Executive Summary: The Exchange Stakeholder Questionnaire

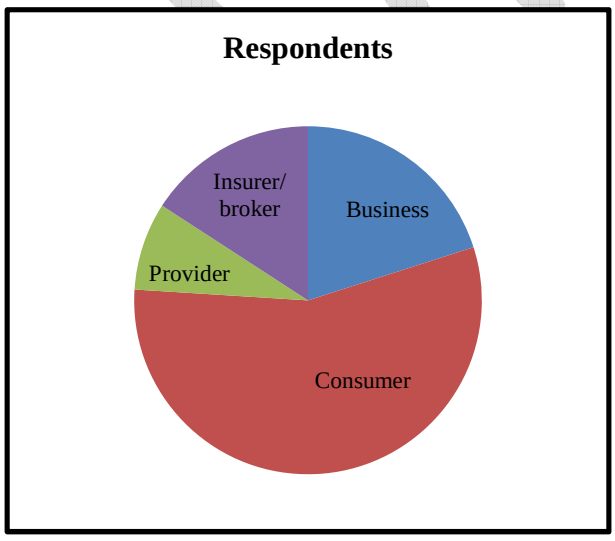
Purpose & Method

In September, 2010 Indiana applied for and received a State Planning and Establishment Grant for the Affordable Care Act's (ACA) Exchanges. The State has not formally committed to developing an Exchange however, Governor Mitch Daniels issued an Executive Order in January 2011 conditionally establishing an Exchange and the State is working on designing the potential Exchange. As an activity under this grant the State developed an online questionnaire describing design options. The purpose of the questionnaire was to gather stakeholder input on the key design questions that all states must address in developing an Exchange. This questionnaire was released in March 2011 in an online format. It was open for responses for three weeks and closed for input March 30th. The questionnaire targeted stakeholder groups including: businesses, individual consumers, health care providers, insurers and brokers.

In order to alert as many potential respondents as possible, the State put out a press release to publicize the availability of the online questionnaire. An e-mail was also sent to all stakeholders from prior engagements, including attendees at prior stakeholder meetings or respondents to the State's first questionnaire in September. The Indiana Economic Development Corporation shared the links to the Exchange questionnaire with the Indiana businesses subscribed to their list-serve. Lastly, information regarding accessing the questionnaire was given to members of the Indiana General Assembly's House and Senate health and insurance committees.

The questionnaires contained sixty-one unique questions and forty-five of these questions allowed either write-in responses or a space to provided additional comments on the specific Exchange design decision. These questions covered topics important to Exchange design including: Exchange Goals, Exchange Business Model, Exchange Data, Exchange Financing, Exchange Market, Exchange and Medicaid, Small Business Health Option Programs (SHOP) Exchange, Premiums and Enrollment, and Navigators and Brokers.

Respondent Profile



Over 2,600 full or partial responses were received including 1,461 consumer submissions, 213 Health Care Provider submissions, 524 business submissions, and 414 insurer and broker submissions.

In all respondent groups those that identified as employers were asked how many employees they had. On average, 51% of respondents who identified as businesses have between two and fifteen employees, 21% are self employed, 18% have between sixteen and fifty employees, and the remaining respondents identifying as businesses

had over fifty employees.

Results:

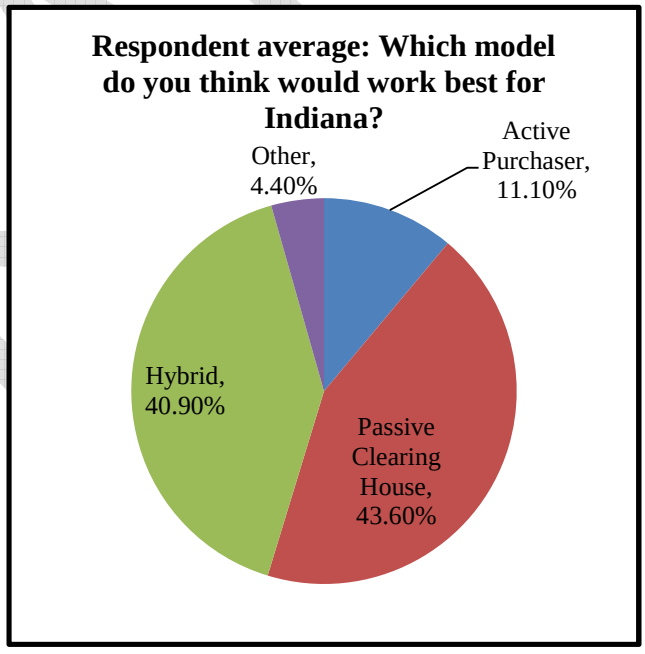
Exchange Goals

Defining the Exchange goals is an important step in the design process and impacts the potential structure and scope of an Exchange. Over half of all respondents supported:

- Making the Exchange a competitive environment for insurers
- Ensuring that the Exchange drives quality improvement and cost containment
- Developing an Exchange that increases the portability and continuity of health coverage

The majority of respondents were not in support of an Exchange that only met the federal requirements or of restricting the number of plans offered on the Exchange through contracts and negotiation with plans. Goals that received support from selected respondents included an Exchange that serves as a negotiator with health plans to achieve lower prices and an Exchange that requires additional quality standards based on state health goals.

Exchange Business Model



Respondents were asked to identify what Exchange business model they would prefer. Generally, respondents showed little support for an Active Purchaser model that would selectively contract and negotiate with insurers. Respondents were more in support of either the Passive Clearing House model that allows all qualified plans to be offered or a Hybrid model that would combine some elements of the Passive Clearing House and Active Purchaser models. Support for these models varied by respondent group. The insurer and broker respondents and the consumers preferred the Passive Clearing House Model, while health care providers and businesses preferred the Hybrid Model. The Active Purchaser model received approximately 11% of total responses.

"Consumers shoul have the knowledg and tools to make good health decisions for their family. It is important that the information be presented in a simple easy to understand format. On everything else we are able to research and compare quality, price and other factors, but it is difficult to impossible to do th with health care. We are expected to blindly purchase health care." – A Hoosier Business

"I like the concept of an Exchange, bu I don't think it should come at the expense of more government regulation, bureaucracy and expense." – A Hoosier Consumer

Exchange Data

The federal government requires that key data related to health plan cost and quality be provided to individuals to assist them in selecting their health care coverage. However, an Exchange could provide additional data beyond the federal requirements.

The questionnaire asked participants to identify what additional data is most important. The majority of respondents indicated that the most important information is cost related: premiums, deductibles, and out-of-pocket maximum costs. Respondents were also interested in knowing the network of available doctors, basic provider quality indicators, and additional cost data such as co-payments and coinsurance. Appointment wait times and provider office hours were considered the least important. All groups except the provider respondents were in favor of using claims data to generate public reports on cost and quality and having the Exchange develop provider report cards. Forty-nine percent of individuals are willing to pay between 0.1% and 3% increase in premiums for additional cost and quality information beyond the federal requirements with comments indicating that respondents felt this information would result in ability to make more value conscious decisions and long term cost reductions.

Exchange Financing

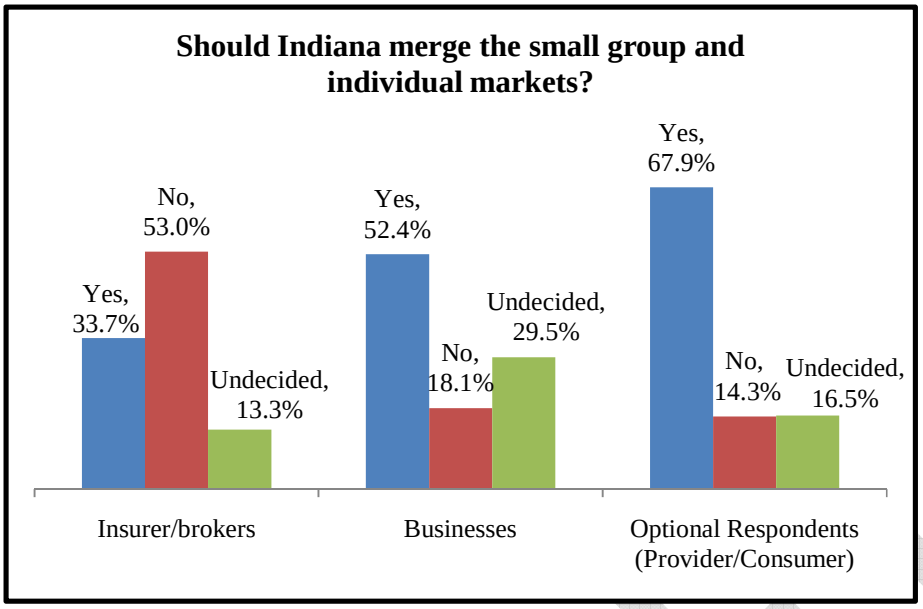
The federal government will fund the implemenatation of the Exchange and the first year of Exchange operations. After the first year, state Exchanges must be self-sustaining. Respondents were asked about what methods should be used for revenue generation to fund continued Exchange operations. The most popular option among all respondents was to charge insurers a fee to list plans on the Exchange. Increases in the state premium tax and fees charged to Exchange users were selected by approximately a quarter of respondents. Many comments indicated that if the Exchange was going to cost additional funds then the State should consider not implementing it. Other comments suggested the creation of additional taxes on cigarettes, alcohol and sugary beverages should be used to fund the Exchange.

Exchange Market

The ACA mandates certain changes to insurance markets and also gives states choices of potential market changes, especially as relates to the Exchange. States must consider the structure of the individual, small and large group markets as well as the market inside and outside the Exchange. Adverse selection, which refers to sick individuals concentrating in one segment of the market, or healthy individuals waiting to seek insurance until they become sick, is a key market issue states must consider. The Exchange design process needs to plan for Exchange market offerings and the governing rules and regulations.

"Transparency is huge. Consumeris is certainly needed but we need to be able to shop the care, get info on costs for the entire episode of care, shop RX prices, fir who's doing cheap MRI's and on down the line. We're giving people the motivation to be better consumers v cost shifting but haven't given them the tools to be goo consumers." –A Hoosier Broker

"I am certain that Indiana can organize more effective cost and quality programs than the Federal government. … If the Federal government's "sing solution for all" approach carries t day we will end up with a two tiered health system. I do not think the best care will be delivered in that system. "–A Hoosi Provider



The small group and individual market risk pools are separate in Indiana. The ACA provides that a state can elect to merge these markets and have one pool for individuals and small businesses. Insurer and broker respondents were not in favor of merging the risk pools while the other respondents were in favor of merging the risk pools for the individual market and the small group market. This would effectively make the small group market more like the individual market; for policies insuring only one there would be no group risk pooling process.

Respondents were indecisive on if the rules governing the Exchange and the outside market should be the same or allowed to be different. Overall, there was support for keeping the market rules as similar to the current structure as possible and also for limiting any additional regulation or requirements that might be placed on insurers offering in the Exchange. Respondents favored keeping the scope of the Exchange market limited and supporting the continued offerings of a wide range of health coverage products on the market outside of the Exchange.

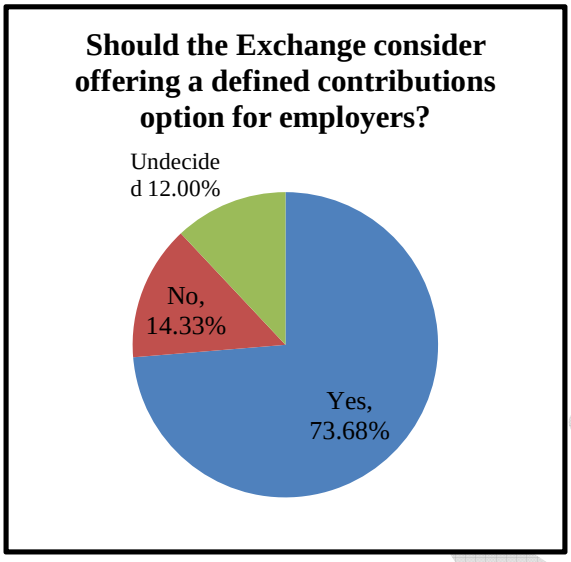
To limit adverse selection respondents favored limiting the open enrollment periods and instituting a penalty for those who get insurance only when ill and then drop coverage. This penalty would be in addition to the federal penalty for not complying with the individual mandate.

Exchange and Medicaid

The ACA extends Medicaid coverage to all individuals under 133% FPL. Individuals in this income range may experience a high degree of income volatility and could frequently move between Medicaid and Exchange coverage. Questions were posed relating to methods to smooth out the transition between Medicaid and the Exchange. Respondents were undecided on if the State should provide Medicaid recipients premium vouchers to purchase coverage on the Exchange. The insurer and broker respondents were not in favor of requiring Medicaid contracted health plans to offer coverage on the Exchange while the remaining respondent groups supported this measure. Respondents were overall in support of offering vouchers to CHIP eligible children so that they can be enrolled in a family plan through the Exchange.

All respondent groups except insurer and broker respondents were in favor of developing a Basic Health Plan[1] option to serve those individuals up to 200% FPL through a Medicaid administered health plan.

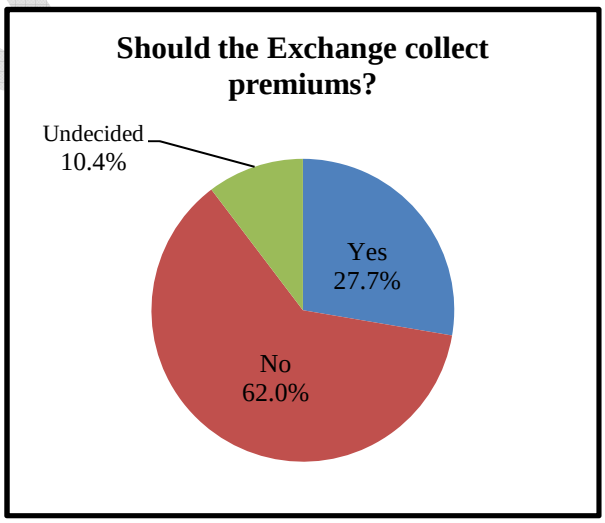
Small Business Health Options Program (SHOP) Exchange



The SHOP Exchange is an Exchange for small employers that offers small group plans. In designing the SHOP portion of the Exchange there is the option to provide additional functionality that may add value for the small businesses using the Exchange to select coverage for their employees. Over 70% of respondents in all respondent groups are in favor of the Exchange allowing employers to provide defined contributions. Under a defined contribution plan an employer could offer employees a fixed contribution which employees could use to purchase a health plan in the SHOP Exchange. Insurer and broker respondents are in favor of the employer limiting the defined contribution plan choice of employees by carrier and benefit tier[2]. The other respondent groups prefer that employees using defined contributions have free choice of SHOP Exchange plans with no limitations on what carrier or tier an employee can select.

Insurer and broker respondents supported requiring employers to have a minimum percentage of employees participating in the employer coverage option and to make a minimum contribution towards coverage. The other respondent groups did not support these requirements. All respondent groups supported the Exchange offering Section 125 plans[3].

Plan Premiums and Enrollment



An Exchange could have administrative functionality which including the ability to collect and aggregate premiums and distribute them to insurers and to fully enroll individuals in plans. How much of this functionality the Exchange contains is a central question in the design process. When asked if the Exchange should collect premiums no respondent groups supported this functionality. However, there was mild support for an Exchange that would facilitate premium aggregation where premium contributions from

[1] The ACA creates the options for states to receive federal funds to cover individual from 133% FPL to 200% FPL through a Basic Health Plan operated by the state Medicaid program.
[2] The ACA creates the plan benefit tiers of bronze, silver, gold and platinum. Bronze plans offer the most basic benefits and platinum plans offer the richest benefits.
[3] Section 125 plans allow employers to contribute pretax dollars towards employees' health plans.

multiple employers and other sources could be aggregated and put towards the purchase of a single health plan.

All respondent groups except brokers prefer an Exchange that has the functionality to allow the individual to shop and compare plans and also to fully enroll the individual in the selected plan. Brokers prefer an Exchange that refers consumers to Exchange Navigators and brokers for enrollment. Around half of respondents are not willing to bear increases in cost to fund Exchange functionality that goes beyond the federal requirements. The remaining respondents would be willing to bear small increases to fund additional Exchange functionality.

Navigators and Brokers

The ACA creates "Navigators" to help guide Exchange users and aid them in using the Exchange and making coverage decisions. Navigators are individuals who are forbidden from having a financial relationship with health plans. Their responsibilities, as outlined by the ACA, include: public education activities, distribution of fair and impartial information about qualified health plans and tax credits, facilitating enrollment in qualified health plans, providing referrals to consumer assistance agencies, and providing information in culturally and linguistically appropriate manners. In the current market the 'navigator' role is largely filled by insurance agents and brokers. How the navigator program will operate and how brokers will interface with the Exchange are questions critical to Exchange design. Respondents support Navigators that are licensed insurance agents and brokers, Exchange employees, and community based agency employees. All respondent groups support Navigators being trained to help people enroll in public programs and support that any compensation should be the same in and outside of the Exchange. All respondent groups believe that Navigator funding should come from the Exchange. With the introduction of Navigators the role insurance agents and brokers will continue to play in the Exchange marketplace is undefined. Most respondents support the idea that brokers should continue to have a role in assisting individuals and groups in the purchase of insurance inside and outside of the Exchange.

Respondent Comments

In the forty-five questions that allowed write-in responses, respondents submitted over 5,000 comments. This included 1,137 from businesses, 2,384 from individual consumers, 1,272 from insurers and brokers, and 434 from providers. These comments show the unique perspectives and concerns of the responding stakeholder groups. Often comment writers did not stick strictly to offering responses to the posed questions and the received write-ins include personal anecdotes, advice, and requests.

Outside comments specific to the questions posed on the Exchange questionnaire five general themes emerged.

- Stakeholders commented about the general direction of Health Care Reform and the efforts surrounding the Exchange; the comments received spanned the spectrum from extreme dissatisfaction with the process to hope and excitement about the results.

"Indiana has been a innovator health insurance ideas and public union rules-- we need you to keep doing that, not to fa in line with everyon else." – A Hoosier Business

"There are three parties in driving th cost of health care- the provider, the patient, and the insurance companie While a lot of attention has been focused on the provider and insurance companie relatively little has been done to addres the biggest variable in the equation-the patient. " –A Hoosi Provider

"Insurers should be able to decide whether they want t participate in the exchange. The government's role is not to dictate privat business decisions.' A Hoosier Broker

- Stakeholders commented on the role of government; the comments received spanned the spectrum from calling for repeal of the ACA and getting government out of health care to calling for a greater role of government through a public option, single payer system or Medicare for all. More comments were received in opposition to the ACA.
- All groups were in accord in demanding greater transparency in health care cost and quality.
- All groups commented in support of making consumers more accountable for health behaviors.
- Additional comments were received by all groups regarding the Insurance market in Indiana and ways in which it could be improved, specifically by allowing interstate insurance market competition.

In general, comments submitted by Hoosier stakeholders show an expectation for the State to offer options outside the ACA framework and provide for full transparency and consumer accountability without burdening the system with harmful government intervention and an increase in bureaucracy.

Conclusion

The Stakeholder feedback provided by insurers, brokers, consumers, health care providers, and businesses is invaluable in Indiana's decision making process around Exchange design options. From the responses to this questionnaire it is clear that these groups of Hoosier stakeholders support an Exchange that preserves as much of the current market structure as possible, is financially sustainable, and provides basic and information on cost and quality to Exchange users.

"Something has to done so that every citizen has access t quality health care. – A Hoosier Consumer

"Proper design of Indiana Insurance Exchange would be great benefit to the public health. The general direction o the program shoul be towards efficien … lessening the cos and "hassle" per transaction that accompanies each encounter provider endure while providing care to patients." – A Hoosier Provider

"The consumer MUST take an activ role in his or her health, and have access to affordabl quality catastrophi coverage with pre-existing conditions non-issue." – A Hoosier Consumer