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September 25, 2024

RE: New Jersey Cost Growth Benchmark and Affordability Standards Report

Dear Office of Health Care Affordability and Transparency Director Shabnam Salih, Health Commissioner Dr. Kaitlan Baston, Human Services Commissioner Sarah Adelman, State Treasurer Elizabeth Maher Muoio, and Acting Director of the Division of Consumer Affairs Cari Fais,

I am pleased to submit to the Interagency Health Care Affordability Working Group the attached final report containing proposals for the development and implementation of cost growth benchmarks and health insurance affordability standards as required by Executive Order 217 (E.O. 217). The report includes a plan under which the State can implement cost growth benchmarks and health insurance affordability standards and identifies policy and legislative changes needed to effectuate cost growth benchmarks and health insurance affordability standards. Consistent with E.O. 217, the report is also being made available on the Department's website at this time.

Thank you for your consideration of the report and commitment to health care affordability for the residents of New Jersey.

Respectfully submitted,

Justin Zimmerman
Acting Commissioner

New Jersey Affordability Standards Report - 2024

STATE OF NEW JERSEY
DEPARTMENT OF BANKING & INSURANCE

September 2024

I. Executive Summary

As part of ongoing efforts to build a stronger and fairer New Jersey, on January 28, 2021, Governor Murphy signed Executive Order 217, setting the framework for building a health care cost growth benchmark program to further improve access to affordable, equitable, high-quality health care within the state.[1] In December 2021, Governor Murphy signed Executive Order 277, which launched the New Jersey Health Care Affordability, Responsibility, and Transparency (HART) Program.[2] In addition to creating the HART Program, the Murphy administration has identified health insurance affordability standards as an additional appropriate means to achieve the goal of improved health care quality at reduced cost. Accordingly, pursuant to Executive Order 217, the Department of Banking and Insurance (the Department) issues this report, which contains proposals for the development and implementation of cost growth benchmarks and health insurance affordability standards, as well as to effectuate the cost growth benchmark. This report includes a plan under which the State may implement cost growth benchmarks and health insurance affordability standards and further effectuate the state benchmark program, and identifies policy and legislative changes needed to effectuate cost growth benchmarks and certain health insurance affordability standards. The overarching goal is that affordability initiatives adopted in New Jersey will complement, enhance, and further other initiatives adopted in New Jersey to improve access to affordable, equitable, and high-quality health care within the state.

For the purposes of this report, health insurance affordability standards are requirements that carriers regulated by the Department must meet to achieve affordability goals. Generally, states use affordability standards in furtherance of, or in conjunction with, other policy goals, such as expanding access to or promoting increased use of primary care, requiring the use of alternative payment models, or encouraging the use of models that include quality incentive payments. These standards may be implemented through a variety of Department functions, including the rate review process, individual market plan management, and development of standard health insurance policy forms. The specific initiatives and proposals to improve affordability standards discussed in this report include enhancing the rate review process, strengthening medical loss ratio requirements, allowing public input into the rate review process and increasing transparency in rate filings, requiring carriers to use incentives to promote the use of primary and preventative care, developing initiatives to promote competition within the marketplace, promoting the use of incentive payments and alternative payment models, updating regulations to streamline and clarify regulatory oversight authority, and developing integrated models that use a variety of strategies to promote affordability throughout the market.

[1] https://nj.gov/infobank/eo/056murphy/pdf/EO-217.pdf
[2] https://nj.gov/infobank/eo/056murphy/pdf/EO-277.pdf

II. Background and Current Landscape

a. Current Access and Affordability Initiatives

New Jersey has taken important steps to improve access to quality and affordable health insurance for the State's residents by bolstering and building on the federal Patient Protection and Affordable Care Act (ACA) and implementing a sweeping modernization of the individual health insurance market in New Jersey, which provides a foundation and framework for potential implementation of affordability standards in that market. This includes establishing the benchmark program pursuant to Executive Orders 217[3] and 277[4], establishing a State-based marketplace pursuant to P.L.2019, c.141[5], providing eligible residents with state financial subsidies to assist with the cost of purchasing health benefits coverage on the State-based marketplace through the Health Insurance Affordability Fund established pursuant to P.L.2020, c.61[6], establishing the Easy Enrollment Health Insurance Program pursuant to P.L.2022, c.39[7], establishing a reinsurance program pursuant to the "New Jersey Health Insurance Premium Security Act," P.L.2018, c.24[8], creating a State shared responsibility requirement pursuant to the "New Jersey Health Insurance Market Preservation Act," P.L.2018, c.31[9], implementing out-of-network reforms under the "Out-of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act," P.L.2018, c.32[10], providing relief from medical debt pursuant to the "Louisa Carman Medical Debt Relief Act," P.L.2024, c.48, and reviewing potential improvements in the small employer market pursuant to P.L.2023, c.182[11].

i. HART/Benchmark Program

Pursuant to Executive Orders 217[12] and 277[13] the Department has worked with the Office of Health Care Affordability & Transparency (OHCAT) to implement the HART Program. The HART Program has established a statewide cost growth benchmark, designed to limit the amount by which health care costs increase year over year, and the Department has led efforts to collect data from the State's large health carriers to support the Program.

[3] https://nj.gov/infobank/eo/056murphy/pdf/EO-217.pdf
[4] https://nj.gov/infobank/eo/056murphy/pdf/EO-277.pdf
[5] N.J.S.A.17B:27A-57 et seq.
[6] N.J.S.A.17B:27A-65 et seq.
[7] N.J.S.A.17B:27A-59.1 et al.
[8] N.J.S.A.17B:27A-10.1 et seq.
[9] N.J.S.A.54A:11-1 et seq.
[10] N.J.S.A.26:2SS-1 et seq.
[11] N.J.S.A.17B:27A-10.14.
[12] https://nj.gov/infobank/eo/056murphy/pdf/EO-217.pdf
[13] https://nj.gov/infobank/eo/056murphy/pdf/EO-277.pdf

The Program was built through strong collaboration among various State agencies, health insurance carriers, health care providers, and other stakeholders, which collaboration resulted in the development of guidance by a Health Care Affordability Advisory Group and the establishment of a compact between the State and various health care industry stakeholders committing the signatories to working to meet the program spending target and data transparency goals.[14]

ii. Get Covered New Jersey – New Jersey's State-Based Exchange

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (together referred to as the Affordable Care Act or ACA) were signed by President Obama in March 2010. Section 1311(b) of the ACA requires each state to establish Health Insurance Exchanges, also known as Health Insurance Marketplaces. New Jersey initially utilized the Federally-Facilitated Exchange (FFE), which provides a platform for consumers to shop for and enroll in coverage in states without a State-Based Health Exchange.

On June 28, 2019, state legislation was enacted to establish a State-Based Health Insurance Exchange in New Jersey. The state operated a State-Based Exchange on the Federal Platform (SBE-FP) for 2020 and a State-Based Exchange (SBE) – referred to as Get Covered New Jersey, GetCoveredNJ or the State-Based Marketplace – beginning in 2021. GetCoveredNJ is a division within the New Jersey Department of Banking and Insurance. New Jersey's SBE, Get Covered New Jersey, began operating in Plan Year 2021 and became the first SBE to open with a state subsidy available, called New Jersey Health Plan Savings (NJHPS), in addition to federal premium tax credits. Since taking over the marketplace in 2020, the Murphy Administration has expanded the Open Enrollment Period to three months, from the six-week window available under the previous federal administration. The Murphy Administration offered state subsidies, expanded plan options by doubling the number of health carriers and increased investments in outreach and trained experts who provide free, unbiased enrollment assistance to residents in the community. New Jersey worked to maximize financial support to reduce monthly health insurance costs to make affordable, comprehensive coverage available for hundreds of thousands of residents. New Jerseyans receive historic levels of financial help and the average amount of financial help for 2024 coverage is at a record high of $566 per person per month or $6,792 a year. Nine in 10 people enrolling in a health plan at Get Covered New Jersey qualify for financial help, and many people receiving assistance can find a plan for $10 a month or less. These actions contributed to consistent growth in enrollment in the individual market. During the most recent Open Enrollment Period, there was record breaking enrollment, with more than 397,000 New Jerseyans signed up for health coverage. This is a 61 percent increase since the Murphy Administration took over the operation of the marketplace from the federal government.

[14] https://www.nj.gov/dobi/division_insurance/HART/Final_Stakeholder_Compact.pdf

iii. State Subsidy Program – New Jersey Health Plan Savings

New Jersey's state subsidy, New Jersey Health Plan Savings (NJHPS), began being delivered in plan year 2021.[15] The NJHPS makes individual health coverage more affordable in New Jersey by providing subsidies to assist in purchasing health insurance, which subsidies are in addition to federal tax credits and, accordingly, further assist New Jerseyans to afford quality health insurance. These savings are delivered to income-eligible consumers through Get Covered New Jersey. The implementation of expanded federal subsidies under the 2021 American Rescue Plan Act and the 2022 Inflation Reduction Act allowed New Jersey to also expand the availability of NJHPS. The additional federal savings made available allowed New Jersey to increase the amount of state subsidies available to eligible consumers and to extend the state savings to residents at higher income levels for the first time, allowing those earning an annual salary of up to 600 percent of the federal poverty to receive state assistance. New Jersey's record marketplace enrollment, described above, is in part attributable to this federal and State partnership to expand access to financial assistance. Specifically, the NJHPS, both on their own and when coupled with federal subsidies, reduce the total amount New Jerseyans pay out of pocket for health insurance. The average amount of financial help available has increased from about $484 a month on average, or about $5,808 for plan year 2021 to $566 per person per month or $6,792 in plan year 2024. The unique affordability resulting from these subsidies is associated with an expansion in the number of individuals receiving coverage under plans sold through Get Covered New Jersey from 246,426 New Jersey consumers who were enrolled in federal marketplace coverage in plan year 2020 to a total of 397,942 New Jersey residents signed up for health insurance during the most recent Open Enrollment Period.

iv. Easy Enrollment Health Insurance Program

The Easy Enrollment Health Insurance Program was established in 2022 with the enactment of P.L.2022, c.39.[16] This program facilitates the process for residents to obtain health insurance through Get Covered New Jersey by allowing uninsured and underinsured residents to indicate their interest in coverage for themselves or a household member on their tax returns or through unemployment insurance benefit claims. The individual's interest in obtaining coverage is then shared with Get Covered New Jersey.

Under the Easy Enrollment Health Insurance Program, Get Covered New Jersey has created a system using data collected through tax returns and unemployment benefit claims to 1) determine a resident's eligibility for health insurance coverage and ability to receive financial help and 2) proactively connect Get Covered New Jersey with qualifying residents to help those

[15] N.J.S.A.17B:27A-65 et seq.
[16] N.J.S.A.17B:27A-59.1 et al.

residents enroll in health coverage. The law also permits Get Covered New Jersey to work with the New Jersey Department of Human Services (DHS) to determine an individual's eligibility for NJ FamilyCare[17] and share data with DHS for that assessment. The Easy Enrollment Health Insurance Program was first implemented for the 2023 tax year, with tax return forms used for that tax year filing including the option for residents to indicate an interest in health benefits coverage.

v. New Jersey Reinsurance Program

New Jersey's reinsurance program was authorized by the 2018 New Jersey Health Insurance Premium Security Act, P.L.2018, c.24.[18] The reinsurance program uses federal pass-through funding to help carriers offset high claims payments, with the goal of reducing premium rates overall and making health insurance more affordable for all New Jerseyans. More specifically, the program uses federal pass through funding, based on the saving of Advance Premium Tax Credits, to provide cost sharing for claims that exceed a certain threshold, called the "attachment point" (which has been set at $35,000 for plan years 2021 through 2024), up to the "reinsurance cap," above which point the insurance carrier is responsible for the remaining value of the claims (the reinsurance cap has been set at $245,000 for plan years 2021 through 2024). In essence, the program lowers the cost to carriers of paying claims that fall between the attachment point and the reinsurance cap, which reduced claims payments result in the carrier charging consumers lower premium rates overall.

New Jersey's reinsurance program was highly successful in its first five years, 2019 to 2023, and resulted in reductions in premium rates of approximately 15% compared with what premium rates would be without the program. CMS recently approved an extension of the program through 2028 and will continue to target a reduction in premiums of 15%.[19]

vi. Shared Responsibility Payments

The "New Jersey Health Insurance Market Preservation Act" established, among other things, shared responsibility payments, which are payments residents are required to make if they fail to maintain qualifying health insurance coverage during a given year.[20] These shared responsibility payments restored, at the state level, tax penalties that were originally established as part of the ACA.[21] The purpose of shared responsibility payments is to counter

[17] NJ FamilyCare is New Jersey's publicly funded health insurance program and comprises the Children's Health Insurance Program (CHIP) and Medicaid Program.
[18] N.J.S.A.17B:27A-10.1 et seq.
[19] More information about the reinsurance program can be found here: https://www.nj.gov/dobi/division_insurance/section1332/index.html
[20] N.J.S.A.54A:11-1 et seq.
[21] https://nj.gov/treasury/njhealthinsurancemandate/responsibilitypayment.shtml

the effects of adverse selection, which is when health insurance is primarily purchased by those who are sicker and in need of more complex or more expensive health care services while healthier people stay out of the market. Adverse selection can significantly increase premiums, making health care less affordable for those who most need it. Shared responsibility payments help restore balance to the health insurance marketplace by providing financial incentives for healthier people to participate in the market, thereby reducing the coverage risk profile for carriers and helping keep premium rates lower for all consumers.

vii. Out-of-Network Reforms

In 2018, New Jersey adopted the "Out-of-Network Consumer Protection, Transparency, Cost Containment, and Accountability Act."[22] This law provides enhanced protections for consumers who receive health care services from out-of-network providers, which enhancements include:

- transparency and various disclosure requirements by providers and carriers;
- the creation of an arbitration system for out-of-network payment disputes; and
- protections for consumers for certain out-of-network bills.

The law prohibits health care providers from balance billing consumers for inadvertent out-of-network services, as well as out-of-network services provided on an urgent or emergency basis, above the amount the person would ordinarily pay for those same services when provided on an in-network basis under the person's health insurance plan. The law additionally established an arbitration process to resolve out-of-network billing disputes.[23]

These protections against out-of-network billing help promote affordability by shielding consumers from unexpected and excessive medical bills.

viii. Medical Debt Relief

The "Louisa Carman Medical Debt Relief Act" additionally promotes affordability in the health insurance marketplace by prohibiting certain medical debt collection practices and establishing a process to cancel medical debt when creditors and debt collectors engage in practices prohibited under the law.[24] The law promotes affordability in the health insurance marketplace by helping shield consumers from the burdens of medical debt, while also protecting them from predatory debt collection practices which can have lasting adverse effects on their finances, credit, and quality of life.

[22] N.J.S.A.26:2SS-1 et seq.
[23] https://www.nj.gov/dobi/division_consumers/insurance/outofnetwork.html
[24] P.L.2024, c.48

ix. Small Employer Market Reform

Enacted in 2023, P.L.2023, c.182[25] requires the Department to conduct a formal study to examine improvements in the small employer market, focusing on greater access to quality affordable health coverage. The law provides the Department one year to complete that study, which is expected to be completed by the end of 2024. Because the challenges in small employer markets are not unique to New Jersey, the study will involve both a close examination of the New Jersey small employer market and review of best practices in other states.

b. Current New Jersey Rate Review, Regulation, and Oversight Requirements

Each year, the Department reviews health insurance rate filings and conducts plan management review for health insurance plans to be offered in the coming year. Affordability is a key consideration when developing rates for the next plan year, and the Department does not currently have explicit authority to consider affordability or affordability standards as part of the annual rate review process. Therefore, it is important to understand the current landscape of rate review in New Jersey, as well as other states, to determine both which affordability standards can be implemented in New Jersey and which affordability standards make the most sense for New Jersey.

i. Rate Review

In New Jersey, health carriers are required to submit to the Department informational filings of their rates for individual, small employer, and health maintenance organization (HMO) plans in the coming year.[26] Carriers are generally not required to submit any rate filings, including informational rate filings for plans offered in large group market (other than HMO rates).[27] For the individual and small group markets, State law provides that the Commissioner of Banking and Insurance (the Commissioner) may disapprove any informational filing upon finding that the filing is incomplete and not in substantial compliance with the law, or that the proposed rates are inadequate or unfairly discriminatory. This form of rate review, which is described in greater detail below under "Rate Review Reform" in subsection a. of section III of this report, is known as "file and use." Notably, review under this statutory authority can examine whether a proposed rate is "inadequate," but not whether a proposed rate might be considered

[25] N.J.S.A.17B:27A-10.14.

[26] See N.J.S.A.17B:27A-9 and N.J.S.A.17B:27A-5.

[27] Rates are generally not reviewed in the large group market (i.e., employers with 51 and over or more employees), based on the presumption that large employers are generally more sophisticated purchasers with greater buying power, and therefore plans marketed to these employers require less oversight by the state to ensure the consumer is obtaining rates that are fair and commensurate with actuarial projections.

"excessive." The current statutory rate review process focuses on certain solvency considerations to ensure that, for each insurance carrier, the final rates are adequate to cover anticipated claims, meet certain loss ratio requirements, and ensure the carrier will remain solvent through the coming plan year. This consideration is of utmost importance from a regulatory perspective. However, the Department has no authority to directly reduce premium rates to ensure affordability. Although marketplace competition has the potential to act as a check on premium increases, historically, it has not proven effective in doing so.

The Department reviews rate filings for compliance with both State and Federal law. Since its adoption in 2009, the ACA has largely superseded many New Jersey health insurance laws and requires carriers seeking to significantly increase plan premiums to submit their rates to the state for review.[28]

Generally, the rate review process is intended to ensure that actuaries and health insurance experts evaluate whether proposed rate increases by insurers are reasonable. The ACA and a New Jersey law enacted in 2019, P.L.2019, c.355[29], require that a summary of rate review justifications and results be accessible to the public in an easily understandable format, and additionally require public justification of rate increases above 10 percent.[30] Under New Jersey law, unlike some other states, rate filings that satisfy all applicable requirements are not "approved," but are instead found complete or are "not disapproved."

Regarding the rate review process, the Department will find a rate change is not in substantial compliance with the law if, for example, the change:

- is based on faulty assumptions or unsubstantiated medical trends;
- would charge different rates to people who pose similar risks;
- does not meet Minimum Loss Ratio (MLR) standards, which require 80% or more of premium to be used for the payment of claims; or
- does not comply with permissible rating factors.[31]

It is worth noting that the 1992 law creating the Individual Health Coverage (IHC) and the Small Employer Health Benefits (SEH) Programs has in many regards been superseded by the ACA, and the relevant New Jersey statutes and regulations have, in many cases, been obviated as a result. For example, the New Jersey statutes still contain provisions establishing a loss sharing

[28] Since 2011, the DOBI rate review process was recognized by the Federal Department of Health and Human Services as meeting the ACA requirements to be an Effective Rate Review Program with regard to New Jersey's Individual Health Coverage and Small Employer Health Benefits markets.
[29] N.J.S.A.17B:27A-61 et seq.
[30] See N.J.S.A.17B:27A-63.
[31] See N.J.S.A.17B:27A-7.

program that is now superseded under federal law.[32] Many provisions of New Jersey law were reformed in 2008, including transferring regulatory oversight regarding approval of policy and contract forms and review of premium rate filings and other similar matters from the IHC Program Board to the Commissioner, and removing loss assessments calculated and collected by the IHC Program.

In many cases, the current regulations do not reflect current practices and, if implemented as currently written, would make it impossible for the state to effectively, comprehensively, and consistently oversee and regulate the individual and small employer markets, both with regard to plans offered through Get Covered New Jersey and plans offered off the State-based exchange.

For example, the relevant IHC regulations were initially adopted prior to the ACA and long precede the 2019 law that authorized New Jersey to assume control over operation of the health insurance marketplace from the federal government and operate its own SBE.[33] With respect to the IHC, the plan design function outlined in current statute and regulations overlaps in many significant ways with both the plan management functions of Get Covered New Jersey and the Department's regulatory forms oversight function. Similarly, IHC regulations contain obviated filing requirements for obsolete plans, such as the "basic and essential" plan, that would not meet current ACA requirements. Finally, the disparate authority and oversight responsibilities outlined in the current IHC law and regulations and in the law creating Get Covered New Jersey are unworkable and the Department is beginning the process to ensure they are clarified and streamlined.

One continuing function of the IHC and SEH programs is the process of developing standard policy forms. These standard policy forms are created by the IHC and SEH Boards and govern the language contained in the insurance policies used in the individual and small employer markets. Although the boards have updated the standard policy forms, generally in response to legislation establishing new health benefits coverage mandates applicable to the IHC and SEH markets, the law and regulations that created the standard policy forms and the requirements for reviewing and updating the forms are outdated.

These and other IHC and SEH Board functions are of continuing relevance to state oversight of the insurance marketplace; accordingly, there may be opportunities to clarify, streamline, and optimize lines of oversight within the marketplace overall.

[32] See N.J.S.A.17B:27A-12.
[33] See N.J.S.A.17B:27A-58.

ii. Medical Loss Ratio

A notable aspect of New Jersey's regulation of health carriers is its unique MLR requirements. New Jersey enforced a MLR requirement prior to the adoption of federal MLR provisions in the ACA, and as far back as 2009 required carriers in the individual and small employer markets to comply with a MLR of 80%.[34] New Jersey's method of calculating the MLR is unique and is considered to be more beneficial to consumers because, unlike the federal calculation, New Jersey's calculation does not treat expenses like quality improvements, technology investments, and federal risk adjustment payments as "claims" in the MLR calculation.

Medical loss ratio refers to a measure of the percentage of premium dollars that a health insurance company spends on health care, as distinguished from profits and administrative expenses like advertising, marketing, overhead, salaries, and bonuses. When a carrier has a higher MLR, it means the carrier is spending a greater proportion of premiums on health claims. When a carrier has a lower MLR, it means a greater proportion of premiums are going toward profit and on administrative expenses, rather than direct health claims payments. In calculating MLR, as a general matter, the numerator of the ratio contains the insurance company's expenses on health "claims," and the denominator contains the "premiums" collected by the insurance company. Which expenses may be included in the numerator and what adjustments insurers may or must make to the denominator greatly affect the resulting MLR. New Jersey's MLR requirements work in conjunction with the rate review process. The Department uses loss ratios both prospectively, as part of rate review, and retrospectively, by requiring rebates to consumers when a company's MLR fails to meet the statutory targets. Carriers are required to file their "anticipated loss ratios" as part of the prospective rate filing process, which anticipated loss ratios are subject to actuarial certification. Ultimately, the department seeks to ensure that carriers establish rates that will achieve MLR targets without needing a retrospective correction.

Notably, New Jersey also recently expanded its MLR requirements to large group carriers. Beginning on January 1, 2020, and continuing for each year thereafter, all carriers authorized to issue large group health benefits plans must return, in the form of aggregate benefits for all large group health benefits plans offered by the carrier, at least 85% of the aggregate premiums collected for all of those plans. New Jersey's large group MLR filing requirements largely mirror the federal large group MLR filing requirements.

[34] The New Jersey MLR was established under N.J.S.A.17B:27A-25(g)(2) (small group market) and N.J.S.A.17B:27A-9(e)(2) (individual market). The federal MLR was subsequently established under U.S.C. § 300gg-18. It may be noted that legislation pending in the 2024-2025 session as Senate Bill 2875, which as of the date of this report has been passed by both Houses of the Legislature, would make certain changes to the MLR calculation requirements for health benefits plans in the individual and small employer markets.

iii. Plan Management

As part of administering the New Jersey State Based Exchange (SBE), Get Covered New Jersey, the Department oversees the plan management process. The primary functions of plan management consist of Qualified Health Plan (QHP) certification and management of the QHP agreement between carriers and the SBE. The process includes:

- Developing and issuing QHP applications;
- Evaluating responses to the application submitted by carriers;
- To the extent applicable, conducting negotiations with carriers;
- Approving carrier QHP applications; and
- Executing QHP certification agreements.

The certification of QHPs includes rate and benefit data collection, receiving rate and benefit data during the QHP certification process, utilization of rate and benefit information to support SBE operations, and analysis of the rates and benefits during the recertification and renewal process. As part of this plan management process, SBEs can leverage the certification process to advance policy goals, including affordability for exchange consumers.

iv. Prompt Pay

Other accountability mechanisms for carriers administered by the Department are the 2023 reforms under the "Ensuring Transparency in Prior Authorization Act."[35] Enacted in 2023, this law constitutes the first major reform of the prior authorization process in decades. As part of that enactment, the Legislature found that, among other things:

> …inefficiencies in any area of the health care delivery system reflect poorly on all aspects of the health care delivery system, and because those inefficiencies can harm patients, it is appropriate for the Legislature to update now the uniform procedures and guidelines for hospitals, physicians, and health insurance carriers to follow in communicating and following utilization management decisions and determinations on patients' behalf.[36]

The "Health Claims Authorization, Processing and Payment Act" (HCAPPA) was enacted in 2005 and established uniform procedures and guidelines for health carriers and medical providers to administer utilization management and claims payment processes. The Legislature also found that, “In the nearly two decades since HCAPPA was signed into law, the process has continued

[35] See P.L.2023, c.296, which is found at N.J.S.A.17B:30-55.1 et seq. and which repealed and replaced the “Health Claims Authorization, Processing and Payment Act” (HCAPPA), formerly found at N.J.S.A.17B:30-48 et al.
[36] N.J.S.A17B:30-55.2

to be a source of abrasion and concern for providers and patients."[37] Under HCAPPA, and now under the newly adopted "Ensuring Transparency in Prior Authorization Act," all New Jersey insurance companies, health, hospital, medical and dental services corporations, HMOs and dental provider organizations (DPOs), and their agents for payment must process claims in a timely manner.[38] A carrier or its agent must remit payment of clean claims pursuant to the certain time frames established by law. Claims that are not paid or denied within these timeframes will begin to accrue interest at a rate of 12%. Additional details and requirements related to claims payment and an independent claims arbitration program are set forth under Department rules implementing the HCAPPA.[39] Rules will be adopted as needed to implement the reforms under "Ensuring Transparency in Prior Authorization Act."

Similarly, pursuant to N.J.S.A.17B:30-30 and N.J.A.C.11:22-1.14, carriers and Organized Delivery Systems (ODSs) must report to the Department on a quarterly and annual basis on the timeliness of claims payments and on the reasons for denial and late payment of claims. The annual report on the timeliness of claims payments and on the reasons for denial and late payment of claims is audited by a private auditing firm at the expense of the carrier or ODS. Although the Department regulations contemplate transparency with these reports, including copies of the audited annual report being provided to the Governor and the majority and minority offices of the Legislature,[40] these reports are cumbersome and challenging to analyze and consolidate into an easily understandable format. Following on the efforts to reform and modernize prompt payment rules under the "Ensuring Transparency in Prior Authorization Act," and the stated Legislative purposes to reduce "abrasion" and to enhance both transparency and efficiency, the Department will review and enhance the process for prompt pay reporting and public disclosure as part of the implementing that Act.

Generally, prompt pay requirements hold payers accountable for processing and making payments on claims in a timely and consistent manner. This, in turn, promotes efficiency in the health care delivery system and reduces friction between payers and providers. which ultimately benefits consumers. Fair and consistent enforcement of prompt payment requirements and transparency concerning payments will help to ensure that claims are reviewed and paid in a prompt, fair, and consistent manner and will help eliminate inefficiencies in the system that can increase administrative costs, create barriers to accessing care, and possibly result in consumers foregoing claims for services that are otherwise covered under their health benefits plans because of the administrative hurdles they encounter when seeking to enforce the terms of their policies.

[37] Id.
[38] N.J.A.C.11:22-1.5.
[39] N.J.A.C.11:22-1.1 et seq.
[40] N.J.A.C.11:22-1.14(b)

III. Potential Enhancements and Reforms to Improve Affordability and Further Implement the State's Benchmark Program

A review of initiatives considered by or implemented in other states identified a variety of options to improve affordability in the health insurance market.

One potential reform is to create or augment the state's ability to approve rates. Additionally, initiatives that improve competition within the market can help reduce costs within that market and provide the state with greater leverage in negotiating rates. Public input into the rate review process can also help improve affordability, as can enhancements to the plan management and design process and ensuring New Jersey continues with its consumer-focused MLR requirements. Finally, the establishment of an all-payer claims database (APCD) can support the state's benchmarking efforts by providing comprehensive claims data to support richer and more contextualized analyses that can be targeted to specific areas of interest.

This section outlines each of these initiatives in more detail, including recommendations to codify New Jersey's benchmark program and include in the legislation the creation of an APCD.

a. Rate Review Reform

Broadly speaking, there are two basic approaches to rate review: "prior approval" and "file and use." Prior approval authority is a stronger form of regulatory oversight and allows states more influence and control over the rates used in that state, as it authorizes the state to approve, reject, or reduce proposed rate increases, usually through negotiations with the insurer. About half of states have prior approval authority. [41] In contrast, "file and use" states, including New Jersey, require carriers to submit certain information and provide certain data to support their filed rates, but leave the states with limited authority to push carriers to make changes to their proposed rates.

The strength and impact of prior approval authority exists on a spectrum, and the level of authority in place in a given state depends on a combination of factors:

- Scope: the types of insurers under review (e.g., individual, small-group, large-group; community-rated, experience-rated; for profit, not for profit; HMO, non-HMO).
- Transparency and Public Input: whether the initial filings and outcomes of the rate review process are publicly available and whether the process includes opportunities for public input, such as public hearings and public comment periods.
- Loss Ratio Requirements: whether the state requires insurers to meet a state-established loss ratio requirement, the MLR calculation methodology, and MLR rate.

[41] https://www.kff.org/wp-content/uploads/2013/01/8122.pdf

- Staff Capacity: the staff and resources dedicated to the rate review process.

It should be further noted that the rate review process and MLR requirements can work hand-in-hand to improve affordability by helping ensure that a minimum percentage of premium dollars collected are spent on claims while simultaneously helping ensure that premium rates, as approved, are appropriately priced for the marketplace, thereby avoiding the need for carriers to issue rebates.[42]

One study found that, from 2010 to 2013, adjusted premiums in the individual market in states that had prior-approval authority coupled with MLR requirements were lower than premiums in states with no rate review authority or that had only file-and-use regulations ($3,489 compared with $3,617).[43] Additionally, adjusted premiums declined modestly (from $3,526 in 2010 to $3,452 in 2013) in prior-approval states with MLR requirements, while premiums increased (from $3,422 to $3,683) in states with no rate review authority or file-and-use regulations only.[44]

The effectiveness of MLR standards may be further enhanced by adopting more stringent MLR requirements. For example, New York enacted an 82% MLR requirement in its individual, small group, and community-rated large group contract forms, and most carriers are required to demonstrate compliance with the 82% MLR standard as a condition of regulatory approval. California similarly established a MLR of 80-85%.[45]

Other studies suggest states will likely be most successful improving affordability if they have:

- statutory authority backed up with the analytic capacity to review rates and to negotiate with carriers; and

[42] Carriers in New Jersey are required to issue a rebate to policyholders when they fail to meet MLR requirements, which generally occurs when the carrier's rates are set higher than is needed to spend 80% of premium income on claims. Carriers are then required to return the excess income to policyholders in the form of rebates in order to bring premium income into alignment with the MLR threshold. Ideally, each carrier's rates are established at a level that is commensurate with MLR requirements, avoiding the need for rebates.

[43] https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.1463 (it should be noted this study period preceded the federal MLR requirements that took effect in 2014)

[44] https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.1463 (it should be noted this study period preceded the federal MLR requirements that took effect in 2014)

[45] New Jersey has a statutory right to adopt an MLR percentage higher than that required by Federal law in its individual, small, or large group markets, as long as it "seek[s] to ensure adequate participation by health insurance issuers, competition in the health insurance market in the State, and value for consumers so that premiums are used for clinical services and quality improvements." 42 U.S.C. § 300gg-18

- the ability to align their approach to rate review with related efforts to constrain provider prices or price increases, and/or advance payment and delivery system reforms.[46]

A strong rate review process can also help regulators counteract the practice of "gaming," whereby plans may submit higher rates knowing those rates will be negotiated downward.[47]

Rate review processes often become a negotiation between the regulators and carriers and are predicated on a complex range of factors. Generally, competition within the marketplace gives states additional leverage in rate review negotiations, particularly when there is competition among carriers offering plans that cover all regions within the state. In New Jersey's individual market, the addition of new carriers into the market has resulted in an increase in competition since 2018.

b. Public Input in Rate Review

Another important consideration in the rate review process is the level of public engagement. The public's access to rate review information and public participation in the rate review process may increase scrutiny and improve the fairness of the final rate. Currently, public access to rate filings in most states is limited. New Jersey law does not provide for a formal role for the public in health rate filings, except in the case of the expanded review required when a carrier's annual informational rate filing proposes a rate increase of 10 percent or more. In such cases, the carrier must provide an enhanced justification on which the public can submit comments.[48]

However, some states design their rate review processes to allow for extensive public education and input. For example, Connecticut's insurance department posts all health insurance filings on its website and makes them available to the public.[49] During the rate review process, consumers may comment about the rates under review. Individual policyholders also receive prior notification from their insurance company when a proposed rate increase is filed with the insurance department. Similarly, Oregon's rate review program posts carriers' justifications of rate increases on the Oregon Insurance Division's website, and the public has opportunities for input through public comments and hearings.[50]

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[46] https://www.commonwealthfund.org/sites/default/files/2022-02/Hwang_health_care_cost_growth_strategy_06_review.pdf
[47] https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05164
[48] N.J.S.A.17B:27A-63
[49] https://portal.ct.gov/cid/consumer-resource-library/insurance-rate-filing/health-insurance-rate-filings-and-decisions?language=en_US
[50] https://dfr.oregon.gov/healthrates/pages/index.aspx

Many states and the federal government allow carriers to shield their rate filings from public scrutiny on the grounds that these filings constitute a trade secret. The trade secret exemption is designed to protect carriers from having business information revealed to competitors. However, for several reasons, this concern may be overstated. Except in very limited circumstances, rate filings are unlikely to contain information that could harm competition or the business interests of carriers. In fact, several states, including New York and California, require public disclosure of the complete justification for rate increases. In short, it has been suggested that the use of the trade secret exemption and similar measures that classify rate filings as confidential protect carriers from public scrutiny even where there is a limited threat to business interests and competition.[51]

c. Incorporating Affordability Standards into Rate Review

Rate review authority is an important aspect of minimizing premium increases but does little to address how medical costs drive increases in health insurance costs. In recent years, more states have begun to consider the affordability of the health insurance products being offered to consumers and the underlying medical costs driving increases in premium rates.[52] With respect to affordability standards specifically, states can expand their rate review processes to encourage or require carriers to promote tools and initiatives that encourage minimization of medical costs and promote efficiencies in the provision of care, such as incentives to promote use of primary and preventative care, which can help avoid the need for more expensive treatments and interventions, and the use of value-based and alternative payment models to encourage providers to minimize redundant, unnecessary, or cost-ineffective treatment modalities.

For example, in approving, disapproving, or modifying an insurer's proposed rate, Vermont's Green Mountain Care Board must determine, in addition to whether the rate protects solvency and is consistent with state law, whether a rate is "affordable, promotes quality care, [and] promotes access to health care."[53] Similarly, Connecticut's affordability index is a tool that helps to define affordability and the impact of policymaking on health care affordability across the state.

One of the first states to incorporate affordability metrics into the rate review process is Rhode Island, which has used a unique insurance rate review approach to keep hospital costs from rising at a rate that exceeds inflation plus one percent. Rhode Island's approach allows regulators to oversee hospital costs and requires insurers to invest in the state's health priorities. Specifically, a contract between a hospital and an insurer must be approved by the

[51] https://www.healthcarevaluehub.org/advocate-resources/publications/health-insurance-rate-review
[52] https://nashp.org/insurance-rate-review-as-a-hospital-cost-containment-tool-rhode-islands-experience/
[53] 8 V.S.A. § 4062

Rhode Island Office of the Health Insurance Commissioner if the average rate increase exceeds the Consumer Price Index for Urban Consumers (less Food and Energy), or "Core CPI-U," minus 1% OR if less than 50% of the average rate increase is for quality incentive payments.

In conjunction with these affordability standards, based on very specific statutory authority, Rhode Island directs insurers to comply with four additional criteria in order to have their premium rates approved:[54]

1. Primary care investment;
    a. Insurers must spend at least 10.7% of annual medical expenses on primary care
2. Spread the adoption of the patient-centered medical home model;
    a. 80% of primary care practices contracting with an insurer must function as a patient-centered medical home
3. Support CurrentCare, Rhode Island's health information exchange; and
4. Work toward comprehensive payment reform across the delivery system (which criterion was further divided into six conditions):
    4.1 Pay for inpatient and outpatient services using "units of service" that encourage efficient resource use;
    4.2 Limit the average annual effective rates of price increase for both inpatient and outpatient services to a weighted amount equal to or less than CMS' National Prospective Payment System Hospital Input Price Index ("IPPS") plus 1% for all contractual years;
        - 50% of the annual hospital rate increases must be earned through the agreed-upon quality measures (see 4.3)
    4.3 Give hospitals an opportunity to increase total annual revenue based on meeting mutually agreed upon quality goals;
    4.4 Include contract terms to meet agreed upon obligations for administrative simplification;
    4.5 Include contract terms that promote and measure improved care coordination; and
    4.6 Include transparency for these six terms in contracts.

The Rhode Island model of incorporating affordability standards into the insurance rate review process is appealing to regulators as a tool to influence payer-provider negotiations. Moreover, affordability standards provide regulators with further insight into insurance market dynamics and the cost shifts that result from state efforts to increase affordability.[55]

[54] https://ohic.ri.gov/sites/g/files/xkgbur736/files/documents/2020/July/31/230-RICR-20-30-4-FINAL-SOS.pdf (see pages 21-28)
See also http://www.ohic.ri.gov/ohic-reformandpolicy-affordability.php
[55] https://nashp.org/insurance-rate-review-as-a-hospital-cost-containment-tool-rhode-islands-experience/

A 2019 *Health Affairs* review found that, from 2010 to 2016, implementation of Rhode Island's affordability standards led to a net reduction in per enrollee spending by a mean of $55.[56] The study showed that outpatient and inpatient utilization did not significantly change, but spending per encounter decreased in Rhode Island compared to a control group.[57] Quarterly fee-for-service spending actually decreased by $76 per enrollee, but the requirement to increase non-fee-for-service primary care spending raised per enrollee spending by $21, netting a quarterly savings per enrollee of $55.[58] In addition, patient cost sharing was lower in Rhode Island after the affordability standards were implemented compared to a control group.[59]

To address any concerns around the impact of the cost control mechanisms on the quality of care, it is worth considering that quality metrics likely did not materially change with implementation of the standards. In fact, interviews conducted for a 2013 review of the standards found that Rhode Island's "at-least-50-percent" provision for hospital contracting caused a "culture shift" among hospitals by causing them to focus their attention on meeting quality measures.[60]

In 2010, a law went into effect in Oregon that expanded the factors Oregon's Insurance Division could consider as part of the rate review process, such as how each carrier approaches cost containment and quality improvement, as well as scrutinizing whether administrative expenses are reasonable. A study of the impact of these new rules found that, by 2013, state officials had cut rate hikes by more than 17% on average, compared to 6% on average prior to 2010. At the same time, carriers' initial rate requests also declined.[61] In addition, rate review decisions were found to have reduced the portion of premium spent on administrative costs by 5.4% on average, going against the trend seen before 2010.[62] A 2015 estimate determined that, since 2010, the Oregon rate review program had cut about $179 million in unjustified costs from premiums.[63]

Similarly, in Delaware, per statute, no health insurer can submit a rate filing where the aggregate unit price increase for non-professional services exceeds a rate pegged to the Core CPI-U; for example, in 2022, the unit price rate increase limit was the greater of 3% or Core CPI +1%.

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[56] https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05164
[57] Ibid.
[58] Ibid.
[59] Ibid.
[60] https://ohic.ri.gov/sites/g/files/xkgbur736/files/documents/4_Concise-Statement-Technical-Document-2015-amendments.pdf
[61] https://www.healthcarevaluehub.org/advocate-resources/publications/health-insurance-rate-review#note1
[62] Ibid.
[63] Ibid.

Delaware's Office of Value Based Health Care Delivery has recommended that progress toward the following affordability standards be considered in the rate review process:

- Primary care investment
    - Insurers increase investments in primary care by 1-1.5% of total medical expense per year until 2025
- Decrease unit price growth
    - Insurers limit unit price growth for non-professional services according to a schedule tied to Core CPI
- Alternative payment model (APM) adoption
    - Minimum of 50% of total medical expense is tied to an APM contract with shared savings and 25% to an APM contract with shared savings and downside risk
    - Provide opportunities for independent providers to participate in pay for performance programs
    - Pilot capitated payments for primary care

It is worth separately noting that one of the primary goals of Delaware's Affordability Standards is to require carriers to invest more in high quality primary care and primary care providers and services. A focus on primary care may reduce overall costs by focusing on prevention.[64] For example, the affordability standards in both Delaware and Rhode Island set minimum payments by insurers for primary care and require increased use of alternative payment models.

d. Plan Management Reforms

As part of the plan management process, State Based Exchanges can leverage the certification process to advance policy goals, including affordability for exchange consumers. At least three states, including California, Rhode Island, and Massachusetts, use what is termed an "active-purchaser" approach, under which the Marketplace negotiates aggressively with insurance carriers in order to obtain the best possible premiums, networks, and benefits for plans sold on the exchange. This "active purchaser model" imposes scrutiny of rates for customers that purchase those products and may act to keep rate increases in check. As an alternative, approximately 10 states use a "clearinghouse" approach, under which the SBE sets the criteria that plans must meet in order to be sold on the SBE, and all plans that meet that criteria are welcome to participate.[65]

California's state-based exchange, Covered California, holds health insurers accountable through its selection of who can participate in the marketplace and through an array of

[64] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9793026/

[65] Robinson, James C., et al., "Whither Health Insurance Exchanges Under the Affordable Care Act? Active Purchasing Versus Passive Marketplaces," *Health Affairs* (October 2015).

reporting and performance requirements. Covered California also requires insurers to promote advanced primary care and integrated and coordinated care. Ultimately, California's active purchaser approach has shown evidence of promoting better care, and an increasing proportion of Covered California enrollees are receiving care through the various approaches developed under this program. Specifically, a 2018 study found that Covered California has had premium growth rates that have consistently been below national averages.[66] Another study found that the strong authority exercised by Covered California may have moderated premium growth compared with what would have been expected based on increasing insurer concentration in that state.[67]

Covered California also encourages carriers to only contract with providers and hospitals that are able to demonstrate that they provide quality care and promote the safety of enrollees at a reasonable price. Covered California works with Cal Hospital Compare, a performance reporting initiative developed in collaboration with various industry stakeholders, and its QHP issuers, to identify areas of "outlier poor performance" for hospitals based on variation analysis.[68] In its annual application for certification, which is used for negotiation purposes, carriers are required to report on strategies to ensure that contracted providers are not charging unduly high prices, and for what portions of its entire enrolled population it applies each strategy.[69] In short, California has built up and leveraged an integrated system of reporting requirements, minimum performance standards, provider incentives, stakeholder partnerships, and accountability standards to drive improvements in the quality of care while reducing the costs of care for consumers.

Similar examples may be found in Massachusetts, which has been operating a SBE the longest of all the states, in a marketplace with significant health plan competition. The Massachusetts SBE determines which plans are offered for sale and restricts the benefit designs that can be offered. Despite operating in a relatively high-cost medical state, the Massachusetts Health Connector had the lowest average premiums of any SBE in the country for 2017 and 2018. It has been suggested that Massachusetts' success at keeping Health Connector premiums low is a function of a number of careful state-level policy choices and program design approaches.[70]

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[66] Bingham, Al, et al., "National vs. California Comparison: Detailed Data Help Explain the Risk Differences Which Drive Covered California's Success," *Health Affairs* (July 2018).

[67] Scheffler, Richard M., et al., "Differing Impacts of Market Concentration on Affordable Care Act Marketplace Premiums," *Health Affairs* (May 2016).

[68] https://hbex.coveredca.com/data-research/library/CoveredCA_Holding_Plans_Accountable_Dec2019.pdf

[69] https://hbex.coveredca.com/stakeholders/plan-management/qhp-qdp-certification/

[70] Notably, Massachusetts has many unique features, including merging the non-group and small group markets, that make it difficult to disentangle the impact of any one policy. See Gasteier, Audrey Morse, et al., "Why Massachusetts Stands Out in Marketplace Premium Affordability," *Health Affairs* (September 2018).

e. Codification of Benchmark Program and APCD

With regard to benchmarking, a review of state policy options reveals that the majority of states that operate a benchmark program have legislation to support the program and, in many cases, an all-payer claims database (APCD).[71] Additionally, many states benefit from pairing the use of an APCD with benchmarking data to support richer and more contextualized analyses around specific areas of interest.[72] It is noteworthy that states, such as Connecticut, that began their benchmark program through an Executive Order, later joined states with legislation by codifying their benchmark programs through legislation.[73]

In order to achieve the state's goals underlying its HART/Benchmark Program, New Jersey must have the capacity to collect, assess the quality of, and analyze health care spending data. These processes require trained staff to manage activities from data specification development and data collection to quality assurance and reporting. Massachusetts, as the earliest adopter of a benchmark program, established a robust annual process for collecting and analyzing data.[74] It should also be considered that Massachusetts had many years of experience operating an APCD along with their benchmark program.

Other states with both an APCD and a benchmark program include Connecticut, Delaware, Nevada, Oregon, Rhode Island, and Washington.[75] The majority of these states have also pursued their benchmark programs through the adoption of legislation. A few smaller states, such as Rhode Island and Delaware, established and continue to operate their benchmark programs pursuant to an Executive Order; however, it is likely these states have been able to proceed without a statutorily-codified benchmark program in part because, as smaller states, they have comparatively few insurance carriers to regulate, as well as because they already had robust data collection capabilities in place through existing APCDs when their benchmark programs were established.

Accordingly, at this time, New Jersey is unique in that it does not have an APCD and is operating a benchmark program through an Executive Order. This means there is an opportunity for the State to establish and develop a robust data collection and analysis capability through an APCD, as well as an opportunity to establish the statutory authority to enforce data collection and cost growth targets through the benchmark program.

[71] https://www.ncsl.org/health/health-policy-snapshot-addressing-commercial-health-care-prices
[72] https://www.manatt.com/Manatt/media/Documents/Articles/RWJF_State-Benchmarking-Models_June-2021_i_FOR-WEB.pdf
[73] https://portal.ct.gov/ohs/programs-and-initiatives/healthcare-benchmark-initiative?language=en_US
[74] https://www.manatt.com/Manatt/media/Documents/Articles/RWJF_State-Benchmarking-Models_June-2021_i_FOR-WEB.pdf
[75] https://www.apcdcouncil.org/state/map

For these reasons, the Department recommends a legislative approach to achieving the state's goals of data transparency and health care cost growth targeting that includes both codifying both the existing benchmark program and create an APCD that will work hand-in-hand to promote affordability and transparency in New Jersey. The legislation should codify the current benchmark program, including both the substance of Executive Order 277 and the Compact, which will solidify both the state's authority to implement the benchmark program and the stakeholder input that helped shape the existing program. The legislation should additionally include the authority, and necessary funding, to concurrently develop an APCD. As the development of an APCD will take time, likely multiple years, the legislation should ensure the APCD is sustainably paired and aligned with the benchmark data goals over the long term. This pairing of an APCD with a benchmark program in statute will provide a solid foundation for the future. Such a law would allow the state to use data to develop and implement a range of policy initiatives to improve and track quality of care, increase affordability and minimize cost growth for years to come.

IV. Conclusion

There are a number of policy options the state can pursue to achieve greater affordability in the regulated insurance markets, as well as to support, expand, and enhance the goals of the benchmark program. Most notably, legislation to codify the benchmark program and create an APCD will create a foundation built on data for the state to build out its policy goals. As each other state that has implemented a benchmark program has done, building a data foundation and capacity through an APCD will provide a sustainable approach for policymakers to increase transparency and develop policies well into the future.

With regard to affordability in the regulated insurance markets, in the short term, the primary tools to influence cost and affordability, such as rate review, plan management, plan design, and other innovative policies, are most prevalent in the individual market. However, it is important to remember that this market, while growing in enrollment over recent years, covers a relatively small proportion of the population. The same can be said for the small group market, which for several years has seen a continuing decline in enrollment, both in New Jersey and nationwide. New Jersey lacks the capacity and historical basis for reviewing rates, conducting plan design, or engaging in other oversight of the large group market, where a significantly larger segment of the population obtains health insurance. New Jersey, unlike states that have prior approval authority or broader rate review authority, is not in the position to implement enhanced rate review overnight.

Notwithstanding the foregoing, there are opportunities for New Jersey to build on an already robust regulatory position to take significant steps forward in these regulated markets. First, based on the positive experiences in other states, incorporation of affordability standards, such

as investments in primary care, alternative payment models, and medical cost controls into the rate review process, are likely to have a positive impact on affordability in those markets. In addition, increasing public access to information obtained and analyzed during rate review could yield similar success to other states with public access to rate filing information. These measures would build on New Jersey's already protective MLR approach and noteworthy focus on solvency regulation. Legislation to provide the Department more authority in rate review, including adopting the prior approval rate review model, would be central to implementing these initiatives. Other potential reforms may include advancing initiatives to promote additional statewide competition across all commercial insurance markets, as well as promoting more robust tracking and enforcement of the existing prompt pay requirements to ensure carriers are held accountable to current standards that promote affordability, transparency, and consumer protections.

Second, streamlining the regulation of the individual market to provide greater capacity and authority through Get Covered New Jersey to conduct plan design and more robust plan management functions could bring even more positive results to the individual market. Outdated operational and regulatory structures are currently being streamlined to allow Get Covered New Jersey to have greater capacity to conduct plan management, eliminate redundancies and ambiguities in oversight authority and regulatory standards, and ensure New Jersey's regulatory systems and processes are in alignment with best practices nationwide. This will allow Get Covered New Jersey to follow states with more active exchanges to influence the affordability and underlying costs associated with individual coverage.

The Department can also take a renewed focus on the transparency measures already existing in the Department regarding carrier payments, carrier spending on primary care, measuring quality of carrier operations, prompt pay reporting requirements, and more robust public reporting of these transparency measures, such as reviewing the process around prompt pay reporting with an eye towards making more of this information available in a more easily understandable format. These transparency measures, along with greater transparency in the rate review process, will allow the public to see that carriers are being held accountable while also providing a view into the underlying cost drivers of health insurance premiums. Potential reforms could include removing confidentiality restrictions on rate filings like the regulation generally requiring actuarial memoranda be kept confidential[76], and posting rate filing information online.

Finally, the state could consider adopting via statute an integrated approach to implementing affordability standards that, like the models adopted in California and Massachusetts, develop multiple interwoven strategies that build upon and enhance each other, thereby simultaneously addressing from multiple angles the myriad factors that can affect the

[76] N.J.A.C.11:1-21A.5.

affordability of health insurance and health care costs overall. However, it is important to first build the foundation for sustainable policymaking through data collection and analysis. States that have implemented the full range of these strategies over decades have not found the silver bullet to manage health care cost and affordability. However, as we have seen from these states that have codified benchmark programs and APCDs, once the foundation is in place to access and analyze the range of health care data that would be available through a codified benchmark program and APCD, the state will have a stronger and more sustainable path to policymaking to address health care costs and affordability.