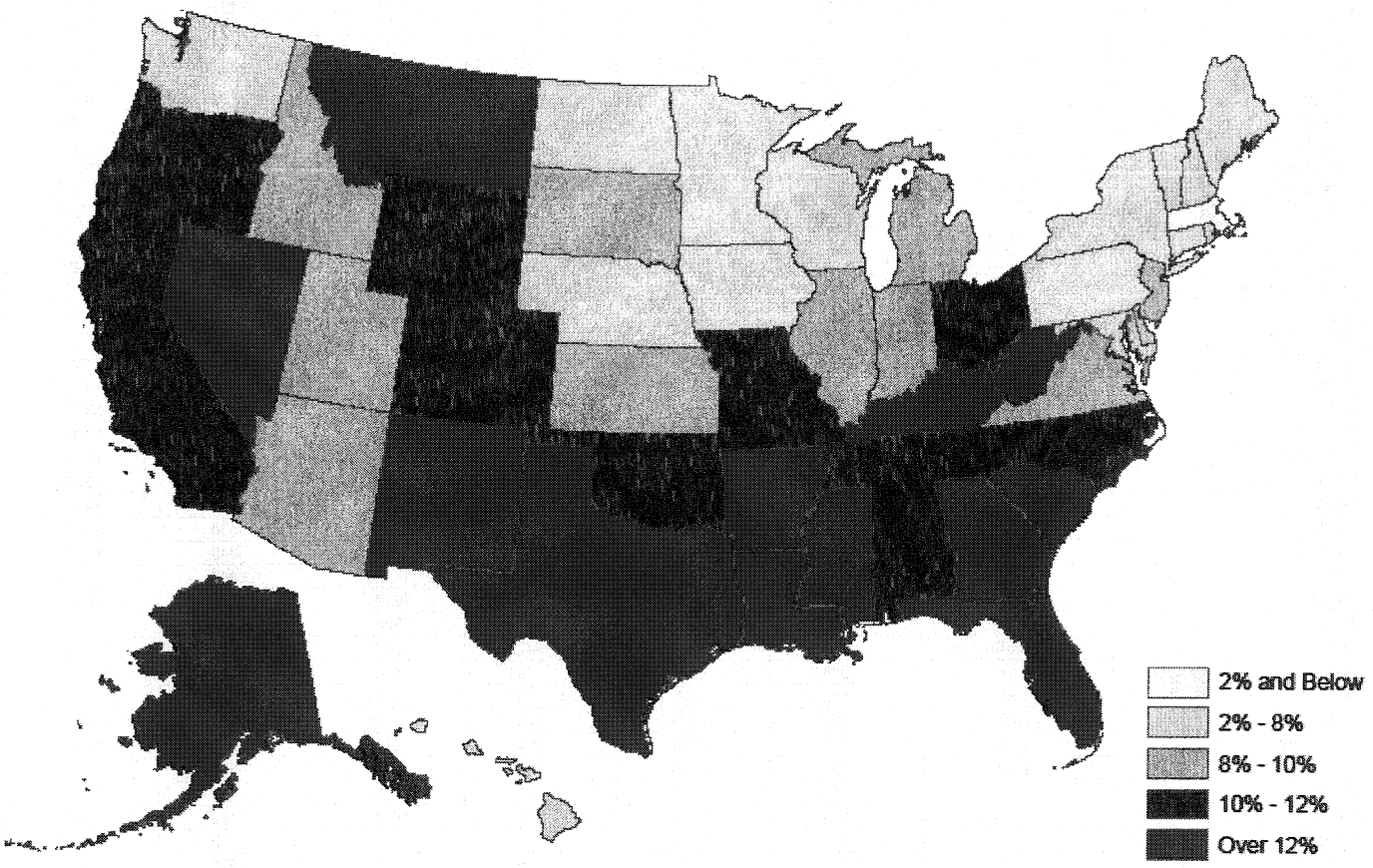
Table 2a. Change in Nonelderly Uninsured Under the ACA

Population (thousands)	Total nonelderly	Before Reform		After Reform		Change	
		Total nonelderly uninsured		Total nonelderly uninsured		Total nonelderly uninsured	
		N	%	N	%	N	Pct Pts
Income Cluster							
Lowest Impact	22,345,634	2,835	12.7%	1,451	6.5%	-1,384	-6.2%
Moderate Impact	46,878,448	6,735	14.4%	3,036	6.5%	-3,699	-7.9%
High Subsidy Impact	66,813,663	12,378	18.5%	5,308	7.9%	-7,070	-10.6%
High Medicaid Impact	132,724,638	28,951	21.8%	13,494	10.2%	-15,458	-11.6%
Eligibility Cluster							
High ESI	89,430,928	12,561	14.0%	5,390	6.0%	-7,171	-8.0%
Low ESI	179,331,455	38,338	21.4%	17,899	10.0%	-20,439	-11.4%

Source: Urban Institute analysis, HIPSM 2011.
Note: We simulate the provisions of the Affordable Care Act fully implemented in 2011.

Figure 2: Percentage Point Decline in the Uninsurance Rate Due to Reform



33x

Table 3. Coverage in the Nongroup Exchanges

	Total nonelderly (thousands)	Total covered in nongroup exchanges		Income distribution (% of total covered)			
		N (thousands)	% of nonelderly	<200% FPL	200-300% FPL	300-400% FPL	400%+ FPL
New England:	**12,167**	**865**	**7.1%**	**28.6%**	**17.8%**	**11.8%**	**41.8%**
Connecticut	3,031	246	8.1%	30.3%	18.9%	6.5%	44.3%
Maine	1,112	98	8.8%	30.8%	19.8%	13.1%	36.3%
Massachusetts	5,434	296	5.4%	27.4%	17.3%	13.8%	41.4%
New Hampshire	1,145	95	8.3%	22.7%	15.5%	17.8%	44.0%
Rhode Island	914	83	9.0%	28.5%	17.6%	11.2%	42.6%
Vermont	531	48	9.0%	34.4%	15.2%	13.2%	37.2%
Middle Atlantic:	**41,438**	**3,558**	**8.6%**	**33.5%**	**20.6%**	**12.1%**	**33.8%**
Delaware	755	61	8.1%	26.9%	21.4%	12.4%	39.3%
District of Columbia	544	49	9.1%	38.8%	13.1%	15.1%	33.1%
Maryland	5,066	405	8.0%	29.1%	15.4%	15.8%	39.6%
New Jersey	7,670	597	7.8%	28.2%	18.3%	10.1%	43.4%
New York	17,047	1,415	8.3%	36.4%	23.5%	10.5%	29.6%
Pennsylvania	10,355	1,030	9.9%	34.4%	20.2%	13.8%	31.6%
East North Central:	**40,309**	**3,519**	**8.7%**	**32.3%**	**23.5%**	**13.9%**	**30.2%**
Illinois	11,434	957	8.4%	33.0%	20.5%	13.2%	33.4%
Indiana	5,460	406	7.4%	30.2%	23.6%	13.7%	32.5%
Michigan	8,645	792	9.2%	27.8%	26.2%	15.0%	31.0%
Ohio	9,944	941	9.5%	36.3%	24.6%	12.2%	26.9%
Wisconsin	4,825	423	8.8%	32.5%	22.7%	18.0%	26.8%
West North Central:	**17,416**	**1,786**	**10.3%**	**32.0%**	**21.9%**	**13.3%**	**32.8%**
Iowa	2,613	252	9.7%	34.1%	22.6%	10.4%	32.9%
Kansas	2,367	248	10.5%	28.7%	22.9%	16.3%	32.1%
Minnesota	4,492	426	9.5%	32.4%	20.0%	9.4%	38.2%
Missouri	5,139	528	10.3%	33.5%	24.2%	14.1%	28.2%
Nebraska	1,564	174	11.1%	29.5%	18.3%	17.4%	34.8%
North Dakota	548	76	13.9%	27.2%	16.9%	18.2%	37.7%
South Dakota	693	82	11.9%	33.2%	22.9%	15.5%	28.4%
South Atlantic:	**44,614**	**3,734**	**8.4%**	**34.9%**	**24.3%**	**11.0%**	**29.9%**
Florida	15,305	1,516	9.9%	33.0%	26.6%	12.4%	28.1%
Georgia	8,828	630	7.1%	38.7%	23.4%	7.2%	30.6%
North Carolina	8,252	640	7.8%	34.3%	20.5%	10.3%	34.8%
South Carolina	3,836	309	8.0%	33.0%	26.2%	18.4%	22.3%
Virginia	6,909	546	7.9%	37.7%	23.5%	7.2%	31.6%
West Virginia	1,484	93	6.3%	32.4%	15.8%	15.9%	35.9%
East South Central:	**15,668**	**1,211**	**7.7%**	**39.6%**	**24.0%**	**13.2%**	**23.1%**
Alabama	4,035	275	6.8%	38.9%	22.2%	12.8%	26.0%
Kentucky	3,683	306	8.3%	31.5%	28.1%	10.9%	29.5%
Mississippi	2,544	203	8.0%	41.8%	26.0%	14.0%	18.2%
Tennessee	5,406	427	7.9%	44.9%	21.4%	14.8%	18.9%
West South Central:	**32,227**	**2,772**	**8.6%**	**36.0%**	**23.8%**	**10.7%**	**29.5%**
Arkansas	2,457	216	8.8%	37.8%	28.8%	11.0%	22.4%
Louisiana	3,861	317	8.2%	36.2%	15.3%	14.5%	34.0%
Oklahoma	3,125	259	8.3%	32.8%	22.5%	16.7%	28.0%
Texas	22,783	1,981	8.7%	36.2%	24.8%	9.3%	29.7%
Mountain:	**19,810**	**1,949**	**9.8%**	**31.6%**	**22.9%**	**15.5%**	**30.1%**
Arizona	5,952	503	8.5%	34.6%	19.0%	18.7%	27.8%
Colorado	4,510	482	10.7%	28.1%	20.6%	17.7%	33.5%
Idaho	1,340	170	12.7%	29.0%	23.1%	14.6%	33.3%
Montana	847	111	13.1%	29.8%	26.5%	13.6%	30.0%
Nevada	2,353	198	8.4%	35.7%	25.3%	11.3%	27.7%
New Mexico	1,839	177	9.6%	33.1%	28.7%	10.1%	28.0%
Utah	2,496	250	10.0%	29.0%	27.6%	13.9%	29.5%
Wyoming	473	58	12.2%	37.7%	22.2%	11.9%	28.2%
Pacific:	**45,114**	**4,440**	**9.8%**	**35.6%**	**19.9%**	**12.0%**	**32.5%**
Alaska	618	61	9.9%	29.2%	25.6%	14.1%	31.1%
California	34,154	3,435	10.1%	36.6%	19.3%	11.4%	32.7%
Hawaii	1,103	64	5.8%	28.7%	21.1%	12.8%	37.4%
Oregon	3,354	342	10.2%	35.9%	23.0%	12.4%	28.8%
Washington	5,886	538	9.1%	31.1%	20.4%	15.3%	33.2%
Total	**268,762**	**23,835**	**8.9%**	**34.1%**	**22.2%**	**12.4%**	**31.3%**

Source: Urban Institute analysis, HIPSM 2011.
Note: We simulate the provisions of the Affordable Care Act fully implemented in 2011.

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Table 3a. Coverage in the Nongroup Exchanges

	Total nonelderly (thousands)	Total covered in nongroup exchanges		Income distribution (% of total covered)			
		N (thousands)	% of nonelderly	<200% FPL	200-300% FPL	300-400% FPL	400%+ FPL
Income Cluster							
Lowest Impact	22,346	1,639	7.3%	28.3%	17.4%	12.1%	42.3%
Moderate Impact	46,878	4,296	9.2%	32.9%	20.5%	13.0%	33.6%
High Subsidy Impact	66,814	6,504	9.7%	32.5%	24.6%	13.7%	29.1%
High Medicaid Impact	132,725	11,396	8.6%	36.3%	22.1%	11.5%	30.1%
Eligibility Cluster							
High ESI	89,431	7,811	8.7%	32.9%	21.4%	13.1%	32.6%
Low ESI	179,331	16,024	8.9%	34.7%	22.6%	12.1%	30.7%

Source: Urban Institute analysis, HIPSM 2011.
Note: We simulate the provisions of the Affordable Care Act fully implemented in 2011.

Figure 3: Percent of Nonelderly Covered in Nongroup Exchanges

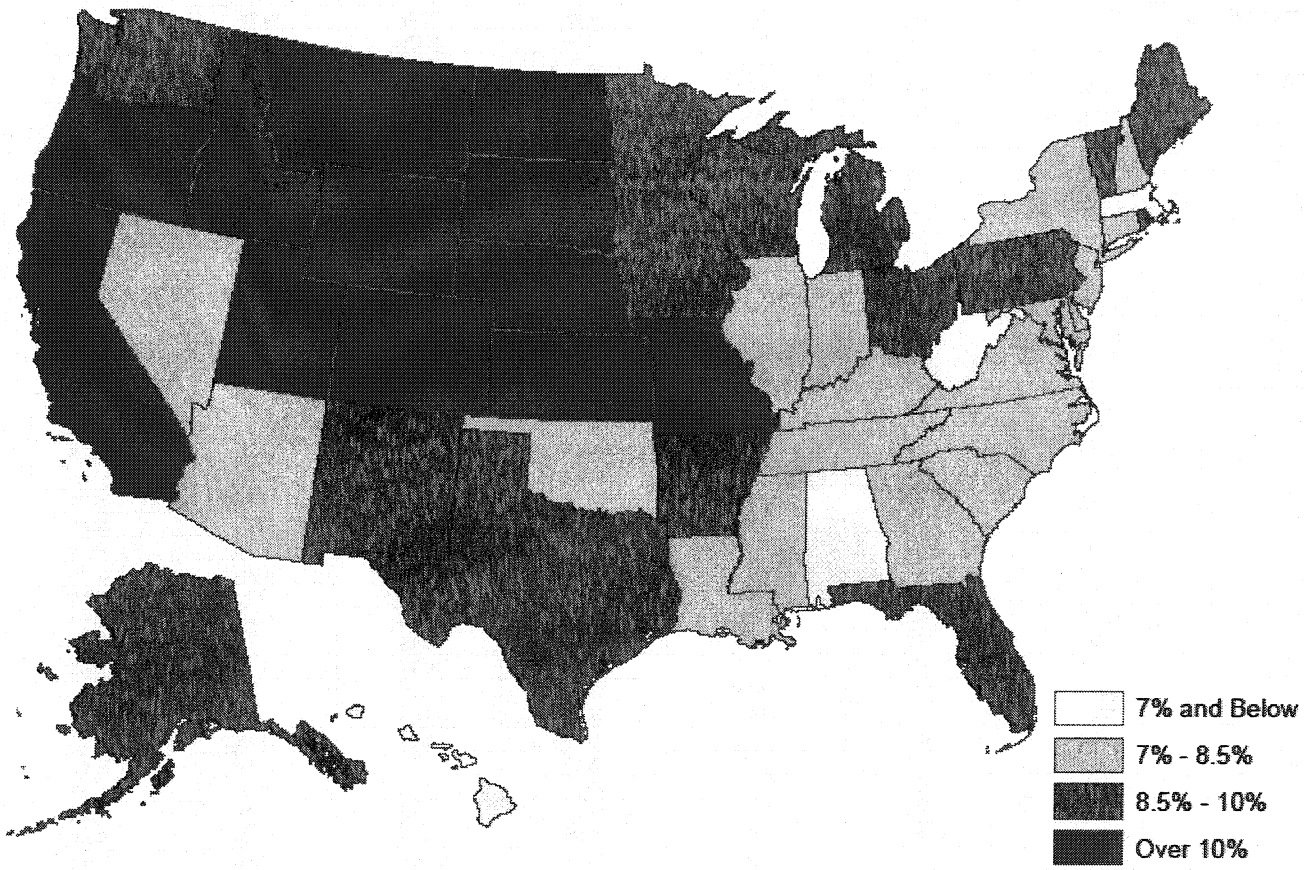

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Table 4. Premium and Cost-Sharing Subsidies in the Nongroup Exchanges

	Premium subsidies ($ thousands)				Cost-sharing subsidies ($ thousands)		
	<200% FPL	200-300% FPL	300-400% FPL	Total	<200% FPL	200-250% FPL	Total
New England:	**479,594**	**290,914**	**99,352**	**869,860**	**155,369**	**13,081**	**168,451**
Connecticut	131,899	102,509	13,818	248,226	43,512	3,730	47,242
Maine	69,527	44,668	13,037	127,232	19,160	2,431	21,590
Massachusetts	132,078	87,061	43,847	262,986	50,844	3,588	54,432
New Hampshire	51,932	22,085	17,842	91,859	7,058	880	7,938
Rhode Island	58,177	27,234	5,168	90,578	20,993	1,958	22,951
Vermont	35,981	7,356	5,641	48,978	13,803	494	14,297
Middle Atlantic:	**2,574,336**	**1,142,048**	**300,035**	**4,016,419**	**558,007**	**64,017**	**622,024**
Delaware	35,399	15,414	4,460	55,274	9,407	902	10,309
District of Columbia	33,550	5,121	4,637	43,308	10,382	172	10,554
Maryland	263,087	43,798	28,382	335,268	62,695	3,229	65,925
New Jersey	368,849	181,889	58,100	608,838	82,273	9,050	91,323
New York	1,098,532	532,917	139,607	1,771,056	230,969	25,102	256,071
Pennsylvania	774,918	362,907	64,849	1,202,674	162,280	25,562	187,842
East North Central:	**2,558,342**	**1,309,634**	**482,668**	**4,350,644**	**576,593**	**55,347**	**631,939**
Illinois	686,728	324,259	106,472	1,117,459	152,272	15,080	167,352
Indiana	317,444	135,629	47,913	500,986	85,283	2,986	88,268
Michigan	474,343	317,278	153,985	945,606	95,416	13,264	108,680
Ohio	768,981	317,396	65,764	1,152,142	170,186	11,970	182,156
Wisconsin	310,845	215,072	108,534	634,452	73,436	12,048	85,483
West North Central:	**1,049,873**	**605,813**	**208,918**	**1,864,604**	**270,780**	**26,900**	**297,680**
Iowa	123,675	78,780	29,162	231,617	41,862	2,260	44,122
Kansas	118,476	90,060	50,339	258,875	22,255	4,478	26,733
Minnesota	282,164	126,601	28,939	437,704	101,352	6,921	108,273
Missouri	327,318	231,493	34,934	593,745	53,951	9,568	63,519
Nebraska	116,971	35,180	32,996	185,147	27,727	887	28,614
North Dakota	33,652	16,459	18,277	68,388	10,337	772	11,109
South Dakota	47,618	27,239	14,271	89,128	13,295	2,014	15,309
South Atlantic:	**3,070,028**	**1,429,043**	**264,898**	**4,763,969**	**701,637**	**57,687**	**759,324**
Florida	1,291,249	651,732	108,537	2,051,518	250,009	18,143	268,152
Georgia	566,332	181,651	33,079	781,062	100,446	10,640	111,086
North Carolina	574,875	224,528	47,013	846,416	179,909	14,865	194,774
South Carolina	172,296	130,903	45,676	348,875	43,052	4,809	47,861
Virginia	397,652	213,721	6,459	617,831	110,878	8,366	119,245
West Virginia	67,625	26,508	24,134	118,266	17,343	863	18,206
East South Central:	**979,736**	**457,487**	**119,256**	**1,556,478**	**233,561**	**18,462**	**252,023**
Alabama	214,716	60,700	19,346	294,761	48,836	5,308	54,143
Kentucky	258,232	106,280	5,313	369,825	34,781	5,490	40,271
Mississippi	160,155	99,532	25,319	285,006	45,488	1,860	47,348
Tennessee	346,633	190,974	69,278	606,886	104,457	5,804	110,261
West South Central:	**2,748,922**	**1,084,335**	**210,839**	**4,044,096**	**453,383**	**66,173**	**519,556**
Arkansas	198,464	100,305	14,284	313,053	43,113	3,161	46,273
Louisiana	206,636	95,458	39,089	341,183	35,903	9,429	45,331
Oklahoma	198,850	96,566	52,918	348,335	45,308	3,245	48,553
Texas	2,144,971	792,006	104,548	3,041,525	329,060	50,338	379,398
Mountain:	**1,283,316**	**731,968**	**265,664**	**2,280,948**	**238,421**	**25,224**	**263,646**
Arizona	331,709	160,322	78,093	570,125	69,294	2,122	71,416
Colorado	261,335	153,183	64,171	478,689	42,899	5,770	48,669
Idaho	82,579	84,973	23,076	190,628	18,480	2,392	20,872
Montana	72,538	36,436	22,318	131,293	10,798	986	11,784
Nevada	162,325	82,082	10,158	254,565	27,464	5,909	33,373
New Mexico	187,012	113,473	19,598	320,082	27,968	2,514	30,482
Utah	135,517	77,894	37,575	250,986	32,704	5,019	37,723
Wyoming	50,300	23,605	10,676	84,581	8,814	513	9,327
Pacific:	**3,459,250**	**1,399,607**	**448,617**	**5,307,474**	**697,991**	**62,132**	**760,123**
Alaska	38,337	14,713	975	54,025	14,609	1,822	16,431
California	2,793,487	1,105,411	307,422	4,206,321	539,011	41,327	580,339
Hawaii	30,486	17,622	1,069	49,176	11,302	668	11,971
Oregon	272,363	85,421	42,914	400,698	64,529	4,367	68,896
Washington	324,577	176,440	96,237	597,254	68,538	13,947	82,485
Total	**18,203,397**	**8,450,848**	**2,400,247**	**29,054,492**	**3,885,742**	**389,023**	**4,274,765**

Source: Urban Institute analysis, HIPSM 2011.
Note: We simulate the provisions of the Affordable Care Act fully implemented in 2011.

36x

Figure 4: Average Subsidy Amount per Nonelderly Person

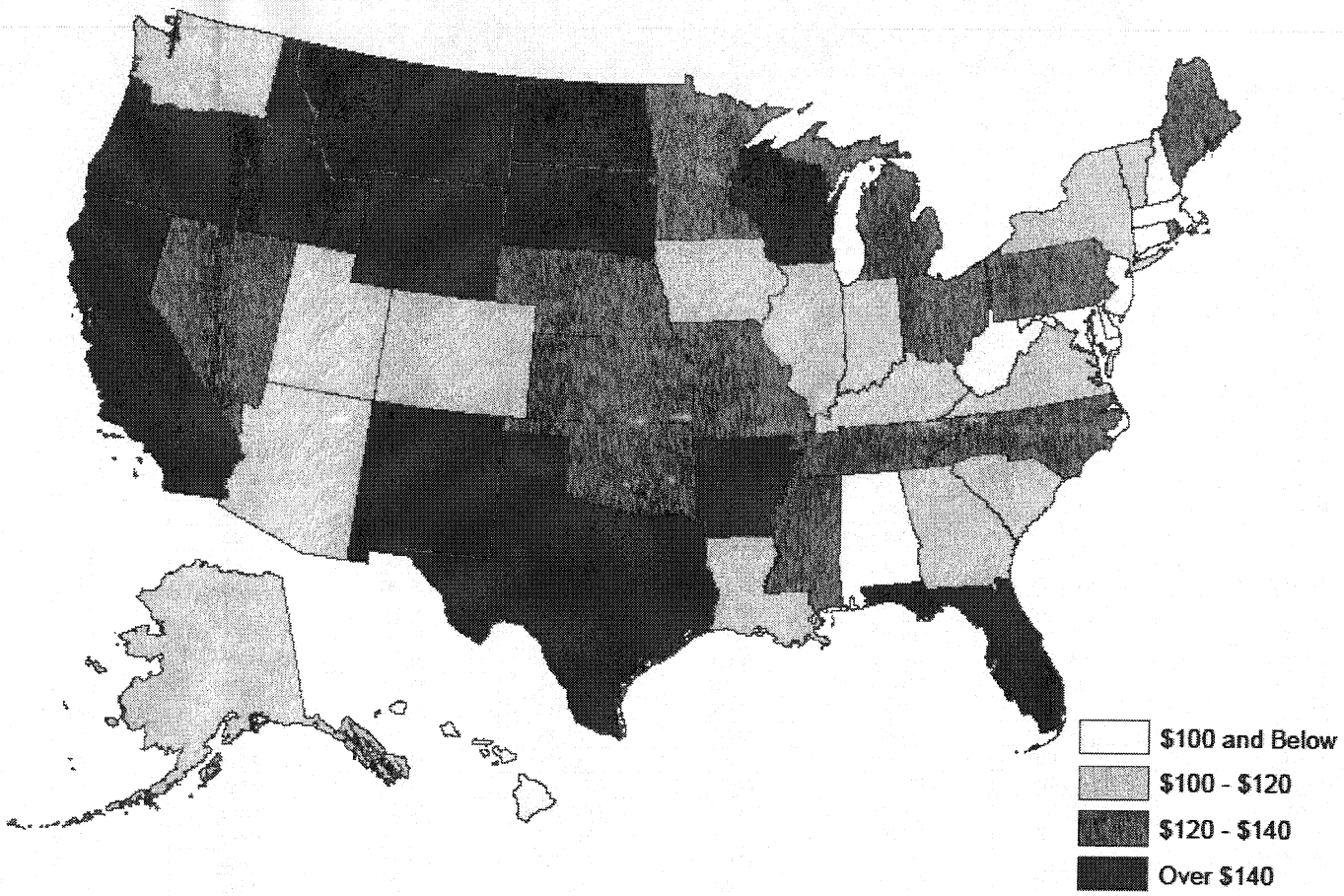

Table 5a. Nongroup Exchange Subsidies per Person

	Premium and Cost-Sharing Subsidies		
	Total	Per nonelderly person	Per person with subsidized coverage
Income Cluster			
Lowest Impact	$1,814,037,099	$81.18	$2,708.52
Moderate Impact	$5,541,225,707	$118.20	$2,920.10
High Subsidy Impact	$9,075,890,164	$135.84	$2,826.59
High Medicaid Impact	$16,898,104,094	$127.32	$3,001.21
Eligibility Cluster			
High ESI	10,260,743,412	$114.73	$2,901.62
Low ESI	23,068,513,652	$128.64	$2,930.27

Source: Urban Institute analysis, HIPSM 2011.
Note: We simulate the provisions of the Affordable Care Act fully implemented in 2011.

Table 5. Nongroup Exchange Subsidies per Person

	Premium and Cost Sharing Subsidies		
	Total	Per nonelderly person	Per person with subsidized coverage
New England:	**$1,038,311,112**	**$85.34**	**$2,865.96**
Connecticut	$295,468,348	$97.48	$3,054.03
Maine	$148,822,683	$133.77	$3,138.99
Massachusetts	$317,418,410	$58.42	$2,519.73
New Hampshire	$99,796,853	$87.19	$2,726.76
Rhode Island	$113,529,721	$124.25	$3,274.77
Vermont	$63,275,097	$119.17	$3,028.53
Middle Atlantic:	**$4,638,442,944**	**$111.94**	**$2,967.89**
Delaware	$65,583,629	$86.86	$2,788.06
District of Columbia	$53,861,859	$98.95	$2,910.51
Maryland	$401,192,556	$79.19	$2,595.72
New Jersey	$700,160,933	$91.29	$2,736.36
New York	$2,027,127,375	$118.91	$3,010.49
Pennsylvania	$1,390,516,592	$134.28	$3,181.51
East North Central:	**$4,982,583,112**	**$123.61**	**$2,895.23**
Illinois	$1,284,811,005	$112.36	$2,983.21
Indiana	$589,254,089	$107.91	$3,053.48
Michigan	$1,054,285,492	$121.96	$2,725.72
Ohio	$1,334,297,349	$134.18	$2,690.73
Wisconsin	$719,935,177	$149.21	$3,354.34
West North Central:	**$2,162,283,805**	**$124.15**	**$2,770.95**
Iowa	$275,739,122	$105.54	$2,663.09
Kansas	$285,608,531	$120.65	$2,492.53
Minnesota	$545,977,110	$121.53	$2,931.75
Missouri	$657,264,378	$127.90	$2,773.90
Nebraska	$213,761,491	$136.65	$3,162.11
North Dakota	$79,496,960	$145.14	$2,432.14
South Dakota	$104,436,213	$150.74	$2,695.06
South Atlantic:	**$5,523,292,592**	**$123.80**	**$2,963.03**
Florida	$2,319,669,751	$151.56	$2,938.73
Georgia	$892,147,868	$101.06	$2,866.41
North Carolina	$1,041,190,025	$126.18	$3,327.29
South Carolina	$396,736,204	$103.41	$2,380.83
Virginia	$737,076,361	$106.69	$3,005.38
West Virginia	$136,472,383	$91.96	$3,529.43
East South Central:	**$1,808,501,498**	**$115.42**	**$2,849.25**
Alabama	$348,904,258	$86.46	$2,517.09
Kentucky	$410,096,154	$111.35	$2,653.71
Mississippi	$332,353,989	$130.63	$2,763.44
Tennessee	$717,147,097	$132.67	$3,240.45
West South Central:	**$4,563,651,711**	**$141.61**	**$3,090.61**
Arkansas	$359,326,418	$146.23	$2,743.70
Louisiana	$386,514,451	$100.10	$2,649.92
Oklahoma	$396,888,269	$127.00	$2,819.43
Texas	$3,420,922,573	$150.15	$3,230.26
Mountain:	**$2,544,593,295**	**$128.45**	**$2,698.93**
Arizona	$641,540,455	$107.78	$2,715.79
Colorado	$527,357,962	$116.94	$2,420.51
Idaho	$211,500,176	$157.86	$2,374.67
Montana	$143,076,950	$168.98	$2,797.04
Nevada	$287,937,200	$122.36	$2,931.76
New Mexico	$350,564,490	$190.67	$3,411.22
Utah	$288,708,703	$115.66	$2,431.50
Wyoming	$93,907,359	$198.45	$3,262.48
Pacific:	**$6,067,596,994**	**$134.50**	**$2,939.74**
Alaska	$70,456,830	$114.01	$2,482.80
California	$4,786,659,451	$140.15	$2,988.96
Hawaii	$61,146,813	$55.46	$2,590.75
Oregon	$469,594,488	$140.03	$2,929.18
Washington	$679,739,412	$115.48	$2,716.32
Total	**$33,329,257,063**	**$124.01**	**$2,921.39**

Source: Urban Institute analysis, HIPSM 2011.
Note: We simulate the provisions of the Affordable Care Act fully implemented in 2011.

38x

Figure 5: New Medicaid Eligibles Enrolled as a Percent of Total Enrollees

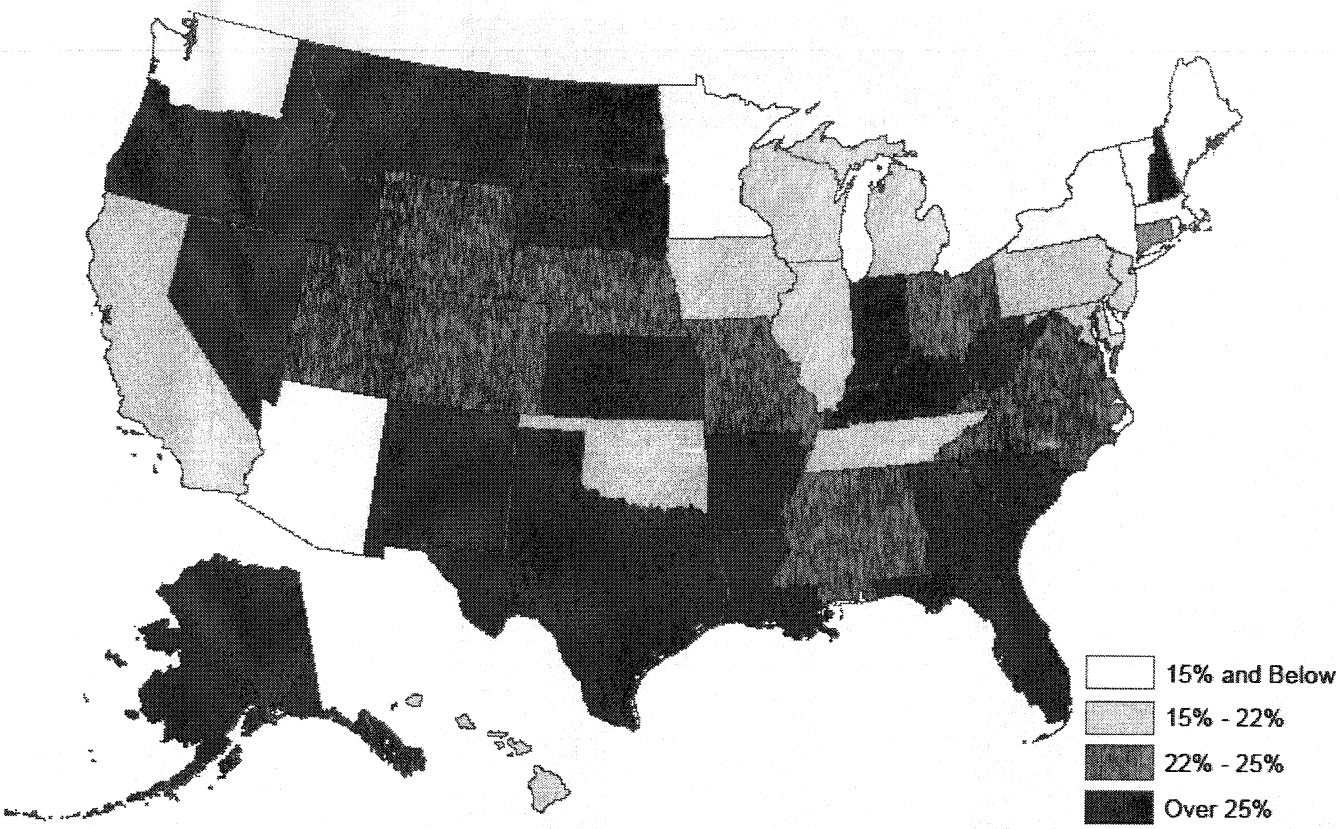

Table 6a. Enrollment in Medicaid/CHIP

Nonelderly persons (thousands)	Total Enrollment				Newly Enrolled Current Eligibles		New Eligibles Enrolled	
	Total	Adult non-parents	Adult parents	Children	Total	% of Enrollees	N	% of Enrollees
Income Cluster								
Lowest Impact	3,737	1,377	529	1,831	338	9.0%	585	15.7%
Moderate Impact	9,050	2,956	1,398	4,696	773	8.5%	1,601	17.7%
High Subsidy Impact	13,866	4,746	2,251	6,870	1,180	8.5%	3,484	25.1%
High Medicaid Impact	32,975	10,305	5,343	17,327	2,644	8.0%	6,580	20.0%
Eligibility Cluster								
High ESI	17,707	5,854	2,819	9,034	1,424	8.0%	3,557	20.1%
Low ESI	41,922	13,530	6,703	21,689	3,510	8.4%	8,694	20.7%

Source: Urban Institute analysis, HIPSM 2011.
Note: We simulate the provisions of the Affordable Care Act fully implemented in 2011.

39x

Table 6. Enrollment in Medicaid/CHIP

Nonelderly persons (thousands)	Total Enrollment				Newly Enrolled Current Eligibles		New Eligibles Enrolled	
	Total	Adult non-parents	Adult parents	Children	Total	% of Enrollees	N	% of Enrollees
New England:	**2,319**	**870**	**396**	**1,052**	**126**	**5.4%**	**266**	**11.5%**
Connecticut	456	169	67	220	40	8.8%	107	23.4%
Maine	275	105	56	114	7	2.5%	37	13.4%
Massachusetts	1,103	439	190	474	45	4.1%	51	4.6%
New Hampshire	149	49	23	77	11	7.2%	39	25.9%
Rhode Island	214	67	43	105	14	6.4%	32	14.8%
Vermont	121	41	17	62	10	8.0%	1	1.1%
Middle Atlantic:	**8,768**	**2,980**	**1,394**	**4,393**	**809**	**9.2%**	**1,087**	**12.4%**
Delaware	139	44	28	67	14	10.1%	13	9.1%
District of Columbia	144	61	19	64	4	2.5%	17	11.9%
Maryland	750	247	97	406	70	9.3%	149	19.9%
New Jersey	1,279	474	152	653	172	13.4%	240	18.8%
New York	4,251	1,334	809	2,108	361	8.5%	207	4.9%
Pennsylvania	2,205	822	289	1,094	188	8.5%	461	20.9%
East North Central:	**8,947**	**2,842**	**1,574**	**4,532**	**683**	**7.6%**	**1,874**	**20.9%**
Illinois	2,504	774	420	1,310	193	7.7%	466	18.6%
Indiana	1,326	376	236	714	85	6.4%	334	25.2%
Michigan	1,894	618	348	928	141	7.5%	332	17.6%
Ohio	2,228	751	402	1,075	189	8.5%	527	23.7%
Wisconsin	996	323	167	505	74	7.4%	215	21.6%
West North Central:	**3,288**	**1,004**	**534**	**1,749**	**334**	**10.1%**	**651**	**19.8%**
Iowa	425	113	60	252	32	7.6%	71	16.8%
Kansas	443	138	68	238	37	8.4%	118	26.7%
Minnesota	795	241	132	422	99	12.5%	60	7.5%
Missouri	1,119	349	200	570	125	11.2%	272	24.3%
Nebraska	287	91	42	154	21	7.3%	69	24.2%
North Dakota	81	29	13	39	7	8.6%	23	28.5%
South Dakota	137	44	20	74	11	8.1%	37	26.6%
South Atlantic:	**9,350**	**3,388**	**1,375**	**4,587**	**735**	**7.9%**	**2,688**	**28.8%**
Florida	3,286	1,319	462	1,506	295	9.0%	1,055	32.1%
Georgia	1,888	616	249	1,023	176	9.3%	544	28.8%
North Carolina	1,900	632	298	971	118	6.2%	474	25.0%
South Carolina	862	330	148	384	60	7.0%	263	30.5%
Virginia	1,020	350	152	518	67	6.6%	244	23.9%
West Virginia	393	141	67	185	18	4.5%	108	27.4%
East South Central:	**4,160**	**1,486**	**649**	**2,025**	**238**	**5.7%**	**957**	**23.0%**
Alabama	976	333	146	496	54	5.5%	232	23.8%
Kentucky	988	364	164	460	42	4.2%	265	26.8%
Mississippi	816	291	116	410	48	5.9%	180	22.1%
Tennessee	1,380	498	223	659	95	6.9%	280	20.3%
West South Central:	**8,223**	**2,331**	**1,267**	**4,625**	**730**	**8.9%**	**2,114**	**25.7%**
Arkansas	687	197	115	375	39	5.7%	182	26.5%
Louisiana	1,044	345	149	549	86	8.2%	304	29.1%
Oklahoma	675	191	97	387	37	5.4%	147	21.8%
Texas	5,817	1,597	906	3,314	568	9.8%	1,481	25.5%
Mountain:	**3,936**	**1,152**	**658**	**2,125**	**413**	**10.5%**	**715**	**18.2%**
Arizona	1,398	366	258	774	155	11.1%	79	5.7%
Colorado	722	229	124	369	69	9.6%	171	23.7%
Idaho	271	76	45	150	25	9.4%	69	25.6%
Montana	161	53	29	79	18	11.5%	43	26.4%
Nevada	378	140	48	191	50	13.3%	95	25.1%
New Mexico	563	163	84	315	36	6.4%	148	26.3%
Utah	359	98	59	203	53	14.9%	89	24.8%
Wyoming	84	27	11	45	5	6.1%	21	24.9%
Pacific:	**10,638**	**3,329**	**1,675**	**5,634**	**867**	**8.1%**	**1,899**	**17.8%**
Alaska	117	44	17	56	10	8.3%	32	26.9%
California	8,460	2,646	1,344	4,470	690	8.2%	1,456	17.2%
Hawaii	225	73	32	120	12	5.5%	42	18.9%
Oregon	730	266	121	342	46	6.4%	255	34.9%
Washington	1,106	299	161	646	108	9.7%	114	10.3%
Total	**59,629**	**19,384**	**9,522**	**30,723**	**4,934**	**8.3%**	**12,251**	**20.5%**

Source: Urban Institute analysis, HIPSM 2011.
Note: We simulate the provisions of the Affordable Care Act fully implemented in 2011.

40x

Figure 6: New Federal Medicaid and Exchange Dollars per Nonelderly

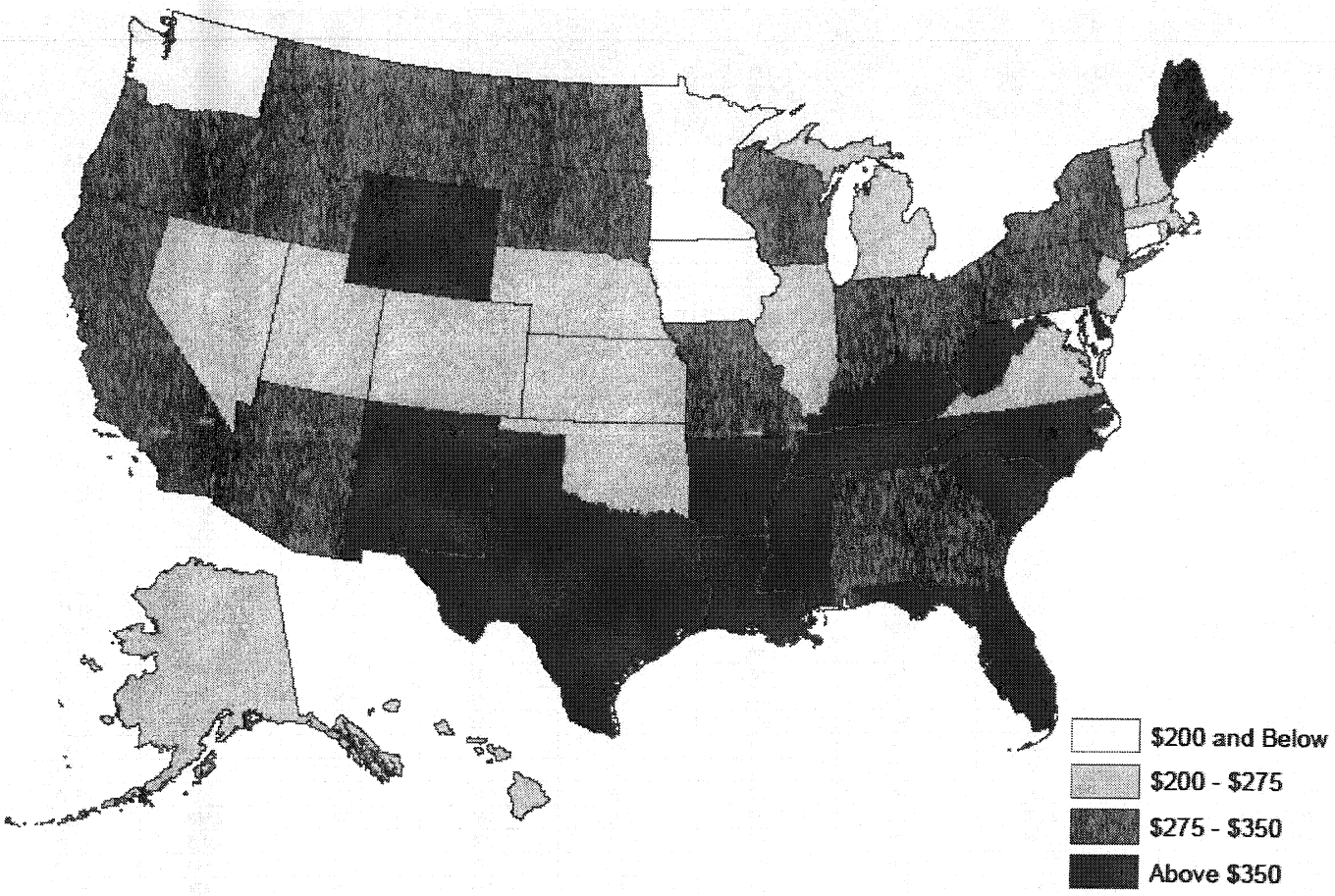

Table 7. Enrollment in Medicaid/CHIP

Nonelderly persons (thousands)	Enrollment by Person Type			
	Total	Adult non-parents	Adult parents	Children
Total	59,629	19,384	9,522	30,723
Newly Enrolled Current Eligibles	4,934	376	850	3,708
Newly Eligible Enrollees	12,251	9,984	2,207	60

Source: Urban Institute analysis, HIPSM 2011.
Note: We simulate the provisions of the Affordable Care Act fully implemented in 2011.

41x

Table 8. Medicaid/CHIP Spending on Acute Care for the Nonelderly

($ millions)	Total costs[1]	Total costs of new eligibles[2]	Percent of costs incurred by new eligibles	Percent of enrollees who are new eligibles
New England:	**14,934**	**891**	**6.0%**	**11.5%**
Connecticut	2,233	367	16.4%	23.4%
Maine	1,943	157	8.1%	13.4%
Massachusetts	7,730	81	1.0%	4.6%
New Hampshire	864	159	18.4%	25.9%
Rhode Island	1,506	118	7.8%	14.8%
Vermont	657	9	1.4%	1.1%
Middle Atlantic:	**55,532**	**4,769**	**8.6%**	**12.4%**
Delaware	1,010	124	12.3%	9.1%
District of Columbia	1,188	102	8.6%	11.9%
Maryland	3,342	588	17.6%	19.9%
New Jersey	6,127	896	14.6%	18.8%
New York	28,754	682	2.4%	4.9%
Pennsylvania	15,110	2,377	15.7%	20.9%
East North Central:	**46,977**	**6,732**	**14.3%**	**20.9%**
Illinois	12,689	1,320	10.4%	18.6%
Indiana	7,764	1,299	16.7%	25.2%
Michigan	9,764	1,151	11.8%	17.6%
Ohio	12,488	1,874	15.0%	23.7%
Wisconsin	4,272	1,088	25.5%	21.6%
West North Central:	**18,496**	**2,057**	**11.1%**	**19.8%**
Iowa	1,882	363	19.3%	16.8%
Kansas	2,269	245	10.8%	26.7%
Minnesota	4,260	184	4.3%	7.5%
Missouri	7,362	854	11.6%	24.3%
Nebraska	1,381	178	12.9%	24.2%
North Dakota	383	96	25.2%	28.5%
South Dakota	958	136	14.2%	26.6%
South Atlantic:	**46,016**	**11,953**	**26.0%**	**28.8%**
Florida	16,596	4,549	27.4%	32.1%
Georgia	8,307	2,134	25.7%	28.8%
North Carolina	10,279	2,804	27.3%	25.0%
South Carolina	3,541	953	26.9%	30.5%
Virginia	5,004	877	17.5%	23.9%
West Virginia	2,288	636	27.8%	27.4%
East South Central:	**24,643**	**4,544**	**18.4%**	**23.0%**
Alabama	5,229	1,062	20.3%	23.8%
Kentucky	6,565	1,123	17.1%	26.8%
Mississippi	3,882	675	17.4%	22.1%
Tennessee	8,968	1,684	18.8%	20.3%
West South Central:	**32,791**	**7,016**	**21.4%**	**25.7%**
Arkansas	2,699	645	23.9%	26.5%
Louisiana	4,190	1,214	29.0%	29.1%
Oklahoma	3,960	410	10.4%	21.8%
Texas	21,942	4,747	21.6%	25.5%
Mountain:	**15,439**	**2,585**	**16.7%**	**18.2%**
Arizona	5,260	420	8.0%	5.7%
Colorado	3,129	727	23.2%	23.7%
Idaho	1,198	225	18.8%	25.6%
Montana	636	123	19.3%	26.4%
Nevada	1,443	261	18.1%	25.1%
New Mexico	1,876	519	27.7%	26.3%
Utah	1,466	216	14.7%	24.8%
Wyoming	429	94	22.0%	24.9%
Pacific:	**45,729**	**5,705**	**12.5%**	**17.8%**
Alaska	601	84	13.9%	26.9%
California	37,363	4,425	11.8%	17.2%
Hawaii	983	156	15.9%	18.9%
Oregon	2,501	750	30.0%	34.9%
Washington	4,282	289	6.8%	10.3%
Total	**300,556**	**46,252**	**15.4%**	**20.5%**

Source: Urban Institute analysis, HIPSM 2011.
Note: We simulate the provisions of the Affordable Care Act fully implemented in 2011.
[1]Spending on acute care for the nonelderly.
[2]Does not include spending on newly-enrolled current eligibles.

Table 9. Federal Medicaid and Exchange Subsidy Dollars

($ millions)	Costs of New Medicaid Enrollees			Additional federal payments for existing enrollees[3]	Total exchange subsidies	Total new federal dollars	Total new federal dollars per nonelderly
	Total costs[1]	Federal payments[2]	Percent reimbursed				
New England:	**1,063**	**848**	**79.8%**	**823**	**1,038**	**2,709**	**223**
Connecticut	242	190	78.5%	78	295	563	186
Maine	213	178	83.2%	72	149	399	358
Massachusetts	216	165	76.3%	619	317	1,102	203
New Hampshire	184	156	84.5%	0	100	255	223
Rhode Island	170	133	78.4%	0	114	247	270
Vermont	38	27	71.5%	54	63	144	271
Middle Atlantic:	**6,143**	**4,865**	**79.2%**	**1,995**	**4,638**	**11,498**	**277**
Delaware	141	120	85.2%	121	66	306	406
District of Columbia	111	98	88.3%	0	54	152	279
Maryland	710	590	83.1%	0	401	991	196
New Jersey	1,416	1,066	75.3%	0	700	1,766	230
New York	1,678	1,260	75.1%	1,627	2,027	4,914	288
Pennsylvania	2,087	1,731	82.9%	248	1,391	3,369	325
East North Central:	**7,579**	**6,324**	**83.4%**	**208**	**4,983**	**11,515**	**286**
Illinois	1,790	1,424	79.6%	0	1,285	2,709	237
Indiana	1,251	1,095	87.5%	44	589	1,728	316
Michigan	1,474	1,231	83.5%	0	1,054	2,285	264
Ohio	2,347	1,981	84.4%	0	1,334	3,315	333
Wisconsin	716	594	82.9%	164	720	1,478	306
West North Central:	**2,416**	**1,955**	**80.9%**	**93**	**2,162**	**4,210**	**242**
Iowa	116	88	75.9%	84	276	448	171
Kansas	290	246	85.0%	0	286	532	225
Minnesota	388	258	66.6%	9	546	813	181
Missouri	1,113	932	83.8%	0	657	1,590	309
Nebraska	245	200	81.7%	0	214	414	264
North Dakota	119	101	84.8%	0	79	181	330
South Dakota	144	128	88.4%	0	104	232	335
South Atlantic:	**13,230**	**11,521**	**87.1%**	**0**	**5,523**	**17,045**	**382**
Florida	5,080	4,372	86.1%	0	2,320	6,692	437
Georgia	2,437	2,116	86.8%	0	892	3,008	341
North Carolina	2,998	2,649	88.4%	0	1,041	3,690	447
South Carolina	1,107	966	87.2%	0	397	1,362	355
Virginia	932	817	87.7%	0	737	1,554	225
West Virginia	676	602	89.0%	0	136	738	498
East South Central:	**4,876**	**4,311**	**88.4%**	**0**	**1,809**	**6,120**	**391**
Alabama	1,149	1,014	88.2%	0	349	1,362	338
Kentucky	1,162	1,038	89.3%	0	410	1,448	393
Mississippi	733	649	88.5%	0	332	981	386
Tennessee	1,832	1,611	87.9%	0	717	2,328	431
West South Central:	**8,056**	**6,944**	**86.2%**	**0**	**4,564**	**11,508**	**357**
Arkansas	705	624	88.5%	0	359	984	400
Louisiana	1,326	1,173	88.4%	0	387	1,559	404
Oklahoma	446	393	88.1%	0	397	790	253
Texas	5,579	4,754	85.2%	0	3,421	8,175	359
Mountain:	**3,209**	**2,678**	**83.4%**	**422**	**2,545**	**5,645**	**285**
Arizona	786	649	82.7%	376	642	1,667	280
Colorado	812	697	85.8%	0	527	1,224	271
Idaho	249	219	88.0%	0	212	431	322
Montana	157	134	85.2%	0	143	277	327
Nevada	411	310	75.4%	0	288	598	254
New Mexico	336	296	88.1%	41	351	688	374
Utah	361	286	79.3%	4	289	579	232
Wyoming	98	87	88.6%	0	94	181	382
Pacific:	**7,340**	**5,859**	**79.8%**	**112**	**6,068**	**12,038**	**267**
Alaska	109	88	80.9%	0	70	158	256
California	5,882	4,695	79.8%	0	4,787	9,481	278
Hawaii	191	161	84.0%	39	61	261	237
Oregon	689	600	87.1%	36	470	1,106	330
Washington	469	315	67.2%	37	680	1,032	175
Total	**53,912**	**45,305**	**84.0%**	**3,653**	**33,329**	**82,287**	**306**

Source: Urban Institute analysis, HIPSM 2011.

Note: We simulate the provisions of the Affordable Care Act fully implemented in 2011.

[1]Spending on acute care for the nonelderly.

[2]Medicaid match rules were used for the expenses of children. We did not attempt to separate enrollment in stand-alone CHIP programs from Medicaid programs for children or CHIP-funded Medicaid programs. Since the large majority of new enrollees are adults, this leads to a modest underestimate.

[3]Includes section 1115 enrollees below 138 percent of the FPL in enhanced match states and 1115 enrollees below 138 percent of the FPL in states with limited-benefit Medicaid programs for adults.

Table 9a. Federal Medicaid and Exchange Subsidy Dollars

($ millions)	Costs of New Medicaid Enrollees			Additional federal payments for existing enrollees[3]	Total exchange subsidies	Total new federal dollars	Total new federal dollars per nonelderly
	Total costs[1]	Federal payments[2]	Percent reimbursed				
Income Cluster							
Lowest Impact	2,768	2,167	78.3%	697	1,814	4,678	209
Moderate Impact	7,056	5,721	81.1%	468	5,541	11,730	250
High Subsidy Impact	14,259	12,067	84.6%	361	9,076	21,504	322
High Medicaid Impact	29,829	25,350	85.0%	2,127	16,898	44,376	334
Eligibility Cluster							
High ESI	14,229	11,804	83.0%	1,459	10,261	23,524	263
Low ESI	39,683	33,501	84.4%	2,194	23,069	58,763	328

Source: Urban Institute analysis, HIPSM 2011.
Note: We simulate the provisions of the Affordable Care Act fully implemented in 2011.
[1]Spending on acute care for the nonelderly.
[2]Medicaid match rules were used for the expenses of children. We did not attempt to separate enrollment in stand-alone CHIP programs from Medicaid programs for children or CHIP-funded Medicaid programs. Since the large majority of new enrollees are adults, this leads to a modest underestimate.
[3]Includes section 1115 enrollees below 138 percent of the FPL in enhanced match states and 1115 enrollees below 138 percent of the FPL in states with limited-benefit Medicaid programs for adults.

Notes

1 Matthew Buettgens, Bowen Garrett and John Holahan, "America under the Affordable Care Act" (Washington, DC: The Urban Institute, 2010).

2 This is lower than the 16.0 million projected by CBO and 15.9 million projected by Holahan and Headen primarily because it is a 2011 estimate rather than a forecast for 2019. John Holahan and Irene Headen, "Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% Poverty" (Washington, DC: The Urban Institute, 2010), http://www.kff.org/healthreform/8076.cfm.

3 Holahan and Headen, 2010.

4 For more about HIPSM and a list of recent research using it, see http://www.urban.org/uploadedpdf/412154-Health-Microsimulation-Capabilities.pdf. A more technical description of the construction of the model can be found in Bowen Garrett, John Holahan, Irene Headen and Aaron Lucas, "The Coverage and Cost Impacts of Expanding Medicaid" (Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, 2009), http://www.urban.org/url.cfm?ID=411905.

5 HIPSM uses data from several national data sets: the March Current Population Survey (CPS) Annual Social and Economic Supplement, the February CPS Contingent Work and Alternative Employment Supplement, the Medical Expenditure Panel Survey (MEPS), the Statistics of Income (SOI) Public Use Tax File and the Statistics of U.S. Business. Distributions of coverage are based on March CPS data with adjustments for the Medicaid undercount.

6 Buettgens, Garrett and Holahan, 2010.

7 National Health Expenditure Accounts, CMS Office of the Actuary. https://www.cms.gov/NationalHealthExpendData/

8 Blumberg, et al., "Achieving Quality, Affordable Health Insurance for All New Yorkers: An Analysis of Reform Options," (Washington, DC: The Urban Institute, 2009) http://www.urban.org/url.cfm?ID=411925

9 See, for example, Bowen Garrett, John Holahan, Allison Cook, Irene Headen and Aaron Lucas, "The Coverage and Cost Impacts of Expanding Medicaid" (Washington, DC: The Urban Institute, 2009), http://www.kff.org/medicaid/upload/7901.pdf.

10 Holahan and Headen, 2010.

11 There are other reasons why the unsubsidized might enroll in the exchanges, e.g., those eligible for employee choice vouchers.

12 There will be some below 138 percent of the FPL who are eligible for subsidies, namely legal immigrants who have been residents less than five years. They are not eligible for Medicaid.

13 Florida, as we have seen, would see the largest decline in its uninsurance rate of any state. The decline is noticeably higher than that of any of its neighbors. Much of the gain in coverage is in the nongroup exchanges, so we should not be surprised that it stands out here as well. Vermont has substantially higher than average per capita health costs and would have a significantly higher than average share of its exchange enrollment in the subsidy eligibility range. Average per capita health costs are from National Health Expenditure Accounts, CMS Office of the Actuary.

14 "Income eligibility levels for children's regular Medicaid and children's CHIP-funded Medicaid expansions by annual incomes as a percent of the federal poverty level (FPL), December 2009," http://www.statehealthfacts.org, Kaiser Family Foundation and "Income eligibility levels for children's separate CHIP programs by annual incomes as a percent of the federal poverty level (FPL), December 2009," http://www.statehealthfacts.org, Kaiser Family Foundation

15 "Medicaid and state funded coverage income eligibility limits for low-income adults, 2009," http://www.statehealthfacts.org, Kaiser Family Foundation

16 For more detailed figures at the national level, see Matthew Buettgens, Bowen Garrett and John Holahan, "America under the Affordable Care Act" (Washington, DC: The Urban Institute, 2010)

17 Delaware and Hawaii, two states in which the share of expenses incurred by the newly eligible would be much higher than the share of newly eligible enrollees, have Medicaid-level benefit programs for childless adults and also have per capita health care costs significantly higher than the national average.

18 For further details on the separation of federal and state Medicaid costs, see Holahan and Headen (2010).

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The views expressed are those of the authors and should not be attributed to any campaign or to the Robert Wood Johnson Foundation, State Coverage Initiatives or the Urban Institute, its trustees or its funders.

About the Authors and Acknowledgments

Matthew Buettgens, Ph.D., is a senior research methodologist, John Holahan, Ph.D., is director and Caitlin Carroll is a research assistant in the Urban Institute's Health Policy Center. This research was funded by the Robert Wood Johnson Foundation. The authors are grateful to Enrique Martinez-Vidal for helpful comments.

About the Urban Institute

The Urban Institute is a nonprofit, nonpartisan policy research and educational organization that examines the social, economic and governance problems facing the nation. For more information, visit www.urban.org.

About the Robert Wood Johnson Foundation

The Robert Wood Johnson Foundation focuses on the pressing health and health care issues facing our country. As the nation's largest philanthropy devoted exclusively to improving the health and health care of all Americans, the Foundation works with a diverse group of organizations and individuals to identify solutions and achieve comprehensive, meaningful and timely change. For more than 35 years, the Foundation has brought experience, commitment and a rigorous, balanced approach to the problems that affect the health and health care of those it serves. When it comes to helping Americans lead healthier lives and get the care they need, the Foundation expects to make a difference in your lifetime. For more information, visit www.rwjf.org.

About State Coverage Initiatives

The State Coverage Initiatives (SCI) program provides timely, experience-based information and assistance to state leaders in order to help them move health care reform forward at the state level. SCI offices an integrated array of policy and technical assistance services and products to help state leaders with coverage expansion efforts, as well as with broader health care reform. Our team of policy experts tailors its approach to meeting state decision makers' needs within the context of each state's unique fiscal and political environment. SCI is a national program of the Robert Wood Johnson Foundation administered by AcademyHealth. For more information about SCI, visit www.statecoverage.org.

NJPCA

New Jersey Primary Care Association, Inc.

Katherine Grant-Davis
President & CEO

TESTIMONY
HEALTH CARE REFORM AND STATE EXCHANGES
MARCH 2011

The NJPCA represents the Federally Qualified Health Centers (FQHCS) in the State of New Jersey. FQHCs are one of the oldest primary care networks and in New Jersey serve approximately 450,000 patients per year, with at least 42% of them being currently uninsured. We therefore have a vested interest in ensuring that the needs of both our provider network as well as the patients we serve are included in the development of these exchanges. We appreciate the opportunity to comment. Our specific comments are as follows:

- States should be required to develop all plans for the exchanges in an absolute transparent manner. All decisions such as how qualified plans will be certified, what State dollars will be used to develop and support the exchanges, how web portals will be developed and operated, draft/final business plans and budgets, governance plans, etc should be shared with all stakeholders and consumers from the very beginning of the process.

- States should be required to host public hearings/forums on the development of these exchanges and solicit input from stakeholders, providers, and consumers on benefit plans and services within those plans.

- States should be directed to ensure that provider networks include **all** essential safety net providers in accordance with the provision directing the exchanges to contract with those entities that serve predominately low income, medically underserved individuals such as health providers defined in Section 340B of the Public Health Act, which would include FQHCs.

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- FQHCs are prominently mentioned in the health reform bill. Language requires that qualified health plans offer contracts to safety net providers and that if any item or service covered by a qualified health plan is provided by a FQHC as defined in [the Medicaid section of the] Social Security Act to an enrollee of the plan, the offeror of the plan shall pay to the center for the item or service an amount that is not less than the amount of payment that would have been paid to the center under Section 1902(bb) of such Act. States must therefore be instructed to ensure that all FQHCs are included in qualified health plans and that they are paid no less than their Medicaid payment rate.

- States much assure that an adequate primary care network of providers is in place in particular in the underserved urban and rural areas and link the development of those networks to recruitment of providers with such entities as National Health Service Corp and State Loan Redemption programs. It is widely thought that there will not be enough **primary care** providers to see those patients who will gain entry into the ranks of the insured. States should be directed to coordinate with programs already in existence that focus on the supply of primary care providers

- It should be reinforced to States that they are allowed to contract with eligible **entities** to carry out one or more functions of the exchange requirements. It is our understanding that eligible entities could include corporations that are not health insurers or controlled by health insurers or state Medicaid agencies. As such, States should be encouraged to look at the current networks of certain providers types (such as FQHCs) to carry out certain functions (e.g. patient navigators) thus saving States money by not recreating the wheel. We believe that diversification of the functions would be beneficial to the State since it would allow certain groups to participate in their own area of expertise.

- The exchanges are required to establish a navigator program that meets the law's criteria including demonstrating that they have existing relationships with target individuals who might benefit from an insurance product. States are required to develop standards to ensure that information made available by the Navigators is fair, accurate, and impartial. States should strongly be encouraged to include all safety net providers in this discussion, such as FQHCs, who have been doing this type of consumer education activity for many years.

- We think an important issue that was raised in the proposed regulation was the type of efforts that States will use to reach individuals who are from diverse cultural origins and those with low literacy. FQHCs are ideal for this type of outreach since these patients are a large majority of who we see. States would be well served to rely on their networks of safety net providers to ensure that outreach plans are utilized that adopt best practices of these providers.

- We also strongly believe that States must be directed to enforce patient choice and care accessibility. The exchanges should ensure patient choice of primary care and other providers such as specialists, nurse practitioners and mental health professionals. Patients must have access to caregivers with linguistic and cultural capacity to provide effective care. The exchanges must promote patients' continuity of care with their current providers. Patients must have access to medically necessary out-of-network care.

- States should be required to implement rules and policies that minimize adverse selection among or between any qualified health plans and ensure that all essential health benefits are included in all qualified health plans.

The NJPCA and its member FQHCs are excited about health care reform and the development of the health exchanges. We strongly believe that the entire process must be a transparent one. The process must also allow for the utmost participation by all stakeholders, consumers, and patients. We thank you for the opportunity to comment and look forward to further dialogue on this issue.

NEW JERSEY STATE HEALTH INSURANCE EXCHANGES

Testimony on behalf of

The March of Dimes Foundation

February, 2011

Laurie Navin,

Director of Program Services

and Public Affairs

March of Dimes, New Jersey Chapter

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NEW JERSEY STATE HEALTH INSURANCE EXCHANGES

Testimony on behalf of The March of Dimes Foundation

Good Afternoon. My name is Laurie Navin, and I am the Director of Program Services and Public Affairs for The March of Dimes, New Jersey Chapter. I am here today to speak on behalf of women of child bearing age, pregnant women, infants and children. We are asking that you take into account several major points when developing the New Jersey Health Insurance Exchange plans.

The mission of the March of Dimes is to improve maternal and child health by preventing birth defects, premature birth and infant mortality. The March of Dimes believes that every woman of childbearing age, infant and child should have access to comprehensive affordable health insurance that meets their needs. We are focused on coverage of preventive services for women and children, as well as coverage of specialty services for women at risk of complicated pregnancies, and children with special healthcare needs, such as those born preterm or with birth defects.

According to the Institute of Medicine, (IOM) Health Insurance status is the most important factor in determining whether a child receives health services when they are needed. In addition, studies funded by the March of Dimes and others have also found that health insurance plays a key role in access to maternity care for pregnant women. Given this information the March of Dimes believes that it is essential that the health insurance exchange's board of directors include a representative with Maternal Child Health experience. This is due to the unique insurance needs of pregnant women, infants and children. Federal guidelines state that in order to qualify as a functional exchange the program must cover certain aspects of maternity and pediatric care and a person with Maternal Child Health experience would be very beneficial in helping the board see what is necessary. The March of Dimes would also like to extend our own expertise in this area if the board ever has any questions or concerns in the realm of pregnancy, infant and child health.

It is also very important that the exchange coordinates with the state Medicaid and CHIP programs that are already in existence. This will severely reduce gaps in coverage from one year to the next. Constituents with fluctuating income levels have changes in eligibility from one year to the next. If the exchange is already in communication with these other two programs, and has an extensive knowledge of what is offered by each individual program then it will be easier for patients to move between coverage seamlessly, leaving less room for gaps in coverage. This is also important for families in which parents may be eligible for coverage through the health insurance exchange but their children are eligible for Medicaid or CHIP due to differing eligibility levels for different populations. The less room for gaps in coverage there is the less likely it is for women to neglect care and cause such conditions as preterm births, birth defects, and high risk pregnancies.

New Jersey should provide one short and simple application that would determine eligibility for Medicaid, CHIP, and subsidies within the exchange, rather than different forms for each. This would help to minimize the paperwork burden and confusion for families, and also provide administrative simplicity for New Jersey and its exchange.

March of Dimes is advocating for Day 1 coverage of preterm babies as well as for babies with birth defects or complications during pregnancy. This allows women the ability to receive medical care immediately, without the worry of costs. Initial neglect can lead to severe

complications during pregnancy that could endanger both the mother and child as well as cost the state money. The cooperation with the Medicaid and CHIP programs can also drastically reduce the number of preterm births in New Jersey, which is causing the state a great deal of money. The medical cost for one premature infant for one year could cover the costs of nearly a dozen healthy, full-term infants, according to new statistics from the March of Dimes. This will maximize the exchanges productivity and helpfulness.

Another way that the insurance exchanges will be able to maximize productivity is taking part in quality measurements and reporting procedures. It is required by federal law that the exchange takes part in a quality improvement activity. Reporting on some of the quality measures that the Washington CHIP and Medicaid programs already report on will help provide a larger data set allowing policymakers and advocates to compare the quality of care provided in Medicaid, CHIP and the exchanges. This type of cross-communication will drastically widen the state's ability to track progress throughout their state and throughout the country as well. Reporting will help develop and implement measures that focus on health outcomes because they provide the most useful data to demonstrate whether pregnant women, infants, and children who depend on exchanges for their health coverage are receiving the best possible care.

The March of Dimes would like to commend the state for everything they have done thus far with the planning of the Health Insurance Exchanges. We would like to continue to work in partnership with governmental and other agencies to reduce gaps in health coverage, and increase the rate of healthy, full-term pregnancies.

I would like to thank the members of the panel for allowing me to testify here today. The March of Dimes looks forward to working with you in the future and if you have any questions at any time feel free to contact us.

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NJPIRG
Standing Up
To Powerful Interests

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March 3, 2011
Senate Commerce and Senate Health, Human Services and Senior Citizens Committees

Written Testimony of Jennifer Kim, NJPIRG Advocate
Re: Federal Health Care Reform Implementation and New Jersey's Insurance Exchange

Thank you for the opportunity to testify on the establishment of a state health insurance exchange in New Jersey. We are very excited that the Senate is taking the time to gather input from different stakeholders and thank the committees for convening this hearing.

NJPIRG is a non-profit, non-partisan, consumer group. We represent citizen members across the state and have previously worked on issues including patients' rights, prescription drug reform, and of course, the recently passed federal health care reform as part of our health care program to rein in costs and improve quality of care for New Jerseyans.

Make no mistake, while health care reform has been passed federally, its success and its impact on consumers falls squarely on the state's shoulders. The most significant step New Jersey must take immediately is to establish a state health insurance exchange. We support an independent, consumer-oriented exchange as a means for individuals and small businesses to obtain better care and lower costs.

In order to ensure the strongest exchange for consumers, we encourage lawmakers to weigh the following considerations:

1. **The exchange must be accountable and transparent.**

• The exchange's mission, governance and leadership must ensure that it is transparent, accountable, and responsive to the interests of all New Jerseyans, businesses and consumers.

• Any governing board should include consumers and business owners, not industry representatives, because the exchange ultimately must advocate for consumers' interests. Input from providers, health plans, brokers, hospitals, and other industry representatives can be solicited through advisory committees, but strong conflict of interest provisions must be in place.

• All meetings must be open to the public and records made available.

2. The exchange should use its buying power to drive affordable, quality health care

• By actively negotiating on behalf of enrollees and purchasers, the exchange should drive a hard bargain to get the best possible value.

• The health insurance exchange should set high standards for safe, quality care that improves health and eliminates health disparities. The exchange should re-evaluate standards as new advancements are made in health care, and hold insurance companies accountable to those standards through strong enforcement.

• The exchange should have rules to eliminate waste in the health system and should limit the availability of plans with excessive premiums and out-of-pocket costs.

3. The exchange should offer easy-to-understand insurance options and offer a no wrong door approach for those eligible for other state insurance programs.

• The health insurance exchange should present clear, understandable health insurance choices that can be compared apples-to-apples, not an endless array of confusing products.

• New Jersey's exchange should operate a user-friendly website with powerful, and easy-to-use tools for consumers to make comparisons between plans on costs and quality, such as out-of-pocket cost calculators and independent rankings on quality and safety measures.

• A toll-free customer service number, with a live person available, in addition to active, culturally-appropriate outreach across the state, will be critical to helping consumers and small businesses navigate their various coverage options.

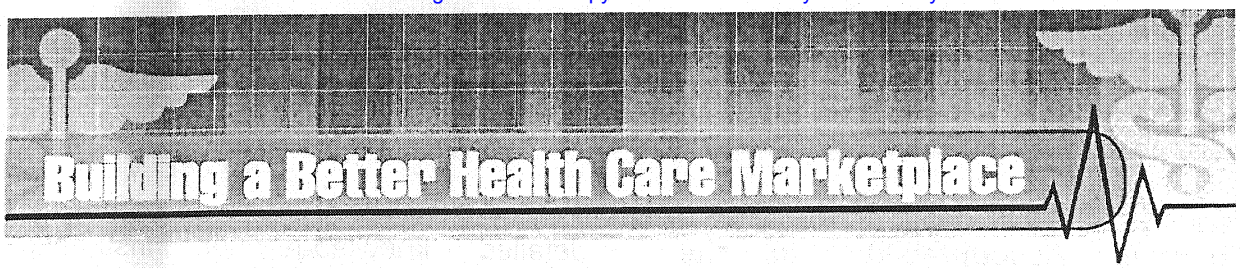
• The insurance exchange should adopt a "no wrong door" policy in which consumers who apply in error to the incorrect state health insurance program are automatically forwarded to the appropriate agency.

4. The exchange should be open to as many New Jerseyans as possible and adopt rules to ensure a stable risk pool.

• Having more people in the exchange creates a more stable risk pool and greater economies of scale. Combining the individual and small business pools should be considered as an option to potentially bring down costs further.

• The exchange must be protected from the risk of adverse selection, with a stable risk pool. Therefore, insurers and brokers should be prevented from cherry-picking low-risk enrollees outside of the exchange through offering low-benefit plans only outside the exchange, or through marketing or steering practices.

We encourage the committee to continue to seek broad public input both in the process of forming the exchange as well as during its ongoing operation to ensure that the exchange is accomplishing its goals. NJPIRG has many resources to share on implementation available including a report "*Delivering on the Promise: A State Guide to the Next Steps for Health Care Reform*" as well as a series of policy briefs on setting up an effective exchange. The first is entitled "*Ensuring Accountability*" and the rest will be released over the next several weeks. Thank you, and we look forward to continuing this conversation as New Jersey moves forward with health care reform.



Policy Brief #1: Ensuring Accountability

The opportunity to create a state exchange will allow New Jersey to increase competition and improve choices in our insurance market. However, to fully realize this opportunity, the exchange must be accountable to the public, and the individual and small business consumers who will buy their coverage through it.

The best way for the state to realize these goals is to make decisions about the exchange's structure and governance to ensure that this important new entity is transparent in its operations, and fundamentally accountable to the public interest. By following the recommendations below, New Jersey can ensure that its health insurance exchange reflects these principles.

About this Series:

The creation of a new health insurance exchange offers states an opportunity to improve health care and lower costs by pooling consumers' bargaining power, creating economies of scale, and pushing insurers toward delivering lower costs and higher quality. New Jersey PIRG's *Building a Better Health Care Marketplace* project provides recommendations to advocates and policymakers for how to create a strong, pro-consumer exchange. Support for the project is generously provided by the Robert Wood Johnson Foundation. For further information, and other policy briefs in the series, visit http://www.njpirg.org.

A Clear Pro-Consumer Mission

The exchange should be operated for the benefit of individuals, businesses and their employees, not insurance companies and providers. This charge should be included in the exchange's legislative mandate and mission. A sample mission statement follows:

The exchange is established in the public interest, for the benefit of the people and businesses who obtain health insurance coverage for themselves, their families and their employees through the exchange now and in the future. It will empower consumers by giving them the information and tools they need to make sound insurance choices. The exchange works to improve health care quality and population health, control costs, and ensure access to affordable, quality, accountable care across the state.

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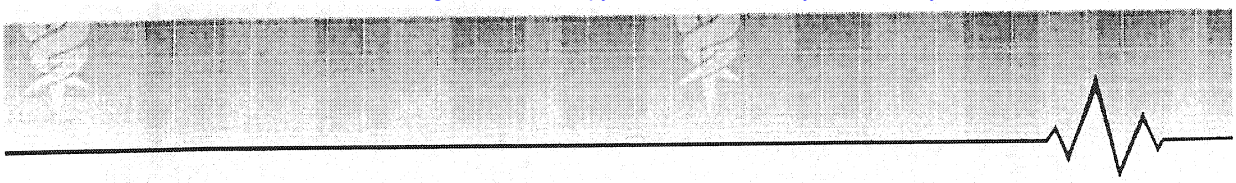

Ensuring Accountability to the Public, Not the Special Interests

The exchange must have an organizational structure that makes it accountable to the public. That accountability can best be insured by creating the exchange as a strong, independent public agency, with a governing board. Allowing the exchange to be governed by a private non-profit organization runs the danger of making it unaccountable to the public or its representatives. At the same time, the exchange will need to have some degree of independence from the state's government; it must have the ability to set its operating rules, recommend needed legislation, and negotiate on behalf of enrollees. Otherwise it will not have the agility and power it will need to be an effective advocate for consumers. Housing the exchange in an existing government agency could deny it this needed independence.

A Governing Board that Represents Consumers and Small Businesses

The governing body for the exchange should consist of representatives drawn from across the state's consumer and business communities. Persons who are or will become enrollees should be selected for service on the board, as well as organizations that represent them. Policy experts and those with detailed knowledge of insurance markets can also render important service. It may be appropriate for government officials, such as the state's health and human services Secretary, to serve in an ex officio capacity, but such ex officio members should not be allowed to dominate the exchange board.

The people's elected representatives in the state legislature and statewide elected offices should have the responsibility of selecting members of the exchange board through gubernatorial and/or legislative appointment. But to prevent undue political influence, the removal of members should only be possible in cases of misconduct or malfeasance. Direct election of exchange board members is not recommended, however, as the impact of special-interest spending could lead to the perverse result of privileging industry interests over those of the public in board member selection.

Strong Protections Against Conflicts of Interest

While the exchange will serve many functions, in large measure the most important is its role as a purchaser of insurance. For it to be effective at this task, it must be a zealous advocate for the interests of consumers, which

means that it must be free of influence from the insurance industry, brokers, and providers. Consumers need the exchange to deliver high quality, affordable coverage – when it comes to negotiating for a better deal, their interests are at odds with those of the insurers. Because brokers are usually paid by insurers on commission for the policies they sell, and pressure on insurers to lower costs might translate to cost pressure on providers, they also should not serve on the exchange board.

Industry stakeholder groups, including insurers, providers, hospitals, and others, should have opportunities for meaningful input into technical and workability decisions. When industry representatives serve in an advisory capacity, strong conflict of interest requirements should be in place to ensure that industry representatives – and others – do not influence decisions that might financially benefit them. An exception to these provisions should, of course, be made for consumers who will financially benefit if the exchange is able to deliver lower costs and higher quality.

Robust Public Participation

Broad public input should be solicited and considered, both in the process of forming the exchange and in its ongoing operation, to ensure that the exchange is meeting the needs of consumers and accomplishing the goals of its mission. When setting rules and procedures, the exchange should provide opportunities for public comment, including open hearings and calls for written comments. A similar process should be followed as a state's legislature considers how to create and structure its exchange. Efforts should be made to solicit feedback from consumers, including individual and small business enrollees, and the consumer advocates who represent them. In addition, because in many states the exchange will serve populations with special health, cultural, and language needs, the exchange should take particular care to make sure that their decisions are informed by these perspectives as well.

Transparency of Budgets and Records

The public – and most importantly, enrollees – need to know that the exchange is working efficiently to promote their interests. The legislature and governor will also need to know the details of its operations, to inform their oversight and deliberations about possible reforms and changes. As result, transparency and public reporting are critical to allowing the exchange to build the trust it needs to do its job.

The exchange's yearly budget and details of its spending and revenue, including any contract agreements it

reaches with insurers or outside vendors, should be made available to the public. Transcripts of hearings and other public proceedings should also be public and easily accessible. Transparency should be the rule across the exchange's activities and records. With that said, the exchange will also engage in negotiations with insurers, which will sometimes require some information to be kept confidential in order to protect the exchange's ability to drive a good bargain on behalf of consumers. Material related to such negotiations should ordinarily not be open to public disclosure, except where the exchange board determines that disclosure would be in the interest of the public and of enrollees.

ADDITIONAL APPENDIX MATERIALS
SUBMITTED TO THE

SENATE COMMERCE COMMITTEE, AND
SENATE HEALTH, HUMAN SERVICES
AND SENIOR CITIZENS COMMITTEE
for the
March 3, 2011 Meeting
Committee Room 4

Submitted by Jennifer Kim, Advocate, New Jersey Public Interest Research Group: Mike Russo, Laura Etherton, and Larry McNeely, "Delivering on the Promise: A State Guide to the Next Steps for Health Care," June 2010, **8** 2010 U.S. PIRG Education Fund.