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Health Insurance Exchanges: Governance Issues for New Jersey

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Preface

In September 2010, Rutgers Center for State Health Policy (Center) was awarded a one year grant from the Robert Wood Johnson Foundation to provide information and support to New Jersey policymakers on key elements of the Patient Protection & Affordable Care Act (ACA). The goals of the project were twofold: (1) to create a neutral forum for stakeholder input into the ACA implementation decisions for New Jersey, and (2) to provide state decision makers with expert consultation and information on implementation options, including the design of a health insurance exchange.

With regard to the second project aim, the Center engaged in a collaboration with Professor John Jacobi and colleagues at Seton Hall University School of Law School (SHU) to complete a series of white papers on the legal considerations of specific provisions within the ACA related to health insurance coverage in New Jersey. The regulation of private insurance – historically a state role – has evolved in recent years into a shared federal-state responsibility. The ACA will significantly restructure the regulation of private insurance, and will require state legislative responses. These changes offer NJ policymakers opportunities to shape how the uninsured gain coverage in the state and how those with insurance are affected by the new law. This paper, entitled *Health Insurance Exchanges: Governance Issues for New Jersey,* is the first in a series of publications that will be released under this collaboration. Later this year, SHU will complete a second paper examining strategies for selecting qualified health plans for offer within the health insurance exchange, followed by a third volume which will discuss the implications of risk adjustment and reinsurance in the exchange.

Acknowledgments

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Health Insurance Exchanges: Governance Issues for New Jersey

John V. Jacobi, J.D.

Executive Summary

The Affordable Care Act (the "ACA")[1] enacted sweeping changes in public and private insurance law. One key aspect of the ACA's reform of the private insurance market is its provision for the creation of health insurance exchanges.[2] The idea of health insurance exchanges is not new. Indeed, New Jersey for almost two decades has operated versions of exchanges for the individual and small group markets, and therefore has some experience in organizing relatively uniform and transparent insurance markets for the benefit of consumers. The ACA creates obligations and opportunities for New Jersey to further this effort. Before the exchanges can begin operating, facilitating the broader provision of health coverage for the people of New Jersey, a fundamental question must be asked: how might the New Jersey Legislature design the governance of this new entity? The issues that arise in connection with exchange governance are many, and their difficulty should not be minimized. The goal, however, is to effectively and efficiently serve the needs of New Jersey within the framework created by the ACA in a manner consistent with the public principles of our State regarding health insurance coverage for individuals and small groups. Other implementation issues will be addressed in future Briefs; the focus of this Brief is the governance of the new entity that will implement the Legislature's vision.

The New Jersey Legislature is actively considering several bills that would create health insurance exchanges.[3] This Brief[4] analyzes a set of key issues central to the design of the

[1] The Patient Protection and Affordable Care Act ("PPACA"), P.L. 111-148 was signed by the President on March 23, 2010, and a "clean-up" amendatory bill, the Health Care and Education Reconciliation Act of 2010 ("HCERA") was signed one week later. For ease of reference, this package of health reform bills will be referred to in this paper (unless otherwise indicated) as the Affordable Care Act, or the ACA.

[2] The ACA requires that states intending to create a health exchange do so by January 1, 2014, and that the Secretary of the United States Department of Health and Human Services ("the Secretary") determine by January 1, 2013 whether each state will in fact meet the 2014 deadline. ACA §§ 1311(b), 1321(c).

[3] *See* A1930 (Conaway, Gusciora, Chivukula, Ramos, and Connors); A3561 (Albano); A3733 (Quijano and Spencer); S2553 (Vitale and Gordon); S1288 (Van Drew); S2597 (Gill and Vitale).

[4] This Brief is part of a larger project analyzing state regulatory and statutory changes required or suggested by the ACA. The analysis and conclusions in this Brief are preliminary, and are subject to elaboration and amendment as the project proceeds. This Brief assumes the ACA as enacted. Pending bills in Congress and pending litigation that would repeal, strike, or otherwise modify the ACA are not considered in this analysis.

exchange[5] entity or entities. Its goal is to provide guidance on how to design the governance of an exchange such that it complies with federal and state law, meshes with New Jersey's legal and public policy history, and is calculated to perform its functions as expeditiously and efficiently as possible

- *The Exchanges' Geographic Scope.* The ACA allows several options for the geographic coverage of exchanges. If a state declines to create exchanges, the federal government will create, or arrange for the creation of an exchange in or for that state. If a state decides to create an exchange, it can do so in several ways: through cooperation with other states, it can form a multi-state exchange, it can form its own state-specific exchange, or it can create several subsidiary exchanges within its borders. This Brief assumes that New Jersey will not default to the federal option. It also concludes that New Jersey is unlikely to join a multi-state exchange, both because New Jersey has sufficient population to be able to support its own exchange, and because New Jersey's long-standing health insurance regulatory and market structures would be somewhat difficult to mesh with those of other states. Further, subsidiary exchanges in New Jersey are unlikely to add sufficient benefit to justify the administrative duplication they would engender.
- *Form of Governance.* The ACA permits the exchange to be within or outside of government. In New Jersey, the exchange governance could be formed within a principal department, as a new independent "in but not of" agency, or as a new nonprofit organization.
    - *Which Form?* One state has located the exchange within government – Utah's exchange is in the Governor's office. Other states that have passed exchange legislation have created "independent" governmental agencies or authorities to house their exchange. As yet, no state has opted to house the exchange in a nonprofit. The three options can be described along a continuum of both public responsiveness and nimbleness of management. Principal state agencies are formally most subject to obligations of transparency and responsiveness to the public; independent (in New Jersey "in but not of") agencies somewhat less so, and nonprofits least of the three. On the other hand, independent nonprofits are most able to respond to changing market conditions or other contextual shifts, "in but not of" agencies less so, and principal agencies least of all.
    - *How Much Does Form Matter?* Under New Jersey law, an exchange in any of the three forms could be legislatively crafted so as to be more or less transparent

[5] States can create a single exchange for both individual and small group coverage, or separate exchanges for the two different markets. ACA § 1311(b)(2). The use of the singular (exchange) or plural (exchanges) in this Brief is not intended to judge or comment on whether those exchanges should be merged.

and more or less nimble. Unlike others states (*e.g.,* New York), there is no constitutional inhibition against the New Jersey Legislature's crafting an individualized set of public responsiveness requirements for the exchange. The starting point matters, however. If the Legislature were to create the exchange as an "in but not of" public entity, it would be subject to laws normally applicable to state agencies*, e.g.,* the Open Public Records Act. But the Legislature could tailor the requirements by, for example, relaxing New Jersey's procurement rules for the exchange to permit it to contract without public bidding on appropriate occasions for actuarial consulting to respond to an insurer's circumstances. The Legislature is free, then, to adopt a policy of transparency and responsiveness in most regards, while relaxing those requirements where circumstances seem to demand such freedom.

- *Conforming to New Jersey's Practice.* The Legislature has several decisions to make in designing a governing board for the exchange. The ACA and commentators provide some guidance in this regard, as does the growing experience of other states as they design their exchange's governing boards. This national experience must, however, be assessed in New Jersey's unique historical and legal context.
    - *Should All of New Jersey's Individual and Small Group Markets Be Brought Within the Exchanges?* New Jersey has had an exchange-like structure for individual and small group markets since 1992. These programs, the Individual Health Coverage ("IHC") and Small Employer Health Benefits ("SEH") programs provide a means for individuals and small employers to shop for standard health insurance plans. The IHC and SEH programs could be combined with the ACA's individual and small group exchanges in New Jersey, simplifying the health insurance marketplace. The states that have created exchanges have opted to leave extant non-exchange markets for health insurance. Individual and small business purchasers may wish to shop for insurance unassociated with the exchanges. In addition, federal law prohibits undocumented persons from purchasing insurance through the exchanges, even if they are willing to pay the full asking price. Further, the rules regarding access to medically necessary abortion coverage are quite complex for plans sold within the exchanges. For these reasons, it may be prudent to maintain individual and small group coverage both inside and outside the exchanges.
    - *How Should the Governance of the Various Individual and Small Group Programs Be Coordinated?* If the Legislature decides to maintain individual and small group programs both inside and outside the ACA exchanges, then New Jersey will have up to four health insurance programs. The wisdom of combining the individual

and small group markets in order to reduce the chance of adverse selection and increase administrative efficiency has been debated over the years in New Jersey. The Legislature has considered these benefits to merger against the social and practical counterarguments, and has maintained these programs to separate existence. Their governance should be coordinated, however, for two reasons. First, individual and small group programs can be seriously impaired if they are subject to adverse selection, pursuant to which the insureds of one program (say, the IHC) come to acquire a higher risk profile than those of another (say, the exchange's individual insurance program). Sharing of information among the programs will be essential to anticipating responsive steps should adverse selection issues arise. Second, there are efficiencies to be gained from close coordination of similar programs. One simple method for coordinating the programs would be for the Legislature to establish a single umbrella board to have governance responsibility for all individual and small group programs, with subsidiary boards or administrative staff responsible for the separate programs. In this way, the Legislature could create structures to assure coordination, while maintaining dedicated resources to administer particular programs.

- *How Should the Board(S) Be Composed?* Several seemingly minor issues should be addressed in crafting the board(s) in order to ensure their success – the number of members, their qualifications, and protections against conflicts of interest.
    - *Size.* Boards are most able to reach consensus and move forward expeditiously if they are relatively small. Most of the exchange boards created in other states have two-to-four *ex officio* members and five-to-ten public members.
    - *Membership Qualifications.* There are two sets of criteria that could be considered: core competencies (experience and training on matters such as actuarial science, health finance, and health care delivery), and representational status (membership in or advocacy for stakeholders). Boards in some states are devoted entirely to the former; in others, both competencies and representational status are considered.
    - *Conflict of Interest.* The board(s) will have difficult decisions to make and will be under substantial time pressure. Gaining trust of the community will be essential to its effectiveness. For this reason, some commentators advise that core stakeholders not be members of the governing board; some states have agreed, and have excluded stakeholders, *e.g.,* employees of insurers or brokers from the board, while other states have

required disclosure of conflicts and recusal from votes where conflicts are salient.

- *Squaring the Circle*: *Accommodating Both Independence and Representation.* It is important that the Legislature accommodate both the need for a credibly independent governing board and the interest of stakeholders for a seat at the table. This can be accomplished by creating both a governing board and an advisory board. The governing board could be small, independent, and expert, and be empowered to oversee the activities of the exchange. The advisory board could be larger, representative of all stakeholders, and assigned the task of developing recommendations on key issues such as cost control, funding for exchange operations, and market consolidation. The Legislature could prescribe the nature of the interaction of the boards, thus assuring that the advisory board's role is meaningful.

Health Insurance Exchanges: Governance Issues for New Jersey

John V. Jacobi, J.D.

Introduction

Improving access to health insurance is a central feature of health reform. The insurance marketplace can be particularly daunting for individual purchasers and small businesses attempting to cover their employees. The principal impediments to increasing insurance access include:

- Complex insurance markets (many insurers offering many different products at many different prices);
- Underwriting and rating restrictions, such as medical underwriting and preexisting illness exclusions;
- High transaction costs for the acquisition and maintenance of coverage in the individual and small group markets; and
- Premium increases, which frequently outpace increases in the cost of living.

Reform efforts often attempt to address these difficulties through the creation of clearinghouses, denominated exchanges, purchasing pools, or purchasing cooperatives. These entities usually organize and disseminate insurance information. In addition, they modify markets by, for example, requiring that insurance plans fit within a limited range of product designs, or restrict insurers' use of underwriting tools. These clearinghouses strike different balances between encouraging free market competition among insurers and regulating insurance activity. The evidence of their success in enhancing access to coverage is mixed.[6]

Many states created versions of exchanges in the 1990s. New Jersey enacted small group and individual market reform laws in 1992, creating the Individual Health Coverage

[6] *See* Rick Curtis and Ed Neuschler, *Insurance Markets: What Health Insurance Pools Can and Can't Do* (California HealthCare Foundation, November 2005), *available at* http://www.chcf.org/~/media/Files/PDF/W/PDF%20WhatHealthInsurancePoolsCanAndCantDo.pdf; *Elliot Wicks, Health Insurance Purchasing Cooperatives* (The Commonwealth Fund, November 2002), *available at* http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2002/Nov/Health%20Insurance%20Purchasing%20Cooperatives/wicks_coops%20pdf.pdf; U.S. GAO, *Private Health Insurance: Cooperatives Offer Small Employers Plan Choice and Market Prices,* GAO/HEHS-00-49 (March 2000).

("IHC") and the Small Employer Health Benefit ("SEH") programs. These programs imposed modified community rating, required that insurance be offered in standard plan designs, guaranteed the issuance and renewal of coverage (while permitting periods of preexisting illness exclusion), and permitted consumers to compare insurers' offerings in a central location, currently through use of web sites. In New Jersey, as elsewhere, these reforms have been somewhat helpful, although problems of affordability and adverse selection have frustrated the Legislature's goal of expanding coverage and reducing uninsurance, particularly in the individual market.[7]

More recently, Utah and Massachusetts have created insurance exchanges. The former is directed at organizing and transmitting information to allow consumers to make informed choices and to facilitate their enrollment in coverage. The latter serves those goals and in addition requires product standardization and administers a subsidy system for low-income consumers.[8]

The ACA's private insurance reform efforts will run through, and indeed to a substantial extent, will be run by exchanges. The ACA provides for the creation in each state of an American Health Benefit Exchange ("AHB") for individual insurance, and the Small Business Health Options Program ("SHOP") for small businesses (although these two exchanges can, at a state's option, be merged). The ACA assigns several tasks to the exchanges, including:

- Qualification of consumers for participation in the exchanges;
- Qualification of participants for premium and cost-sharing subsidies;
- Certification of health insurance plans for participation in the exchanges;
- Organization and presentation to consumers of information on health plan offerings;
- Coordination of consumer eligibility for state and federal subsidy/public insurance programs; and
- Establishment and funding of a patient navigator program to help consumers evaluate their choices within the exchange system.[9]

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[7] P.L. 1992, c. 161 and 162, codified as amended at N.J.S.A. 17B:27A-2 *et seq.* and 17B:27A-17 *et seq. See e.g.,* Alan C. Monheit *et al., Community Rating and Sustainable Individual Health Insurance Markets in New Jersey,* 23:4 HEALTH AFFAIRS 167 (2004); Katherine Swartz and Deborah W. Garnick, *Lessons from New Jersey,* 25 J. Health Pol. Pol'y & Law 45 (2000).

[8] *See* Sabrina Corlette *et al., The Massachusetts and Utah Health Insurance Exchanges: Lessons Learned* (Georgetown University Health Policy Institute, March 31, 2011) *available at* https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%2520Us/News%2520and%2520Updates/2011/Week%2520Beginning%2520April%252003/MassAndUtahExchangesLessonsLearned.pdf.

[9] ACA §§ 1311, 1411.

The ACA exchanges, then, will have critical roles in New Jersey. They will be responsible for adeptly and efficiently administering substantial aspects of private health insurance access in the State, so as to serve the goals of increased access to high-quality health coverage within a framework of broad product choice, constrained costs, and minimized adverse selection. For the exchanges to succeed in discharging these difficult mandates, their governance structure must be designed with care. This Brief considers issues New Jersey must address in designing the exchanges.

Geographic Scope

The first decision point for New Jersey[10] involves the geographic reach of its exchanges. The ACA permits three choices in this regard. New Jersey may join with neighbors to create "regional or other inter-state exchanges" with the approval of the Secretary; it may create its exchanges as state-wide New Jersey entities; or it may create "subsidiary exchanges," thereby dividing New Jersey into regions covered by separate exchanges.[11] Multi-state exchanges are likely to appeal to states with populations smaller than New Jersey's. In such circumstances, a multi-state exchange could facilitate the gathering of risk pools of sufficient size to create actuarial stability, and could permit the sharing of the cost of administration of exchanges.[12] New Jersey's population is sufficiently large to support sound insurance pooling within the State, and its operation of exchanges would be of a sufficient scale to justify a State-specific administrative structure. Further, the creation of multi-state exchanges would require the coordination of those exchanges with the public insurance programs of the several member states, and would require the coordination or harmonization of New Jersey's well-established insurance regulatory structure with those of the regulatory structures of other states. Further, a central, ongoing concern of any exchange will be the prevention of harmful risk segmentation. Monitoring of New Jersey's complex insurance market will be an arduous task; expanding the

[10] Prior even to this issue is whether the State wishes to create an exchange. The ACA creates incentives for states to create exchanges, and empowers state exchanges as central players in private sector health insurance reform. The ACA also contemplates, however, that some states may decline to create exchanges, in which case the Secretary "shall (directly or through agreement with a not-for-profit entity) establish and operate such Exchange within the State. . . ." ACA, § 1321(c)(1). It is assumed for purposes of this Brief that New Jersey has made the tentative decision to prefer its own operation of exchanges to ceding that responsibility to the United States in order, among other reasons, to maintain legal and public policy authority over the administration of affected insurance markets.

[11] ACA § 1311(f).

[12] *See* Peter Newell and Robert L. Carey, *Building the Infrastructure for a New York Health Benefit Exchange: Key Decisions for State Policymakers* at 6 (United Hospital Fund 2011), *available at* http://www.uhfnyc.org/publications/880723.

relevant market to encompass one or more neighboring states would significantly increase the difficulty of monitoring and maintaining a stable market.[13]

New Jersey may, in the alternative, create exchanges for sub-regions of the State. The ACA permits such "subsidiary exchanges" so long as each serves a "geographically distinct area" and the area includes coherent insurance markets within the State.[14] To the extent market conditions (including labor costs and other components of health costs) vary from region to region within a state, those areas of the state may be coherent health insurance markets; the ACA permits states to create separate exchanges to serve such "separate" markets. It is possible that states with regions differing sharply and coherently may find such subsidiary exchanges useful. While New Jersey's insurance marketplace is certainly complex, it does not seem to be cleanly divisible in geographic terms. In addition, whatever gains that could be achieved through a focused regional approach may well be washed out by the duplication of administrative efforts that would be required were the State to be split into multiple regions for his purpose.[15] No state to date has created subsidiary exchanges.

Form of Governance

The exchanges may operate as "a governmental entity or nonprofit entity that is established by a State."[16] In New Jersey, as in other states, the choice is really among three, and not two, forms: within an executive agency, as an "independent" governmental agency, or as a non-profit corporation formed by New Jersey for this purpose. This section will both describe the advantages and disadvantages of the various forms and discuss some of the subsidiary issues that must be considered along with the choice of form.

Which Form?

Most (although not all) states enacting exchange laws have opted for the "independent" governmental agency model.

- Massachusetts's "Commonwealth Health Insurance Connector Authority" is an "independent public entity not subject to the supervision and control" of any governmental actor, "except as specifically provided by law." It is governed by a ten-member board comprising four *ex officio* members and six appointed members:

[13] *See* Linda J. Blumberg, *Multistate Health Insurance Exchanges* (Urban Institute, April 2011), *available at* http://www.rwjf.org/files/research/72109multistateexchanges201104.pdf; Paul N. Van de Water and Richard P. Nathan, *Governance Issues for Health Insurance Exchanges* (National Academy of Social Insurance, January 2011), *available at* http://www.nasi.org/sites/default/files/research/Health%20Policy%20Brief%20No%201.pdf.
[14] *See* ACA § 1311(f)(2); see 42 U.S.C. 300gg(a)(2).
[15] *See* Newell & Carey, *supra* note 12 at 7-8.
[16] ACA § 1311(d)(1).

- A member of the American Academy of Actuaries;
- A health economist;
- A representative of small businesses;
- A specialist in employee health plans;
- A representative of a health consumer organization; and
- A representative of organized labor.

No member may be an employee of an insurer doing business in Massachusetts.[17]

- Utah's Health Insurance Exchange operates within the Governor's Office of Economic Development's Office of Consumer Health Services. It operates as part of the Governor's office, and does not have an independent board.[18]
- California's Health Benefit Exchange is an 'independent public entity not affiliated with any agency or department." It is governed by a five-member board. The voting, *ex officio* chair is the Secretary of California's Department of Health and Human Services. The other four members are to be selected on the basis of their expertise in matters of health insurance, health finance, or health care delivery. They may not be employees of insurers, brokers, or health care providers.[19]
- West Virginia recently enacted an exchange law. Its Health Benefits Exchange will be located in the Office of the West Virginia Insurance Commissioner, but will be governed by a ten-person board. Four of the members will be *ex officio* state officers. The remaining six members will represent:
  - Individual health care consumers;
  - Small employers;
  - Organized labor;
  - Insurance producers;
  - Payors (selected by an advisory group comprising insurers); and
  - Health care providers (selected by an advisory group comprising providers).[20]
- Maryland's Health Benefit Exchange is a "public corporation" governed by a nine-member board. Three of the members are *ex officio* State officers. Three members will

[17] Mass. Gen. Laws Ann. C. 176Q, § 2.
[18] Utah Code Ann. § 63M-1-2504, as amended by 2011 Laws of Utah c. 400 (HB 128).
[19] Cal. Gov. Code Title 22, § 100500.
[20] 2011 W.Va. Laws No. 100 (SB 408), cited language to be codified at W.Va. Code §§ 33-16G-3, 5. (effective June 10, 2011).

represent the interests of employers and individual consumers and "may" have public health research expertise. The final three members will have demonstrated knowledge and expertise in health insurance, health care, health finance, and/or public health research. While serving on the board, appointees may not have an affiliation with an insurer, carrier trade organization, or other entity in a position to contract with the exchange.[21]

- Colorado's Health Benefit Exchange is a "nonprofit unincorporated public entity" that is an "instrumentality of the state." It is governed by a board of twelve members, nine of whom will be voting members. The non-voting *ex officio* members are three agency heads. The nine voting members are appointed by the Governor or legislative leaders. Voting members must have at least two of the following competencies: health insurance and health benefits, health finance, health delivery system administration, health care delivery, health insurance purchasing, economics or actuarial sciences, consumer navigation or assistance, information technology, and starting a small business. The appointing authorities are charged with considering "the geographic, economic, ethnic, and other characteristics of the state when making the appointments."[22]

The choice among the three models (state agency, independent state board, and non-profit) requires consideration of the trade-offs among the models. New Jersey could opt to locate the exchange in a state agency, presumably one of the Departments intimately connected with the exchange's work. The Department of Banking and Insurance has expertise in insurance and actuarial matters. The Department of Human Services is expert in the administration of subsidized insurance programs, and has experience in evaluating applicants for citizenship status and income history. Commentators have observed, however, that no single agency has expertise in all areas of exchange responsibility, and inter-agency cooperation will therefore be necessary. In addition, they have observed that the obligations of the exchange may be in tension with existing agency obligations, and that confusion, or even conflicts of interest, among regulators and regulated entities could arise.[23]

In the alternative, New Jersey could create a new nonprofit corporation to serve as the exchange.[24] New Jersey has consigned some portions of its public functions to nonprofits in the past. Blue Cross and Blue Shield of New Jersey (now Horizon), for example, was accorded special statutory status in 1938.[25] The symbiotic relationship between the State and the

[21] 2011 Maryland Laws c. 2 (HB 166), cited language to be codified at Maryland St. Ann. 31-102 – 104.
[22] Colo. SB 11-200, to be codified at Colo. Rev. Stat. 10-22-101 *et seq*.
[23] *See* Van de Water and Nathan, *supra* note 13 at 4-5; Newell and Carey, note 12 *supra* at 10-13.
[24] The New Mexico Legislature passed an exchange bill that would have created New Mexico's exchanges in private nonprofit corporations. The bill was vetoed by the Governor. *See* N.M. SB 38 and 370 (vetoed by Governor 4/8/2011).
[25] P.L. 1938, c. 366, codified as amended at N.J.S.A. 17:48-1 *et seq* and N.J.S.A. 17:48A-1 *et seq.*

corporation allowed Blue Cross and Blue Shield favored tax status and discounts on provider charges on one hand, while obliging the corporation to maintain continuous open enrollment to persons otherwise unable to obtain health insurance, and to do so subject to rate oversight by the State.[26] This partnership obligated Blue Cross and Blue Shield to serve as "insurer of last resort" for the people of New Jersey, allowing them access to health insurance notwithstanding their uninsurability in private market terms.[27]

The analogy between exchanges and Blue Cross and Blue Shield holds to the extent the exchanges merely provide information and facilitate enrollment in privately-marketed insurance products. As is described above, however, the exchanges will be engaged in activities more traditionally undertaken by state actors. For example, the exchanges will be charged with the responsibility to determine whether an insurer may participate in the exchanges. That is, after an exchange determines that an insurer qualifies under federal standards as a "qualified health plan," the exchanges must perform an additional analysis to determine whether to allow the insurer to participate in the exchange, taking into consideration "the interests of qualified individuals and qualified employers in the State" and the insurer's explanation for and justification of its history of premium increases.[28] In addition, the exchanges will play a central role in obtaining and using consumers' personal information related to their qualification for participation in the exchanges (for example, citizenship and residency information) and their entitlement to premium and cost-sharing subsidies.[29]

The consignment of these sensitive tasks to a new nonprofit would go beyond the outsourcing of public functions pursuant to the partnership that existed between New Jersey and Blue Cross and Blue Shield. Qualification of insurers to participate in the exchanges is granting permission to engage in a lawful business. New Jersey courts have been critical of efforts to outsource the key governmental function of sorting who and who may not engage in a lawful business, and have, for example, struck down a requirement that the Medical Society of New Jersey sign off on an applicant wishing to do business as a health services corporation,[30] and a requirement that a private airport owner approve a licensure application for an aviation instructor.[31] In brief, these cases reflect a judicial disinclination to permit the State to delegate

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[26] *See* Matter of November 14, 1989, Non-Group Rate Filing by Blue Cross and Blue Shield of New Jersey, 239 N.J. Super. 434, 438 (1990).

[27] *Id.* at 437-38, *quoting* Borland v. Bayonne Hospital, 122 N.J. Super. 387, 399 (Ch. Div. 1973) *aff'd* 136 N.J. Super. 60 (App. Div. 1975)*, aff'd* 72 N.J. 152 (1977), *cert. den.* 434 U.S. 817 (1977). In more recent years, New Jersey has shifted its program for open access to insurance from Blue Cross and Blue Shield to the IHC program. *See* P.L. 1992, c. 161.

[28] ACA § 1311(e)(1) and (2).

[29] ACA § 1311(d)(4). These and other functions may, with the State's authorization, be outsourced to other entities. ACA § 1311(f)(3).

[30] Group Health Insurance of New Jersey v. Howell, 40 N.J. 436, 445 (1963), *subsequent opinion on other issues* 43 N.J. 104 (1964)

[31] New Jersey Department of Transportation, Division of Aeronautics v. Brzoska, 299 N.J. Super. 510, 513 (App. Div. 1976). In both *Howell* and *Brzoska* the courts noted that the infirmity in the delegation practice arose both

to private entities fundamental state powers,[32] suggesting at least that striking a balance between proper public control of key State responsibilities and delegating sufficient independence to permit the efficient operation of exchanges might be difficult using the nonprofit form.[33]

The third option, and the one adopted by the majority of states enacting exchange statutes, is to create the exchange as an "independent" government agency. The New Jersey Constitution requires that "[a]ll executive and administrative offices, departments, and instrumentalities of the State" be allocated to one of the principal departments of the executive branch, and that the head of each department be "under the supervision of the Governor."[34] As is true in other states, New Jersey often finds it convenient to create a public body with a degree of independence from the heads of principal agencies, but still formed as a part of State government, to perform public functions.[35] Most[36] of the enabling legislation of these agencies identifies them as located "in but not of" principal agencies, apparently for the purpose of meeting the constitutional requirement. For example, the Health Care Facilities Financing Authority is "established in the Department of Health and Senior Services," but is "a public body

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from the general constitutional prohibition on delegation of public functions to private entities and to the lack of clear standards for the private exercise of public authority by those private actors. It is possible, therefore, that a very detailed set of rules governing the delegation of authority to an exchange, accompanied by substantial powers of oversight retained by the State, would pass muster under these cases. It is unclear whether such delegation under circumstances substantially curtailing exchanges' ability to operate independently would serve any practical benefit.

[32] *See generally* Timothy Stoltzfus Jost, *Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues* 3 (Commonwealth Fund, September 2010), *available at* http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2010/Sep/1444_Jost_hlt_ins_exchanges_ACA_eight_difficult_issues_v2.pdf.

[33] *See generally* Van de Water and Nathan, *supra*, note 13 at 7-8; Jost, *supra* note 32 at 3.

[34] N.J. Const., Art. V, § IV, ¶¶ 1 and 2.

[35] New Jersey courts have been clear that delegation of public responsibility to government agencies does not violate any constitutional prohibition against legislative delegation of power so long as the purpose of the enabling statute is clear and the means by which the agency may pursue the statutory goals is appropriately detailed, thereby preventing arbitrary action. *See* New Jersey Mortgage Finance Agency v. Crane, 56 N.J. 414, 426-27 (1970). Delegation to a governmental entity, therefore, stands on a different footing than does delegation to a private entity. *See Howell* and *Brzoska, supra.*

[36] But not all. The Passaic Valley Sewerage Authority preexisted the 1947 Constitution, and has apparently therefore been grandfathered as an independent authority not tied to a principal agency. *See* P.L. 1902, c. 48, codified as amended at N.J.S.A. 58:14-1 *et seq*. The University of Medicine and Dentistry also exists independently of any principal agency*, see* P.L. 1964, c. 231, P.L. 1966, c. 302, P.L. 1967, c. 271 (creating the College of Medicine and Dentistry) and P.L. 1970, c. 102, codified as amended as N.J.S.A. 18A-64G-1 *et seq*. The Legislature not only created the University of Medicine and Dentistry without locating it within any principal agency, but also recited that it "shall be given a high degree of self-government and [ ] the government and conduct of the University shall be free from partisanship." N.J.S.A. 18A-64G-3.1. It may be that the difficult social and political issues surrounding the founding of the College of Medicine and Dentistry explain its apparently exceptional status under Article V of the Constitution. *See Commemorating the Fortieth Anniversary of the Newark Rebellion* (UMDNJ undated) available at http://www.umdnj.edu/home2web/newark67/; Newark Agreements ("Agreement Reached Between Community and Government Negotiators Regarding New Jersey College of Medicine and Dentistry and Related Matters"), available at http://www.umdnj.edu/comreweb/pdf/Newark_Agreements_of_1968.pdf.

corporate and politic" governed by seven members. Three of the members are *ex officio* government officials, and the other four are appointed by the Governor with the advice and consent of the Senate. The powers of the Authority are exercised by these seven members, who act by majority vote. The independence of the Authority is tempered by the requirement that its minutes are subject to gubernatorial veto; a veto of the minutes by the Governor renders the actions undertaken by resolution of the members null.[37]

"Independent" state authorities, then, occupy a middle ground between principal government agencies on the one hand and nonprofit corporations on the other.[38] Each of the three forms has its advantages and disadvantages as the governing vehicle of exchanges. Principal agencies contain substantial existing expertise, are readily amenable to public oversight, and may call on resources of State government. But they tend to have deep expertise as to only a subset of the responsibilities placed on exchanges, and may be perceived as susceptible to swings in political power as administrations change. Private nonprofit corporations are structurally more independent of the political process and they can be quite nimble in their actions, but they would be required to develop expertise from scratch, and their degree of independence may be incompatible with the public nature of many of the obligations of exchanges. Independent authorities could have ready access to a range of State expertise through *ex officio* membership of Commissioners. They could enjoy a degree of independence from political control, yet would be subject to greater public oversight than are nonprofit corporations.[39] They could, however, be somewhat less nimble than an independent nonprofit.[40]

These distinctions are subject to adjustment by the Legislature. The Legislature, in creating the exchange in one of the three forms, can tailor the obligations and powers of the exchanges so as to match its preferences for nimbleness of administration versus formalization

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[37] N.J.S.A. 26:2I-4. The power of the Governor to veto minutes of "independent" authorities is present in some but not all of the enabling legislation of the authorities. Bills have been introduced in the current Legislature to expand the gubernatorial exercise of this veto power. *See* A952, A3860, S2359, and S2654. In addition, bills have been introduced in the current Legislature to create some fiscal oversight of the contracting undertaken by "independent" authorities. *See* A3545, A3853, S1884, and S2735. *See also* Ginger Gibson*, Gov. Christie proposes legislation granting state more oversight, control over independent boards,* N.J. Star-Ledger, March 30, 2011, available at http://www.nj.com/news/index.ssf/2011/03/gov_christie_proposes_legislat.html. *See also, Editorial: No De Facto Fourth Branch,* NEW JERSEY LAW JOURNAL, June 20, 2011, p. 22 (describing the lack of clarity in the oversight of "in but not of" agencies in New Jersey).

[38] In contrast with the treatment of the delegation of government power to private actors, New Jersey courts have rejected claims of improper delegation of legislative authority to independent administrative agencies. *See* New Jersey Mortgage and Financing Agency v. McCrane, 56 N.J. 414, 426-27 (1970).

[39] California, for example, adopted the independent state authority model as a structure more flexible than a principal state agency, yet more transparent and accountable than private nonprofit. *See* Micah Weinberg and Leif Wellington Haase, *State-Based Coverage Solutions: The California Heath Benefits Exchange* at 4 (Commonwealth Fund May 2011) available at http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2011/May/1507_Weinberg_california_hlt_benefit_exchange_ib.pdf.

[40] *See id.*

of process; free range of hiring and procurement versus adherence to principles of bidding and contracting applicable to public agencies; and exercise of broad discretion versus adherence to forms of outside administrative review. Put differently, each of the three models (principal agency, "in but not of," and nonprofit) has a default position along the range of more-to-less formal structure, with the range running from principal agency as the most formal (and subject to the most controls and public processes), to nonprofits as the least formal, with "in but not of" agencies in between. But, as the following section describes, there is room for variation from the default position in each form. The Legislature could, for example, exempt an exchange in a principal agency from the usual obligations of the Open Public Records Act, or it could impose obligations on a nonprofit to maintain open records to an extent beyond that usually applied to nonprofits. The following section will describe several key requirements of open or responsive government in New Jersey law. It then will examine arguments for and against relaxing these requirements in legislation creating health insurance exchanges. For ease of reference, the following section will focus on the application of these requirements to "in but not of" agencies, and will refer where appropriate to their application to the other two forms.

How Public?

As is described above, the form of the exchange – principal agency, independent agency, or private nonprofit – does not determine the extent to which the exchanges will be subject to transparency and accountability requirements. While principal agencies tend to be most transparent and accountable and nonprofits the least, with independent agencies in between, the Legislature can craft the application of general requirements to suit its assessment of the ideal balance of openness and nimbleness. The California legislation, for example, "grants the exchange some exemptions to state personnel and contracting procedures and gives its board the power to promulgate regulations on an emergency basis for two years."[41] New Jersey, similarly, could examine the transparency and accountability rules generally applicable to public bodies, and assess whether, in the case of exchanges, the rules should apply in the usual way. The rules are, of course, in the law for good public policy reasons, and therefore a justification should be advanced to explain exceptions granted exchanges.

Several key responsive government provisions might be specifically addressed in exchange legislation to clarify the Legislature's judgment as to their applicability to exchanges.

- *Open Public Records.* New Jersey's Open Public Records Act[42] requires that government agencies, including "any independent state authority, commission, instrumentality or agency" maintain "government records" in a manner that allows them to be inspected by the public. Government records are generally those kept in the course of official

[41] *Id* at 4.
[42] N.J.S.A. 47:1A-1 *et seq.*

business, although there are exceptions for personally-identifying information, trade secrets, and other sensitive information. It is particularly important for the Legislature to speak clearly on the extent to which Open Public Records rules apply to exchanges, as New Jersey law includes both statutory and common law rights to access to governmental records,[43] and a clear statement from the Legislature reserving documents from public access would be required to avoid a presumption of openness. That being said, the transparency afforded by exchanges' maintenance of presumptively open records would further their perceived legitimacy.

- *Open Public Meetings.* New Jersey's "sunshine law," or Open Public Meetings Act,[44] requires that the public have adequate notice and the right to attend meetings of public bodies, with limited exceptions. "Public bodies" include any "commission, authority, board, council, committee or other group of two or more persons organized under the laws of this State, and collectively empowered as a voting body to perform a public governmental function affecting the rights, duties, obligations, privileges, benefits, or other legal relations of any person or collectively authorized to spend public funds." Unless the Legislature exempts the exchange boards, they would seem to fit this definition of public body.

- *Conflict of Interest.* To "preserve public confidence," the Conflict of Interest Law[45] prohibits State officers and employees from receiving things of value intended to influence them in their official duties, and restricts State officers and employees from representation of an entity in which they have an interest before the office or agency in which they are employed, during and, under some circumstances, after their employment with that office or agency. Applicable offices and agencies include "any division, board, bureau, office, commission or other instrumentality within or created by such department, the Legislature of the State and any office, board, bureau or commission within or created by the Legislative Branch." These requirements have been clarified by regulation,[46] and particular agencies' adoption of Codes of Ethics.[47] In addition, Governors have issued Executive Orders extending ethics requirements to include mandatory trainings, financial disclosures, and "pay to play" restrictions.[48] The question of conflicts has particular salience in the exchange context, as trust in the

[43] *See* N.J.S.A. 47:1A-8; Home News v. Department of Health, 144 N.J. 446 (1996).
[44] N.J.S.A. 10:4-6 *et seq.*
[45] N.J.S.A. 52:13D-12 *et seq.*
[46] N.J.A.C. 19:61-1.1.
[47] *See* listing on the State Ethics Commission's website: http://www.nj.gov/ethics/ethics/.
[48] *See, e.g.,* Executive Order 41 (2005), Executive Orders 122 and 134 (2004), and Executive Order 10 (2002) available at http://www.state.nj.us/infobank/circular/eoindex.htm.

governance of exchanges will be essential to the exchange mission. Conflicts are therefore taken up further below, in Section III(c).

- *Procurement.* The purchase of goods and services by public agencies out of state funds is generally required to proceed by public, competitive bidding, following public advertisement of opportunity to bid, in order to serve the public benefit and protect competition.[49] In some cases, independent public agencies are exempt from these provisions either because they have been so exempted by their enabling legislation or because they purchase goods and services out of funds derived from operations, and not from "state funds."[50] Because an exchange may purchase goods and services from funds derived from federal or state coffers, or from assessments or income, it would be useful for the Legislature to state whether public bidding processes apply to the exchanges' purchases. The Legislature could exempt the exchange from public bidding rules and instead require that procurement be undertaken on a competitive basis,[51] perhaps subject to audit by the New Jersey Office of State Comptroller.[52] In the alternative, the Legislature could make the exchange generally subject to public bidding rules, but exempt, for example, contracts with consulting actuaries, to permit timely response to market developments.[53] At a minimum, it would be useful to clarify that the exchange's decisions to certify health insurers to offer coverage through the exchange is *not* a procurement decision subject to public bidding, but rather is governed by the rules for such certification contained in state and federal law.[54]

- *State Personnel Law.* New Jersey's public employee system is governed by its Civil Service Act,[55] and the New Jersey Constitution.[56] The Legislature has the power to shape the application of civil service principles to employees of independent agencies, and it would be useful for the Legislature to consider the application of those principles to the exchanges.

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[49] *See* N.J.S.A. 52:35-6 *et seq.* In re: DBC Project Number A0716-00, 303 N.J. Super. 384, 396-97 (App. Div. 1997). New Jersey's Constitution, unlike that of some states, does not inhibit the Legislature from tailoring the application of procurement rules to particular agencies. *See* New York Const. Sec. I art. V (requiring Comptroller audit of all "official accounts;" Newell and Carey, *supra* note 12 at 16-19 (describing New York procurement law).

[50] *See* Kingston Bituminous Products Co. v. New Jersey Turnpike Authority, 80 N.J. Super. 25 (1963).

[51] *See* 2011 W.Va. Laws No. 100 (SB 408), to be codified at W.Va. Code §§ 33-16G-3(c) (effective June 10, 2011).

[52] *See* N.J.S.A. 52:15C-1 *et seq*.

[53] See 2011 Maryland Laws c. 2 (HB 166), cited language to be codified at Maryland St. Ann. 31-105(C)(6).

[54] Whether such certification would colorably constitute "procurement" rather than the mere application of a regulatory structure depends in part on whether the exchange is to relate to insurers as an "active purchaser" or as a more passive aggregator of information. That issue will be the subject of a separate Brief in this series.

[55] N.J.S.A. 11A:1-1 et seq.

[56] *See* N. J. Const. Art. VII, § 1, para. 2, which contains a general requirement that public positions be awarded by merit and fitness.

New Jersey Questions: Conforming Our Practices to the ACA

How Should the Governance of Individual and Small Group Programs Be Coordinated?

New Jersey has, in a sense, been experimenting with exchanges since 1992. In that year, New Jersey created the IHC and SEH programs, by which individuals (IHC) and groups of 2-50 employees (SEH) could purchase insurance coverage. The plans made available through the programs must conform to standard product design, and to limitations on rating variation (both programs currently employ modified community rating). The programs were created to expand the availability of health insurance to individuals and small groups by standardizing product offerings and creating easy access to information about the available products (currently web-based[57]). The programs have experienced shifting enrollment over the years, for reasons that are examined elsewhere.[58] Enrollment trends in the SEH show a large but slow decrease in covered lives from 1997 (slightly over 1 million covered lives) to the first quarter of 2011 (857,905 covered lives). The record in the IHC has been complicated by the addition of "basic and essential" (bare bones) coverage in 2003. Enrollment in standard policies in the individual market has decreased from over 150,000 in 1997 to under 50,000 in the first quarter of 2011. The basic and essential enrollment has steadily increased, and in the first quarter of 2011 reached over 80,000.[59]

Currently, only IHC and SEH program health benefit plans may be offered in New Jersey to eligible individuals and defined small employers. New Jersey is planning to develop individual and small group exchanges (or a combined individual and small group exchange) by 2014, pursuant to the ACA. The ACA permits the states to maintain individual and small group markets outside the ACA exchanges. The language seems to assume the continued non-exchange markets, stating that it should not be read to prohibit the sale or purchase of health coverage "outside of an Exchange."[60] Although there may be efficiencies to be gained by combining all individual and small group insurance within the ACA exchanges, insurers may prefer to have an alternative market, and some consumers and business owners may wish to avoid doing business within the exchanges. As states have adopted exchange legislation, they have tended to allow existing individual and small group markets to continue to exist outside of the exchanges. As participants in the California process have reported,

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[57] *See* http://www.state.nj.us/dobi/division_insurance/ihcseh/ihcrates.htm (IHC) and http://www.state.nj.us/dobi/division_insurance/ihcseh/sehguide/index.html (SEH).

[58] *See* Alan C. Monheit *et al., Community Rating and Sustainable Individual Health Insurance Markets in New Jersey,* 23:4 HEALTH AFFAIRS 167 (2004); Mark A. Hall, *The Competitive Impact of Small Group Health Insurance Reform Laws,* 32 U. MICH J. L. REF. 685 (1999).

[59] *See* Historical Comparison of Enrollment (New Jersey Department of Banking and Insurance 5/23/2011) available at http://www.state.nj.us/dobi/division_insurance/ihcseh/enroll/1q11historical.pdf.

[60] ACA § 1312(d)(1) and (2).

> One of the first decisions states must make is whether to have an individual insurance market outside the exchanges... Even in California, where there is wide support for federal reform and a broad cross-section of stakeholders issued a report calling for a sole-source exchange, this option was not seriously considered.[61]

Colorado, West Virginia, and Maryland similarly have determined to create ACA exchanges while leaving in place their preexisting markets.[62]

Other provisions of the ACA may drive the discussion on this issue. The ACA prohibits undocumented persons from participating in ACA exchanges, even if they are not receiving any subsidy and are paying full premiums.[63] In New Jersey, as in other states,[64] many undocumented persons currently purchase individual coverage or are covered in small groups. To create a circumstance in which these currently insured persons are forced to become uninsured would have the apparently perverse effect of reducing the percentage of persons covered by private insurance, and increasing reliance on charity care and emergency department services. In addition, the ACA's rules on coverage of abortion services are administratively complex. The ACA prohibits the use of federal subsidies for low-income individuals for prohibited abortion services.[65] If an exchange plan covers abortion services that are not eligible for federal support, the plan must generate separate premium bills, one for abortion services and one for all other services. The funds obtained from the former source must be kept in segregated accounts, subject to audit by the Commissioner of Banking and Insurance.[66] While mechanisms could be developed, then, for the coverage of medically necessary abortion services within the exchange, the administration of funds may be quite onerous. To the extent the Legislature wishes to ensure the availability of coverage of all medically necessary abortions in a manner consistent with the coverage of other medical procedures, it may wish to maintain individual and small group markets outside the exchange.

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[61] *See* Weinberg and Haase, *supra* note 39 at 6 (footnotes omitted).

[62] *See* Colo. Rev. Stat. 10-22-102; W. Va. Code 33-16G-6(a) (referring to health plans sold outside the exchange); Md. Code 31-102(c)(5) (exchange supplements existing market). In addition, the New Mexico bill vetoed by the Governor would have created exchanges as supplements to the existing markets. *See* N.M. SB 38 and 370 (vetoed by Governor 4/8/2011).

[63] ACA § 1312(f)(3) ("Access Limited to Lawful Residents" in the exchanges).

[64] *See* Jost, *supra* note 32 at 10-11.

[65] ACA § 1303, 10104(c). Federal funds under current law may be used in cases of rape, incest or to save the life of the mother. The ACA adopts federal prohibitory rules on funding for abortion as of 6 months before the beginning of the plan year. ACA § 303(b)(1)((B), as amended by § 10104(c). *See Focus on Health Reform: Access to Abortion Coverage and Health Reform* (Kaiser Family Foundation, November 10, 2020) available at http://www.kff.org/healthreform/upload/8021.pdf. The New Jersey Constitution requires that Medicaid cover medically necessary abortion services even though federal funds may not be used for the payment for such services. *See* Right to Choose v. Byrne, 91 N.J. 287 (1982). Whether these constitutional principles will also require New Jersey to fund medically necessary abortion services for some exchange participants is beyond the scope of this brief.

[66] ACA § 1303(b)(2)(C), as amended by § 10104(c).

How Should the Governance of Separate Individual and Small Group Programs Be Related?

The IHC and SEH boards have substantial responsibilities for their programs. They are composed quite differently. The IHC program has as its members "[a]ll carriers subject to the provisions of" the program's enabling statute.[67] Its board has nine members:

- The Commissioner of the Department of Banking and Insurance, *ex officio*;
- Four members appointed by the Governor with the advice and consent of the Senate, including
    - A representative of an employer, recommended by a "business trade organization," with experience in the "management or administration of a health benefit plan; "
    - A representative of organized labor, recommended by the AFL-CIO, with experience in the "management or administration of a health benefit plan;" and
    - Two representatives of consumers "who are reflective of the population of the State;
- Four members elected by the board members (subject to approval by the Commissioner) representing carriers including
    - A health service corporation;
    - A health maintenance organization;
    - A domestic insurance company; and
    - A foreign insurance company licensed to do business in the State.[68]

The SEH program is a nonprofit entity whose members are "[a]ll carriers issuing health benefits plan policies and contracts in this State."[69] Its board has eighteen members:

- The Commissioner of Banking and Insurance and the Commissioner of Health and Senior Services, *ex officio*;
- Ten board members elected by the program's membership, including representatives of
    - Three carriers who principally serve the small business market;
    - One carrier who principally serves the large business market;
    - A health service corporation;

[67] N.J.S.A. 17B-27A-10.
[68] N.J.S.A. 17B:27A-10(b).
[69] N.J.S.A. 17B:27A-28.

- Two health maintenance organizations;
- Three small employers, at least one of whom represents minority small employers;

- Six public members appointed by the Governor with the advice and consent of the Senate, including:
  - Two insurance producers licensed to sell health insurance;
  - One representative of organized labor;
  - One physician licensed in the State; and
  - Two persons representing the general public and not employed by a health benefits plan provider.

Both boards have significant responsibilities for their respective programs. In particular, they have the authority to set the terms of the standard plans offered in their programs and to assess the programs' members for the costs of administering the programs.[70]

If the Legislature determines to maintain a small and individual market outside the ACA exchanges, then New Jersey could have up to four separate programs, with up to four separate governing boards:

- The IHC board for individual insurance outside the ACA exchange;
- The SEH board for small group insurance outside the ACA exchange;
- The AHB Exchange for individual insurance; and
- The SHOP Exchange for small business insurance.

It is reasonable to ask whether it is efficient or appropriate for each of these four programs to have separate boards.[71] In light of the similarity of the responsibility of each of the four programs, it may be that the Legislature would prefer to consolidate some of the functions.

As has been suggested on several occasions above, one of the principal concerns of the complex enterprise of governing New Jersey's individual and small group markets has been and will continue to be combating adverse selection. Adverse selection arises not only when consumers can enter and exit the insurance market, but also when they can move from one product to another, or one market to another. In the recent past, for example, the risk profile of New Jersey's IHC market was affected by the "defection" of "groups of one" (that is self-employed persons in workplaces of one), from an increasingly high-cost IHC program to a then

[70] N.J.S,A. §§ 17B:27A-11, 32, and 33.

[71] This assumes that New Jersey elects not to merge its individual and small group markets, and elects to retain its individual and small group markets outside the ACA exchanges.

lower-cost SEH program.[72] The imbalance has been addressed, reducing the erosion of the individual market. It is likely, however, that such imbalances will arise in the future. Wherever there are borders among insurance programs, such that consumers can elect to move from one to the other, adverse selection can arise, leaving the possibility that some programs will thrive and others will face crippling increases in cost. If New Jersey elects to maintain both individual and small group coverage, and to maintain each program both inside and outside the ACA exchange structure, there will be many borders and much opportunity for adverse selection.

In order to maintain focus and vigilance respecting the dangers of adverse selection, coordination and/or consolidation of the governance of the four programs may be appropriate. This coordination could be achieved in a number of ways. California, for example, has established individual (AHB) and small group (SHOP) exchanges, each to be administered by separately-dedicated staffs, but administered by the same board.[73] Similarly, the Board of Trustees of Maryland's Health Benefit Exchange will govern both the individual exchange and a SHOP exchange.[74] In both states, then, a board has been created to oversee the activities of both exchanges (individual and small group), allowing for separate management but common governance. The remedy for any threat to the financial integrity of the separate markets may be the ultimate responsibility of the Department of Banking and Insurance or the Legislature; coordination of the governance of the programs will increase the likelihood that such threats will be identified in a timely fashion.

In New Jersey, many permutations are possible. Most simply, four boards could simply coexist, coordinating informally. Next, the AHB and SHOP programs could be governed by a single board (as in Maryland and California), (see diagram #1). If the Legislature were determined to maximize coordination, perhaps to minimize the development of adverse selection, it could create an "umbrella" board – call it the small group and individual markets oversight board (SIMO) - to govern all four markets: the individual and small group markets *within* the exchange, and the individual and small group markets *outside* the exchange. Variations on this theme include one in which the SIMO board is responsible for overall governance, setting policy and standards, and coordinating the markets to prevent adverse selection, with two subsidiary boards (perhaps with membership that interlocks with the SIMO board) to govern the AHB and SHOP programs on the one hand, and the IHC and SEH programs on the other (see diagram #2). Another variation would be similar to that displayed in diagram #2, but would leave separate the IHC and SEH boards, although they would be subsidiary to the SIMO board (see diagram #3).

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[72] *See* Alan C. Monheit *et al., Community Rating and Sustainable Individual Health Insurance Markets in New Jersey,* 23:4 HEALTH AFFAIRS 167, 171 (2004);

[73] *See* Weinberg and Haase, *supra* note 39 at 5.

[74] 2011 Maryland Laws c. 2 (HB 166), to be codified at Maryland St. Ann. 31-108.

A refinement of the models discussed above would couple a governing board with an advisory board comprising key stakeholders (see diagram #4). This binary structure would allow the governing board to remain relatively small, while permitting interested and essential constituencies a meaningful seat at the table. This structure could resolve some of the governance issues discussed below in Section III(c): the governing board could be small enough to facilitate relatively nimble consensus-based decision-making in response to changing conditions; conflicts of interest problems could be mitigated by distancing stakeholders from decision making while permitting robust stakeholder participation in an advisory process; and interested and knowledgeable market participants could be charged with developing long-term analysis of important issues such as cost containment strategies, refinement of risk adjustment, and possible mergers of markets for small and individual coverage. Under this model, the governing board (with or without subsidiary boards) would have general responsibility for overall governance, setting policy and standards, and coordinating the markets to prevent adverse selection while the advisory board would facilitate the exchange's compliance with its consultation obligations under the ACA,[75] both to enhance constituent participation and to avoid the possibility of conflicts of interest on the governing board.[76] States have dealt variously with advisory committees in their exchange legislation. Maryland requires its governing board to create advisory committees with membership including:

- Insurers, health benefits plans, managed care organizations, and third-party administrators;
- Producers and brokers;
- Health providers, including hospitals, FQHCs, providers of specialty care for people with disabilities and chronic illness, physicians, nurses, nursing homes, hospice providers, and experts in health care in prisons and jails;
- Employers;
- Public employees, particularly those with direct expertise in Medicaid issues;
- Consumers, including consumers who are hard to reach or who have special needs;
- Advocates for those consumers;

[75] *See* ACA § 1311(d)(6), 10104(e)(2) (requiring the exchange to consult with, *inter alia,* consumers, representatives of small businesses and the self-employed, advocates for hard to reach consumers, Medicaid officials, and those with expertise in insurance enrollment and retention).

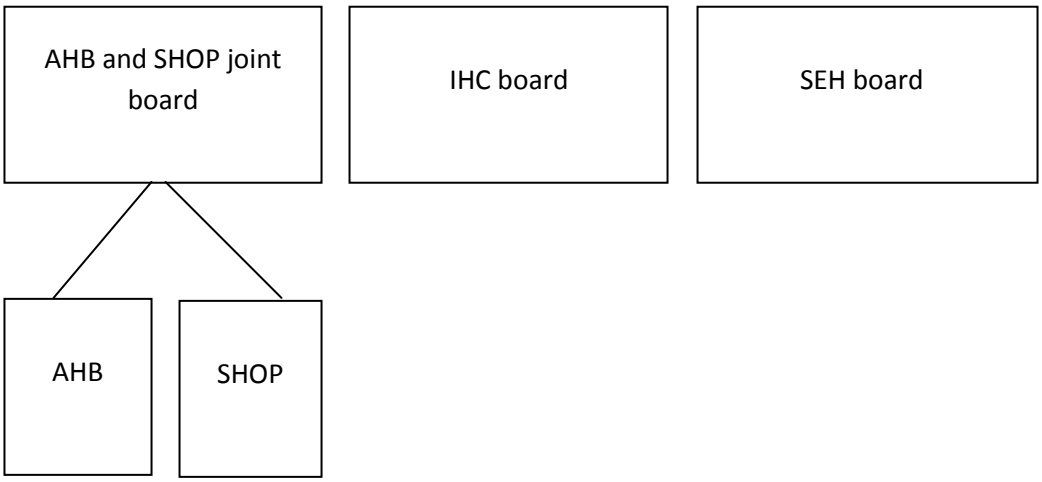
[76] *See* Timothy Stoltzfus Jost, *Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues,* Commonwealth Fund, September 2010, p. 7, available at http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2010/Sep/1444_Jost_hlt_ins_exchanges_ACA_eight_difficult_issues_v2.pdf; *Implementing Health Insurance Exchanges: Options For Governance and Oversight,* Families USA, April 2011, p. 16, available at http://familiesusa2.org/assets/pdfs/health-reform/Exchanges-Governance-and-Oversight.pdf.

- Researchers and academics;
- Others with relevant knowledge or representational capacity.[77]

Oregon requires the exchange's governing board to create an "Individual and Employer Consumer Advisory Committee" including individuals and businesses purchasing coverage, Medicaid recipients, and organizations assisting in enrollment efforts, in particular for hard to reach populations.[78] It permits the board to create additional advisory committees.[79] Colorado empowers its exchange governing board to create advisory groups, but does not mandate that it do so.[80] The adoption of a binary structure in New Jersey – with a compact governing board and a more expansive advisory board - would allow the enabling legislation to focus on the initial, essential tasks the governing board must address to establish an exchange, while delegating to the advisory board the responsibility to confer on issues essential to the long-term success of the enterprise. The relationship between the two boards could be formalized in legislative language describing mandatory consultation and reporting responsibilities.

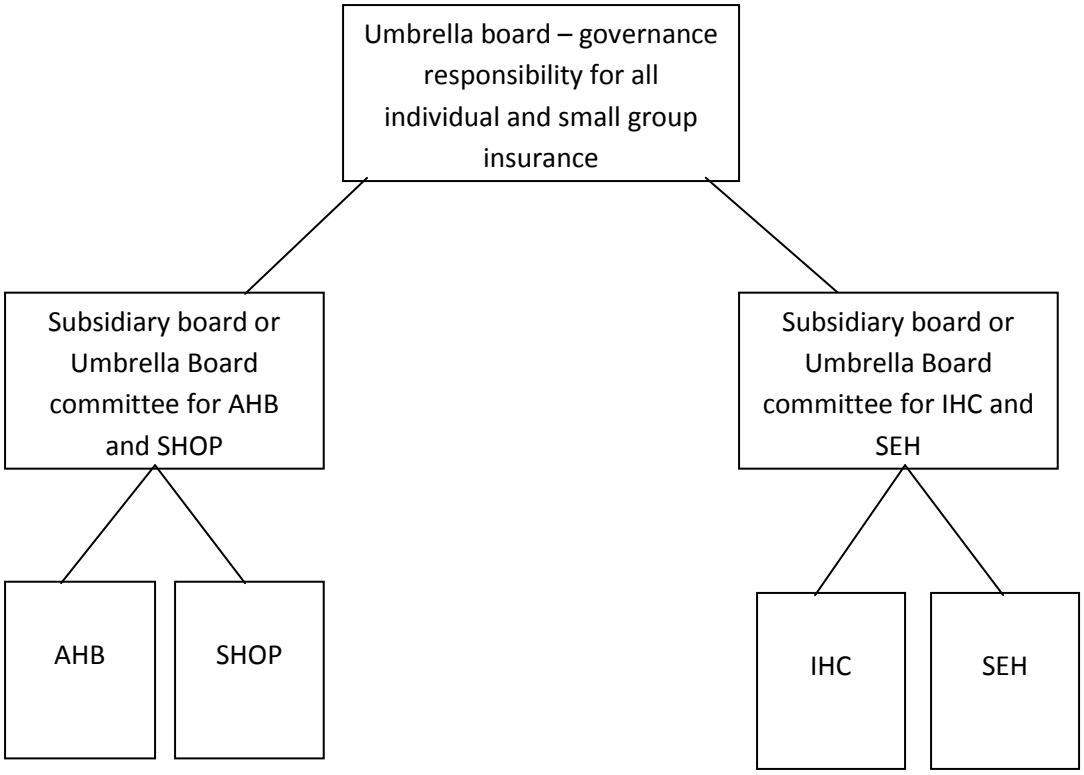
A few of the possible permutations are diagrammed below:

1. Single board for AHB and SHOP; retain IHC and SEH boards.

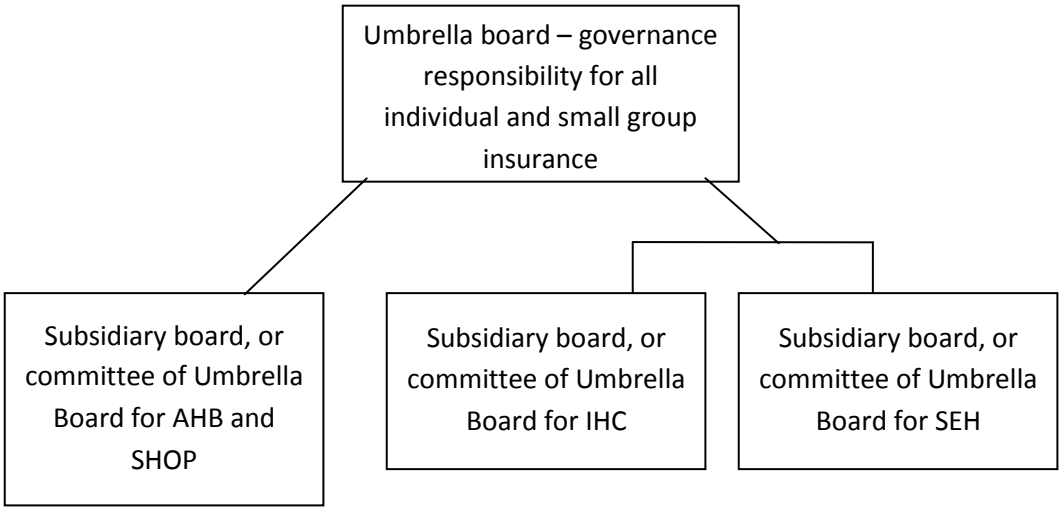


[77] 2011 Maryland Laws c. 2 (HB 166), to be codified at Maryland St. Ann. 31-106(G).
[78] Oregon L. 2011 c. 415 (signed by Governor June 16, 2011), Section 7. *See* http://gov.oregonlive.com/bill/2011/SB99/.
[79] Oregon L. 2011 c. 415 (signed by Governor June 16, 2011), Section 8.
[80] Colo. SB 11-200, to be codified at Colo. Rev. Stat. 10-22-106(d).

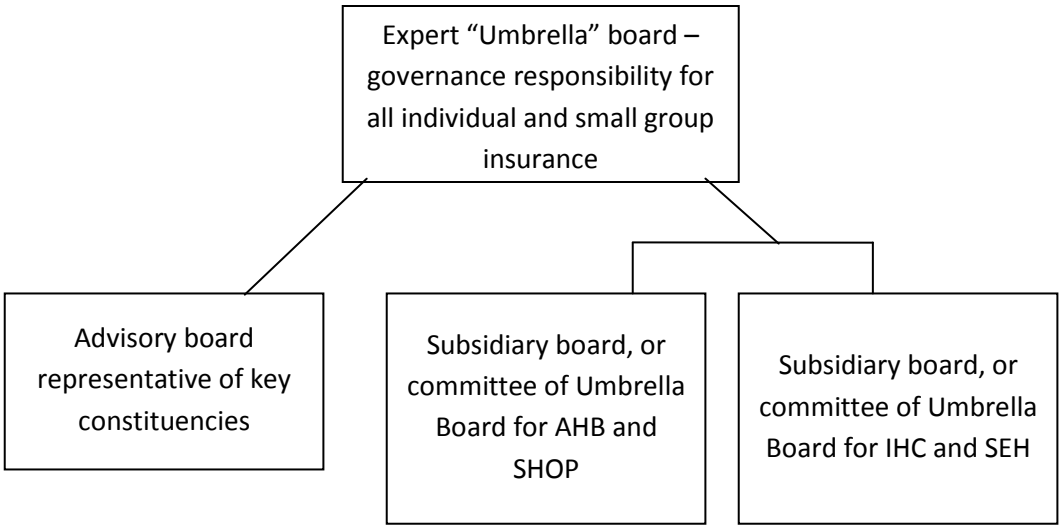
2. Single umbrella individual and small group exchange board; subsidiary boards (or committees of the umbrella board) for AHB/SHOP, and for IHC/SEH.



3. Single umbrella individual and small group exchange board; subsidiary boards or committees of the umbrella board for AHB/SHOP, for IHC, and for SEH.



4. Single umbrella individual and small group exchange board comprising experts competencies; advisory board comprising representatives of key constituency groups; and committees of the umbrella board for AHB/SHOP and for IHC/ SEH.



Each of the options diagrammed above achieves some economies of scale, as well as some enhanced opportunity for coordination.

What Should Be the Composition of the Exchange Boards?

New Jersey could decide to create its exchange in an existing department of the executive branch, as did Utah.[81] In that case, the exchange likely would be governed by the same means as other programs operated by a designated department and no governing board would be necessary. If New Jersey chooses one of the other two options – a new independent agency or a new nonprofit corporation – it will have to determine qualifications for board membership appointment. As is described above, most states have created new independent state agencies in which to house their exchanges, and have created governing boards. These states have included key government officials as voting or non-voting *ex officio* members. In New Jersey, the Commissioner of Banking and Insurance, the Commissioner of Human Services or the Director of Medicaid,[82] and the Commissioner of Health and Senior Services would be likely choices. The public members could be appointed by the Governor with advice and consent of the Senate, or the appointing power could be distributed among the Governor and legislative leaders. The remaining issues regarding board composition concern board size, the mix of

[81] Utah Code Ann. § 63M-1-2504, as amended by 2011 Laws of Utah c. 400 (HB 128).

[82] The exchanges have substantial responsibilities for coordinating public and private insurance. Medicaid is a division of the Department of Human Services.

experts and constituency representatives on the board(s), and the treatment of conflicts of interest.

Size

The board of the exchanges, whether it is a nonprofit or an independent governmental agency, will be similar in function to that of a board of a nonprofit public service corporation. The boards of nonprofit organizations in recent years have become smaller, as engaged governance has risen in importance. Smaller boards are able to act with greater dispatch, and the members of relatively small boards tend to be more active than are members of larger boards, in which the broad dispersal of responsibility can lead some members to take less responsibility. Members of smaller boards have more opportunity to participate in decision-making, and consensus is easier to reach with fewer members. On the other hand, larger boards can be more inclusive, allowing all constituencies to be recognized. If the work of a board is likely to be controversial, expanding the board to permit full representation of points of view can permit it to be more effective. In addition, larger boards are important if the board itself will be the source of the expertise needed to run the organization.[83]

In this case, there are arguments for both a small board and a large board. A small board could be engaged and focused on the activities of the exchange. These activities are likely to evolve over time, and timely response will be vital. In addition, continuity of thought and stable consensus as to governance will be important, and a smaller board is more likely to cohere than is a larger board. On the other hand, a larger board would permit fuller representation of the various constituencies interested in the progress and direction of the exchange. Allowing these constituencies to participate in governance decisions could limit the extent to which collateral or parallel discussions and disputes would distract the work of the exchanges. Whatever the size of the board, it will be important to stagger the length of the appointments. One purpose of composing a board of directors for an exchange (rather than assigning the governance task to an administrative official, for instance) is to provide for a degree of insulation from shifts in political control of government over the years. In this way, an exchange can maintain a relatively consistent and predictable governance philosophy subject, of course, to appropriate public oversight. This independence is commonly enhanced by staggering the appointments by varying the length of the initial appointments so that the membership comes up for renewal in different years. The West Virginia Legislature, for example, provided for a four-year term for the six public members of the exchange board; the *initial* appointments, however, are for one,

[83] *See* CHARLES F. DAMBACH *ET. AL.,* STRUCTURES AND PRACTICES OF NONPROFIT BOARDS at 29-30(2d Ed. 2008) (a publication of BoardSource, formerly the National Center for Nonprofit Boards); BOARDSOURCE, THE NONPROFIT ANSWER BOOK at 50-51 (2d Ed. 2007).

two, three, or four years.[84] In that way, some but not all of the terms of public members will arise each year, allowing for both continuity and regular reconsideration of appointments.

Membership Criteria

Potential members of boards could be selected on the basis of several factors, including technical expertise, constituency representation, and social representation. The first factor is vital for a working board. An ability to grapple with the economic and business decisions of the board, with an understanding of the ramifications of decisions on individual consumers, small businesses, and health care providers is vital. Some background and training in areas central to the work of the boards therefore is essential. Social representation – that is, diversity in the makeup of the board – also is important. Diverse boards are both more effective and more respected.[85] Constituency representation also is important. The ability of interest groups to feel comfortable with the makeup of the boards lends stability to the boards' work. [86]

Recently enacted state legislation, summarized in the Appendix, favors relatively small governing boards: California's board has five members, Maryland's nine, Massachusetts' and West Virginia's ten, and Colorado's twelve, only nine of whom will be voting. These statutes focus on the expertise of the members.[87] Some (Massachusetts, West Virginia, and Maryland) explicitly identify some members as representing constituencies; others (California and Colorado) do not, but focus selection criteria on expertise. It may be that this difference is less significant than it may appear. Colorado's board criteria, for example, do not focus on constituent representation, but rather to expertise, requiring that members have expertise in some of the following areas:

- Health insurance and health benefits;
- Health finance;
- Health delivery system administration;
- Health care delivery;
- Health insurance purchasing;
- Economics or actuarial science;
- Consumer navigation and assistance;
- Information technology; and

[84] 2011 W.Va. Laws No. 100 (SB 408), to be codified at W.Va. Code §§ 33-16G-5(b). *See* Oregon L. 2011 c. 415, Section 4 and 5 (providing for four-year terms for public members, but providing for staggered initial appointments).

[85] *See* Dambach *et al., supra* note 82 at 32.

[86] *See id.*

[87] *See supra* section IIa.

- Starting a small business.[88]

As is described above, one way to gain the benefits of nimble governance and broadly inclusive long-term guidance is for the Legislature to create a relatively small governing board and a broadly inclusive advisory board. The division of labor could accommodate the need for intensive oversight of the operation of the exchange by the governing board, with consideration of medium and long-term issues delegated in the first instance to the advisory board. In this way, the apparently optimal size of the governing board could be maintained while ensuring meaningful input from constituencies with substantial interest in the exchange's governance.

Conflicts of Interest

A problem that often arises in setting the composition of a public purpose board is the desire to maximize expertise while minimizing conflicts of interest. The exchange will benefit from the free flow of information, but private interests should not infect public decision-making, and public position should not be used for private gain. States have dealt variously with this problem. Maryland deals with the issue by requiring disclosure and recusal consistent with its general conflict of interest law.[89] California, perhaps concerned with the large number of structural or positional conflicts that would arise as a matter of course in board governance, precludes board membership for persons employed by, consultant to, or otherwise representative of insurers, brokers, health care providers, or health care facilities.[90] Professor Timothy Jost, a leading commentator on health exchanges, has addressed the puzzle of attempting to fashion a board that is both representative and free from significant conflicts:

> Consumers, small businesses, and organized labor could … be represented on the board. * * * Under an interest-representation model, health insurers and brokers or agents who either sell health insurance products through the exchange or compete with the exchange should not be represented on the board, both because they have a conflict of interest and because they might gain an unfair advantage over competitors. Health care providers might also have a conflict of interest, as they are paid by health insurers and will face increasingly tough bargaining with insurers as insurers try to hold down costs in the new competitive environment. An advisory board could represent insurer, producer, and provider interests while avoiding a conflict of interest.[91]

As Professor Jost mentions, one way to avoid the problem of conflicts of interest is for the Legislature to create separate governing and advisory boards. A governing board, if made

[88] *See* Colo. SB 11-200, to be codified at Colo. Rev. Stat. 10-22-101.
[89] 2011 Maryland Laws c. 2 (HB 166), to be codified at Maryland St. Ann. 31-104(N).
[90] Cal. Gov. Code Title 22, § 100500(f).
[91] Timothy Stoltzfus Jost, *supra* at 6-7.

up of *ex officio* members and a small number of public members, could include the competencies and experience necessary for governance without creating the conflicts that could impair its effectiveness.[92] A more inclusive advisory board could be broadly representative, and, as it would not have ministerial authority, could include current employees and representatives of constituencies directly interested in the business of the exchange.

In sum, the conflicts issues could be addressed in two ways: by requiring disclosure of conflicts by governing board members, and by requiring that conflicted members recuse from decisions on a case by case basis, or by creating separate boards – a governing board in which no member is permitted to have a current conflict of interest, and an advisory board in which members would not have governing authority and therefore could have direct interests in exchange business.

The factors described above should be considered, but no clear right answer as to the size or composition of the board emerges. The Legislature should consider, however, that the exchange boards are likely to be "working" boards – that is, they will be called upon to act in a timely fashion on a variety of as yet unknown issues. Gridlock or administrative delay could harm the effectiveness of this venture. It may be that some combination of nimbleness and broad representation; expert membership and broader coverage of constituencies can be achieved by adopting one of the hybrid models described in the previous section.

Conclusion

New Jersey's health insurance exchange will play an important role in improving access to health insurance. It will help residents select coverage, provide a conduit for federal subsidies, review insurers' requests to participate in important markets, and evaluate insurers' performance. It is essential that the exchange be organized in a manner that engenders trust among consumers, employers, insurers, and health care providers. The task of building that trust begins with crafting the appropriate governance model for the exchange. The ACA leaves this task to the New Jersey Legislature, and New Jersey law leaves the Legislature with many options. The exchange can be housed within a principal State agency, as an independent "in but not of" agency, or as a private nonprofit.

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[92] *See* Cal. Gov. Code Title 22, § 100500(c)(1) for one compilation of such competencies. That section requires that each of the five members of the governing board demonstrate expertise in at least two of these areas:

- Individual health care coverage;
- Small employer health care coverage;
- Health benefits plan administration;
- Health care finance;
- Administering public or private health delivery systems; and
- Purchasing health plan coverage;

The Legislature can design the exchange's legislative mandate to ensure that the various existing and new health insurance markets are appropriately and efficiently coordinated. The legislative mandate can ensure appropriate transparency and public responsiveness, while permitting nimble management. General rules on open meetings and records, conflicts of interest, and public bidding can be applied wholesale, or tailored to the exchange's particular circumstances. The board composition can be mandated so as to ensure appropriate expertise, independence from structural conflicts of interest, and the ability to operate through consensus.

One form of governance that could appropriately accommodate the variety of demands on the exchange would be one in which:

- The exchange is a government agency in but not of a principal department;
- The governing board is relatively small, with two or three *ex officio* members and five or six public members selected for their familiarity and expertise in key substantive areas, and their independence from business ties to interested stakeholders;
- The governing board is required to consult with a larger advisory board, comprising representatives of the key stakeholders;
- The governing board has supervisory authority over all individual and small group insurance markets, including those remaining outside the formal exchange structure; and
- The exchange is generally subject to the transparency and public accountability provisions applicable to government agencies, with tailored exceptions necessary to permit it to respond quickly and efficiently to market changes.

Appendix: Summary of Board Composition in Recently Enacted State Exchange Laws

Board Composition	**Maryland**	**Massachusetts**	**West Virginia**	**California**	**New Mexico**	**Colorado**
Number of members	9	10	10	5	12	12
How members are appointed	The Governor with advice and consent of the senate appoints the 6 public members.	The Governor appoints 3 public members. The Attorney General appoints 3 public members as well.	The Governor appoints 4 of the 10 public members. Those that represent the interests of payors and health care providers are elected by majority vote.	The public members are all appointed: 2 by the Governor, 1 by the Senate Committee on Rules, and 1 by the Speaker of the Assembly.	The Governor appoints 4 public members and the New Mexico legislative council appoints 6 members.	The Governor appoints 5 voting members, the President of the Senate, Minority Leader and Speaker of House of Rep. each appoint 1 member.
Public Members ***(Experts and Representatives)***	Three members of the Board represent the interests of employers and individual consumers of products offered by the Exchange. Three members of the Board must have expertise in at least two areas: individual or small employer health coverage, health benefit plan admin., health care finance, admin. of public or private health care systems, purchasing and enrollment or research.	Three members of the Board represent the interests of: small business, health consumer organizations, and organized labor. Three members of the Board are selected based on their expertise or specialty, including a health economist, an employee benefits specialist, and a member of the American Academy of Actuaries.	Members of the board are selected based on representation. The 4 persons chosen by the Governor represent the interests of individual health care consumers, small employers, organized labor, and health care producers. The other 2 public members represent the interests of payors and health care providers. There are no expert members.	Members of the Board are selected based on expertise in at least two of the following areas: individual or small health care coverage, health benefits plan admin., health care finance, administering a public or private health care delivery system, purchasing health plan coverage. There are no representative members.	Members of the Board are selected based on their expertise in purchasing coverage in individual and small group markets, health care finance, health care economics, health care policy, enrollment of underserved resident, or admin. of private or public health insurance. There are no representative members.	Members of the Board are selected based on expertise in 1, preferably 2 of the following: individual or small employer health insurance, health benefits admin., health care finance, admin. of public/private health care delivery system, health care services, purchase of health insurance, health care consumer navigation, economics/ actuarial sciences, info. Tech., or starting a small business. There are no representative members.

Continued on next page

Board Composition	**Maryland**	**Massachusetts**	**West Virginia**	**California**	**New Mexico**	**Colorado**
Ex Officio Members	There are 3: The Secretary of Health and Mental Hygiene, the Commissioner, and the Executive Director of Maryland Health Care Commission.	There are 4: The Secretary for Administration and Finance, the Director of Medicaid, the Commissioner of Insurance, and the Executive Director of the Group Insurance Commission.	There are 4: The West Virginia Insurance Commissioner, The Commissioner for the West Virginia Bureau for Medical Services, the Director of West Virginia Children's Health Insurance Program, and the Chair of West Virginia Health Care Authority.	There is 1: The Secretary of California Health and Human Services.	There are 2: The Superintendent of Insurance of the Insurance Division (non- voting) and the Secretary of Human Services (voting).	There are 3: The Executive Director of Health Care Policy and Financing, Director of Economic Development and Trade, and the Commissioner of Insurance.

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