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Stakeholder Views about the Design of Health Insurance Exchanges for New Jersey:

Volume I: Findings from Stakeholder Forum Discussions & Survey

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Preface

In September 2010, the NJ Department of Banking & Insurance was awarded a one year grant from the U.S. Department of Health & Human Services to support health insurance exchange planning activities, as authorized by the Patient Protection & Affordable Care Act (ACA).

An interagency state Working Group, led by the Policy Advisor to the Governor for Health Care, was established to coordinate New Jersey's response to the ACA, including the decision whether NJ should create its own health insurance exchange(s), and if it does, what shape the exchange(s) should take. The Working Group engaged Rutgers Center for State Health Policy to complete a series of analytic activities to inform the state's exchange planning process. As part of that work, the Center conducted discussion forums and a survey with health care stakeholders to systematically gather their views about how New Jersey should respond to the opportunity of creating one or more health insurance exchanges for the state. Findings from these stakeholder engagement efforts are compiled in a three volume series entitled, *"Stakeholder Views about the Design of Health Insurance Exchanges for New Jersey".*

Volume I, *"Findings from Stakeholder Forum Discussions & Survey"*, includes combined summaries from thirteen stakeholder forums and an online stakeholder survey designed to elicit input on a number of strategic exchange planning issues. The Center reached out to broad constituencies including providers, consumers, insurance carriers, employers, and brokers to participate in both the forums and the survey. Part I of this report provides the methods and findings from the stakeholder forum discussions, followed by the design and results from the online exchange planning survey in Part II. This report concludes with a discussion highlighting the areas of consensus and disagreement found within and among the stakeholder groups. Detailed proceedings from the stakeholder forum discussions can be found in Volume II (Michael et al., 2011), and additional materials about the forums and survey can be found in the appendices provided in Volume III (Cantor et al., 2011b). The Center also produced estimates of eligibility and enrollment under ACA coverage provisions, which are presented in a separate report (Cantor et al., 2011a).

Acknowledgments

Funding for these volumes was provided by the New Jersey Department of Banking & Insurance under a grant from the US Department of Health & Human Services. We are grateful for valuable comments on drafts of the design and content of the Stakeholder Discussion Guide and Exchange Planning Survey by members of the New Jersey interagency Working Group on the Affordable Care Act. We also thank our colleague Douglas McCarthy for his thoughtful contributions to the development of these materials, as well as Patricia Calogero, Bram Poquette and Adrian Zareba for their expert assistance with the execution of the forums and survey as well as the preparation of these reports.

The authors are solely responsible for the design and content of the Forums Discussion Guide and the New Jersey Exchange Planning Survey, as well as all analyses, findings and conclusions presented in this report.

Stakeholder Views about the Design of Health Insurance Exchanges for New Jersey: Volume I: Findings from Stakeholder Forum Discussions & Survey

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Executive Summary

The Patient Protection and Affordable Care Act (ACA) requires the creation of state-based health insurance exchanges for individuals and small businesses. States have the option of developing their own exchanges and the federal government will create exchanges for states electing not to do so on their own. Under a planning grant from the US Department of Health & Human Services, the State of New Jersey is considering whether and how to create exchanges. In an effort to inform this policymaking process, and at the request of the state Working Group on the ACA, Rutgers Center for State Health Policy (CSHP) engaged in a two-fold process to gather comprehensive input from a broad array of stakeholder groups in New Jersey. These activities included a series of stakeholder forum discussions as well as an online stakeholder survey. While there was certainly a diversity of opinion expressed among stakeholder groups, which is documented in this report, overall findings from the forums and the survey were largely consistent and common themes emerged.

In the first phase of this project, thirteen forums were conducted across the state in New Brunswick, Trenton, Montclair and Camden. These included four groups with provider representatives, three with consumer groups, two with representatives of employers, two with health insurance carriers, and two with insurance brokers. The forums were hosted between February and April 2011. A total of 152 participants attended the exchange planning group forums, and fifty-seven percent of organizations invited to participate sent at least one representative to the forums.

There were varying levels of agreement among the participants in response to questions that probed a number of key exchange design issues. Nevertheless, throughout the robust conversations, common themes and concerns could be heard, both from within stakeholder groups and across the various constituencies. A frequent, though not exclusive, pattern of shared opinion was observed between insurance carriers and brokers, while consumer groups and provider organizations tended to be in accord on many of their perspectives. Employers' responses covered the landscape of opinion, depending on the topic.

Participants largely agreed on basic questions about exchange development:

- A near complete consensus was evident across groups that New Jersey should create its own health insurance exchange, rather than default to federal administration.
- Stakeholders also generally agreed that New Jersey should create a single exchange, but that it should be responsive to varying needs of small businesses and individuals across all regions of the state. Participants also agreed that in order to increase the exchange's chances for success, the enrollment process should be characterized by simplicity and ease of use for individuals and small employers.

On other exchange design questions, there was more divergence of opinion among stakeholders, for example:

- Consumers urged that the exchange play an active role in structuring and guiding the market, while insurers and brokers wanted the exchange to act as more of a clearinghouse of plans; providers and employers were mixed on this question.
- The role of navigators, which are required under the ACA, and other specific exchange functions were other topics on which the stakeholder groups held varying opinions.

The forums posed a series of specific questions to the invited stakeholder participants. While participation was broad, the structure of the forum process unavoidably guided the focus of responses. The forums also took place at a point in time of ongoing uncertainty about federal guidelines for the development of state exchanges. Most participants expressed appreciation for the opportunity to participate in the forums and urged that the dialogue about New Jersey's response to the ACA continue as planning proceeds.

Upon completion of the forums, the Center for State Health Policy initiated the second phase of the stakeholder engagement process. On April 15, 2011 an e-mail invitation with a link to a web-based survey was sent to a list of 282 stakeholder representatives. The stakeholder representatives, selected by the Center to assure broad input, were encouraged to forward the link to their constituents. One reminder e-mail was sent on April 27, 2011 and the field period was closed on May 12, 2011. A total of 618 individuals completed the survey.

Part II of this report summarizes survey responses among 11 stakeholder groups, including patient care providers; care delivery organizations; other health care industries; consumer advocacy groups; health insurance companies; health insurance agents and brokers; non-health related businesses; business trade groups; labor unions; academic, consulting and foundation representatives; and others. Where the number of respondents was large enough, some groups were further subdivided (e.g., large and small businesses) in the analysis. Detailed tables showing responses for these subgroups are provided in an Appendix E in Volume III (Cantor et al., 2011b).

Some areas of consensus or near consensus are evident in responses to the survey:

- Most respondents across all stakeholder groups agree that New Jersey should develop its own exchange(s) rather than defaulting to the federal government.
- Respondents across stakeholder groups also largely agree that access to coverage through the exchange(s) should not be limited to individuals that are required to use an exchange under the ACA. While somewhat more mixed, majorities of respondents in most stakeholder groups support the idea of allowing larger businesses to purchase through the Small Business Heath Options Program (SHOP) exchange than the minimum group size set by the ACA.
- There is also broad support for creating a Basic Health Plan, which would permit the state to use federal funding to establish a Medicaid-like option for persons just above the ACA Medicaid income eligibility threshold.

In other areas, consensus among respondents was not evident:

- While majorities of five of the 11 stakeholder groups support creating an independent governing board for NJ exchange(s), opinions were more mixed in others with substantial shares of respondents expressing that they are not sure about the optimal form of exchange governance.
- Should such a board be created, large majorities of respondents across most stakeholder groups would support board membership for representatives of consumers/patients, businesses, providers, and (to some degree) commissioners of relevant state government agencies. Opinions are divided about whether insurers or agents/brokers should be represented on the exchange board.
- Stakeholder opinion is also divided about whether the exchange(s) should largely serve as a clearinghouse for all qualified health plans or whether it should have the authority to limit participation, for example through competitive bidding (called the "active purchaser" model). The clearinghouse model is strongly favored by insurers, providers, and agents/brokers. The active purchaser approach receives high levels of support from most other groups.
- Whether to merge non-group and small-group market risk pools is another topic on which stakeholders are divided. Insurers and agents/brokers oppose merging markets by large margins while half or more of respondents from other groups support merger.

Many respondents did not register opinions in response to many of the survey questions. More technical questions were most likely to garner "not sure" responses. For example, in a series of questions about possible strategies for avoiding health risk selection against the exchange(s), 20% to 60% of some groups failed to proffer support or opposition. As noted, questions on governance also had a large share of "not sure" responses in some groups.

While the number of survey respondents was fairly large and participants were quite diverse, methodological caveats apply. The survey was not designed to be statistically representative of all possible stakeholders, and caution should be used in extrapolating from findings to the broader community of interest. Survey questions were crafted to be unbiased, but there are many other possible ways questions could have been asked which may have generated different responses. In addition, the survey relied mainly on closed-ended, multiple choice questions which do not reveal how well-informed opinions are or the reasoning behind those opinions.

Part I: Findings from Stakeholder Discussion Forums

Introduction

The 2010 Patient Protection and Affordable Care Act (ACA) provides guidelines for creating state-based health insurance exchanges to promote and support efficient markets for the purchase of health insurance coverage by individuals and small businesses. The ACA affords states the option of developing health insurance exchanges, though it mandates that the federal government intercede and create and run the exchanges for states that choose not to develop them on their own. In order to qualify to create a state-run health insurance exchange, the Secretary of the US Department of Health & Human Services must certify that a state has made significant progress in exchange planning or is on a "glide path" to development by January 2013, in anticipation of the exchange being operational on January 1, 2014.

Under federal Exchange Planning Grants, states considering this option were asked to gather information from interested stakeholders as to how these exchanges should be developed and implemented. The State of New Jersey's Working Group on the ACA, comprised of senior officials from the Office of the Governor and the Departments of Banking & Insurance, Human Services, and Health & Senior Services, engaged Rutgers University Center for State Health Policy (CSHP) to conduct group forums and an online survey to gather this input. This section of the report summarizes the findings of the stakeholder forums.

Methods

The forums were intended to provide the opportunity for diverse health care stakeholders to offer views on whether and how New Jersey should structure health insurance exchanges. CSHP prepared a discussion guide and lists of stakeholder groups to invite to the forums, in consultation with the state's Working Group. Invitations were extended to the leadership of statewide stakeholder organizations, and they determined who would represent their constituency at the forums. CSHP analysts took detailed notes of discussions at each forum which were used to analyze participant views and identify themes heard throughout the conversations. Participants in the group forums included stakeholders representing the diverse regions of the state. Forums included discussions with five key health care stakeholder groups: providers, consumers, employers, health insurance carriers, and insurance brokers. A list of

organizations invited to send representatives to the forums and a roster of participants are provided in Appendices A & B, respectively, in Volume III (Cantor et al., 2011b).

CSHP conducted thirteen group forums in February, March, and April 2011. These included four provider forums, three with consumer groups, two with employers, two with health insurance carriers, and two broker forums. The forums were conducted in northern, central, and southern New Jersey to best reflect the locations of those attending the meetings. In addition, three of the forum sessions were offered in the evening to accommodate participant schedules.

A total of 152 participants attended the exchange planning forums (44 representing providers, 36 consumers, 21 employers, 31 insurers, and 20 brokers). Fifty-seven percent of invited organizations sent at least one representative to the forums (67% among provider organizations, 46% among consumer organizations, 41% among employer organizations, 76% among insurance carriers, and 62% among brokers). The group forums were moderated by CSHP faculty, using a discussion guide that can be found in Appendix C in Volume III (Cantor et al., 2011b). All materials and procedures for this project were reviewed and approved by the Rutgers University Institutional Review Board and all participants received a formal informed consent document and were read an oral consent script before beginning the guided discussion.

Findings

Structure and Governance of Exchanges for New Jersey

Most participants in all stakeholder groups – consumers, providers, employers, carriers, and brokers – agreed that New Jersey should establish its own exchange and not have the responsibility default to the federal government. While the potential advantages of regional "subsidiary" exchanges or a multi-state exchange were noted by some forum participants, there was broad consensus that a state-wide approach was preferable.

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The ACA establishes the "American Health Benefit Exchanges" for individuals/families and a "Small Business Health Options Programs" or "SHOP" exchange for small businesses. A fundamental question is whether, as permitted under the law, these two exchanges should be developed as separate entities or combined. This can be achieved administratively, through a common risk pool, or both. Overall, there was broad stakeholder consensus about combining these two exchanges administratively, but there was a good deal of disagreement about the wisdom of combining the exchange risk pools (discussed further below). Employer participants echoed comments

made by many of the stakeholders that the exchanges should lead to "simplification" and "efficiency", themes consistent with the idea that individual and SHOP administrative functions should be merged.

In spite of the preference voiced by many participants that New Jersey should create a single exchange for both businesses and individuals, there was broad agreement that if it does so the state-wide exchange should be designed to:

- Accommodate differences in the health and insurance needs of different regions and populations across the state;
- Be attentive to the needs of small businesses, which are quite different than those of individual purchasers; and
- Leverage, and not duplicate, the strengths of New Jersey's existing regulatory infrastructure.

Many participants noted both the challenges and urgency of getting the "back office" infrastructure of the exchange "right." A common theme heard throughout the forums was that if the initial enrollment and eligibility functions become too difficult for the public to navigate, it could undermine the overall success of the exchange.

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Insurance carriers highlighted an exchange design issue that did not emerge in the other forums – whether the SHOP exchange would be organized around employee choice or employer choice. While expressing concerns about an employee choice model (e.g., that it would be complex and hard to administer), they noted that this issue was interlinked with decisions about whether these exchanges should be combined; i.e., if focused on employee choice, they asserted that there might as well be a single exchange since the mechanism would effectively operate like an individual, rather than a group, insurance market.

Consumers and provider groups were consistent in their opinions that the individual and small group exchanges should be combined, both administratively and in risk pooling. Overall, these groups supported the idea of maximizing the number of covered lives in the exchange, in part to enhance its leverage in the marketplace.

In addition to opinions about organization of the exchange, stakeholders were asked to comment on their preference for its structure and relationship to New Jersey government. Specifically, they were asked if the exchange should be operated within government, for instance as part of the Department of Banking & Insurance (DOBI); established as a separate public authority; incorporated as a nonprofit organization; or set up as some other kind of entity. There was a wide range of discussion and reasoning across all stakeholder groups in response to this question.

Some stakeholders believed that the state's "rightsizing" initiatives, along with potential "conflicts" stemming from merging regulator with distributor functions, and a lack of ability to be "nimble" made the case against a DOBI-based exchange. While some saw the benefits of somehow aligning the exchange with an existing infrastructure and the "critical mass of expertise" within the state, others wanted to create a firewall between the two. It should be noted that while there was significant disagreement regarding under what purview the exchange should operate, there was near unanimous acknowledgment of DOBI's core administrative and technical competence and a recommendation that the expertise be utilized and not reinvented elsewhere.

For consumers, while opinions were mixed, most participants preferred a public authority model for the exchange, but disagreed about the role of existing agencies in its governance. Most consumer participants argued that the exchange should not be housed within an existing state agency, believing that these agencies were "overstressed" and that the current "climate" was not right for the state to take on the responsibility of operating an exchange. Still, others argued that what was most important were the *characteristics* of the exchange, wanting to ensure the exchange was both transparent and accountable.

Carriers examined this question through a different lens. As a group, they expressed concern over creating another set of regulators. They warned against a "redundant regulatory body", citing the issues of inefficiency and costs. That said, the insurance carriers were comfortable with certain technical functions, e.g., rate regulation, remaining under the jurisdiction of DOBI.

Models of Governance

In addition to discussing the structure of the exchange, the groups were asked to consider various models of governance. There was certainly a diversity of opinion among the stakeholders with regard to the size, composition, and qualifications of a potential governing body. However, consistent themes discussed included the need for diverse representation and technical expertise on a governing board, should one be created, as well as establishing a culture of flexibility and nimbleness.

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Consumers believed they should play a critical role on an exchange board. Many spoke of the need to ensure that "real" consumers, i.e., those who actually purchase insurance, and those with a range of health care needs, be included among the board members. Nearly universally, consumers argued that no one with an interest in the sale or service of health insurance products should be permitted on the board.

Brokers expressed a desire to see an exchange board with broad representation and limited terms. They cited the existing Small Employer Health Benefits Program Board as an example of an acceptable model, with a mix of stakeholder representation. They also acknowledged the need for providers to be part of the composition. Brokers, as well as some from other stakeholder groups, were definitive in their belief that members of the board should not stay on in perpetuity, arguing for limited terms to help ensure the board stays "fresh" on products needed in the marketplace. Participants from multiple stakeholder groups emphasized that, regardless of how it is structured, the exchange governing board should be insulated from politics. Some carriers suggested "staggering" appointments as a means of insulating exchange governance from undue influence of any given set of political actors. They also advocated keeping the board to a manageable size with highly expert members.

Participants from multiple stakeholder groups emphasized that, regardless of how it is structured, the exchange governing board should be insulated from politics.

Some employers argued for a balanced board, though of a limited size, to represent key stakeholders interests—including purchasers, providers and carriers. Providers, as a group, also advocated for a multi-stakeholder exchange board, with some suggesting that it mirror the composition of the forums. Some providers looked at the board as a way to balance the scales of perceived power with the insurers, while others spoke to the need to include "at risk groups" on the board.

Financing the Exchange

The ACA provides funds to finance the development and first year of exchange operations. After that period, the exchange must identify a strategy for self-financing. Most stakeholders mentioned some type of insurer-based assessment as the preferred funding option, but other options were proffered as well. Several stakeholder groups noted that the financing mechanism should depend on the functions vested in the exchange, concluding that it therefore may be premature to select a financing option.

Most consumer and many provider representatives advocated for insurer-based financing of the exchange. Some participants suggested that this strategy is appropriate because insurers have "deep pockets." A few participants suggested that insurers should be prohibited from passing such fees on to insurance buyers, but others argued that such a pass-through was unavoidable. In addition, many participants argued that an insurance-based fee should extend to non-exchange plans as well as those within the exchange, either because this strategy will keep the surcharge low for any given policyholder or to assure that plans in the exchange are not disadvantaged (see discussion of adverse selection that follows).

Not surprisingly, insurance carriers had a contrary perspective. Instead, they advocated for "thinking big" in terms of exchange financing. Most were in favor of broad-based funding for the exchange, with all who benefit from it—consumers, providers (including the pharmaceutical industry) and carriers—having a share in its costs.

Market Structure and Risk Pooling

Adverse Selection

Analysts are concerned that health plans in the exchange will attract disproportionately high risk enrollees, driving up exchange premiums and the cost of government subsidies. Others have suggested risk selection among different types of plans might arise. Either development could limit the effectiveness of the exchange, and potentially undermine its long term viability. While groups who participated in these forums seemed to agree that this was a serious concern that should be addressed, many expressed uncertainty about possible solutions.

Brokers and insurers generally agreed that a strong market outside the exchange and certain administrative measures were the best approach to mitigate adverse risk selection. Brokers pointed to the need for a "healthy non-exchange marketplace" that would help ensure competitive products and pricing so that the exchange would not become the "carrier of last resort." Carrier representatives suggested a number of concrete administrative measures to protect the integrity of the risk pool, including:

- Adopting a set open enrollment period that would be the same inside and outside the exchange, with late enrollment penalties attached;
- Allowing consumers to jump only one plan level (i.e., "precious metal" level) at a time to keep people from just "buying up" when they are sick;
- Locking people into plans for a year as well as considering incentives for consumers sticking with plans over time; and
- Thinking about keeping consistent rules inside and outside the exchange—though this suggestion was not embraced unanimously by carriers as a good idea.

Participants representing consumer, provider, and employer groups recommended hedging against adverse risk selection by requiring the same plans inside and outside the exchange. In a similar vein, employers argued for ensuring a range of plans and a level playing field to protect the exchange from risk selection. Expressing a starkly different perspective, insurance carriers were nearly universally opposed to requiring the offer of identical plans inside and outside the exchange. Almost all argued for the need for market flexibility in terms of determining which plans would be offered inside and outside of the exchange.

Risk Pooling

The ACA permits states to merge individual and small group market risk pools or treat them as separate pools for premium rating purposes as is currently done in New Jersey. When the topic was addressed in the forums, employer representatives were generally not enthusiastic about the prospect of combining the pools. Most employers would opt to keep the markets separate so that the small employers do not bear the cost of what they perceive to be higher risk in the individual market. Consumers and providers, in particular, articulated support for combining risk pools. Again, many consumer representatives endorsed this idea on the principle that the risk pool should be "as big as possible."

Employer representatives were generally not enthusiastic about the prospect of combining non-group and small-group risk pools, while many consumer and provider representatives support merging markets.

Some participants suggested that under the ACA individual enrollment mandate, the risk differential between the individual and small group markets may be reduced, supporting the idea of merging markets. It should be noted, however, that there was some concern expressed among stakeholder groups that the financial penalty under the individual mandate may not be sufficient to substantially modify purchasing behaviors.

Initially, several carriers argued that these are "two separate pools with two separate types of risk" and they "should stay that way." They warned that the two are "sufficiently distinct" and that merging them would disrupt the pools by having one subsidize the other, perhaps leading to affordability concerns that ultimately might discourage small employers from continuing to offer insurance, an unintended consequence that should be avoided.

However, as the possibility of an employee choice model on the SHOP exchange was raised, some carrier representatives indicated that "all vestiges of group insurance will die very quickly…, and it really becomes an alternative to an [individual] consumer pool." If this were the case, some argued, it might make sense to combine them. Therefore, an employee choice or defined contribution model might lead some carriers to support combining the markets.

The ACA also permits states the option of raising the group size limit in the SHOP exchange to firms up to 100 workers, from the current limit of 50 employees, prior to 2016. The law also permits states to allow groups over 100 members to enroll through the SHOP exchange starting in 2017. Responses about whether New Jersey should exercise these options varied, with providers and consumers mainly in favor of including larger firms in the pool as soon as permitted. This support is consistent with the idea promoted by these groups that broader risk pools and greater exchange enrollment are preferred. Carriers, on the other hand, expressed concerns about the possible adverse risk implications of moving into the over-100 employer market. In general, employers, carriers, and brokers expressed caution in moving before required by the ACA, noting the value of a successful operational launch before considering

expanding the purview of the exchange. The latter groups echoed a sentiment frequently heard in the forums that to assure successful implementation and positive consumer experiences suggests the wisdom of not pursuing too many "bells and whistles" in the exchange during its initial phase. Many of the groups cautioned against expanding the reach beyond the initial scope of responsibilities outlined in the law. An incremental approach was frequently advocated.

Finally, in general there was strong support among the groups (with the exception of some brokers) that it would be wise to open the exchange to individuals not eligible for Medicaid or federal tax subsidies. However, with regard to the challenge of providing coverage for those who are undocumented immigrants, there was agreement about the importance of the issue, but group participants acknowledged that the ACA strictly limits options for offering access to affordable coverage for this group.

Exchange Functions and Operations

Active Purchasers vs. Clearinghouse

The New Jersey exchange could serve primarily as a health insurance clearinghouse or it could be an "active purchaser" on behalf of insurance consumers. Forum participants from different perspectives had markedly different views about defining the role and scope of the exchange. Most consumer representatives strongly supported making the exchange an active purchaser, while carrier and broker participants voiced equally strong support for the clearinghouse model. Consumer groups argued for the exchange to negotiate better rates, set high standards for plans, provide oversight, including helping to "police" minimum benefits and ensuring adequate provider networks, and provide quality information to help consumers compare plans. More than other constituencies, consumer groups believed that an active purchaser model could also facilitate improvements in the affordability and quality of care by negotiating with carriers. Conversely, carriers and brokers would opt for a clearinghouse model exchange, believing that it should promote competition among all qualified plans, and citing the series of regulatory protections that New Jersey already had in place. Employer groups and provider constituencies offered mixed responses on this question.

Most consumer representatives strongly supported making the exchange an active purchaser, while carrier and broker participants voiced equally strong support for the clearinghouse model.

The Role of Navigators

The ACA creates a role for "navigators" to facilitate the exchange enrollment process and provides guidelines for their selection (e.g., by prohibiting conflicts of interest). However, identifying which organizations, groups or constituencies should assume these functions and

defining their specific duties is left largely to the states. Stakeholders were asked to respond to questions about the navigator responsibilities and possible intersections with broker functions, eliciting spirited responses.

Carrier participants suggested adopting models from the Medicaid market or Medicare State Health Insurance Assistance Program—with the navigator providing "non-biased representation," "divorced" from financial interest. On the other hand, many brokers see themselves as fulfilling the navigator role and warned of possible implications if a navigator was not properly licensed and sufficiently expert in the details of health insurance. Some brokers advocated that licensed brokers should be treated as ACA navigators, and others argued that navigators should be trained or even licensed and certified to be permitted to sell through the exchange, coining the term "Certified Navigators." Other stakeholders were also somewhat skeptical about navigators, expressing their belief that many of the groups commonly discussed as potential navigators, such as faith-based and community organizations, did not have the necessary expertise to properly guide people through the selection and enrollment process.

On the other end of the spectrum, consumers stressed engaging qualified, objective and community-focused organizations as navigators. Consumer representatives offered a range of suggestions about the kinds of organizations that should serve as navigators. They discussed the need to look at *characteristics* important for navigators including groups that were free of conflict and steeped in the culture of the communities they would serve.

Despite the difference of opinion with regard to the role of brokers and navigators in facilitating enrollment into the exchange, there was a clear message that resonated throughout the groups: having the public's enrollment experience be as streamlined and efficient as possible is critically important. If people viewed the enrollment process as a bureaucratic knot that they were forced to untangle, that could have a very negative effect on the overall success of the exchange.

On a related topic, the forum participants were asked about additional responsibilities that the exchange might assume, including establishing marketing standards and completing billing transactions for plans, and even integrating health information technology into their processes. While there was certainly some discussion and debate about these administrative functions, the majority of stakeholders were skeptical or even negative about layering on many of these responsibilities to the exchange, particularly at the earliest stages of implementation. The primary exceptions were some employers, who favored the exchange taking on the billing function, and consumers, who advocated for the exchange having a strong role in establishing marketing standards.

A clear message from all of the groups: Having the public's enrollment experience be as streamlined and efficient as possible is critically important.

No doubt, one of the reasons that stakeholders are hesitant for the exchange to expand its function is because it will be grappling with a number of extremely difficult and unavoidable challenges from the outset. One example of such a challenge is managing the intricacies of health insurance transitions, i.e., when a person's coverage or subsidy eligibility changes due to fluctuation in income, family status, age or other reason.

Stakeholders were asked how the exchange could make transitions as "seamless" as possible between Medicaid and exchange plans and for those who become eligible for Medicare. In addition, participants were asked whether New Jersey should create a "Basic Health Plan" (BHP) for people with incomes between 133% and 200% of the federal poverty level, which could ease transitions for this population. Forum participants were generally in support of the BHP option, and some advocated that periods of guaranteed eligibility (e.g., 12 months) for both Medicaid enrollees and those with subsidies through the exchange would be critical to easing transitions. Some participants observed that the most worrisome transitions are from Medicaid to private insurance (and back), as Medicaid clients are accustomed to more intensive levels of service and richer covered benefits than are available in private plans. Providers noted the need for consistent and robust provider networks to reduce the impact of transitions.

Benefit Design Issues

Participating stakeholders were mixed in their reactions to a question about the degree to which plan benefits in the exchange should be standardized or whether carriers should be allowed flexibility in designing plans. Many stakeholders emphasized the value of simplicity and standardization on the one hand while others recognized the advantage of allowing the market to tailor products to specific consumer or employer circumstances. Carriers anchored the end of the continuum wanting to minimize limits on product variation, while consumers advocated for a limited number of standardized plan options.

Participating stakeholders were mixed in their reactions to a question about the degree to which plan benefits in the exchange should be more standardized or whether carriers should be allowed flexibility in designing plans.

Forum participants engaged in a lively debate about how to address the issue of benefit mandates. New Jersey has a number of mandated benefits that may go beyond those deemed as "essential" under the ACA. Since the ACA requires states to subsidize the cost of mandated benefits that are not part of the federal essential benefit package for purchasers within the exchange, New Jersey will need to either identify a subsidy mechanism or repeal the mandates. While opinions differed about solutions, a theme across many stakeholders was that this requirement offers an important opportunity to reassess the need and scope of New Jersey's benefit mandates.

Employers were near unanimous in believing New Jersey's mandates needed to be reevaluated. While some suggested that it was hard to weigh-in on mandated benefits without knowing the composition of the ACA essential benefits package, others saw the essential benefits as "great political cover" for eliminating the mandates altogether, believing that the state should stay as close to the federal outline as possible and avoid the "politicking" of opening up mandates. Insurers, which have historically opposed benefit mandates, noted New Jersey will have no other viable recourse than to repeal those not in the federal package.

The ACA will likely require New Jersey to revisit benefit mandates, a development welcomed by many stakeholders.

While some consumer group representatives urged that mandates were necessary and should be left intact because they improved the quality of life for populations who benefited from them, others acknowledged the fiscal reality that the state would be unable to afford to subsidize the cost of the mandates currently in place. Some suggested that there could be a political firestorm if certain mandated benefits were repealed and it would take a Solomon-like choice to decide which benefits were retained and which were eliminated.

Stakeholders were also asked specifically whether dental benefits should be integrated as part of comprehensive health benefit plans or offered as separate plans. Employers and brokers opted for keeping dental separate, citing cost and operational implications, while providers and consumers tended to favor benefit integration, noting clinical connections between dental and overall health status. Carriers, however, were somewhat mixed on the question of integrating dental benefits, preferring to let the market determine how dental benefits ought to be offered.

Part II: Findings from the New Jersey Exchange Planning Survey

Introduction

The federal Patient Protection and Affordable Care Act (ACA), enacted in March 2010, requires the creation of state-based health insurance exchanges to facilitate effective markets for the purchase of health insurance coverage by individuals and small businesses, and administer federal subsidies for eligible purchasers. The ACA gives states the option of developing plans for health insurance exchanges and requires the federal government to create exchanges for states that choose not to develop them on their own.

Under federal Exchange Planning Grants, states considering this option were asked to gather information from interested stakeholders as to how these exchanges should be developed and implemented. The State of New Jersey's Working Group on the ACA, comprised of senior officials from the Office of the Governor and the Departments of Banking & Insurance, Human Services, and Health & Senior Services, asked Rutgers University Center for State Health Policy (CSHP) to conduct group forums and an online survey to gather this input. This section of the report summarizes the findings of the online survey. Following a description of the development and administration of the survey, this section of the report provides the results of each survey question.

Survey Development and Administration

The New Jersey Exchange Planning Survey was developed by CSHP staff in consultation with the State of New Jersey's Working Group on the ACA. Funding for the research was provided by the New Jersey Department of Banking & Insurance under a grant from the US Department of Health & Human Services. The survey strategy was reviewed and approved by the Rutgers University Institutional Review Board.

The survey was conducted via Survey Monkey™, an online survey software program. CSHP developed an extensive list of health care and insurance stakeholder organizations in New Jersey for the exchange group forums and the Planning Survey. Invitations to participate in the survey were sent via email to directors of these stakeholder groups, to any additional exchange forum participants, and to other potentially interested parties on CSHP's mailing list. These stakeholder groups included a wide array of organizations representing health care providers,

consumers, insurance carriers, employers and businesses, and insurance brokers from all geographic areas of New Jersey and representing different demographic and socioeconomic groups.

The first email invitation was sent on April 15, 2011, to 282 individuals. A reminder email was sent on April 27, 2011. Those who received the email invitation were asked to send an online link to the survey to members of their organizations. The field period for the survey closed on May 12, 2011.

A total of 618 participants were eligible for and completed the survey. Eligible participants had to certify that they are at least 18 years of age and either work in New Jersey, own or operate a business in New Jersey, or work for a New Jersey employer. Only one survey response was accepted from the IP address of any individual computer. Finally, individuals who began the survey but did not answer at least one of the policy questions on the survey were excluded from the sample. All responses were anonymous and no personal identifying information was recorded. The survey contained 42 questions (see Appendix D in Volume III for the survey questionnaire (Cantor et al., 2011b)). CSHP research staff coded (grouped into common themes) the responses to 5 of the questions that included "other, specify" options and one question that was open-ended.

The final survey data was downloaded into SPSS, a statistical software program, for data analysis. Based on a series of questions about survey participant roles in New Jersey health care, each survey participant was classified into one of 11 stakeholder groups (Table A). Four of these groups for which the number of respondents was sufficient to support analysis (patient care professionals, health care organizations, consumer advocacy groups, and businesses) were further subdivided into subgroups. Participants who did not report involvement in health care but classified themselves as a proprietor/owner, other executive, human resources or other senior manager were classified as representing non-health related businesses. Persons classifying themselves as an employee but not an executive or manager of a business and who did not report involvement in the health sector in any way were classified as "other, unclassified" respondents. While not shown separately, it is noteworthy that of the five labor union survey participants, three work for unions that operate health benefit/welfare funds. Tables 1-16 that are referenced throughout this report and contain responses for these subgroups are provided in Appendix E in Volume III (Cantor et al., 2011b).

As noted, individuals who began the survey but did not answer any of the exchange design-related questions were eliminated from the sample. All respondents provided sufficient information so they could be classified by stakeholder type based on questions 11-16 and 18-23 in the questionnaire. (Detailed information about how stakeholder categories were derived from the survey questionnaire is available upon request.) Some respondents skipped one or more of the exchange design questions. For most questions, non-responders were excluded from tabulations shown in the tables and charts in this report. The exact number of excluded

cases is shown in notes to the tables in Volume III, Appendix E (Cantor et al., 2011b) showing distributions of responses to the respective survey questions. The percent of respondents not answering ranges from under 1% to 11% among these questions. Missing cases were handled differently for questions 28 and 30. These questions were presented as grids of choices, and respondents without clear opinions may have simply skipped some options. Thus, respondents not answering these questions were combined with those checking "not sure" for presentation in the tables and charts.

Cross-tabulations were conducted for each of the policy questions on the survey by these stakeholder groups. This report provides a series of charts arraying participant responses to specific exchange design questions by the 11 stakeholder groups. The charts array stakeholder groups in order of support for exchange design features (i.e., listed from highest to lowest support for the response category most often supported), while responses in the tables are shown in a common order for ease of reference. Coded responses to open-ended questions are also provided by these groups. Additionally, detailed tables are provided showing responses for the 11 main stakeholder groups and selected subgroups. While considerable effort was made to reach out to a broad range of health care stakeholders in New Jersey, the sample for the survey is self-selected and should not be considered statistically representative of any particular group.

Table A: Number of Survey Participants by Stakeholder Group

Stakeholder Group	Number of Participants (n)	Percent of Participants
Patient Care Professionals and Staff	124	20.1%
Physicians	42	6.8%
Other Patient Care	82	13.3%
Health Care Delivery Organizations	95	15.4%
Hospitals	49	7.9%
Other Care Delivery Organizations	46	7.4%
Other Health Care Industries	8	1.3%
Consumer Advocacy	44	7.1%
Health Care Only	20	3.2%
Health Care and Other Issues	24	3.9%
Health Insurance Companies	20	3.2%
Health Insurance Agents and Brokers	177	28.6%
Businesses (Non-Health Care)	77	12.5%
Small Businesses (1-50 workers)	48	7.8%
Large Businesses (51+ workers)	29	4.7%
Business Trade Groups	10	1.6%
Labor Unions	5	0.8%
Academics, Consulting, Foundations	20	3.2%
Other, Unclassified	38	6.1%
Total	618	100.0%

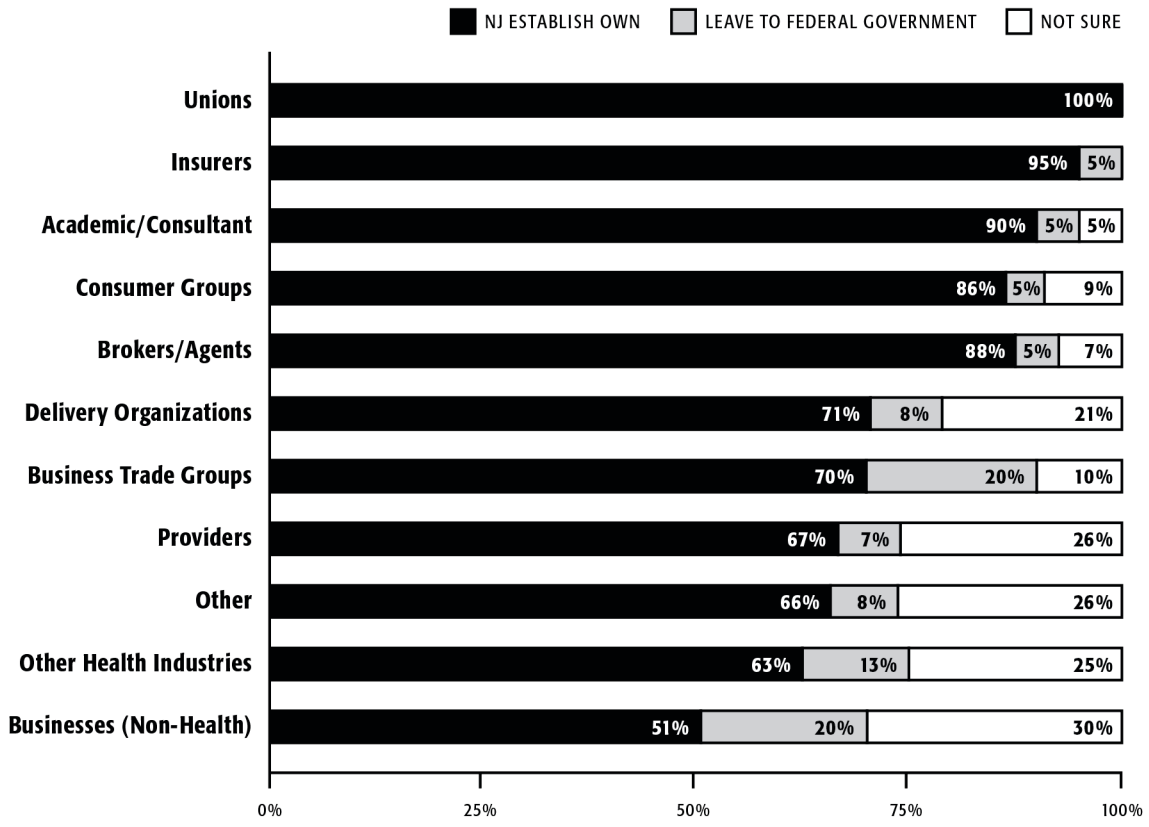
Findings

Structure and Governance of Exchanges for New Jersey

The first decision that New Jersey officials must make is whether to create an exchange at all, or leave it to the federal government to create an exchange for the state. Figure 1 and Table 1* show that the majority of all of the survey stakeholder groups supports the idea of New Jersey establishing its own exchange or exchanges. In fact, the level of support for New Jersey moving ahead with exchange development is extremely high in most groups, with less than two-thirds support only evident among non-health-related businesses and health-related industries not directly involved in patient care. Even among these groups, however, opposition to New Jersey creating its own exchange is low, with larger numbers reporting that they are unsure which direction is best.

Figure 1 | **State or Federal Exchange**

The ACA permits states to develop their own health insurance exchange(s) If states elect not to develop exchange(s) for its residents, the federal government will do so. ***Should NJ establish its own exchange(s) or leave it to the federal government to create the exchange(s) for NJ state residents? (Q24)***



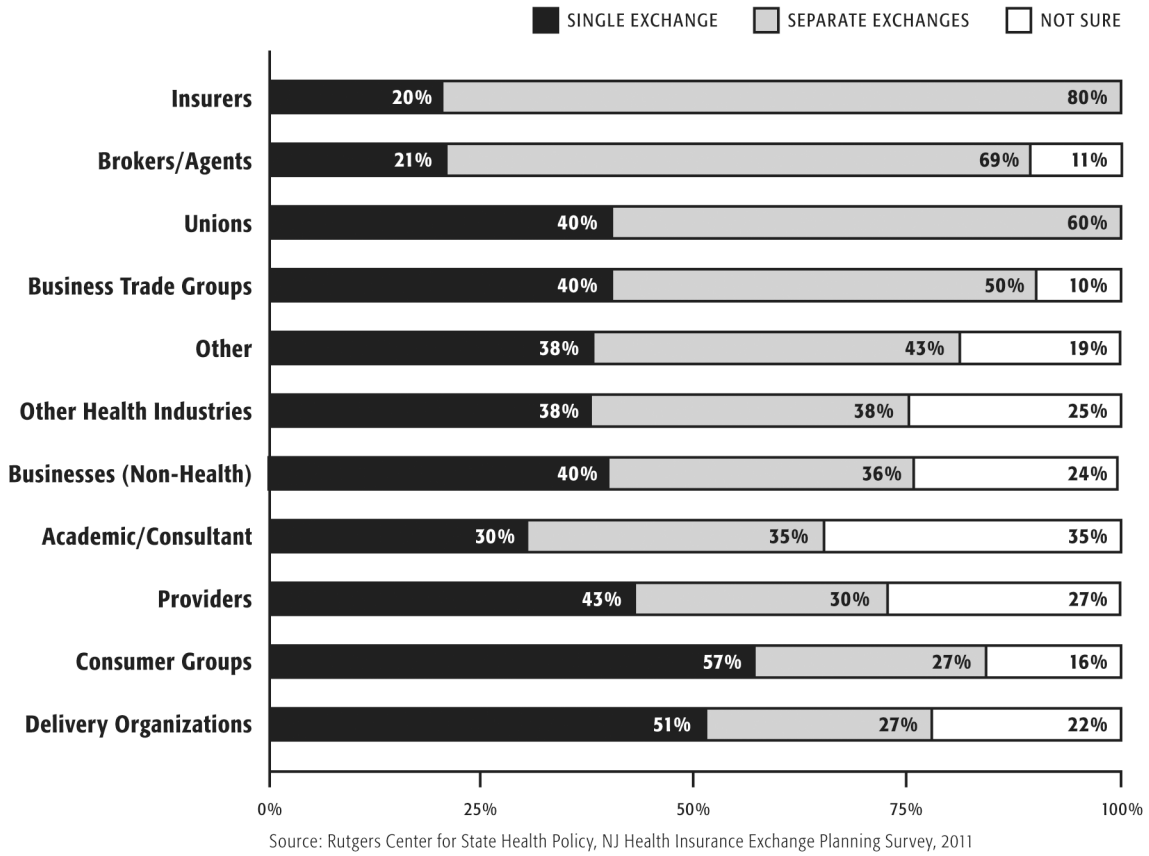
Source: Rutgers Center for State Health Policy, NJ Health Insurance Exchange Planning Survey, 2011

*Note: Tables 1-16 can be found in Volume III, Appendix E (Cantor et al., 2011b).

Should New Jersey proceed with developing its own exchange infrastructure, it must decide whether to create one or two exchanges. Each state will have an American Health Benefit Exchange (AHBE) for individuals and families purchasing in the subsidized non-group market and a Small Business Health Options Program or SHOP exchange for the small-group market. States have the option of structuring separate AHBE and SHOP entities or combining these functions into a single organization. Figure 2 and Table 2 show that there are differences of opinion about this choice. Large majorities of participants working for health insurance companies or agents/brokers endorse the idea of separate exchanges, while half or more of representatives of consumer groups and health care delivery organizations endorse a combined entity. Other groups show more mixed responses.

Figure 2 | **Single or Separate Exchanges for Individuals and Small Businesses**

Should NJ create a single exchange for individuals, families, and small employers or should it create two separate exchanges, one for individuals and families, and one for business purchasers? (Q25)

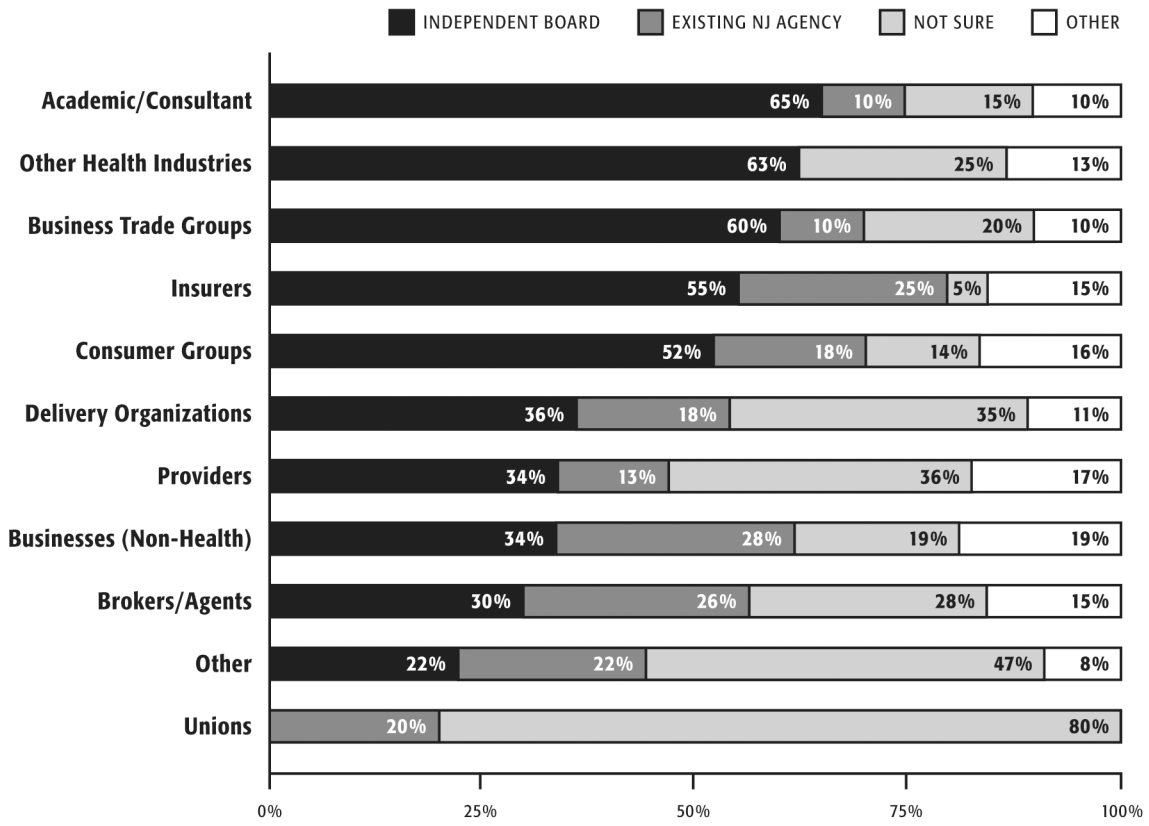


Source: Rutgers Center for State Health Policy, NJ Health Insurance Exchange Planning Survey, 2011

There is also no clear consensus about how New Jersey exchange(s) should be governed (Figure 3 and Table 3). Majorities within a diverse set of groups (academic/consultant/ foundation representatives, non-provider health care industries, business trade groups, health insurers, and consumer groups) endorse the idea that New Jersey exchange(s) should be governed by an independent board of directors; other groups expressed more uncertainty. In fact, the plurality of participants in several stakeholder groups checked "not sure" in response to this question. Only in a couple of instances does more than one in four participants endorse the idea that the exchange(s) should be overseen by an existing state agency. The most common "other/specify" response to this question expressed the desire that the exchange be insulated from politics or state government influence, and many respondents used the open-ended option to comment on which groups ought to be represented on an exchange governing board (Table 3).

Figure 3 | **Exchange Governance**

Which ONE best describes your view of how New Jersey exchange(s) should be governed? (Q26)

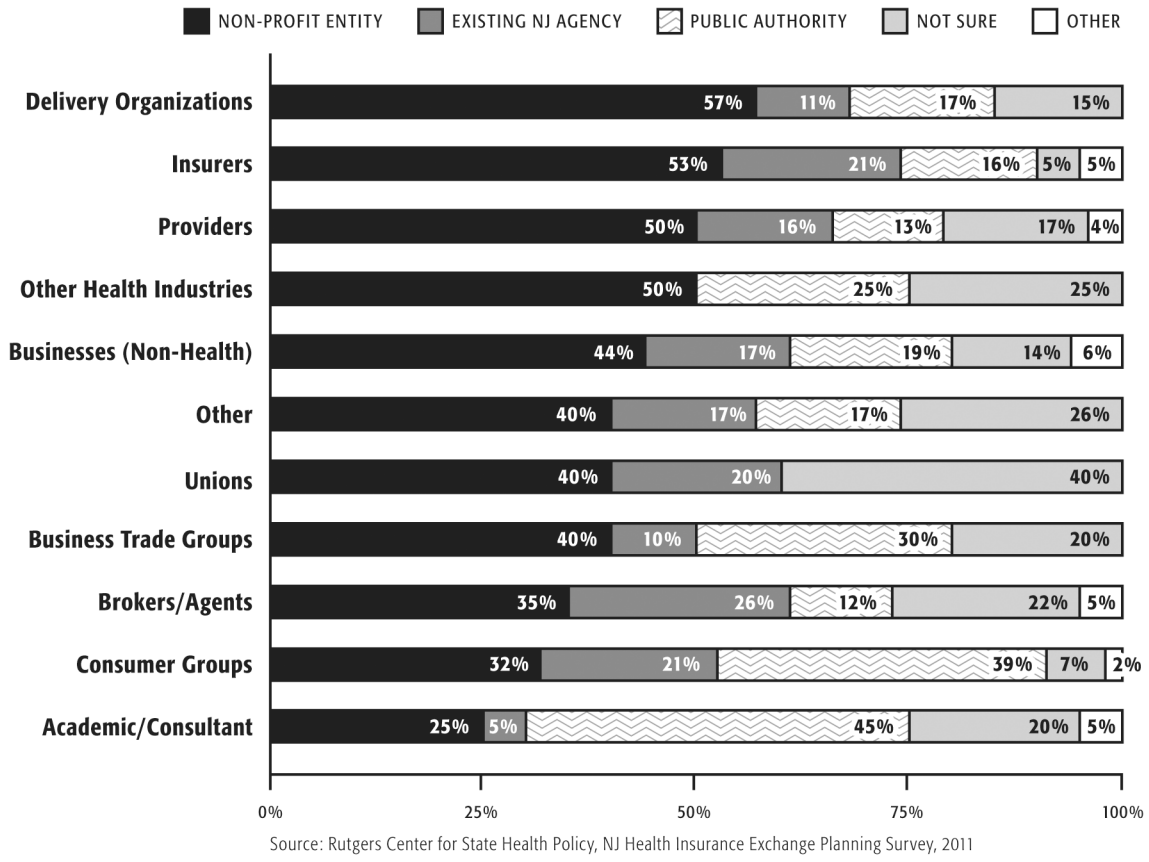


Source: Rutgers Center for State Health Policy, NJ Health Insurance Exchange Planning Survey, 2011

The survey also asked about the optimal organizational home for New Jersey exchanges (Figure 4 and Table 4). Establishing a state-chartered non-profit entity outside of state government was the preferred choice among most stakeholder groups, receiving majority support among health care delivery organizations, insurers, health care providers, and other health care industries. Consistent with stakeholder views of governance (discussed above), few survey participants in any group endorsed lodging New Jersey exchange(s) within an existing state agency. The idea of creating a new public authority outside of existing agencies received plurality support among academic/consultant/foundation participants and consumer groups. Some groups had a high proportion of "not sure" responses.

Figure 4 | **Operational Home of the Exchange**

Which ONE best describes the way New Jersey exchange(s) should be operated? (Q27)



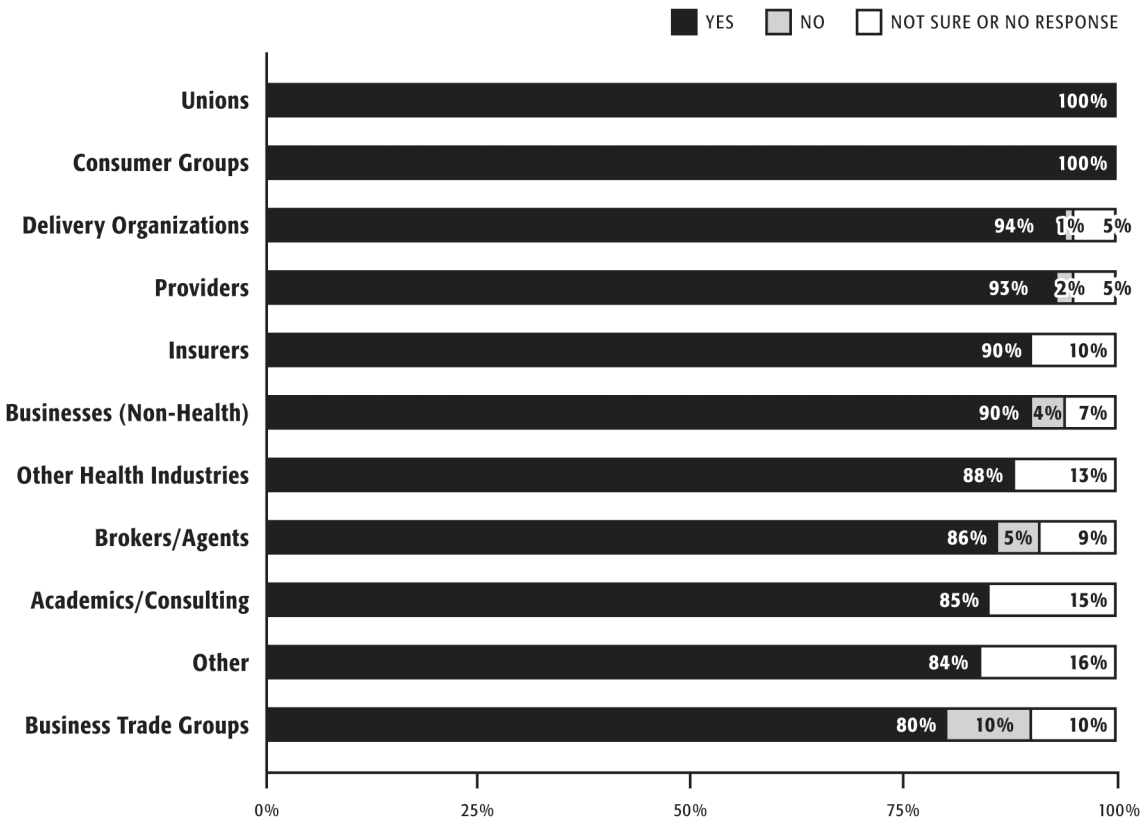
Source: Rutgers Center for State Health Policy, NJ Health Insurance Exchange Planning Survey, 2011

When viewed together, responses about governance (Figure 3) and structure (Figure 4) are largely consistent. For example, roughly half of participants who support structuring the exchange(s) as a non-profit entity or separate public authority also endorse governance under an independent board, while about two-thirds of supporters of lodging the exchange(s) within an existing agency also support governance by an existing agency.

Survey participants were also asked a series of questions about the composition of an independent exchange governance board, should New Jersey decide to structure such a board (Figures 5a-5f and Tables 5a-5f). A large majority (two-thirds or more) of participants across all stakeholder groups endorse appointing representatives of consumers and patients, businesses, and health care providers to the exchange board. The majority of all stakeholder groups also endorse having the commissioners of relevant state agencies sit on the board. Consensus is less evident about including representation of insurance companies and agents/brokers on the board. The most significant opposition is to board inclusion of agents and brokers, particularly among unions, consumer groups, providers and care delivery organizations, and academic/consultant/foundation respondents (Figure 5d). Opposition to insurance company representation was also evident among a substantial minority of consumer and provider survey participants (Figure 5c). Few participants provided responses to an open-ended “other-specify” question about exchange board composition.

Figure 5a | **Consumer or Patient Representatives on Exchange Board**

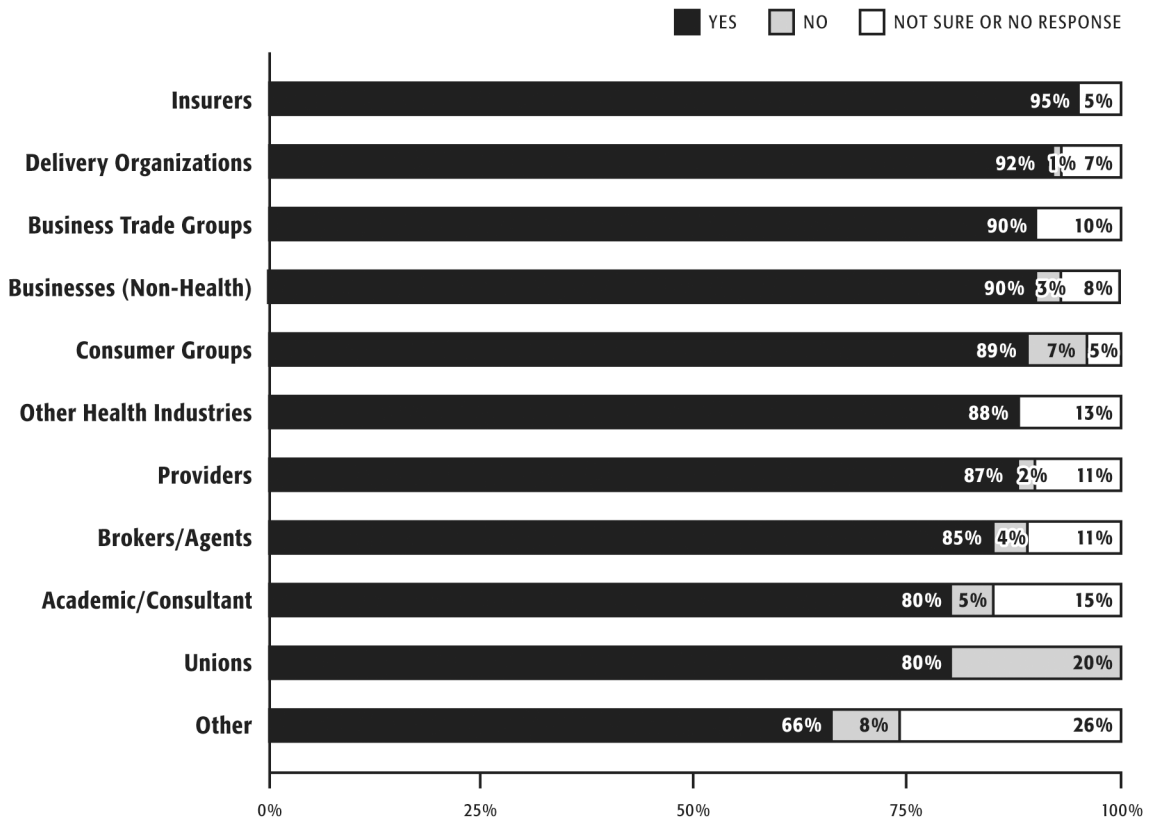
If the NJ exchange(s) were governed by an independent Board of Directors, what groups should be represented on the Board? (Q28)



Source: Rutgers Center for State Health Policy, NJ Health Insurance Exchange Planning Survey, 2011

Figure 5b | **Business Representatives on Exchange Board**

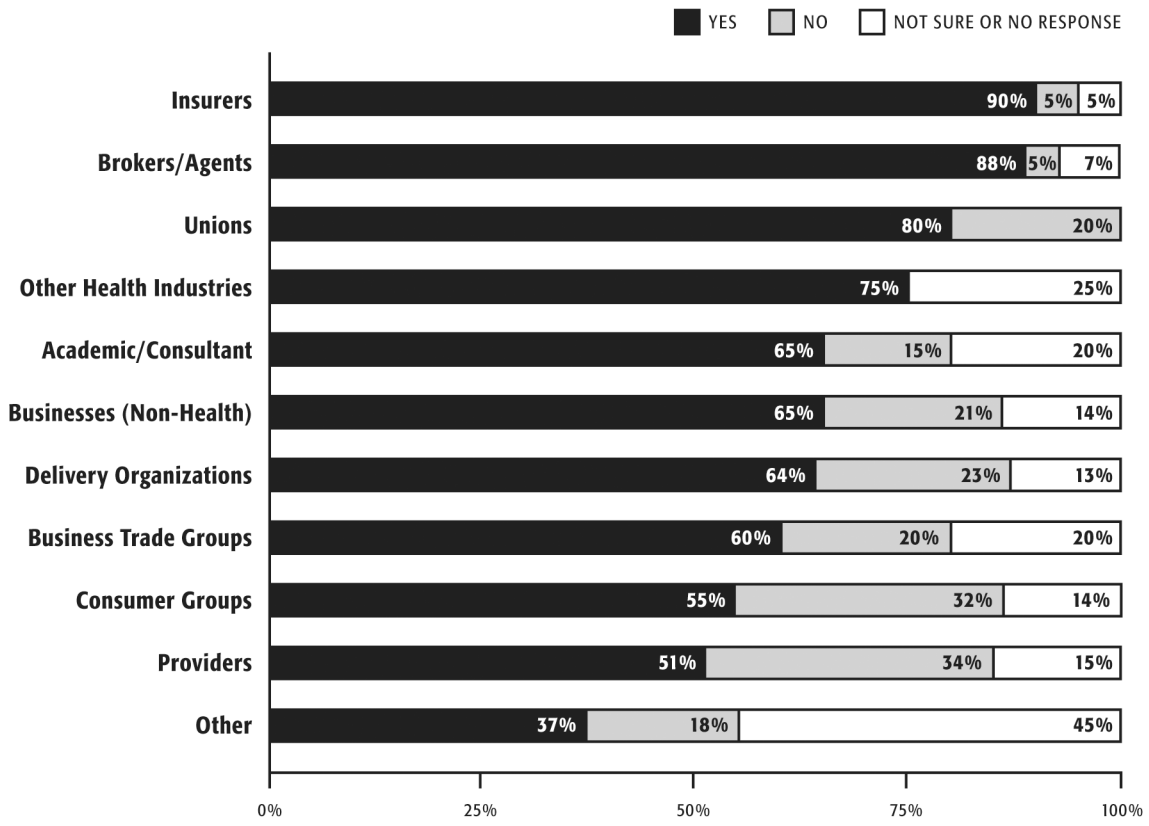
If the NJ exchange(s) were governed by an independent Board of Directors, what groups should be represented on the Board? (Q28)



Source: Rutgers Center for State Health Policy, NJ Health Insurance Exchange Planning Survey, 2011

Figure 5c | **Health Insurance Company Representatives on Exchange Board**

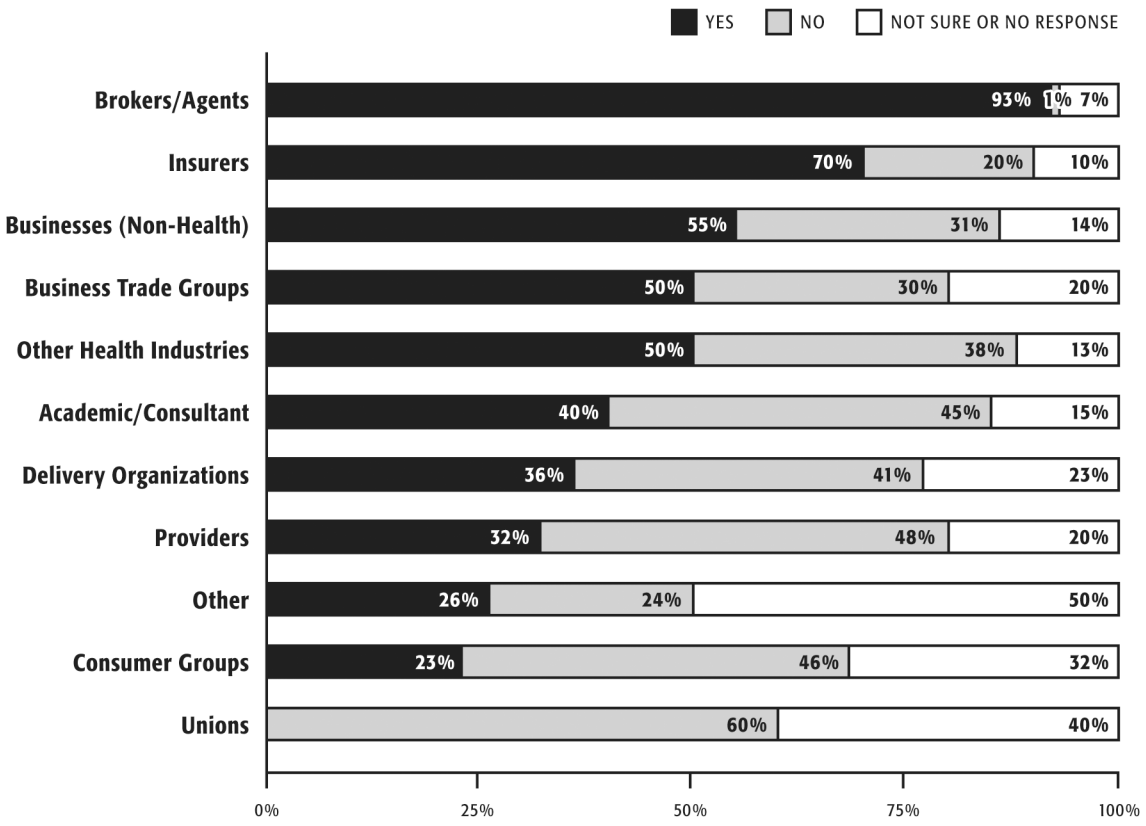
If the NJ exchange(s) were governed by an independent Board of Directors, what groups should be represented on the Board? (Q28)



Source: Rutgers Center for State Health Policy, NJ Health Insurance Exchange Planning Survey, 2011

Figure 5d | **Health Insurance Broker/Agent Representatives on Exchange Board**

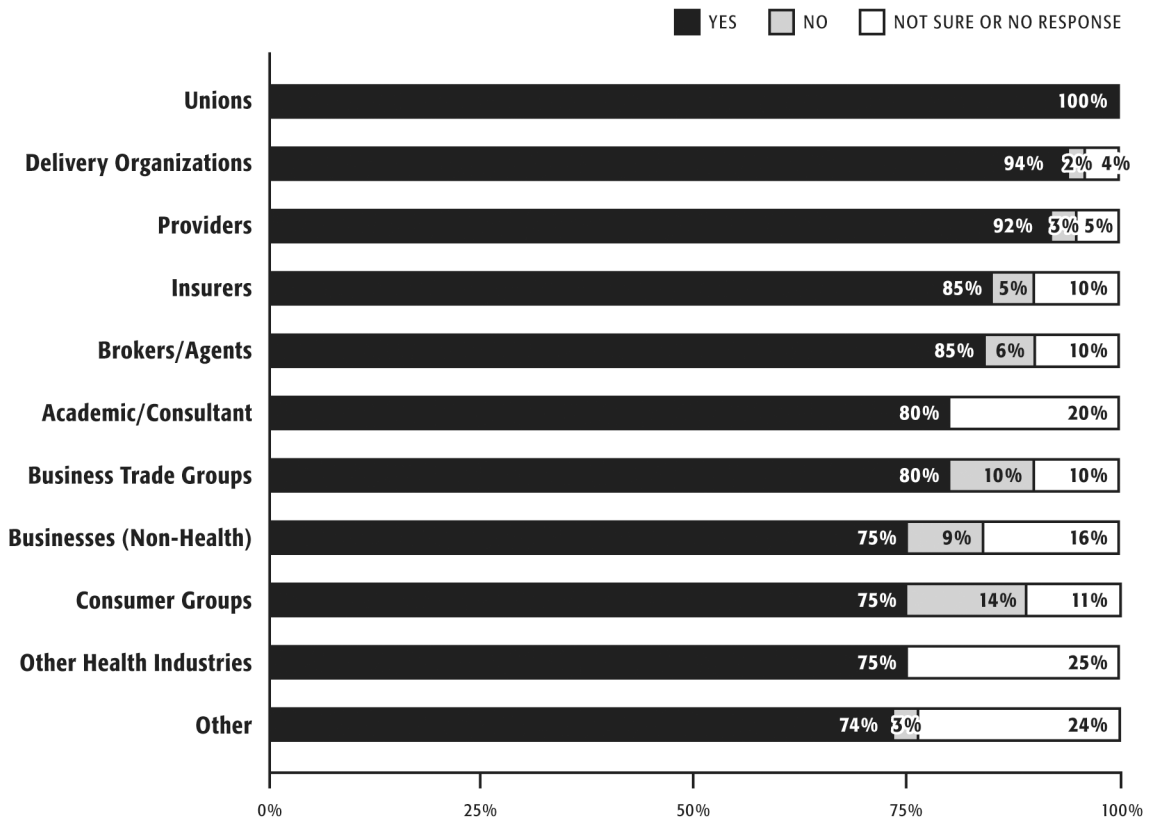
If the NJ exchange(s) were governed by an independent Board of Directors, what groups should be represented on the Board? (Q28)



Source: Rutgers Center for State Health Policy, NJ Health Insurance Exchange Planning Survey, 2011

Figure 5e | **Health Care Provider Representatives on Exchange Board**

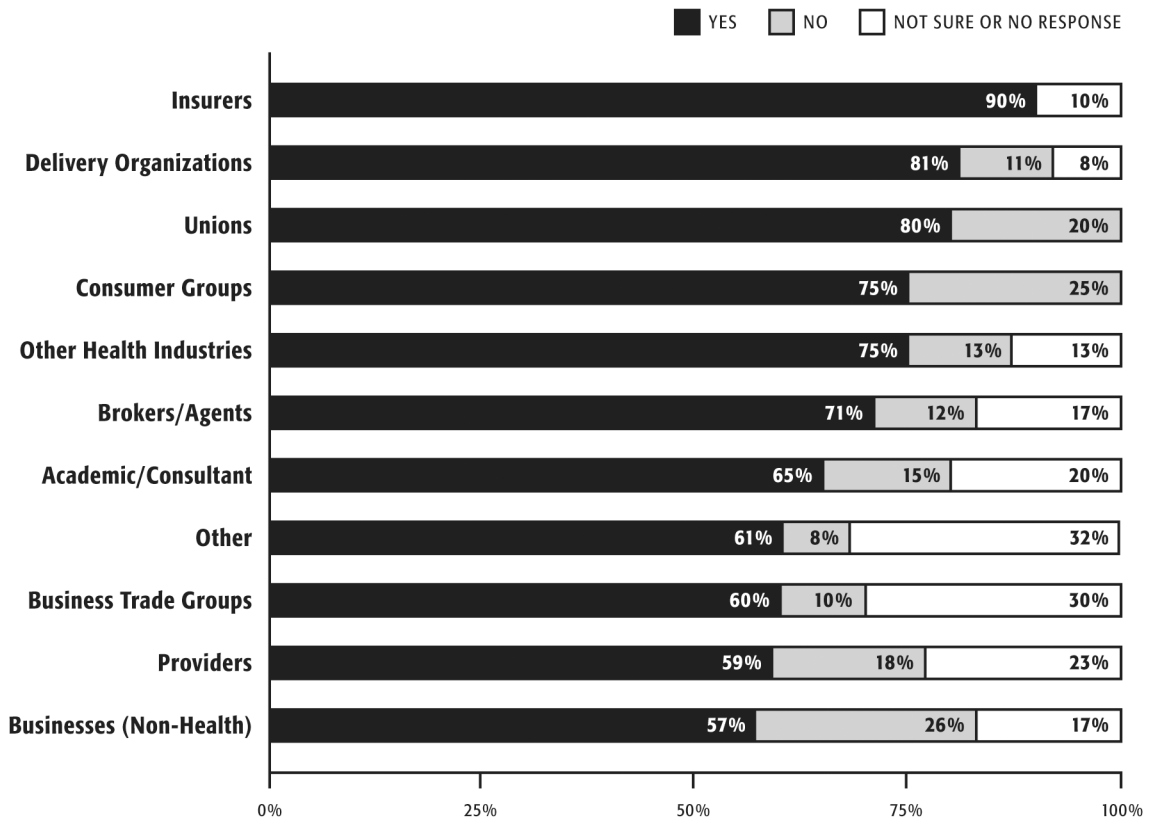
If the NJ exchange(s) were governed by an independent Board of Directors, what groups should be represented on the Board? (Q28)



Source: Rutgers Center for State Health Policy, NJ Health Insurance Exchange Planning Survey, 2011

Figure 5f | **Commissioners of Relevant State Departments on Exchange Board**

If the NJ exchange(s) were governed by an independent Board of Directors, what groups should be represented on the Board? (Q28)



Source: Rutgers Center for State Health Policy, NJ Health Insurance Exchange Planning Survey, 2011

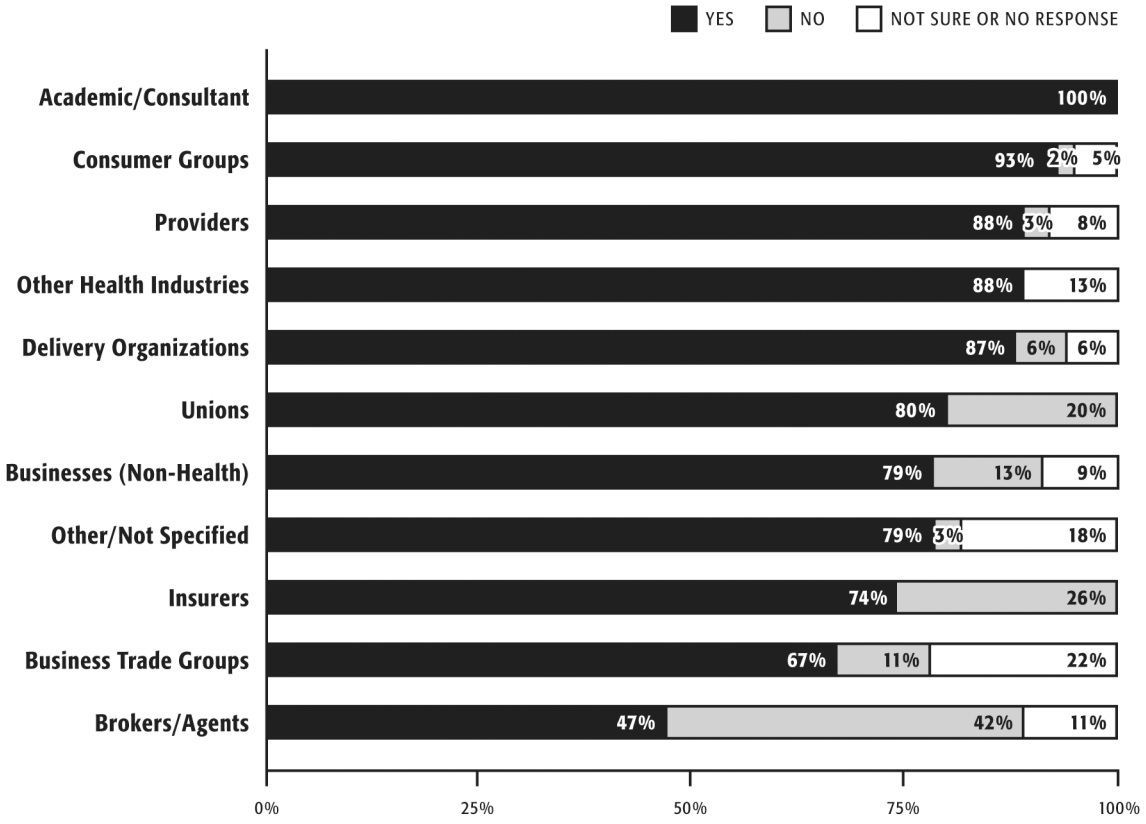
Market Structure and Risk Pooling

A series of survey questions asked how New Jersey health insurance markets should be structured in the context of exchange implementation in 2014. The way health insurance markets are regulated relates to exchange functioning in many respects. For example, the extent to which individuals or businesses are permitted or encouraged to purchase coverage through an exchange can influence the extent to which adverse risk selection may occur against the exchange or a particular market segment.

The ACA requires that people eligible for and wishing to receive federal premium tax credits must obtain coverage through an exchange, and exchanges must also be available to enroll Medicaid eligible populations. However, states may permit individuals who are not eligible for tax credits or Medicaid to buy coverage through the exchange. Figure 6 and Table 6 show that across stakeholder groups two-third majorities or stronger support the idea of allowing non-subsidy eligible persons to enroll through a New Jersey exchange(s), with the sole exception of agents/brokers, who are split on whether such enrollment should be permitted.

Figure 6 | **Permitting Non-Subsidy Eligible Individuals and Families to Purchase Coverage within Exchange**

Persons receiving federal health insurance tax credits or cost-sharing subsidies will be required to purchase coverage within an exchange. However, exchanges may also permit non-subsidized populations to purchase coverage through the exchange. ***Should New Jersey permit individuals and families to purchase coverage within its exchange(s) even when they are not eligible for government subsidies? (Q29)***

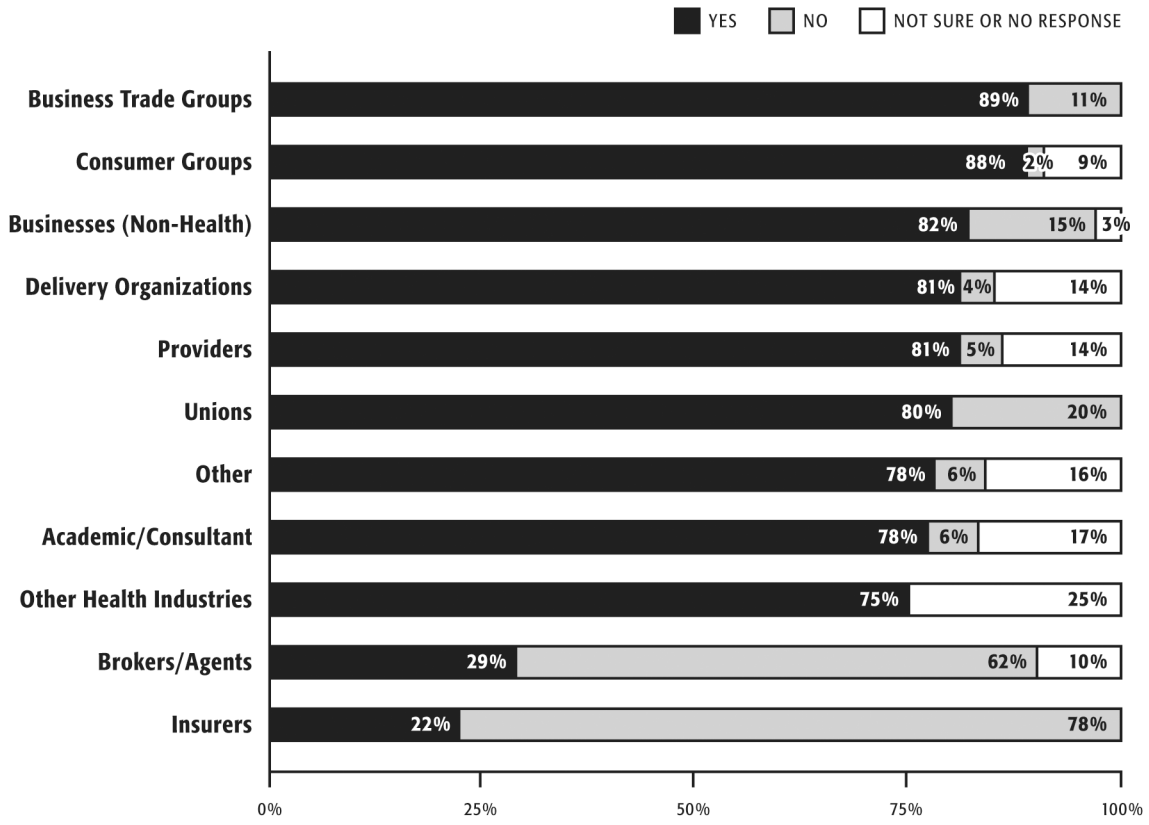


Source: Rutgers Center for State Health Policy, NJ Health Insurance Exchange Planning Survey, 2011

States have limited discretion about the definition of "small business" for the purposes of obtaining coverage through a SHOP exchange. Prior to 2016, New Jersey may keep its definition of small groups eligible to purchase in the SHOP exchanges as up to 50 employees, but after that time, the upper limit must rise to 100 under the ACA. The survey asked whether New Jersey should wait until 2016 to raise its small group size limit or whether it should do so in 2014 when the SHOP exchange opens for business (Figure 7 and Table 7). Three-fourths or larger majorities of most stakeholder groups support early expansion of the small group size definition, with equally strong opposition to the idea from brokers/agents and insurance company representatives.

Figure 7 | **Which Small Businesses Permitted to Purchase Coverage**

If NJ establishes an exchange for small businesses (i.e., a Small Business Health Options Program or SHOP exchange), then businesses would help enroll their employees in qualified health plans offered in an exchange. The ACA defines small business as having fewer than 100 workers, though prior to 2016 states may define a small business as having less than 50 workers. ***In addition to small businesses under 50 workers, should small businesses with 50 to 100 workers be permitted to purchase coverage in the NJ exchange before 2016? (Q31)***



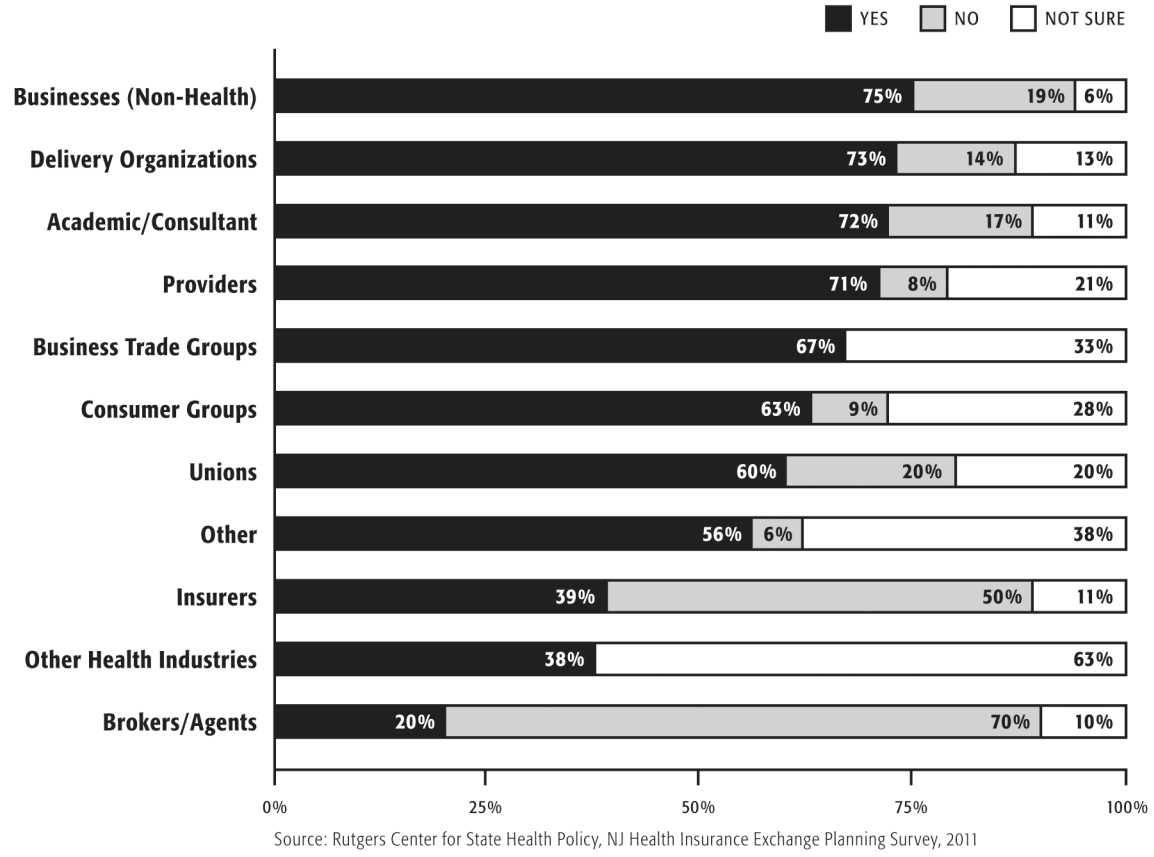
Source: Rutgers Center for State Health Policy, NJ Health Insurance Exchange Planning Survey, 2011

In a related question, the ACA permits, but does not require, states to open their exchanges to even larger businesses (over 100 employees) starting in 2016. Figure 8 and Table 8 show that the majority of most stakeholder groups support this idea. It is noteworthy that the greatest support (88.5%) for this idea is among large businesses (51 or more employees) (Table 8). Nevertheless, half of insurer respondents and more than three-fourths of agents/brokers oppose it. Many stakeholders from business trade groups and non-patient-care health-related industries responded that they are unsure about their support for large-business access to the exchange.

Figure 8 | **Permitting Large Businesses to Purchase Coverage in Exchange**

After 2016, states may also allow employees of large businesses to purchase coverage in the exchange.

Should large businesses with over 100 workers be permitted to purchase coverage in the NJ exchange after 2016? (Q32)

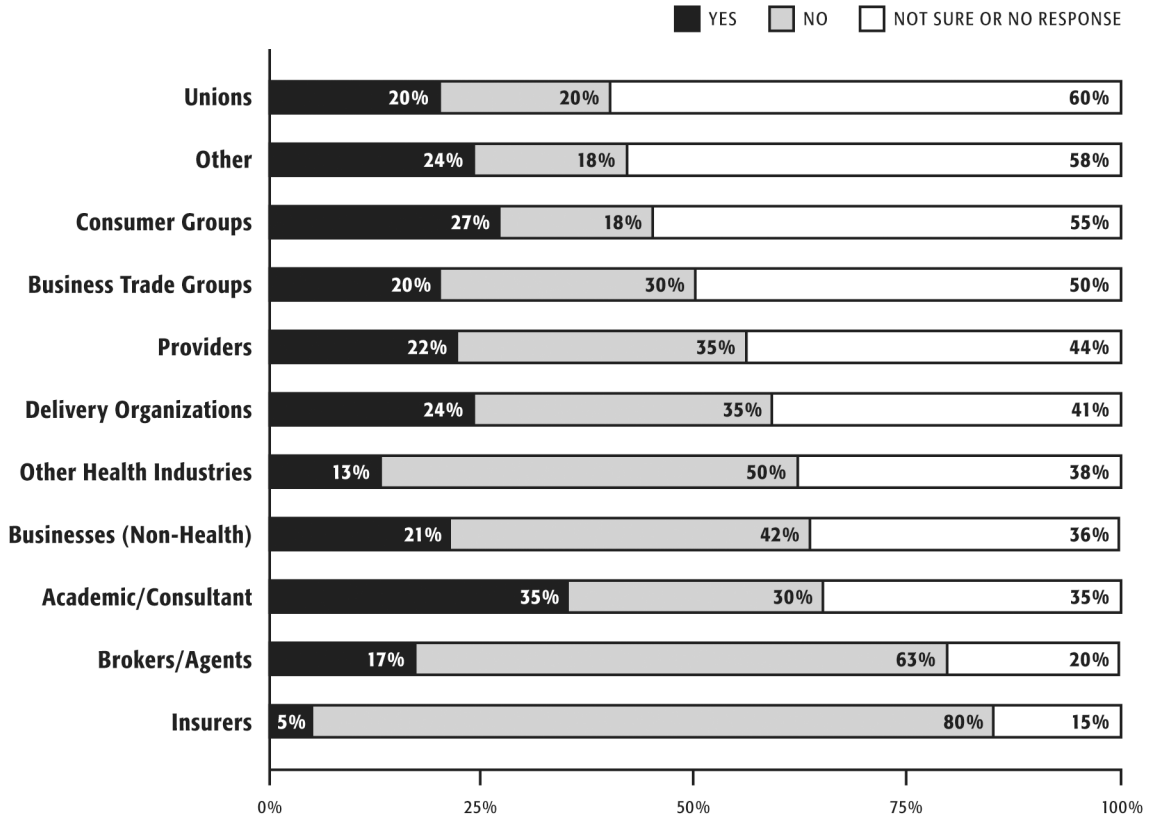


Source: Rutgers Center for State Health Policy, NJ Health Insurance Exchange Planning Survey, 2011

A series of survey questions asked about possible strategies to prevent health risk selection against health insurance exchanges (in other words, to prevent "cream skimming" by non-exchange plans) (Figures 9a-9e and Tables 9a-9e). Perhaps the most noteworthy observation about responses to these questions is the degree to which large numbers of respondents across stakeholder groups (with the exception of insurers and, in some cases, agents/brokers) responded "Not Sure" or left these questions unanswered. Large majorities of insurer and agent/broker respondents oppose limiting the sale of all non-group and small-group coverage to the exchange(s). Substantial shares of insurer respondents also oppose requiring that plans sold outside the exchange(s) be identical to those sold in the exchange(s) or requiring that all carriers selling outside the exchange(s) to also sell within them. Alternatively, the majority of insurers (as well as most other stakeholder groups) supports the idea of carriers operating outside the exchange(s) to offer some of the standardized plans required within the exchange(s) but to retain flexibility to offer other plans outside the exchange(s) as well. Across most other stakeholder groups, there is substantial support for most of the options in the survey to prevent risk selection against the exchange(s). Few participants provided responses to an open-ended "other-specify" question about strategies to avoid risk selection.

Figure 9a | **Avoid "Cream Skimming" by Eliminating Markets Outside the Exchange**

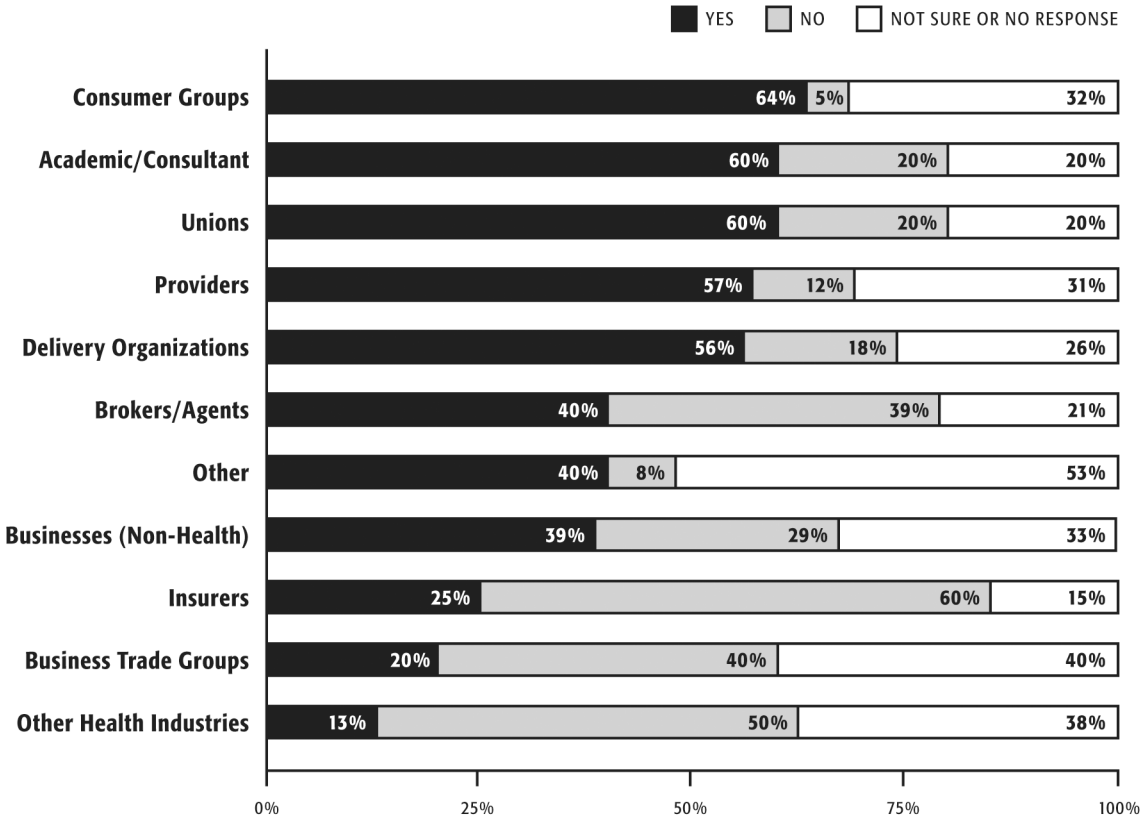
The ACA allows states to use various strategies to prevent health insurance plans from "cream skimming" (i.e., disproportionately attracting healthier enrollees) which would make coverage in the exchange(s) more expensive than coverage outside the exchange(s). ***Should NJ limit the sale of all non-group (for individuals and families) and small-group (for small businesses) plans exclusively to the exchange? (Q33)***



Source: Rutgers Center for State Health Policy, NJ Health Insurance Exchange Planning Survey, 2011

Figure 9b | **Avoid "Cream Skimming" by Requiring Same Plans in and out of Exchange**

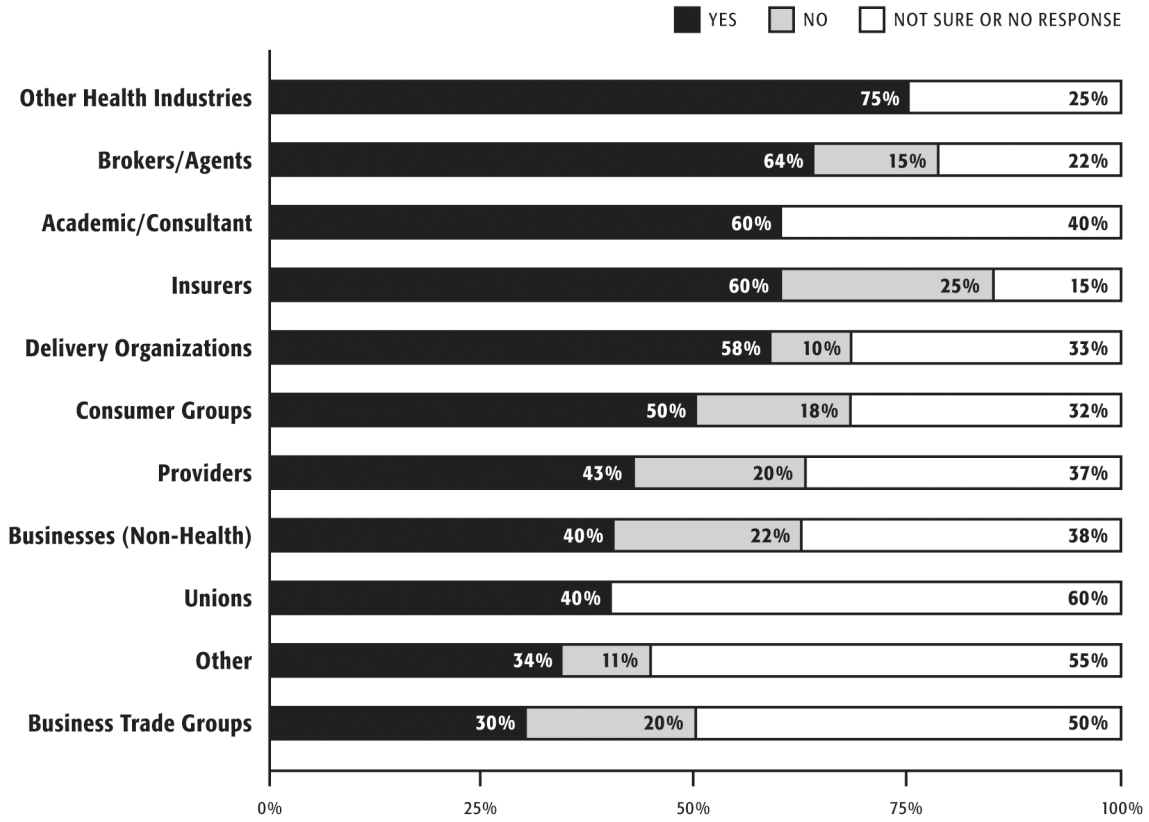
The ACA allows states to use various strategies to prevent health insurance plans from "cream skimming" (i.e., disproportionately attracting healthier enrollees) which would make coverage in the exchange(s) more expensive than coverage outside the exchange(s). ***Should NJ require all non-group and small-group plans sold outside the exchange to have identical benefit designs and follow the same reporting and conduct regulations as plans within the exchange? (Q33)***



Source: Rutgers Center for State Health Policy, NJ Health Insurance Exchange Planning Survey, 2011

Figure 9c | **Avoid "Cream Skimming" by Requiring Some Plans in Common in and out of Exchange**

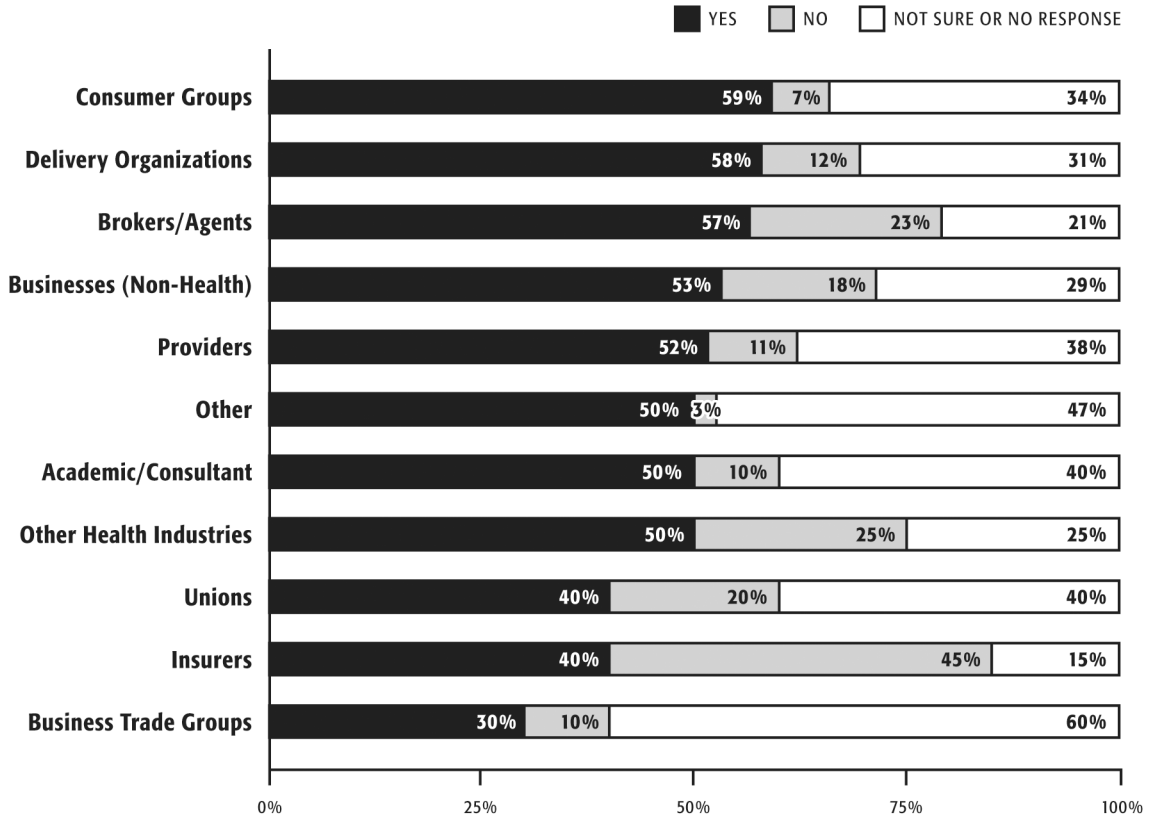
The ACA allows states to use various strategies to prevent health insurance plans from "cream skimming" (i.e., disproportionately attracting healthier enrollees) which would make coverage in the exchange(s) more expensive than coverage outside the exchange(s). ***Should NJ require insurers operating outside the exchange to offer certain plans (e.g., "silver" and "gold" level plans) that the ACA requires insurers to sell within the exchange, but allow more flexibility in the design of other kinds of plans sold outside the exchange as well?(Q33)***



Source: Rutgers Center for State Health Policy, NJ Health Insurance Exchange Planning Survey, 2011

Figure 9d | **Avoid "Cream Skimming" by Requiring Carriers to Participate in Exchange**

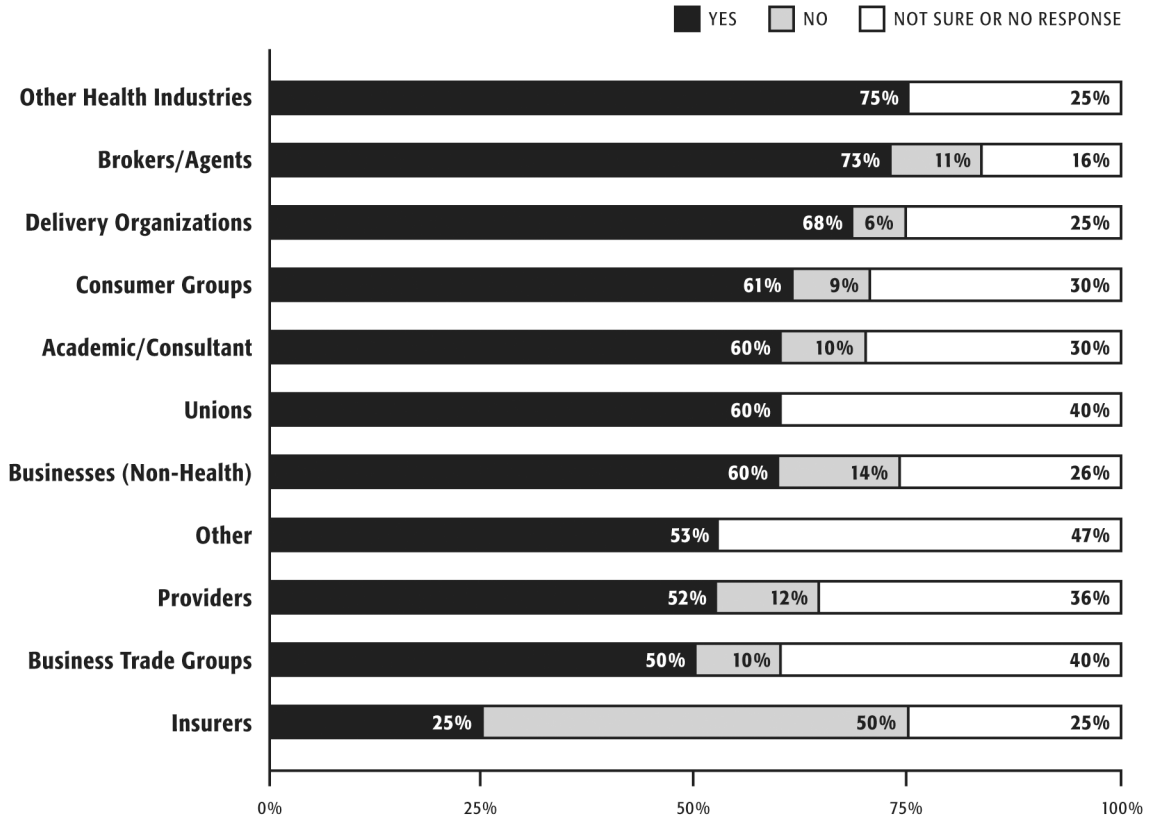
The ACA allows states to use various strategies to prevent health insurance plans from "cream skimming" (i.e., disproportionately attracting healthier enrollees) which would make coverage in the exchange(s) more expensive than coverage outside the exchange(s). ***Should NJ require insurers selling non-group and small-group plans outside the exchange to offer plans inside the exchange as well? (Q33)***



Source: Rutgers Center for State Health Policy, NJ Health Insurance Exchange Planning Survey, 2011

Figure 9e | **Avoid "Cream Skimming" by Requiring Same Broker Commissions in and out of Exchange**

The ACA allows states to use various strategies to prevent health insurance plans from "cream skimming" (i.e., disproportionately attracting healthier enrollees) which would make coverage in the exchange(s) more expensive than coverage outside the exchange(s). ***Require that broker commissions paid by insurers be the same for plans within and outside the exchange? (Q33)***

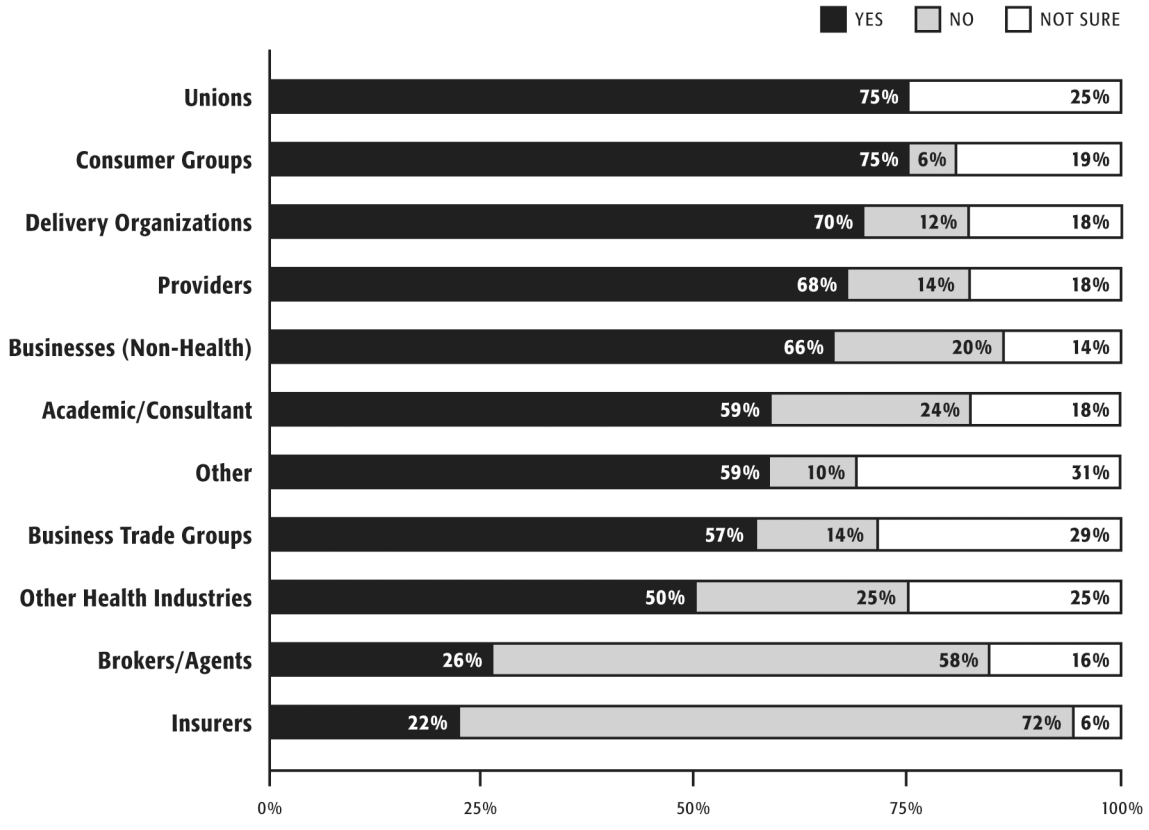


Source: Rutgers Center for State Health Policy, NJ Health Insurance Exchange Planning Survey, 2011

Currently, New Jersey's non-group and small-group health insurance markets have separate risk pools. That is, premiums are established in each market independently of the other. The ACA permits states to merge these risk pools, meaning that premiums will be determined based on the expenditures of plan participants regardless of whether they enroll as individuals or through small businesses. Figure 10 and Table 10 shows survey responses about whether New Jersey should merge its markets. With the exception of agents/brokers and insurers, the majority of each stakeholder group supports combining the non-group and small-group risk pools. Large majorities of insurers and agents/brokers oppose this option.

Figure 10 | **Combining Non-Group and Small-Group Risk Pools**

Currently, premiums in New Jersey's non-group and small-group markets are established separately (i.e., separate risk pools). The ACA permits states to merge the non-group and small-group markets into a single risk pool for premium rating purposes. ***For premium rating purposes, should NJ combine the non-group and small-group risk pools? (Q34)***



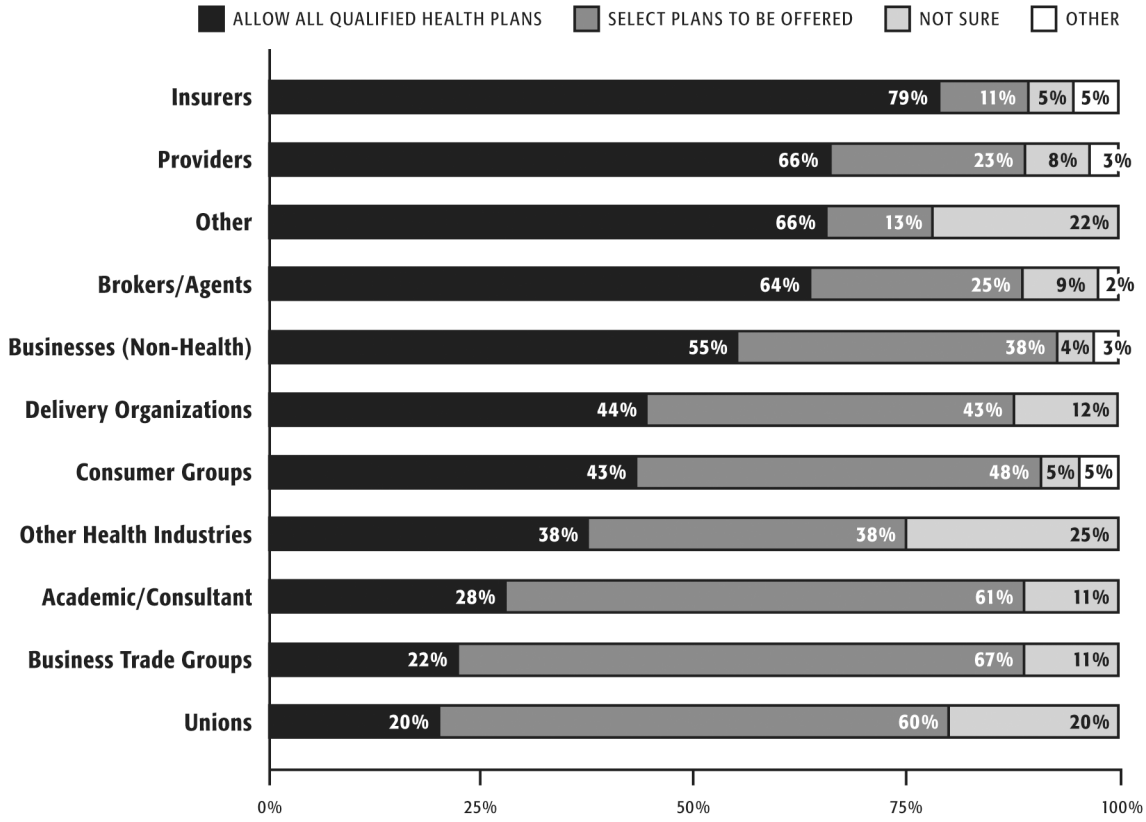
Source: Rutgers Center for State Health Policy, NJ Health Insurance Exchange Planning Survey, 2011

Exchange Functions and Operations

There is significant disagreement among stakeholder groups about whether all qualifying health plans should be sold through the New Jersey exchange(s) or whether the exchange(s) should limit the number of carriers or plan options available (Figure 11 and Table 11). The all-qualified-plans approach is sometimes referred to as the "clearinghouse" model versus an "active purchaser" model that would conduct competitive bidding or apply specific criteria to limit the number of plans or carriers in the exchange. The majority of participants representing insurance carriers, health care providers, agents/brokers, and non-health businesses (as well as "other/not specified") support the all-qualified-plans approach, while majorities of representatives of unions, business trade groups, and academic/consultant/foundation groups support limiting offerings. The other groups, including consumers, delivery organizations, and other health industries, are more mixed in their views.

Figure 11 | **How Qualifying Health Plans Should be Selected for Offer**

The ACA requires that exchanges make available a choice of health plans that meet minimum coverage standards (qualifying health plans) for purchasers receiving federal subsidies. Carriers also still must meet state requirements for authority to sell in the state, and states may determine the number of carriers and the number of options that carriers may offer through exchange(s). ***Which of the following statements best describes how you believe qualifying health plans should be selected for offer through the NJ exchange(s)? (Q30)***

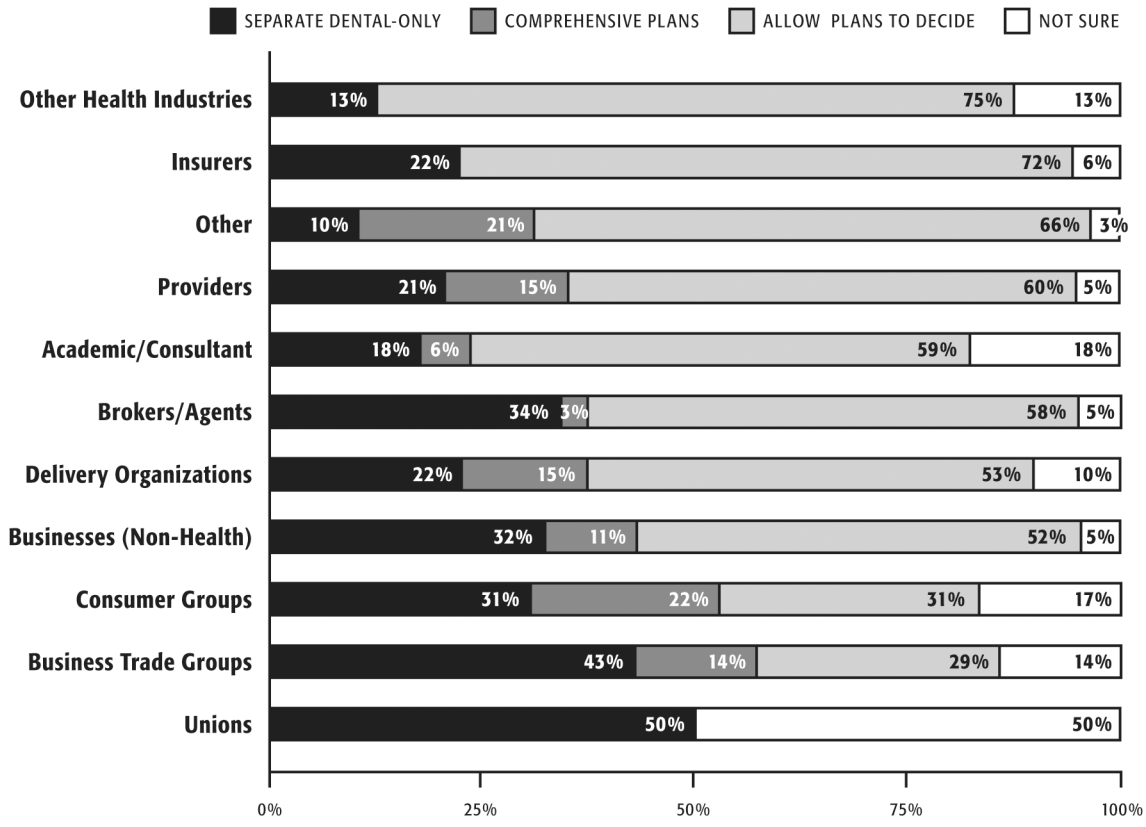


Source: Rutgers Center for State Health Policy, NJ Health Insurance Exchange Planning Survey, 2011

The majority of survey participants in most stakeholder groups support the status quo in how dental health benefits are offered (Figure 12 and Table 12). That is, eight of the 11 stakeholder groups favor allowing health plans to decide whether to offer dental-only plans alongside medical plans versus offering plans combining the two. Nevertheless, substantial shares of some groups (unions, business trade groups, consumer groups, non-health related businesses, and agents/brokers) support requiring dental plans to be sold separately from medical plans.

Figure 12 | **How Dental Benefits Should be Offered**

How should dental benefits be offered within the NJ exchange(s)? (Q35)

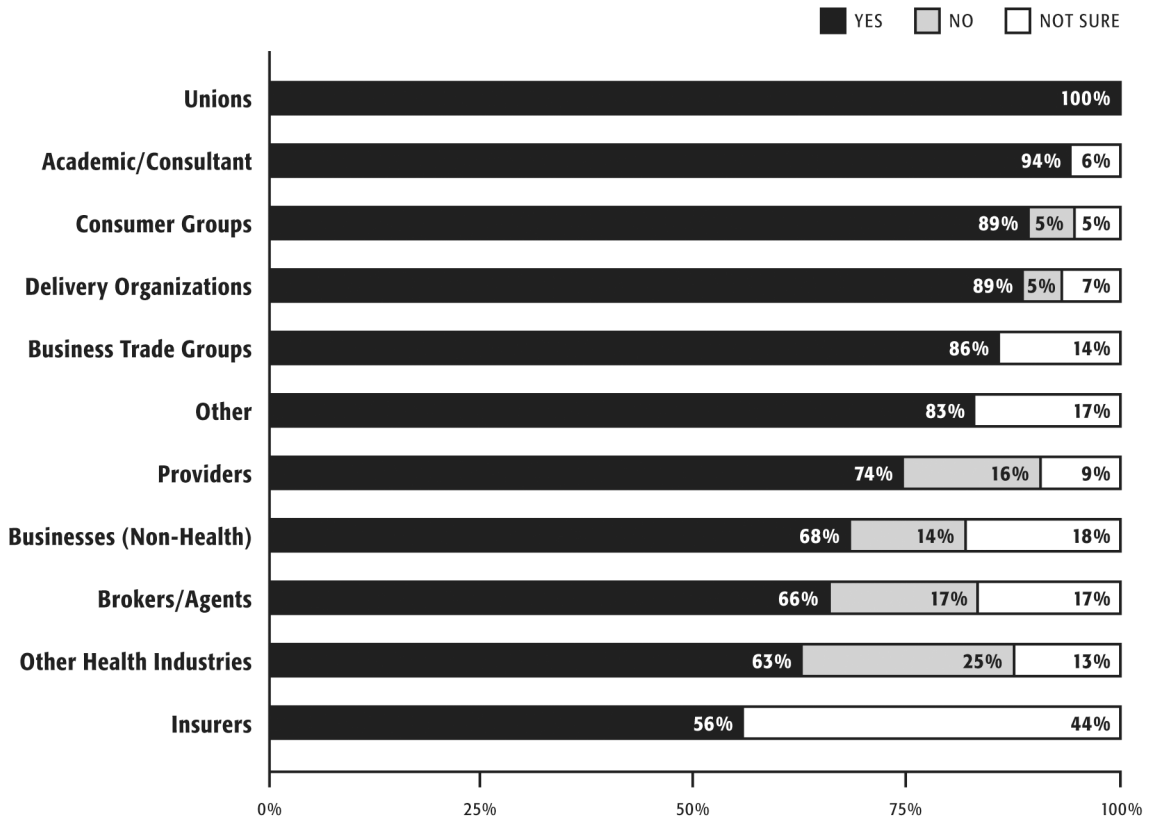


Source: Rutgers Center for State Health Policy, NJ Health Insurance Exchange Planning Survey, 2011

The ACA permits states to create "Basic Health Plans" (BHPs) for exchange enrollees just above the Medicaid income-eligibility threshold (i.e., between 133% and 200% of the federal poverty level, based on ACA-defined Modified Adjusted Gross Income). Under this option, states would collect 95% of federal subsidy funds (i.e., tax credit and cost-sharing assistance) for these individuals, which would allow them to be enrolled in Medicaid or Medicaid-like programs. Without BHPs, individuals whose incomes rise just above the Medicaid eligibility threshold would be required to purchase a private plan through a health insurance exchange. Figure 13 and Table 13 show very broad support for New Jersey pursuing developing a BHP across all stakeholder groups.

Figure 13 | **Basic Health Plan Implementation**

The ACA permits states to create a "Basic Health Plan" for many individuals above the income eligibility for Medicaid (133% of the federal poverty level) but below twice the federal poverty level (200%). Under this provision, states would receive 95% of the federal subsidy amount to enroll eligible persons in a state-operated health plan like Medicaid. A key purpose of the Basic Health Plan is to promote continuity of coverage for persons losing eligibility for Medicaid. ***Should New Jersey implement a Basic Health Plan or not? (Q36)***



Source: Rutgers Center for State Health Policy, NJ Health Insurance Exchange Planning Survey, 2011

Other Considerations

The final question in the survey asked about any other issues New Jersey should consider with respect to health insurance exchange design. Responses to this open-ended question were coded and grouped into common themes. The major topic areas of these responses are listed in Figure 14 and details of responses by stakeholder group are shown in Table 14.

Figure 14: Topics Mentioned in Open Ended Question about Exchange Design

Expand government role	Exchange governance issues
Encourage competition and plan choice	Exchange financing issues
Make exchange easy to use and effective	Broker roles
Promote enrollment in the exchange	Other exchange design and regulatory issues
Cover specific services or professionals	Contain rising costs
Address barriers to care/enhance access	Other or un-interpretable responses

Few clear themes emerge from responses to this question. Among the more commonly mentioned topics (each respondent could mention up to three) is that health plans should cover specific services or professionals; this theme emerged especially among health care providers, health services delivery organizations, and consumer/patient representatives. Respondents in some groups endorsed an expanded role for government, such as single payer or adding a public plan option. But admonitions to increase competitive forces in health insurance markets were also mentioned relatively frequently by participants in these same and other stakeholder groups. Other comments related to strategies to address fairness and effectiveness of exchanges and other aspects of health care.

Part III: Discussion

Conclusions

Two modalities were used to gather input from a broad spectrum of New Jersey health care stakeholders to inform the state's response to health insurance exchange provisions of the Affordable Care Act: thirteen, two-hour forums offered an opportunity for in-depth discussion of exchange design issues, while the web-based New Jersey Exchange Planning Survey reached a broader array of stakeholders and asked more specific questions about the design of exchanges. Examined together, these sources provide rich information about the perspectives of key New Jersey constituencies on exchange design issues as the planning process was getting under way in early 2011. In general, the two sources paint a consistent picture of stakeholder positions.

The forums and survey reveal some areas of consensus and others of disagreement. Foremost, in both the forums and the survey, participants across stakeholder perspectives nearly universally agreed that New Jersey should establish its own exchange. Respondents across stakeholder groups also largely agreed that access to coverage through the exchange in New Jersey should be broad. That is, persons not eligible for subsidized plans should be permitted to purchase through the exchange. Consistent with this view, participants in most stakeholder groups also favor allowing larger businesses than are required by the ACA to purchase through the SHOP exchange, although there is dissent from this view among brokers and insurance carriers.

Questions about the relationship of exchanges for individuals and small businesses in New Jersey elicited more disagreement and uncertainty. Most forum participants agreed that exchange administrative functions for individuals and small employers should be combined in a single entity, but the survey revealed more division on this question. In both the forums and the survey, participants were divided on the wisdom of combining the non-group and small-group risk pools, with strong opinions held on both sides. The majority view in most groups in the survey was that the risk pools should be merged, although brokers and insurers disagreed with this view by wide margins. Perspectives from business representatives were more mixed. The forum revealed room for discussion about merged markets, depending on the way the SHOP exchange functions (i.e., as an employer or employee choice model).

The forum discussions revealed that in designing its exchange the state should emphasize administrative efficiency and it should build on New Jersey's history of active insurance market regulation. Participants also emphasized that however the exchange(s) are

ultimately organized, the design must be responsive to unique and varying needs of individual and small group insurance buyers across the state.

With regard to where the exchange should be located organizationally and how it should be governed, no single direction emerged from the collective responses. Feelings on whether the exchange should be housed within a non-profit entity, an existing state agency, a new public authority, or somewhere else were mixed both across and within stakeholder groups in both the forums and the survey. Creating a non-profit entity received the plurality of support in the survey for many of the stakeholder groups, although the idea of creating a new public authority also received considerable support among some groups. The forums revealed a more nuanced discussion of the preferred organizational form. Forum participants, across diverse stakeholder perspectives, emphasized several considerations they saw as important in designing the exchange organizational structure: the exchange must be insulated from politics, it should not unnecessarily replicate functions of the Department of Banking and Insurance, and it should be nimble in response to market needs.

On a related question, the majority of survey respondents in five of eleven stakeholder groups endorsed the idea of establishing an independent board of directors, while no clear consensus was evident among the other groups on preferred governance strategy. In fact, many participants in both the forums and survey expressed uncertainty about how the exchange should be governed. When asked in the survey which groups should be represented on an exchange governing board, if New Jersey creates such a board, there was strong consensus about including representation from consumers/patients, business, providers, and (to a significant degree) the commissioners of relevant state agencies. Opinions were more divided on whether insurer or agent/broker representatives should be included.

The extent to which the New Jersey exchange should be an active purchaser, exercising considerable purchaser discretion in selecting plans, versus a clearinghouse for all qualified plans was an area of notable disagreement. In general, consumer groups anchored the view that the exchange should actively advance broad goals of cost containment, quality improvement, and efficiency. Other groups, most notably carriers, favored an exchange that is more streamlined, with an emphasis on allowing markets to drive plan choice, cost containment, and quality. Employers, brokers, providers, and business interests were more mixed in their views on many of these issues.

There was also disagreement about strategies to avoid adverse risk selection against the exchange. Moreover, questions about risk selection elicited the highest proportion of “Not Sure” responses or non-response of all of the questions asked in the survey, underscoring the technical complexity of these issues. Overall, the survey responses suggest that many groups support requiring plans offered inside and outside the exchange to have key features in common, including some groups that support requiring that plans be identical in and out of the exchange. Carrier representatives in the forums offered concrete ideas about strategies to

minimize adverse selection, including adopting open enrollment periods, limiting the extent to which consumers can "buy up" to richer plans when their care needs increase, and other ideas.

On other questions, stakeholders agreed on a general direction, but differed on specific actions. For example, stakeholders agreed on the importance of making transitions between Medicaid and private plans for consumers whose incomes change as seamless as possible, but their suggested ways to do this were varied. One policy option on which there is very high support across all groups is that New Jersey should create a Basic Health Plan, which would provide a means of funding for the state to create a Medicaid-like plan for persons just above the Medicaid income eligibility threshold. Similarly, stakeholders agreed on the value of maximizing enrollment, but suggested different tactics to do so. In addition, stakeholders largely agreed on the value of some sort of training for navigators, but they offered very different views for who should fill those roles.

Questions about benefits design and other specific exchange functions generally also failed to generate consensus, with the exception of most stakeholders embracing a common theme concerning state mandated benefits, i.e., that the ACA offers the opportunity to undertake a serious review of mandates. Other design questions – the degree of desirable product variation, integration of dental benefits, and the role and compensation of brokers – produced an array of responses across stakeholders.

Interpretation and Generalization of Findings

Like any opinion research strategy, the two methods used to gather stakeholder input have limitations that should be kept in mind when interpreting and generalizing from findings. The forums and survey were conducted at an early stage of policy development. Some forum participants voiced frustration that it is difficult to formulate clear policy choices in light of the absence of specific guidance from the federal government; and, as noted, "Not Sure" was not an uncommon response to some survey questions. Participants' level of knowledge of the ACA varied and many acknowledged their lack of understanding of some health insurance terminology and concepts such as risk pooling, churning, and adverse selection; though, overall, participants effectively grasped the fundamental issues of exchange structure, governance, and financing. Forum participants were not provided with the discussion guide prior to the sessions, and some may have given different responses had they had the opportunity to consider their answers or consult with colleagues before participation.

While every effort was made to ask questions in the forums and on the survey as impartially as possible, the information gathered using both strategies was undoubtedly influenced by the way questions were asked. In addition, willingness to participate in the forums and survey was visible across stakeholder groups, but participation was limited to the invited groups. There are almost certainly other health care stakeholder groups in New Jersey

with strong views about health reform that were unintentionally excluded from the forums. The survey was completed anonymously, so it is likely that respondents felt free to provide candid opinions. While forum participants were promised that they would not be quoted directly in project reports, they were informed that their participation would not be treated as confidential. Thus, some forum participants may have been reluctant to voice controversial opinions.

The number of forum participants and survey respondents was fairly large (152 and 618, respectively) and these groups were quite diverse; nevertheless, the samples are not statistically representative. Rather, a list of invited participants was developed by the Center for State Health Policy with the intent of achieving broad representation. In order to seek the broadest possible input, stakeholder groups on the list were invited to forward the invitation to participate in the survey to their constituents. Nevertheless, some relevant groups may have been inadvertently excluded from the survey invitation. Because formal probability sampling from a known population of possible respondents (i.e., a sampling frame) was not used, there is no way to calculate a survey response rate. In addition, the number of respondents in some stakeholder groups was fairly small and some categories are quite heterogeneous, and some nuances of differences in responses may be hidden in the group averages.

Finally, the information in this report represents a summary of opinions voiced, and the authors exercised judgment in identifying patterns. The process of summarizing and synthesizing findings clearly leaves out details that some readers would like to have been emphasized more. Readers interested in more detail are encouraged to read the proceedings in Volume II (Michael et al., 2011) and detailed survey tables available in Volume III that includes the appendices to this report (Cantor et al., 2011b).

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