Exchange Questionnaire Report

Indiana's Stakeholder Outreach

June 20, 2011

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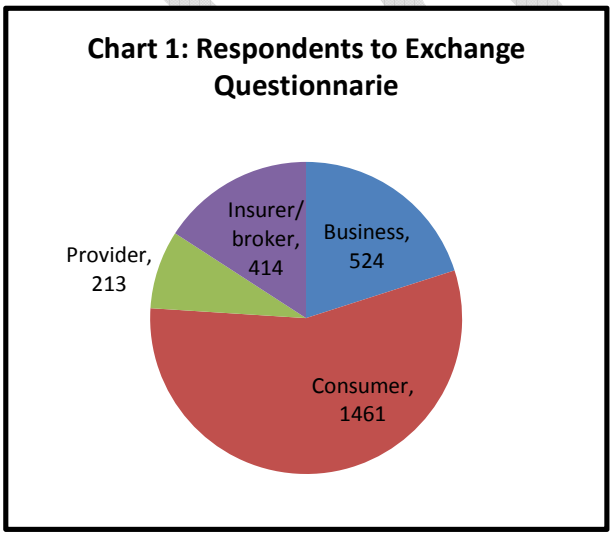
Exchange Questionnaire Introduction

The Affordable Care Act (ACA) mandates creation of health insurance Exchanges that will serve as health insurance marketplaces and as distributors of federal subsidies to purchase insurance coverage. If, by 2013, a state does not create a functioning Exchange that meets the requirements outlined in the ACA then the federal government will establish an Exchange in the state.

To begin research on the Exchange concept in September 2010, Indiana applied for and received a State Planning and Establishment Grant. Under this grant the State has worked to define Exchange design options in an attempt to develop a design for a potential Exchange that might best serve Hoosiers.

In January 2011, Indiana Governor Mitch Daniels issued an Executive Order (EO) based on work completed under this Exchange planning grant. This EO directed the Secretary of the Family and Social Services Administration (FSSA) and the Commissioner of the Indiana Department of Insurance (IDOI) to work together to begin planning a potential state based Exchange. As part of this effort, Indiana developed a questionnaire to obtain input from a variety of stakeholders on key Exchange design issues. The State sought stakeholder feedback through web-based questionnaires to individual consumers, health care providers, businesses, insurers and brokers. Providers, individual consumers, and businesses received shortened versions of the questionnaire while insurers and brokers received the full version. The insurers and brokers received the same questionnaire due to the overlap in the many design decisions relevant to both insurers and brokers. These groups received the longest questionnaire as their areas of expertise lead them to have an understanding of how technical and regulatory insurance market changes may affect Hoosiers.

To alert as many potential respondents as possible, the State put out a press release to publicize the availability of the online questionnaire. Several media outlets carried the story. An e-mail was sent to all stakeholders from prior engagements, including attendees at prior stakeholder meetings and 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 to share with their colleagues and constituents.



Over 2600 total responses were received over the three week period the questionnaires were open for input. These responses included 1,461 consumer submissions, 213 Health Care Provider submissions, 524 business submissions, and 414 insurer and broker submissions. Few questions required answers and the majority of respondents did not respond to all questions.

To help develop a profile of respondents, the questionnaire asked if they identified with any other stakeholder group. At least 40% of respondents in all groups identified as individual

consumers and 43.9% of consumers identified as 'other'. For the respondents in all groups that identified as an employer follow-up questions showed that half of them have between 2 and 15 employees[1].

Table 1

Please indicate below what respondent groups you identify with.				
N= 2443	**Insurer/brokers (n= 410)**	**Businesses (n=500)**	**Providers (n=209)**	**Consumers (n=1324)**
Individual Consumer	41.0%	60.4%	62.2%	N/A
Insurer	10.0%	11.2%	9.6%	14.5%
Health Care Provider	1.7%	32.5%	N/A	12.1%
Business	29.8%	N/A	56.9%	24.5%
Advocacy Group	4.1%%	3.0%	9.6%	12.6%
Insurance Agent/Producer	84.9%%	4.3%	2.9%	6.9%
Other	4.1%	19.1%	25.8%	43.9%

The questionnaires limited responses to only one per IP address to help control for duplicate responses. Respondents who identified as more than one category of stakeholder could indicate this at the beginning of the questionnaire or were allowed to take the questionnaire in multiple stakeholder categories. While the State received substantial responses, this questionnaire is limited due to the fact that there is no guarantee that the respondents are a representative sample of Hoosier constituents. However, outside of statistical significance, the collected stakeholder responses and comments provide valuable qualitative feedback to the State on Exchange design options.

The complete questionnaire administered to insurers and brokers contained 61 unique questions. Shortened versions were administered to providers, individual consumers, and businesses; however, it should be noted that respondents had the opportunity to request to see and answer all the questions on the questionnaire. On the full questionnaire, 45 questions allowed either write-in responses or a space to provide additional comments on the specific Exchange design decision. The write in comment response was significant; over 5,200 meaningful comments received. Feedback received through comments is included throughout this report[2].

The questions presented to respondents were divided into the following categories: Exchange Goals, Exchange Business Model, Exchange Data, Exchange Financing, Exchange Market, Exchange and Medicaid, SHOP Exchange, Premiums and Enrollment, Navigators and Brokers and Demographics and Current Coverage.

[1] See Table a in Appendix 2

[2] Please see Appendix 1 for more detail and discussion on the stakeholder feedback received through respondent write-in comments.

Exchange Goals

Identifying the overall goals of the Exchange is a critical step in Exchange design. Defining key principles provides a context to guide decisions around the formation of the Exchange as structural and scope issues are addressed.

Questionnaire respondents were asked to select from a list of possible Exchange goals. In all stakeholder groups over half of respondents thought that the Exchange should: be a competitive environment for insurers, drive quality improvement and cost containment, and increase the portability and continuity of health coverage. The majority of respondents were not in support of only meeting the federal requirements of the Exchange or restricting the number of plans offered on the Exchange through negotiation. A consumer respondent urged caution in developing Exchange principals, "I like the concept of an Exchange, but I don't think it should come at the expense of more government regulation, bureaucracy and expense." The aggregate responses showing support of various Exchange goals are listed in the following chart.

Table 2

Please select the principles that you think should guide the formation of Indiana's Exchange:					
Goal	**Insurer/ broker (n=367)**	**Consumer (n = 1311)**	**Business (n=458)**	**Provider (n=193)**	**Average**
Promote and increase competition among health insurers	66.8%	71.5%	72.9%	68.4%	**69.9%**
Increase the portability and continuity of health coverage	59.7%	66.4%	57.9%	71.0%	**63.8%**
Provide cost and quality data on health care providers to help promote consumerism and increase transparency in the health insurance market place	68.4%	66.1%	55.7%	43.5%	**58.4%**
Be a driver of quality improvement and cost containment in the health insurance marketplace	57.5%	57.15%	57.2%	53.9%	**56.4%**
Help small businesses with administrative functions and minimize the burdens related to offering health insurance	44.4%	50.2%	60.7%	62.7%	**54.5%**
Offer all qualified health plans on the Exchange	38.4%	53.5%	50.9%	60.6%	**50.9%**
Serve as a negotiator with health plans to achieve lower prices	27.0%	54.6%	53.1%	46.1%	**45.2%**
Promote consumer directed health plans	45.2%	42.0%	36.3%	37.3%	**40.2%**
Require additional quality standards based on State health goals (e.g. smoking rates, obesity, etc.)	35.4%	28.6%	23.8%	31.6%	**29.9%**

Allow only a limited number of plans that meet certain criteria to be offered on the Exchange	27.8%	13.7%	19.2%	15.0%	**18.9%**
Only meet the minimum federal requirements for an Exchange	23.4%	8.8%	8.1%	9.8%	**12.5%**
Other	7.9%	15.0%	9.2%	13.5%	**11.4%**

Business Model

All groups were asked what business model they preferred for the Exchange. Respondents were given the options below:

- An Active Purchaser Business Model that would negotiate and selectively contract with insurers.
- A Passive Clearing House Model that would allow all qualified plans to be offered.
- A Hybrid Model that combined elements of the Active Purchaser and Passive Clearing House.

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. Not all respondents supported an Exchange of any type; a business respondent offered "I'm not sold on the exchange idea. It will serve to artificially drive up costs by setting rules that favor specific insurers. Open competition is the best approach."

Table 3

Which model do you think would work best for Indiana?					
	Insurer/brokers (n=353)	**Consumers (n=1184)**	**Providers (n=180)**	**Businesses (n=423)**	**Average**
Active Purchaser	11.9%	10.4%	9.4%	12.5%	11.1%
Passive Clearing House	50.7%	44.5%	41.7%	37.6%	43.6%
Hybrid	33.1%	37.0%	46.1%	47.5%	40.9%
Other	4.2%	8.1%	2.8%	2.4%	4.4%

Exchange Data

One of the responsibilities of the Exchange is to provide consumers with data to facilitate their health coverage purchase and health care selection decision making. The data most highly valued by consumers should be given the most prominence when designing the Exchange web portal interfaces. Some of the required data is outlined in the ACA and is intended to help consumers and carriers select health plans.

This data will be further defined by the federal government in forthcoming regulations. However, an Exchange has the potential to provide enhanced quality data that goes beyond the federal requirements. This data could include clinic and provider cost and quality metrics. Consumers could leverage these metrics as tools to help them choose places of care. Additionally, there is the potential that having a resource that provides cost and quality reports on providers and clinics could drive competition between

providers and improve quality in the State.

To aid in these Exchange design decisions, respondents were asked to rate what data was most important to them on a 1 to 5 scale. All groups indicated that the most important data is cost related: premiums, deductibles, and out of pocket maximum cost. Following cost data, respondents were most interested in knowing the network of available doctors, basic provider quality indicators, and additional cost data such as co-payments and co-insurance. Appointment wait times and provider office hours were considered the least important. Respondents showed mild need for health care provider quality data, health plan enrollee satisfaction, claims denial rate, patient satisfaction by provider, and the average cost of specific services. Please view the full list of potential data below. Respondent comments showed strong support for accurate price information and quality data; a business respondent offered, "Consumers should have the knowledge 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 that with health care. We are expected to blindly purchase health care." [3]

Table 4

What type of data will be important for consumers to have when making health plan selection decisions? (Average respondent ranking from 1 to 5)					
Data	**Insurer/broker (n=333)**	**Consumer (n=1111)**	**Business (n=285)**	**Provider (n=170)**	**Average (1 to 5 ranking)**
Premium	4.78	4.75	4.79	4.70	**4.76**
Deductible, or the amount of covered expenses the enrollee pays in full each year before plan benefits begin.	4.45	4.72	4.71	4.65	**4.63**
Yearly maximum out-of-pocket expenses, the total of deductible, co-payments, and co-insurance that an enrollee could be responsible to pay over a year.	4.45	4.69	4.68	4.58	**4.60**
Network of available doctors and facilities	4.45	4.62	4.63	4.55	**4.56**

[3] Please see Appendix 1 for more respondent perspectives on health care cost and quality.

Co-payments, the fixed amounts paid by the enrollee for each office visit or pharmacy prescription filled.	4.25	4.57	4.58	4.46	**4.47**
Co-insurance, a payment for services where the enrollee's share of payment is based on a percentage of total cost.	4.21	4.41	4.58	4.38	**4.40**
Health care provider quality	4.15	4.49	4.13	4.15	**4.23**
Benefit tier (Bronze, Silver, Gold, etc.)	3.84	3.94	4.38	3.94	**4.03**
Health Plan quality (e.g. National Committee for Quality Assurance)	3.78	4.27	4.15	3.86	**4.02**
Health plan enrollee satisfaction	3.71	4.25	3.87	4.00	**3.96**
Claims denial rate	3.57	4.23	3.98	3.98	**3.94**
Patient satisfaction by provider	3.69	4.19	3.80	3.83	**3.88**
Average cost of specific services	3.74	4.11	3.84	3.79	**3.87**
Average health care provider appointment wait times	3.26	3.63	3.39	3.26	**3.39**
Office hours of health care provider	3.08	3.53	3.16	3.21	**3.25**

Respondents were also asked if the Exchange should use claims data to generate public cost and quality reports on health care providers. All respondent groups except providers were in support of using claims data to generate cost and quality reports[4]. One provider offered, "Of the quality standards, these need to

[4] See Table b in the Appendix

be imposed on the consumer rather than providers, as is traditionally done. Consumers are the only ones who can make lifestyle changes."[5]

An additional question on potential quality data focused on if the Exchange should make provider report cards available to Exchange consumers. As above, all groups except health care providers showed support for this option[6].

Respondents were asked what additional costs they were willing to pay for additional quality information on plans and providers that went above and beyond the federal requirements. Forty-one percent (41%) of respondents are not willing to pay any increase in premium cost for quality data reporting that goes above and beyond the federal requirements. Forty-eight percent (48%) are willing to pay between a 0% and 3% premium cost increase and the remaining respondents show an even greater willingness to pay.

Table 5

What percent premium increase would you be willing to pay to have access to more detailed cost and quality information on providers and plans?					
Increase in premium cost	**Insurer/broker (n=331)**	**Consumer (n=1067)**	**Business (n=251)**	**Provider (n=166)**	**Average**
0% increase	35.0%	38.1%	44.0%	47.0%	**41.0%**
0% to 1% increase	23.3%	28.3%	30.5%	25.9%	**27.0%**
2% to 3% increase	26.6%	22.2%	18.9%	18.1%	**21.5%**
3% to 4% increase	6.6%	4.1%	1.8%	3.6%	**4.0%**
more than 5% increase	8.5%	7.2%	4.7%	5.4%	**6.5%**

Exchange Financing

The ACA provides federal funding for Exchange operations for 2014 to 2015 and after 2015 the Exchange must fund itself. Respondents were presented with various funding options to support long term Exchange operations and asked to indicate what options they felt should be utilized to finance the Exchange after 2015. From this list of financing options the most popular option among all respondent groups was to charge insurers a fee to list plans on the Exchange. Increases in the 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. A broker respondent offered, "If the federal government is mandating the Exchange then they should absorb any additional cost to ensure quality and cost measures." Other comments suggested additional taxes on cigarettes, alcohol and sugary beverages should be used to fund the Exchange.

[5] Please see Appendix 1 for more detail on respondent perspectives on consumer accountability.
[6] See Table c in Appendix 2

Table 6

How should Indiana's Exchange be financed?					
Financing Option	**Insurer/broker (n=330)**	**Consumer (n=1083)**	**Business (n=274)**	**Provider (n=167)**	**Average**
Charge insurers a fee to offer plans on the Exchange	40.0%	45.9%	39.4%	53.3%	**44.7%**
An increase in the current premium tax for all health plans sold in Indiana (Indiana's current premium tax is 1.3%)	16.4%	28.3%	35.4%	28.7%	**27.2%**
Charge a fee to individuals to use the Exchange	39.7%	18.7%	25.9%	21.6%	**26.5%**
An increase in the current premium tax on health plans qualified to be sold through the Exchange (Indiana's current premium tax is 1.3%)	31.8%	23.0%	27.4%	21.6%	**26.0%**
Support the creation of risk pools to purchase insurance and charge a fee to join a risk pool	22.7%	22.3%	21.9%	34.7%	**25.4%**
Charge a fee to small businesses to use the Exchange	29.7%	11.7%	20.4%	16.8%	**19.7%**
Other (please specify)	15.2%	18.7%	17.2%	19.2%	**17.6%**
Charge license fees for Navigators	14.8%	8.6%	8.0%	7.2%	**9.7%**
Create a new tax	3.6%	7.7%	4.4%	5.4%	**5.3%**
Issue bonds and borrow money	2.1%	4.5%	1.1%	4.2%	**3.0%**

Exchange Market and Rules

The ACA mandates changes to the insurance markets. Some of these changes are offered as options a State can choose to implement. States also need to make design decisions about what types of products will be offered on the Exchange and how the Exchange will function in the context of the overall insurance market. Many commentators urged the state to keep things simple when considering the Exchange rules; one broker commented, "I believe the exchange should keep things simple, in order to begin and maintain a very high level of professionalism."

One of the questions facing Exchange design teams is whether to merge the risk pools for the small group market and the individual market. The small group market includes businesses that employ between two and fifty employees who are purchasing group coverage. The individual market consists of individuals or

families who are purchasing insurance without the aid of an employer. In Indiana, the prices in the individual market are actually lower than the price in the small group market due to the Indiana Comprehensive Health Insurance Association (ICHIA), the state's high risk insurance pool. This pool provides insurance for the highest risk individuals with the most costly conditions, thus lowering the prices for the individuals remaining in individual risk pool. Merging the risk pools for individuals and small businesses would make the premiums in these markets the same. However, under the ACA, costs could increase across the board as the legislation requires community rating, guarantees issue of health insurance to all individuals regardless of preexisting health conditions, and does not contain provisions specifically supporting the maintenance of a high risk pool.

When asked about combining the risk pools, the insurer and broker respondents support keeping the small group and individual risk pools separate. Businesses would like to see these markets merged. Comments from businesses indicate they would like to see them merged to leverage a larger risk pool. This question was optional for provider and consumer respondents; however, 29 Providers and 180 Consumers elected to answer the question. The consumer and provider groups were in favor of merging the risk pools for the market on and off the Exchange, with consumers offering that they thought merging the markets could reduce the individual rates as a larger risk pool would be created.

Table 7

Should Indiana merge the small group and individual markets?				
	Insurer/brokers (n=300)	**Businesses (n=353)**	***Providers (n=29)***	***Consumers (n=180)***
Yes	33.7%	52.4%	*67.9%*	*66.7%*
No	53.0%	18.1%	*14.3%*	*18.3%*
Undecided	13.3%	29.5%	*17.9%*	*15.0%*

When asked what plans should be offered on the Exchange the insurer and broker respondents think the Exchange should only offer comprehensive plans that meet the federal benefit requirements. Respondents identifying as insurers were not as opposed to offering other benefit plans on the Exchange as those identifying as brokers. Comments indicate that brokers specifically feel that the Exchange will already competing with them and it should not sell optional health insurance products. They prefer that offering these additional insurance products remain a domain of brokers. Business respondents and the providers and consumers electing to respond to the question support the offering of other stand-alone benefit plans on the Exchange. Comments indicate that these stakeholder respondents would appreciate having a one stop shop for all health insurance products.

Table 8

Should the potential Exchange offer other stand-alone benefit plans (example: vision plans)?				
	Insurer/brokers (n=300)	**Businesses (n=352)**	***Providers (n=29)***	***Consumers (n=179)***
Yes, stand alone vision should be offered	11.3%	20.2%	*17.2%*	*16.8%*
Yes, vision, and other stand-alone coverage plans	25.0%	54.8%	*51.7%*	*48.0%*

should be offered				
No, the Exchange should only offer plans with comprehensive coverage	56.7	17.3%	*27.6%*	*29.6%*
Undecided	7.0%	7.7%	*3.4%*	*5.6%*

Another question surrounding the offering of health plans on a potential Exchange is whether plans that are not statewide should be offered. Some of Indiana's largest plans are regional. When this question was posed, all respondent groups support was strongest (over 65%) for making it a requirement that all Exchange plans be offered statewide. Respondents did not support offering regional plans on the Exchange. As above the brokers specifically commented that the sale of plans only available regionally should remain a product offered by brokers and should not be for sale on the Exchange. Comments from other groups indicate that this question may have been misinterpreted the questions intent. A majority of respondents in these groups seemed to assume that the question was asking if in the Exchange will offer only regional plans or only plans available statewide, instead of allowing the opportunity to offer regional plans to offer on the Exchange.

Table 9

Should the potential Exchange offer plans only available in specific geographic areas or should all plans offered on the Exchange have the requirement to be available statewide?				
	Insurer/brokers (n=301)	**Businesses (n=352)**	***Providers (n=28)***	***Consumers (n=175)***
Plans only available in certain geographic locations should be allowed to offer on an Exchange.	25.6%	16.2%	*25.0%*	*16.6%*
All plans offered on an Exchange should be available statewide.	65.8%	77.6%	*67.9%*	*77.1%*
Undecided	8.6%	6.3%	*7.1%*	*6.3%*

Exchange Enrollment Periods

Central to how the Exchange will be designed are the enrollment periods. The ACA indicates that the structure of the first open enrollment period will be determined by the Secretary of Health and Human Services by January 1st 2012. The Secretary will also determine the annual enrollment periods and special enrollment periods to be considered once the Exchange is operational. It is possible that individual states will be able to structure enrollment periods at their discretion.

The structure of the enrollment periods has implications on the volume of enrollees the Exchange will be expected to support at any one time. For example, in a once yearly enrollment period all Exchange

enrollees would need to be served around the same time, while an open or rolling enrollment period would distribute inquiries over the year. This enrollment period also has implications on the potential for adverse selection in the Exchange. With a once yearly enrollment period, individuals are less likely to wait until they become sick to purchase insurance; however, if enrollment is continuous and individuals can purchase insurance at any time they may be more inclined to put off the purchase until medical care is needed. The questionnaire posed questions both on how the Exchange should conduct open enrollment and how to limit adverse selection through enrollment policies.

The insurer and broker respondents and businesses were asked how open enrollment should be conducted in the individual market. This question was optional for provider and consumer respondents. Insurer and broker respondents preferred once yearly enrollment and the other respondent groups preferred continuous enrollment. Suggestions from the write in category pointed out that Medicare Advantage has difficulty with their once yearly enrollment period and leaned towards a system as used by Indiana's Bureau of Motor Vehicles for rolling enrollment based on either last name or date of birth. Respondents expressed concern that a continuous enrollment period could increase adverse selection, as individuals may wait to enroll only when they are ill[7]. A broker respondent commented, "Limited enrollment periods already exist in the small group market through open enrollment periods and change of status. Similar rules should apply to the exchange and individual market."

Adverse Selection

Adverse selection refers to the phenomenon of people who are sicker being concentrated in certain insurance plans or markets. Adverse selection can also occur when people wait to become insured until they are sick. For insurance markets to function optimally, healthy individuals must participate. With the creation of the Exchange and the ACA's requirement for guarantee issue, there is the potential that adverse selection could exist between the Exchange and the outside market. If sicker individuals are concentrated in the Exchange, insurers may decline to offer products on the Exchange and prices could be higher inside the Exchange. Ensuring that adverse selection is minimized between the Exchange and outside market represents a critical component of Exchange planning and design.

The questionnaire posed several possible solutions to the problem of adverse selection. All respondent groups support all of the suggestions offered on how to mitigate adverse selection in the small group and individual markets. The suggestions offered were: Institute limited enrollment periods; institute a waiting period of thirty days for covered services, institute penalties for dropping coverage and then enrolling again when ill. All respondent groups seem conscious that managing adverse selection will be a challenge in the Exchange and support the efforts towards mitigation.

Comments indicate that a thirty day waiting period for preexisting conditions is not sufficient, and that there should be a six to twelve month waiting period. However, the ACA does allow waiting period exclusions for preexisting conditions. Additional suggestions included following the Medicare Part D methodology where those who did not sign up when the plans were first made available were required to pay additional fees, or requiring those that drop coverage or remain uninsured to enter the Exchange at a lower benefit level. A business respondent offered, "…Couple enrollment/effective date of coverage with

[7] See Table d in the Appendix

some elimination period to address adverse selection. You can't wreck your car and then apply for physical damage coverage. Health insurance should work the same way."

Table 10

Support for strategies to prevent adverse selection:	Insurer/brokers (n = 300)	Businesses (n=345)	*Providers (n=27)*	*Consumers (n=169)*
Supports: Institute limited enrollment periods for the individual market	72.4%	56.5%	*57.7%*	*58.4%*
Supports: Institute limited enrollment periods for the small group market	65.4%	59.8%	*53.8%*	*53.8%*
Supports: Institute a waiting period of 30 days for covered services for the individual market	71.8%	70.3%	*59.3%*	*57.9%*
Supports: Institute a waiting period of 30 days for covered services for the small group market	63.8%	66.3%	*53.8%*	*54.7%*
Supports: Institute penalties for dropping coverage and then enrolling again when ill for the individual market	90.1%	79.8%	*66.7%*	*77.3%*
Institute penalties for dropping coverage and then enrolling again when ill for the small group market	86.4%	78.9%	*69.2%*	*74.5%*

Movement between benefit tiers within the Exchange is also a concern for adverse selection. The Exchange creates plan designations including bronze, silver, gold and platinum and these different designations represent different levels of benefits. It is possible that an individual could purchase the least expensive and least comprehensive coverage and then wait until they become ill to purchase more comprehensive coverage. This would concentrate the sickest individuals in the richest benefit plans.

When asked about how to control adverse selection within benefit tiers, the greatest support was for allowing individuals to move up or down only one benefit level relative to the previous year's benefit level. This option received support from approximately 70% of questionnaire respondents in all

respondent groups. Other suggestions included charging fees to move up a benefit level but not to move down as long as coverage is continuous; brokers also suggested that the State look to Medicare Part D methodology for movement among the offered plan levels.

Table 11

Support for strategies to prevent adverse selection among benefit tiers:				
	Insurer/brokers (n=296)	**Businesses (n=341)**	***Providers (n=27)***	***Consumers (n=167)***
Supports: Requiring individuals to lock-in to an Exchange benefit level for a multiple year period.	45.9%	35.1%	*39.1%*	*39.6%*
Supports: Allow individuals to move up or down only one benefit level relative to the previous year's benefit level.	70.8%	69.8%	*70.8%*	*69.4%*
Undecided	57.6%	53.4%	*64.0%*	*43.4%*

Insurance and Exchange Marketplace

The Exchange could become the sole avenue in a State where an individual or small group could purchase insurance coverage. A State has the choice to allow the market for insurance to continue outside the Exchange or to require that all health insurance purchases for individuals and small groups are conducted through the Exchange. The questionnaire asked if the Exchange should be the sole venue to purchase comprehensive insurance products or if the insurance market should be allowed to continue outside of the Exchange. Respondents in all groups support continuing to allow both individual and small group products to be sold outside of the Exchange. Ninety percent (90%) of insurer and broker respondents, 73% of business respondents, 54% of consumer respondents and 55% of provider respondents support allowing the individual and small group market to continue outside of the Exchange[8].

Assuming that a market for health insurance exists outside of the Exchange, the structure of the rules governing the markets inside and outside of the Exchange will need to be defined. The rules in the Exchange and in the market for insurance outside of the Exchange could be the same or different. Having different rules inside and outside the Exchange could increase regulatory complexity and impact adverse selection between the Exchange and the outside market. Allowing the rules to be different in the Exchange and the outside market may provide a more amenable market environment to some insurers' marketing of products outside of the Exchange.

[8] See Table e in the Appendix

The insurer and broker respondents were indecisive when asked if the market rules should be the same for the market inside and outside the Exchange. Among the other respondent groups there was support for ensuring that the rules governing the markets inside and outside of the Exchange were consistent.

Table 12

Should rules be the same for the markets inside and outside of the Exchange?				
	Insurer/brokers (n=299)	**Businesses (n=345)**	***Providers (n=28)***	***Consumers (n=171)***
Rules should be the same for individual and small group market inside and outside of the Exchange	42.5%	51.0%	*50.1%*	*59.6%*
Rules should be the same for small groups inside and outside of the Exchange	2.3%	3.8%	*0.0%*	*1.2%*
Rules should be the same for the individual markets inside and outside of the Exchange	4.0%	2.3%	*10.7%*	*5.3%*
No, the rules inside and outside of the Exchange do not need to be consistent in the small group or individual markets	42.5%	31.5%	*25.0%*	*25.1%*
Undecided	8.7%	11.6%	*14.3%*	*8.8%*

The ACA creates special criteria for the 'Qualified Health Plans' that are required to be offered on the Exchange. A state could extend this requirement and require all health insurance plans sold in a state to be "qualified" under federal regulations. The questionnaire asked if insurers should be allowed to offer plans outside of the Exchange that are not qualified to be sold on the Exchange. The insurer and broker respondents appear to support the sale of products on the market outside the Exchange that are not qualified to be sold on the Exchange. The business group was supportive of allowing products to be sold outside of the Exchange but at a lesser degree than the insurer and broker respondents. Some business respondent comments indicated the desire to simplify the purchase of insurance and ensure affordability. The optional providers and consumer respondents showed no strong preference on this issue.

Table 13

Assuming that a health insurance marketplace exists outside of the Exchange, should health insurers be allowed to offer health plans on the outside market that are not qualified to be sold on the Exchange?				
	Insurer/brokers (n=299)	**Businesses (n=340)**	***Providers (n=28)***	***Consumers (n=171)***
Offer plans on the individual market outside the Exchange that are not qualified to be sold inside the Exchange	23.4%	16.5%	*14.3%*	*19.9%*
Offer plans on the small group market outside the Exchange that are not qualified to be sold inside the Exchange	6.0%	3.8%	*0.0%*	*3.5%*
Offer plans on the individual and small group market outside the Exchange that are not qualified to be sold inside the Exchange	52.4%	39.4%	*35.7%*	*26.3%*
Do not allow plans to be sold on the outside market if they are not qualified to be sold on the exchange	13.0%	25.6%	*35.7%*	*38.0%*
Undecided	3.3%	14.7%	*14.3%*	*12.3%*

The questionnaire asked if plans offered on the Exchange should be required to be offered on the outside market. This requirement could help to equalize the Exchange and the market outside of the Exchange; however, it creates additional market regulation. When asked if health insurers should be required to sell the plans they sell on the Exchange in the outside market, no respondent group showed a strong preference for any particular option.

Table 14

Assuming there is a market outside of the Exchange for health insurance, should health insurers be required to sell the pans they offer on the Exchange in the outside market?				
	Insurer/brokers (n=298)	**Businesses (n=340)**	***Providers (n=28)***	***Consumers (n=169)***
Yes, health insurers should be required to offer individual plans sold on the Exchange in the outside market	10.4%	10.9%	*7.1%*	*16.6%*
Yes, health insurers should be required to offer small group plans sold on the Exchange in the outside market	3.4%	2.4%	*0%*	*1.2%*
Yes, health insurers should be required to offer both individual and small group plans sold on the Exchange in the outside market	32.9%	27.6%	*35.7%*	*24.3%*
No there should be no requirement on health insurers selling small group or individual products to offer on the Exchange.	40.3%	40.9%	*39.3%*	*41.4%*
Undecided	13.1%	18.2%	*17.9%*	*16.6%*

To ensure that the Exchange has a sufficient offering of health plans from competing carriers, Indiana could make it a requirement that if insurers sell comprehensive health insurance plans in the state they are required to offer a plan on the Exchange. The insurer and broker respondents and the business respondents demonstrate little support for this requirement and there is slightly more support from the optional provider and consumer respondents. One broker respondent offered "Insurers should be able to decide whether they want to participate in the Exchange. The government's role is not to dictate private business decisions."

Table 15

Should all health insurers who sell small group or individual health plans in the state be required to offer on the Exchange?				
	Insurer/brokers (n=294)	**Businesses (n=336)**	***Providers (n=28)***	***Consumers (n=167)***
Yes, health insurers who sell small group products in Indiana should be required to sell on the Exchange	7.8%	14.6%	*15.4%*	*18.6%*
Yes, health insurer who sell individual products in Indiana should be required to sell on the Exchange	1.0%	1.8%	*0%*	*4.2%*
Yes, health insurers who sell small group or individual products in Indiana should be required to sell on the Exchange	19.7%	33.0%	*46.2%*	*38.3%*
No there should be no requirement on health insurers selling small group or individual products to offer on the Exchange.	71.4%	50.6%	*38.5%*	*38.9%*

Requiring health insurers to offer Exchange plans in both the individual and small group markets helps increase portability and if an individuals' employment status changes, he or she can stay with the same plan. As an enrollee moves from employer coverage to individual coverage when life circumstances change, it is more likely that he or she could keep the same or similar coverage if a rule exists requiring insurers offer a product on both the individual and small group markets. However, this requirement could present a burden for those companies that specialize in one type of market and may decrease the number of insurers offering health plans in Indiana. There was no clear consensus amongst insurer and broker respondents on whether there should be a requirement for carriers to offer in both the small group and individual market. Businesses and the providers and consumers who elected to answer this optional question supported requiring insurers to offer plans in both the individual and small group markets.

Table 16

Should health insurers be required to offer Exchange plans for both the individual and small group markets?				
	Insurer/brokers (n=296)	**Businesses (n=346)**	***Providers (n=28)***	***Consumers (n=171)***
Yes, health insurers should be required to offer in both the individual and small group markets	44.3%	64.3%	*74.1%*	*71.3%*
No, health insurers should not be required to offer in both the individual and small group markets	42.9%	22.5%	*14.8%*	*19.3%*
Undecided	12.8%	13.2%	*11.1%*	*9.4%*

A state can use the federal requirements for Exchange plans or can develop additional state requirements that a plan must meet to be certified on the Exchange. For example, a State could require a plan desiring to offer on the Exchange to attain an additional quality certification in addition to the federal requirements. Respondents were asked if Exchange plans should be subject to additional certification requirements based on quality and cost of care. This question was posed on the insurer and broker questionnaire and on the business questionnaire and was optional for providers and consumers. Responses show that slightly over half of respondents in all stakeholder groups supported having additional certification requirements pertaining to quality of care for Exchange plans.

Table 17

Should plans offered on a state Exchange be subject to additional state certification requirements pertaining to quality and cost of care?				
	Insurer/brokers (n=295)	**Businesses (342)**	***Providers (n=28)***	***Consumers (n=171)***
Yes, Plans offered on the Exchange should be subject to additional State certification requirements pertaining to quality of care.	51.5%	52.0%	*53.6%*	*55.6%*
No, plans offered on the Exchange should not be subject to additional state	36.9%	31.6%	*32.1%*	*28.7%*

certification requirements pertaining to quality of care.				
Undecided	11.5%	16.4%	*14.3%*	*15.8%*

Making Exchange plans attractive to consumers will also be important to ensuring Exchange success. A challenge for insurers will be how to price the plans they will be offering on the Exchange. Due to the new Medical Loss Ratio rules posed by the ACA, the new individuals that will be covered, and the new forum in which to purchase insurance, there are many uncertainties for insurers. Insurers set rates based on perceived risk and in the new market environment these many unknowns render accurate risk calculation challenging. This could lead to frequent repricing of plans and pose difficulties for both the Exchange and for enrollees. Respondents were asked if the Exchange should limit Exchange plans to repricing only at enrollment or renewal. Over 80% of respondents in every respondent group supported limiting repricing on Exchange plans to enrollment or renewal periods in both the individual and the small group market.

Table 18

Should Exchange plans be limited to repricing their products only at enrollment/renewal?				
	Insurer/brokers (n=297)	**Businesses (n=343)**	***Providers (n=29)***	***Consumers (n=172)***
Yes, in the individual market Exchange plans should be limited to repricing their products only at enrollment/renewal.	86.2%	88.3%	*89.7%*	*84.2%*
Yes, in the small group market, Exchange plans should be limited to repricing their products only at enrollment/renewal.	87.5%	88.6%	*89.7%*	*83.7%*
No, plans offered on the Exchange should not be subject to additional state certification requirements pertaining to quality of care.	9.1%	6.1%	*6.9%*	*10.5%*
Undecided	4.7%	5.2%	*3.4%*	*5.3%*

Exchange and Medicaid

The ACA expands Medicaid eligibility to all individuals up to 133% of federal poverty level. It is expected that this segment of the population will likely have income variations that cause them to move between Medicaid and the Exchange. Making the transition from Medicaid to Exchange coverage as seamless as possible presents a challenge for Medicaid, the Exchange, and health insurers. The Medicaid questions were targeted towards health care providers, insurer and broker respondents. These questions were optional for business and individual consumer respondents.

One option to decrease coverage transitions between Medicaid and the Exchange would be to offer Medicaid enrollees vouchers to purchase commercial health coverage on the Exchange. When asked if the State should provide premium vouchers to Medicaid individuals to buy commercial health insurance on the Exchange, insurer and broker respondents and providers were entered almost equal 'Yes' and 'No' responses, with approximately 20% of respondents selecting 'Undecided'. The 44 business respondents and the 166 consumers who elected to answer this optional question responded in a manner similar to the insurer and broker respondents and the providers.

Table 19

Should the State provide premium vouchers to Medicaid eligible individuals to buy commercial health coverage products on the Exchange?				
	Insurer/brokers (n=292)	**Providers (n=167)**	***Business (n = 44)***	***Consumers (n= 166)***
Yes	36.0%	41.9%	*38.6%*	*41.0%*
No	45.2%	36.5%	*50.0%*	*43.4%*
Undecided	18.8%	21.6%	*11.4%*	*15.7%*

Another strategy to ease the transition between Medicaid and the Exchange would be to require the insurance plans that have Medicaid contracts to offer a similar plan on the Exchange. Individuals transiting out of Medicaid could select the Exchange version of the plan and continue with similar coverage and access to provider networks. This could facilitate transitions between the Exchange and Medicaid. In general, providers were more supportive than insurer and broker respondents, though two out of the three Medicaid contracted health plans that responded were in support of this measure. For both provider and insurer and broker respondents, over 20% selected 'Undecided' to this question. Of the 44 business respondents and 166 consumer respondents who elected to answer the Medicaid optional questions over half of them supported requiring Medicaid contracted health plans to offer on the Exchange.

Table 20

Should Medicaid contracted health plans be required to offer a commercial product with a

comparable provider network on the Exchange to aid individual's transitions between Medicaid and Exchange products?				
	Insurer/brokers (n=291)	Providers (n=164)	*Business (n=44)*	*Consumers (n=166)*
Yes	34.4%	47.0%	*52.3%*	*54.8%*
No	43.3%	29.9%	*40.9%*	*28.3%*
Undecided	22.3%	23.2%	*6.8%*	*16.9%*

While Medicaid eligibility ends at 133% of Federal Poverty Level (FPL), eligibility for children up to age 19 continues in the Children's Health Insurance Program (CHIP) to 250% FPL. The difference in these eligibility levels could result in families enrolled in different coverage sources and provider networks. A possible solution would be to offer vouchers to the parents of CHIP eligible children for the purchase of commercial family coverage on the Exchange. Providers and insurer and broker respondents were in favor of this measure with over 50% of respondents in support. This measure was most popular among the limited number of optional business and individual consumer respondents who elected to answer this question. One provider respondent offered, "The goal is to get people off of Medicaid and on to regular insurance plans. Premium vouchers that cover the whole family give less incentive to migrate off of Medicaid plans."

Table 21

Should Medicaid provide premium vouchers to parents of CHIP children to aid in the purchase of a family health coverage product on the Exchange?				
	Insurer/brokers (n=291)	Providers (n=196)	*Business (n = 44)*	*Consumers (n = 166)*
Yes	50.2%	55.4%	*65.9%*	*64.8%*
No	34.0%	24.7%	*31.8%*	*25.5%*
Undecided	15.8%	19.9%	*2.3%*	*9.7%*

The ACA gives the option that a State could create a Medicaid expansion program called a Basic Health Plan that provides services for individuals up to 200% FPL. This program could help reduce the number of people moving between Medicaid and the Exchange as recent research notes that individuals around 150% FPL experience high income volatility[9]. Since a Basic Health Plan would be run by the State Medicaid program, provider reimbursement would likely be lower than in commercial plans. This could yield savings that could be used to fund health Exchange operations. However, these savings come at the expense of the health care providers who may have to shift costs to other patients to keep their facilities running. Under the Basic Health Plan option the State also takes on risk; if member health cost exceeds federal subsidies then the State is liable to fund the difference. Additionally, a Basic Health Plan may crowd out the private insurance market, as these individuals would otherwise be insured through federally subsidized coverage offered on the Exchange. Providers and insurer and broker respondents were asked whether Indiana should consider offering a Basic Health Plan. Over half of providers responded that they

[9] Sommers, B., Rosenbaum, S. (2011). Issues in health reform: How changes in eligibility may move millions back and forth between Medicaid and insurance exchanges. Health Affairs, 30, 2.

supported the measure while the optional business and consumer respondents were the most supportive. A greater number of insurer and broker respondents supported the Basic Health Plan than opposed it. All respondent groups had high degrees of 'Undecided' responses.

Table 22

Should Indiana consider establishing a Basic Health Plan?				
	Insurer/brokers (n=290)	**Providers (n=166)**	***Business (n=43)***	***Consumers (n = 167)***
Yes	47.6%	51.8%	*60.5%*	*59.3%*
No	33.4%	27.1%	*23.3%*	*17.4%*
Undecided	19.0%	21.1%	*16.3%*	*23.4%*

Exchange Small Business Health Option Programs (SHOP) Exchange

The ACA requires Exchanges to serve two distinct customer bases. First, an Exchange serves those individuals who are seeking insurance coverage for themselves or their family. Second, it serves small businesses that are seeking to purchase coverage for their employees. This facet of the Exchange is called the Small Business Health Option Programs (SHOP) exchange and its purpose is to simplify the administration of health insurance for small employers. A State can develop one Exchange that serves individuals and a separate Exchange that serves small businesses or a combined Exchange that serves both individuals and small groups. Insurer and broker respondents and business respondents were asked questions about services that should be offered in the SHOP Exchange and how the SHOP exchange should be structured.

One of the challenges of the SHOP Exchange is how to define the small group market. In 2014 the SHOP is required to serve businesses with up to 50 employees and by 2017 the ACA requires the SHOP to serve businesses with up to 100 employees, though a SHOP could serve up to 100 employees in 2014 if desired. While in group insurance risk is typically pooled over all participants resulting in a group risk score, a small group market that starts at one employee resembles the individual market as it includes policies with no risk pooling (e.g. self-employed individuals or individuals seeking coverage for only a single employee). Currently, the Indiana small group market definition is from 2 to 50. When the question of market size was posed insurer and broker respondents preferred keeping the small group definition at 2 to 50 while businesses, and the optional provider and consumer respondents preferred changing the definition to 1 to 50.

Table 23

What should the small group definition be for initial Exchange participation in 2014?				
	Insurer/brokers (n=277)	**Businesses (n=277)**	***Providers (n=22)***	***Consumers (n=130)***
1 to 50	33.9%	30.0%	*40.9%*	*43.8%*
2 to 50	50.2%	25.6%	*13.6%*	*18.5%*
1 to 100	6.5%	21.7%	*22.7%*	*24.6%*
2 to 100	9.4%	22.7%	*22.7%*	*13.1%*

An optional function of the SHOP Exchange could be offering defined contributions. Defined contributions allow for an employer to contribute a fixed amount towards their employees' health coverage. The employee can then go to the SHOP and purchase coverage. Over 70% of respondents in all stakeholder groups support offering the defined contribution option for employers[10]. A business respondent expressed, "A defined contribution could result in some businesses staying in business."

If the Exchange offers businesses the option of defined contributions then the related functionality needs to identified. For example, should an employer choose the carrier or the benefit tier and allow the employee to pick a plan? Or should employees using defined contributions have the choice of any Exchange plan? The answers have implications for adverse selection among the plans and pricing for the insurers. For example if employees are allowed to chose any plan among any tier then the highest health care users may gravitate towards the most expensive plans with the richest benefits and the employees that use care the least may select the lowest cost plans with fewer benefits. This serves to concentrate the sick and healthy populations in different plans. Furthermore, traditionally in the small group market, plan pricing is offered based on the size of the group and if employees are allowed to choose any plan from any carrier with their defined contribution option. This presents challenges to carriers based on how to price these plans.

Business and insurer and broker respondents were asked to indicate if employees using defined contributions should be limited in plan choice to plans or tiers selected by their employer or if they should be allowed to choose any plan in any tier. All respondent groups had the strongest support for allowing employees to choose any plan with no restrictions placed by their employer. When the insurer and broker group was separated by insurer and broker respondents there was no significant difference in the responses.

Table 24

If the Exchange offers defined contributions should employees have a choice among all possible plans across benefit tiers (Bronze, Silver, Gold, etc.), be limited to all possible plans within a benefit tier, or be limited to employer plan selections?				
	Insurer/brokers (n=280)	**Businesses (n=272)**	***Providers (n=22)***	***Consumers (n=126)***
Employees using defined contributions should be limited to a benefit tier specified by their employer but have free choice of plans in that tier.	15.7%	21.0%	*13.6%*	*7.9%*
Employees using defined contributions should be limited to a selection of plans determined	6.8%	6.3%	*4.5%*	*6.3%*

[10] See Table f in the Appendix

by their employer within a single benefit tier.				
Employees using defined contributions should be able to select any plan from any tier	47.5%	49.6%	*63.6%*	*57.1%*
Employees using defined contributions should be limited to a selection of plans determined by their employer across different benefit tiers	15.0%	9.6%	*18.2%*	*14.3%*
Undecided	15.0%	13.6%	*0.0%*	*14.3%*

The Exchange could impose requirements employers must meet in order to use the SHOP to purchase coverage. One of these requirements could be minimum contribution requirements on employers purchasing coverage for their employees through the Exchange. This would help to ensure SHOP purchased coverage remained affordable for enrollees. Currently, in Indiana there is no State requirement that employers make minimum contributions to coverage for their employees, however, every carrier that offers small group policies in Indiana requires that employers contribute at least 50% of the premium for a single policy. Insurer and broker respondents supported the SHOP Exchange having the requirement that employers make a minimum contribution to their employees' insurance coverage while the other stakeholder groups did not support this requirement.

Table 25

Should employers purchasing coverage in the Exchange be required to make a minimum contribution towards their employees' health plans?				
	Insurer/brokers (n=276)	**Businesses (n=277)**	***Providers (n=22)***	***Consumers (n=125)***
Yes, employers purchasing coverage in the Exchange should be required to make a minimum contribution towards their employees' health plans	62.3%	40.8%	*31.8%*	*40.0%*
No, employers purchasing coverage in the	30.8%	47.7%	*54.5%*	*54.4%*

Exchange should not be required to make a minimum contribution towards their employees' health plans				
Undecided	6.9%	11.6%	*13.6*	*5.6*

Employers could also be required to have a minimum percentage of their employees participating in their employer sponsored coverage in order to access the SHOP Exchange. As there are no requirements for employers with fewer than fifty employees to offer coverage, this could help to guarantee that employers who are offering coverage are offering it to all of their employees and are encouraging their employees to take advantage of the employer sponsored coverage. It could also increase employer cost and cause some employers not to participate or offer through the Exchange. Insurer and broker respondents supported the requirement that employers purchasing in the SHOP Exchange have a minimum number of their employees participating; however, the other respondent groups did not support this requirement.

Table 26

Should employers purchasing coverage for their employees in the Exchange be required to have a minimum percentage of their employees participating in the plan?				
	Insurer/brokers (n=273)	**Businesses (n=278)**	***Providers (n=22)***	***Consumers (n=125)***
Yes, employers purchasing coverage for their employees in the Exchange should be required to have a minimum percentage of their employees participating	54.6%	20.1%	*22.7%*	*22.0%*
No, employers purchasing coverage for their employees in the Exchange should not be required to have a minimum percentage of their employees participating	37.4%	72.3%	*63.6%*	*68.5%*
Undecided	8.1%	7.6%	*13.6*	*9.4*

Optionally, the SHOP Exchange could offer the administration of Section 125 Plans. Section 125 Plans offer employees the choice between taxable and non taxable benefits and have the effect of reducing

employee gross salary before the calculation of federal income taxes and social security taxes. Insurer and broker respondents and businesses were asked if the Exchange should consider administering Section 125 plans. If the Exchange does not offer these plans then employers could still seek them outside of the Exchange, however, for very small employers the Exchange could facilitate Section 125 plan administration. All respondent groups showed support for this option, over 70% of businesses and the optional provider and consumer respondents supported the Exchange administering Section 125 plans while 58% of the insurer and broker respondents supported the Exchange administering these plans. Comments from the broker group showing less support for Section 125 plans indicated that the administration of Section 125 plans should not be handled by the Exchange but should remain a product offered by brokers and sold only outside the Exchange.

Table 27

Should the Exchange consider administering Internal Revenue Code §125 (Cafeteria Plans) where employees on a pre-tax basis can contribute to the purchase of group insurance?				
	Insurer/brokers (n=280)	**Businesses (n=275)**	***Providers (n=22)***	***Consumers (n=127)***
Yes, the Exchange should consider administering §125 plans.	57.9%	78.5%	*77.3%*	*74.0%*
No, the Exchange should not consider administering §125 plans.	33.2%	11.3%	*9.1%*	*15.5%*
Undecided	8.9%	10.2%	*13.6%*	*11.0%*

Free Choice Vouchers

The ACA included Free Choice Vouchers to aid employees who work for employers that are offering health insurance but face a high cost of coverage. Free Choice Vouchers would have been available to employees between 134% and 399% FPL whose premium contribution falls between 8.0% and 9.8% of their household income. Qualifying employees would have had a choice to receive an employer funded voucher to purchase coverage from the Exchange. This voucher program was removed from the ACA in legislation passed in April 2011. This questionnaire took place in advance of the additional legislation and asked questions about how free choice vouchers should be calculated and administered. Vouchers could be provided at a flat rate to all employees, or could reflect the differing cost of coverage for employees in different age groups. In this case an older employee would receive an age adjusted voucher which would be worth more on the Exchange than the voucher of a younger employee.

Questionnaire results indicated that all respondent categories showed the strongest support for having a voucher with a flat amount per coverage tier regardless of the age of the employee. Scaling the voucher to be adjusted for age was a less popular choice among all respondent groups.

Table 28

Should the amount of the Free Choice Voucher be based strictly on the employer contribution for

the employee's coverage tier (a flat amount for each coverage tier), or should it be adjusted based on the age of the employee (the value of the voucher decreases for the youngest worker and increases for the oldest worker)?				
	Insurer/brokers (n=277)	**Businesses (n=251)**	***Providers (n=22)***	***Consumers (n=126)***
The Free Choice Voucher should be a flat amount per coverage tier regardless of the age of the employee.	44.8%	46.9%	*40.9%*	*46.0%*
The Free Choice Voucher should be adjusted to the age of the employee so that older employees with higher premium cost will receive more than younger employees with lower premium cost.	31.4%	27.4%	*27.3%*	*28.6%*
Undecided	23.8%	25.6%	*31.8%*	*35.4%*

Premiums and Health Plan Enrollment

Insurer and broker respondents were asked additional questions about Exchange enrollment and premium collection functionality. These questions were optional for all other respondent groups. In regards to enrollment in health plans the Exchange could have different degrees of functionality. One option would be to emphasize the Exchange as a shopping place and to collect limited enrollment information. The purchaser would be referred to the insurer to complete the purchase of the health insurance product. Alternatively, the Exchange could refer clients to Navigators or it could complete the enrollment and allow for the purchase of the plan without referring to the insurer.

The insurer and broker respondents were undecided if buyers should be able to complete the purchase of their health plan on the Exchange or if they should be directed elsewhere. The limited number of optional consumer, provider and business respondents support an Exchange where the purchase of the health plan is completed through the Exchange. When breaking down the insurer and broker group those identifying as insurers have greater support for a full service exchange (53%) while those identifying as brokers prefer an Exchange that refers to Navigators or brokers to complete the purchase of health coverage. One broker respondent offered, "My preference would be that consumers would have to make the final deal with the insurer so the risk of not "reading the fine print" would be less. However, for convenience, it would be good for it to be a single source."

Table 29

Should the Exchange provide the ability to shop, compare and purchase health plans or should the

Exchange only provide comparison data and direct buyers to the individual insurers to complete the purchase of the health plan?				
	Insurer/broker (n=272)	***Businesses (n = 43)***	***Providers (n=13)***	***Consumers (n=101)***
Buyers should be able to shop, compare and purchase plans on the Exchange	37.5%	*62.8%*	*76.9%*	*62.4%*
The Exchange should direct customers to the insurers to complete the purchase of the health plan	18.8%	*16.3%*	*7.7%*	*15.8%*
The Exchange should direct customers to a listing of approved (State licensed and certified) Navigators to complete selection and enrollment functions	36.4%	*14.0%*	*0.0%*	*19.6%*
Undecided	7.4%	*7.0%*	*15.4%*	*2.0%*

The Exchange could collect premiums and remit them to insurance companies. Alternatively, premium collection for coverage sold on the Exchange would remain the responsibility of insurance companies. Insurer and broker respondents and businesses were asked if the Exchange should collect premiums for the small group market. All respondent groups showed the most support for premium collection remaining a responsibility of health insurance companies.

Table 30

Should the Exchange collect premium contributions from employers, employees and other sources

and distribute them to health insurers?				
	Insurer/brokers (n=281)	**Businesses (n=277)**	***Providers (n=22)***	***Consumers (n=127)***
Yes, the Exchange should collect premiums	26.3%	36.7%	*40.9%*	*38.6%*
No, premium collection should remain a responsibility of health insurers	59.8%	46.0%	*45.5%*	*45.7%*
Undecided	13.9%	17.3%	*13.6%*	*15.7%*

Additionally, insurer and broker respondents were asked if in the individual market, the Exchange should collect premiums from individuals and distribute them to health insurers. Similar to the results above for the small group market, in the individual market all stakeholder groups wanted premium collection to remain a responsibility of health insurers.

Table 31

In the individual market, should the Exchange collect premium contributions from individuals and distribute them to health insurers?				
	Insurer/brokers (n=274)	***Businesses (n= 43)***	***Providers (n=13)***	***Consumers (n=100)***
Yes, the Exchange should collect premium contributions from individuals and distribute them to health insurers	19.7%	*41.9%*	*23.1%*	*26.0%*
No, premium collection should remain an responsibility of health insurers	72.6%	*55.8%*	*61.5%*	*58.0%*
Undecided	7.7%	*2.3%*	*15.4%*	*16.0%*

Related to premium collection, an Exchange could operationalize the functionality to aggregate premium contributions from multiple sources and distribute lump sum payments to insurers. This functionality could be useful to part-time employees and families with multiple employer contributions. Premium aggregation would allow a family to purchase a single plan using contributions from multiple employers. When asked if the Exchange should have the ability to aggregate premiums in the individual market insurers and brokers were not in support. Of the optional respondent groups, businesses and providers supported premium aggregation.

Table 32

In the Individual market should the Exchange have the functionality to aggregate premium contributions from multiple sources (individuals, part-time employers, subsidy contributions, etc.) and distribute lump sum premium payments to insurers?				
	Insurer/brokers (n=274)	***Businesses (n= 43)***	***Providers (n=13)***	***Consumers (n=99)***
Yes, the Exchange should have the functionality to aggregate premium contributions from multiple sources	22.6%	*48.8%*	*69.2%*	*36.4%*
No, the Exchange should not have the functionality to aggregate premium contributions.	60.2%	*37.2%*	*15.4%*	*52.5%*
Undecided	13.1%	*14.0%*	*15.4%*	*11.1%*

Any Exchange functionality that goes beyond the federal requirements has the potential to increase the cost of operating the Exchange. These costs could be reflected in insurance premiums. Additional functionality would include defined contributions, premium collection, and premium aggregation.

Insurer and broker respondents and businesses were asked about how much they were willing to pay for additional Exchange functionality that went beyond the federal requirements. Insurer and broker respondents and consumers are the least willing to bear additional costs for additional functionality, while business and provider respondents are willing to pay small premium increases to fund Exchange functionality that goes above and beyond the ACA requirements. A business respondent offered that the amount he or she is willing to pay "is wholly dependent on the functionality offered by the Exchange. It must be high quality service at a lower cost than a business can do internally."

Table 33

Relative to premium costs what would you be willing to pay for additional Exchange functionality?				
Increase in premium cost	**Insurer/broker (n=271)**	**Business (n=266)**	***Consumer (n=96)***	***Provider (n=13)***
0% increase	59.8%	48.9%	*52.1%*	*23.1%*
0% to 1% increase	19.2%	32.0%	*25.0%*	*46.7%*
2% to 3% increase	14.4%	15.5%	*11.5%*	*15.4%*

3% to 4% increase	2.2%	1.5%	*5.2%*	*7.7%*
more than 5% increase	4.4%	2.6%	*6.3%*	*7.7%*

Brokers and Navigators

The ACA creates Navigators to help individuals negotiate the Exchange and find appropriate public and private coverage options. According to ACA provisions insurance brokers can be Navigators but Navigators cannot be paid by insurance companies. Many responsibilities of the Navigator role created by the ACA overlap with the current role brokers play in the marketplace. According to the ACA Navigators are required to conduct public education, outreach, assist in enrollment, distribute fair and impartial information, and provide referrals to consumer assistance in a linguistically and culturally appropriate manner. Currently in Indiana, brokers provide many of these services to individuals and small businesses and they are compensated by insurers. Meeting the requirements regarding Navigators without crowding brokers out of the market is a challenge facing the Exchange.

Insurer and broker respondents preferred Navigators to be licensed agents and brokers; this response was also popular among the optional respondent groups. The optional respondent groups also supported Navigators who are Exchange employees and social services or community based agency employees.

Table 34

Who should hold the Navigator positions in Indiana's Exchange?				
	Insurer/brokers (n=270)	***Businesses (n=35)***	***Providers (n=15)***	***Consumers (n=96)***
Exchange Employees	27.4%	*54.3%*	*86.7%*	*42.0%*
Licensed Insurance brokers/Agents	92.2%	*57.1%*	*33.3%*	*46.2%*
Social services agency employees	11.1%	*31.4%*	*26.7%*	*45.4%*
Medicaid advocacy groups	9.3%	*11.4%*	*13.3%*	*31.9%*
Community based agency employees	5.6%	*22.9%*	*53.3%*	*42.9%*
Non-profit faith based organizations	7.0%	*20.0%*	*26.7%*	*30.3%*
Other contractors	7.4%	*28.6%*	*20.0%*	*11.8%*
Other (please specify	0.3%	*11.4%*	*0.0%*	*13.4%*

Insurer and broker respondents preferred that Navigators be compensated on commissions, per member per month, or as a percentage of the premium for each plan sold. The optional respondent groups all showed a strong preference for Navigators to be salaried as Exchange employees[11].

All respondent groups support training Navigators to help people enroll in public programs[12], support that Navigators should be licensed[13], and support that any compensation should be the same in and outside of the Exchange[14]. All respondent groups feel that the Exchange should fund the Navigator program[15].

With the introduction of Navigators the role insurance agents and brokers will continue to play in the Exchange marketplace is undefined. Respondents were asked what the role of brokers should be in the context of the Exchange and the outside market. Most respondents support brokers having a role in helping those individuals and groups seeking insurance inside and outside of the Exchange. A broker respondent offered, "Brokers should help individuals and employers and employees select plans inside and outside the exchange. There should be a formal relationship, since the brokers should be compensated."

Table 35

What should the role of brokers be relative to the Exchange?				
	Insurer/brokers (n=272)	***Businesses (n=36)***	***Providers (n=15)***	***Consumers (n=117)***
Brokers should help individuals, employers and employees select plans inside and outside of the Exchange but have no formal relationship with the Exchange	52.9%	*50.0%*	*33.3%*	*40.2%*
Brokers should function as Exchange Navigators	34.2%	*19.4%*	*20.0%*	*17.9%*
Brokers should only help individuals, employers and employees select plans in the markets outside of the Exchange	3.7%	*11.1%*	*20.0%*	*23.9%*
Undecided	5.9%	*13.9%*	*20.0%*	*12.0%*

[11] See Table g in Appendix 2
[12] See Table h in Appendix 2
[13] See Table i in Appendix 2
[14] See Table j in Appendix 2
[15] See Table k in Appendix 2

Other (please specify)	3.3%	*5.6%*	*6.7%*	*6.0%*

Current Coverage

Respondent groups that identified as employers were also asked who managed their employee benefits. The greatest concentration of responses indicated that respondents manage their employee benefits themselves.

Table 36

Who manages employee benefits for your business?				
	Insurer/brokers (n= 156)	**Businesses (n=500)**	**Providers (n=209)**	**Consumers (n=198)**
Human resource generalist	7.1%	24.0%	33.1%	14.1%
Benefits manager	17.9%	12.0%	26.6%	7.6%
Outsourced to a benefits management company	3.2%	5.4%	12.1%	7.1%
Insurance agent/producer	28.2%	15.2%	14.5%	12.6%
Do it myself	44.9%	50.0%	28.2%	48.5%
Do not offer any employee benefits	12.2%%	12.4%	4.8%	18.7%
Other	3.2%	6.2%	10.5%	10.1%

Individual consumers and providers were asked about their current health coverage. Forty-eight point three percent (48.3%) of individual consumers and 64.6% of providers helped to choose their current coverage option[16]. As demonstrated by write in comments, approximately 20% of individual consumers and providers that helped choose their current coverage indicated that they were assisted by a broker. Over 90% of consumer and provider respondents indicate that they have a decent understanding of their insurance coverage[17]. For individual consumers, 55% said they would contact the insurance company if they had a question on coverage and 15% would contact an agent or broker. For providers 39.3% indicated they would contact their insurance carrier and 24.5% would contact an agent or broker[18].

When asked to think about how they would prefer to secure coverage in a potential exchange 74.7% of consumers and 79% of providers would like Navigators providing Exchange support to be licensed.[19] Fifty-eight point seven percent (58.7%) of consumers and 68.1% of providers would prefer to receive assistance, if needed, in the Exchange by a licensed and regulated Navigator that does not have a financial

[16] See Table l in Appendix 2
[17] See Table m in Appendix 2
[18] See Table n in Appendix 2
[19] See Table o in Appendix 2

relationship with a plan. Fifteen point two percent (15.2%) of consumers and 11% of providers would prefer to find the information by themselves through online research[20].

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 have the greatest support for an Exchange that preserves as much of the current market structure as possible, is financially sustainable, and provides basic information on cost and quality to Exchange users. Stakeholder comments show strong support for transparency and consumer accountability initiatives and urge the state to innovate in health care reform implementation.

[20] See Table p in Appendix 2

Appendix 1: Respondent Comments and Hoosier Stakeholder Perspectives

Indiana's Health Benefits Exchange Questionnaire contained 61 unique questions on the design of the Indiana Exchange. Forty-five of these questions contained the option for respondents to provide comments. The stakeholders groups responding to the survey submitted over 5000 meaningful write in responses and comments. Responses were defined as meaningful if they consisting of more than one word and were not 'no comment'. Write-in responses 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 range of 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 of the questions posed on the American Health Benefits Exchange questionnaire, five general themes emerged in the stakeholder comments.

1. Stakeholders held polarized opinions about the general direction of Health Care Reform. Comments called both for repeal of the Affordable Care Act (ACA) and for public option, single payer system or Medicare for all.
2. Similar to the general direction of Health Care Reform, stakeholders commented about the role of government in health care. Comments supported both getting government out of health care and also a greater role of government in the health care marketplace.
3. All groups were in accord in demanding greater transparency in health care cost and quality.
4. All groups supported making consumers accountable for health behaviors.
5. Additional comments were received by all groups regarding the insurance market in Indiana and ways in which it could be improved.

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 government intervention and additional bureaucracy.

General Direction of Health Care Reform Efforts and Exchange Planning

Respondents expressed gratitude at being asked for their input through the electronic questionnaire. However, stakeholders leaving comments in all groups expressed various levels of confusion and or satisfaction/dissatisfaction with the general direction of health care reform and urged the State to think of solutions beyond the ACA framework. In terms of the general direction of health care reform efforts there was no consensus among stakeholder respondents but few were content with the current state of the process. A selection of comments reflecting opinions on health care reform efforts and the Exchange are displayed below.

"I'm not sold on the exchange idea. It will serve to artificially drive up costs by setting rules that favor specific insurers. Open competition is the best approach." – A Hoosier Business

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

"Exchanges should not be in place period." – 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 "single solution for all" approach carries the 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 Hoosier Provider

"Proper design of an Indiana Insurance Exchange would be of great benefit to the public health. The general direction of the program should be towards efficiency, lessening the capital paid to insurance companies, increasing the proportion of capital directed at actual preventive and acute care of citizens, and lessening the cost and "hassle" per transaction that accompanies each encounter providers endure while providing care to patients." – A Hoosier Provider

"I don't like this. Repeal Obamacare. Get a waiver for our state." – A Hoosier Consumer

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

"Obamacare is a monumental building block in the creation of the ever-growing Nanny State--let Hoosiers remain free of this budget-busting, health-defeating, idea. Offer something better--consumer-based health options, untangled from well-meaning, but totally misguided and inept bureaucrats who've never run a business in their lives."—A Hoosier Consumer

"I am in favor of a national healthcare program. Something has to be done so that every citizen has access to quality health care." – A Hoosier Consumer

Government Role

Comments on the government role in the insurance marketplace and in health care followed two tracks. In the business and insurer and broker respondent group the comments consisted mainly of stakeholders rejecting any increased government rule in the health insurance marketplace. In the consumer groups both the rejection of too much government in health care and the health insurance market place and a call for a single payer system, Medicare for all, or a public option were present. A selection of comments representing these perspectives is displayed below.

"*Continue to protest against government mandates and intrusions into personal decisions." –A Hoosier Business*

"I do not believe the objective of the exchange will properly function economically or provide a valuable service." –A Hoosier Broker

"I don't feel it is the government's role to mandate an individual's health benefit selection. Different people have different needs and should be free to elect a plan that best fits their needs"—A Hoosier Broker

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

"Competition is not nearly as good as cooperation. However, if the Government competed with for profit insurance companies, the price would definitely drop." – A Hoosier Consumer

"Get government out of the picture so that insurers could offer a wider variety of plans from coverage for only major expenses to coverage for everything." – A Hoosier Consumer

"I support a single payer plan with no insurance companies in the mix. Until we do that, I think the exchange should strive to represent the insured rather than the insurer with an eye to fairness, service, and cost." – A Hoosier Consumer

Transparency

An overriding theme in all stakeholder groups is the need for greater transparency in the health care marketplace. Write-in comments requested clear price information on health care services. Consumers want to be able to get the best prices with the mystery of pricing in the health care market place minimized. Consumers wrote in personal accounts of their frustration of dealing with the vagaries of health care prices. Providers expressed nervousness about transparency, feeling that complying could bring additional costs to already strapped practices and also requested transparency about insurance companies' payment of claims and statistics on first time denials and later payments. Providers were supportive of transparency measures as long as they did not require extra work, additional cost, or single out providers.

"Mandate up front and ACCURATE (as adjusted by insurance company negotiation) price transparency for all procedures. This competition that will be formed when pricing availability is combined with consumer conservatism like that offered by HSA plans." – A Hoosier Business

"Consumers should have the knowledge 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 that with health care. We are expected to blindly purchase health care." – A Hoosier Business

"Consumers need the quality and cost information in order to be wise consumers. That is the single biggest thing we can do to control spiraling out of control costs." – A Hoosier Business

"Transparency is huge. Consumerism 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, find who's doing cheaper MRI's and on down the line. We're giving people the motivation to be better consumers via cost shifting but haven't given them the tools to be good consumers." –A Hoosier Broker

"I believe it is in the best interests of all consumers of health care to have the exchange publish all possible information regarding costs and quality on each and every health care provider. Whenever, this info is readily available and the public begins to shop for health care as a commodity, the industry begin a strategic renovation that will, in a short time, allow capitalistic market forces to lower the cost of health care, and greatly improve the quality. …This is the one thing that healthcare reform could do that would have the greatest overall impact in greatly improving US healthcare." –A Hoosier Broker

"Making costs transparent will drive competition to reduce costs." --A Hoosier Broker

"I think a standardized price guide for hospital vs. outpatient setting and rural vs. would be helpful to both providers and consumers.'—A Hoosier Provider

"Make provider reimbursement more transparent so that patients may see how much their co-insurance costs will be BEFORE committing to care." – A Hoosier Provider

"We need information on all providers of health care! We need information on all health insurance companies! We need to know what health care costs, upfront, before we come in for the treatment! Publish everything about health care so the people can decide when where and how to get health care in a responsible way." –A Hoosier Provider

"Mandate that health care providers make the price of services available to consumers upfront, before services are provided... A consumer should be able to get the cost of routine service and be able to shop competitive offerings for routine or non-critical care." – A Hoosier Consumer

"Publish the cost of health services as charged by hospitals. Consumers may then compare costs for the same procedures provided by different health care providers. Show data for return rate to hospital following treatment, incidence of infection, surgical errors, medication errors etc. for area hospitals." –A Hoosier Consumer

"Transparency in costs… Most people do not get there car fixed without getting an estimate on the cost. Why should health care be different?" – A Hoosier Consumer

"The costs of most healthcare related services seems to be way too high. I think there needs to be transparency regarding what drives costs. …We compete with everything else globally, why not healthcare? Why are medical providers "special?" Just wondering." – A Hoosier Consumer

"Require health providers to publish their charges for services so consumers can educate themselves as to the cost of health care. Consumer need to be involved in the cost verses reward decisions. When possible have insurance providers reveal to consumers prior to test and procedures being preformed what their out of pocket cost are going to be. The power to control cost should be consumer driven, not provider driven." – A Hoosier Consumer

"…We need more transparency in healthcare cost and quality. Healthcare is a "high priced" purchase that is almost impossible to shop around (for). There is no information available regarding success rate of drugs for conditions vs. cost. Operation and procedure costs are not discussed upfront." – A Hoosier Consumer

Consumer Accountability

All groups were supportive of promoting consumer accountability. Providers commented that they feel singled out for the responsibility of providing care when their advice and the prescribed care regimen do little when not followed. Insurers and brokers felt consumers should have greater incentives to improve their health. Businesses wanted to be able to reduce their costs through requiring greater consumer accountability for health. Even in the individual consumer group there were many write in comments requesting that consumers be required to be accountable for their health and for preventable conditions. Write in responses from the individual consumer group indicated that these respondents did not want to be required to pay higher premiums because of other individuals' unhealthy habits (for example: obesity, smoking). All groups support consumer accountability and incentives for positive health behaviors. Comments showing the scope of this support are displayed below.

"We'd like to see some good coverage at affordable prices with incentives for staying healthy. Too many people think insurance is permission to run to a doctor at every whip stitch instead of taking responsibility for their own health and well-being." – A Hoosier Business

"I believe there should be some wellness standards tied to a tiered approach. You can't buy the Cadillac benefits if your health condition is total debauched by self-infliction. We shouldn't have to pay for another's excesses and profligate lifestyle" – A Hoosier Business

"Health care isn't free. It's not free when provided by the government (Medicare, Medicaid) and it's not free when paid for by an insurance company. As long as people view health care and health insurance as the same, the true problems will never be solved. There is very little mention in any of this about personal responsibility and wellness. Until we all take responsibility for our own health and make the changes needed to live a healthier life, costs will continue to rise for the providers, the insurers and consumers because the root of the problem is not addressed." –A Hoosier Broker

"Of the quality standards, these need to be imposed on the consumer rather than providers, as is traditionally done. Consumers are the only ones who can make lifestyle changes." –A Hoosier Provider

***"**State health goals need to be directed at patients not providers (ex lower premiums to consumers who don't smoke or who lose weight) vs. penalizing providers whose patients smoke or are obese which only disincentivizes caring for noncompliant or difficult pts." – A Hoosier Provider*

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

"Patients should be rewarded for their efforts to keep themselves healthy. Less ER visits, normal BMI, more use of preventative services should be rewarded monetarily or by discounts in premiums paid." –A Hoosier Provider

"(The Exchange) must be focused on prevention. Obesity, smoking, other high risk behaviors must be included. People must be held accountable for these high risk behaviors." – A Hoosier Consumer

"Provide insurance premium discounts (maybe rebates) for people who live healthy lifestyles (non-smoking, exercising, healthy weight range)." – A Hoosier Consumer

***"**Make it so the consumer has more involvement. Education is important since the medical card has been our credit card all these years and we need to change our behavior. This will help keep cost down." – A Hoosier Consumer*

***"**The consumer MUST take an active role in his or her health, and have access to affordable, quality catastrophic coverage with pre-existing conditions a non-issue." – A Hoosier Consumer*

***"**I am very concerned about my health premiums going up because of people who have chosen to not take good care of their health. Example-over weight, smoke, and drinking. I don't want to pay for their medical bills for those who have failed to take care of themselves or spent their money on other items then good health care in the past but now want me to take care of them." – A Hoosier Consumer*

Insurance Markets

Another result of reviewing the write-in responses from Business, Insurers and Brokers, and Individual Consumers was the request for insurance coverage across state lines and for allowing out of state insurance companies to compete in the state. A selection of comments displaying this opinion is below.

"Allow for inter-state competition, be the first state to invite outside competition. I can buy my car/life insurance nationwide, why not my health insurance?" – A Hoosier Business

"Increasing competition by allowing out of state insurance firms to participate will drive down costs and weed out mismanaged firms." –A Hoosier Broker

"Promote nation wide offering of insurance. Let consumers buy insurance from any company in the nation regardless of where the home office is located." – A Hoosier Consumer

Appendix 2: Tables and Figures

Table a

How many people do you employ?					
	Insurer/brokers (n = 260)	Businesses (n =35)	Providers (n=124)	Consumers (n=198)	Average
1/Self-employed	3.1%	68.6%	2.4%	11.1%	21.30%
2-15	63.8%	46.7%	35.5%	57.1%	50.78%
16-50	16.9%	14.3%	23.4%	16.2%	17.70%
51-99	5.6%	17.1%	4.8%	5.1%	8.15%
100+	10.6%	11.4%	33.9%	10.8%	16.68%

Table b

Should the Exchange use claims data to generate public reports on provider or clinic cost and quality? All groups except providers responded favorably to this option.					
	Insurer/broker (n=329)	Consumer (n=1098)	Business (n=280)	Provider (n=168)	Average
Yes	72.0%	69.1%	68.2%	38.7%	**62.00%**
No	11.9%	11.2%	20.4%	38.7%	**20.55%**
Undecided	16.1%	19.3%	11.4%	22.6%	**17.35%**

Table c

Should the Exchange make provider "report cards" on standard measures available to Exchange consumers?					
	Insurer/broker (n=332)	Consumer (n=1105)	Business (n=280)	Provider (n=169)	Average
Yes	76.8%	80.4%	73.9%	45.6%	**69.18%**
No	9.9%	8.2%	16.4%	33.1%	**16.90%**
Undecided	13.3%	11.4%	9.6%	21.3%	**13.90%**

Table d

How should open enrollment be conducted on the individual market?				
	Insurer/brokers (n=300)	Businesses (n=350)	*Providers (n=27)*	*Consumers (n=176)*
Open Enrollment should occur once a year	31.0%	18.9%	*11.1*	*19.9%*
Open Enrollment should occur twice a year	22.3%	26.9%	*14.8%*	*15.9%*
Open enrollment should coincide with date of birth	17.0%	9.7%	*11.1%*	*13.6%*
Open enrollment should be continuous	22.7%	35.1%	*51.9%*	*40.3%*

Other (please specify)	7.0%	9.4%	*11.1%*	*10.2%*

Table e

Should comprehensive health insurance products continue to be sold in the market outside of the Exchange or should the Exchange be the only place to purchase these products?				
	Insurer/brokers (n = 296)	**Businesses (n =346)**	***Providers (n=29)***	***Consumers (n=175)***
Both Individual and Small Group health insurance products should be available outside of the Exchange.	90.2%	72.8%	*55.2%*	*54.3%*
Individual products should be available for purchase only on the Exchange.	1.4%	2.6%	*3.4%*	*3.4%*
Small Group products should be available for purchase only on the Exchange.	1.0%	1.2%	*3.4%*	*0.6%*
Both Individual and Small Group products should only be offered on the Exchange.	2.4%	12.4%	*13.8%*	*32.0%*
Undecided	5.1%	11.0%	*11.1%*	*9.7%*

Table f

Should the Exchange consider offering a defined contributions option for employers?				
	Insurer/brokers (n = 280)	**Businesses (n =279)**	***Providers (n=22)***	***Consumers (n=129)***
Yes, the Exchange should consider offering a defined contributions option for employers.	70.7%	73.1%	*77.3%*	*73.6%*
No, the Exchange should not offer a defined contributions option.	18.2%	11.5%	*13.6%*	*14.0%*
Undecided	11.1%	15.4%	*9.1*	*12.4*

Table g

How should the Navigators of the Exchange be compensated?				
	Insurer/brokers (n = 267)	***Businesses (n =35)***	***Providers (n=15)***	***Consumers (n=119)***
Flat rate per transaction	15.7%	*20.0%*	*26.7%*	*26.1%*
Percentage of premium for each plan sold	33.0%	*14.3%*	*6.7%*	*6.7%*
Hourly	4.9%%	*22.9%*	*13.3%*	*24.4%*
Salaried as Exchange employees	10.9%	*45.7%*	*73.3%*	*48.7%*
Commissions	40.8%	*14.3%*	*13.3%*	*14.3%*
Per member per month	30.7%	*20.0%*	*0.0%*	*13.4%*
Other (please specify)	5.2%	*2.9%*	*13.3%*	*11.8%*

Table h

Should Navigators be trained to help people enroll in public programs (e.g. Medicaid) as well as private health plans?				
	Insurer/brokers (n = 271)	***Businesses (n =36)***	***Providers (n=14)***	***Consumers (n=117)***
Yes, Navigators should be trained to help people enroll in public programs.	56.1%	*91.7%*	*78.6%*	*78.6%*
No, Navigators should only be trained on to help people enroll in commercial products.	35.8%	*8.3%*	*14.3%*	*17.1%*
Undecided	8.1%	*0.0%*	*7.1%*	*4.3%*

Table i

Should Navigators be licensed?				
	Insurer/brokers (n = 270)	***Businesses (n =36)***	***Providers (n=15)***	***Consumers (n=118)***
Yes, Navigators should be licensed.	94.4%	*72.2%*	*100.0%*	*69.5%*
No, Navigators should not be licensed.	2.6%	*11.1%*	*0.0%*	*14.4%*
Undecided	3.0%	*16.7%*	*0.0%*	*16.1%*

Table j

Should compensation for Navigators and/or brokers be required to be the same inside and outside of the Exchange?				
	Insurer/brokers (n = 268)	***Businesses (n =36)***	***Providers (n=15)***	***Consumers (n=118)***
Yes, compensation should be required to be the same inside and outside of the Exchange.	53.0%	*50.0%*	*66.7%*	*45.8%*
No, compensation should not be required to be the same inside and outside of the Exchange.	39.6%	*36.1%*	*6.7%*	*34.7%*
Undecided	7.5%	*13.9%*	*26.7%*	*19.5%*

Table k

Who should fund the Exchange Navigator program?				
	Insurer/brokers (n = 260)	***Businesses (n =35)***	***Providers (n=15)***	***Consumers (n=117)***
The Exchange	64.2%	*68.6%*	*73.3%*	*64.1%*
Health Insurers	52.3%	*46.7%*	*66.7%*	*50.4%*
Individuals	23.5%	*14.3%*	*26.7%*	*19.7%*
Employers	20.4%	*17.1%*	*13.3%*	*25.6%*
Other	8.8%	*11.4%*	*6.7%*	*23.1%*

Table l

Were you involved in the purchasing decision of your current health insurance coverage?		
	Providers (n = 161)	**Consumers (n=1067)**
Yes, I helped choose the coverage option.	64.6%	48.3%
No, the coverage option was provided for me through an employer or other group.	34.8%	50.0%
I don't know.	0.6%	1.8%

Table m

How well do you understand your current health insurance coverage?	Providers (n = 163)	Consumers (n=1067)
Completely	58.3%	45.4%
Somewhat	39.3%	47.3%
A little	1.8%	4.9%
Not at all	0.6%	2.4%

Table n

If you have a question or need assistance with your health insurance coverage, who do you contact?	Providers (n = 163)	Consumers (n=1082)
A licensed health insurance producer (agent/broker)	24.5%	15.3%
Your employer	22.1%	13.7%
Your insurance carrier	39.3%	55.1%
I figure it out on my own	7.4%	8.2%
Other	6.7%	7.7%

Table o

Should those who provide support in the Exchange health insurance enrollment process, so called Navigators, hold a certification or license to counsel and advise consumers?	Providers (n = 162)	Consumers (n=1077)
Yes, those who provide support in the Exchange should hold a certification or license to counsel and advise consumers on health insurance decisions.	79.0%	74.7%
No, a certification or license should not be required to advise and counsel consumers on health insurance decisions.	8.6%	10.7%
Undecided	12.3%	14.6%

Table p

If you needed assistance with comparing insurance options how would you prefer to receive it?	Providers (n = 163)	Consumers (n=1082)
From a licensed health insurance producer that is regulated by the State and that may be getting paid by a health plan.	9.8%	11.9%
From a Navigator (unlicensed and paid Exchange grantee).	1.8%	2.9%
From a Navigator that is licensed, regulated, and does not have a financial relationship with a plan.	68.1%	58.7%
By contacting the insurance carrier call center.	3.7%	6.1%
By researching online.	11.0%	15.2%
Other	5.5%	5.2