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# Center for State Health Policy

*A Unit of the Institute for Health, Health Care Policy and Aging Research*

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

### Volume II: Proceedings from Stakeholder Forum Discussions

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## Preface

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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 U.S. 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, from February-April 2011 Rutgers Center for State Health Policy (CSHP) conducted a series of thirteen discussion forums with stakeholder groups throughout New Jersey. The stakeholder forums, held in Trenton, New Brunswick, Montclair and Camden, New Jersey, included four forums with health care providers, three with consumer groups, two with employer groups, two with insurance carriers and two with health insurance brokers. A total of 152 participants attended the exchange planning group forums, and fifty-seven percent of invited organizations sent at least one representative to the forums.

This volume includes the proceedings from these forums, organized by stakeholder group. A summary and analysis of the findings from the stakeholder discussions as well as from a stakeholder survey that was conducted under this grant can be found in companion sections of Volume I (Cantor et al., 2011a). Appended material, including a roster of forum participants and the discussion guide, can be accessed in Volume III (Cantor et al., 2011b). For a glossary of relevant ACA terminology, please visit <http://www.healthreformgps.org/glossary/>.



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## Summary of Provider Forums

There was much focus among providers on the role of the exchange in keeping plans honest and ensuring that the system worked better than our present one in delivering needed care. Overall, providers were most concerned about the exchange promoting adequate, fair coverage that included broad networks. There were varying opinions on the structure and specifics of the exchange, but a push for keeping it simple and efficient. Among some providers, there was a sense that their input on certain exchange issues was premature, and a plea for another chance to weigh-in as the state gets further along in its planning.

### ***Exchange Organizational Structure, Governance and Financing***

Overall, providers agreed with the concept of New Jersey establishing a health insurance exchange. With the exception of one provider, who wondered about exploring economies of joining a federal exchange, forum participants were in favor of the State establishing a health insurance exchange—believing that its “progressive” policies, “better protections” and chance to “build on” what it has, made the case for a New Jersey exchange. In the words of one, we are “far better served by creating our own.”

While there were several questions about what a regional exchange might look like, many suggested that one or few exchanges for New Jersey made sense, with an eye toward recognizing “regional differences” and the distinct markets within the State.

Across the board, providers pushed for merging the individual and small-group exchanges. There was overall agreement that the state should combine the individual and small group markets into a single exchange, with providers arguing for a better overall risk pool and eliminating the waste and bureaucracy of “multiple administrative structures.” Providers argued to combine the two “to keep costs down.” While there was a warning that small

businesses will “push back” at the possibility of their risks worsening by going through the same portal as individuals, and some pleas to protect small businesses (with many of the attending providers being small businesses themselves), others countered that keeping a “high-risk pool alone” would risk failure and raise costs.

Providers were mixed on whether New Jersey’s exchange should be inside or outside government. In terms of the organizational structure of the exchange, reactions were mixed as to whether the exchange should fall within or outside a state agency. Citing the need for more information, one participant noted, “Either could be horrible or great.” While some cautioned that separate authorities could sometimes be “sticky,” others pushed for a “tight, structured” authority or nonprofit with appropriate oversight—preferring the exchange be “board-run rather than government-run.” Another cited the need for form to follow function, “What you want people to know decides where it’s put...For some, a government agency might be off-putting... [This] might speak to a quasi-governmental agency or nonprofit...On the other hand, you miss potential for coordination with this option.” Others suggested the benefits of the stability associated with a state agency. “There shouldn’t be a whole new bureaucracy...” “Do this efficiently.”

Providers pushed for a multi-stakeholder exchange board. In discussing the board for the exchange, some suggested it mirror the composition of the forums. “Within the board, you need a wide scope of representatives...providers, business owners, consumer groups.” There was caution on skewing the board and a push for ensuring “broad representation” and keeping it “market driven.” Some providers looked at the board as a way to balance the scales with insurers. Others spoke to the need to include “at risk groups” on the board. According to one, including seats for primary care and patients (described as those who know the “maze and malaise”) will ensure the right people are there “to wave the flag.” Others were skeptical about the ultimate power of any board, particularly if there was some sort of Executive-override associated with the exchange.

There were differing schools of thought on financing the exchange, with the majority of providers pushing for spreading costs across the New Jersey insurance industry. Providers had varying opinions on how the exchange should be paid for once Federal funds discontinue. Most pushed for some sort of insurance industry financing. Others wondered if some sort of systems savings (through smarter use of services or reduced bureaucracies) could be captured to help pay for the costs. Many questioned what the overall estimated cost for a New Jersey exchange would be. Below are some of the options discussed.



- Spread Costs Across All Insurers. A significant majority of participating providers believed that all insurers doing business in the state should contribute. “If you do business in New Jersey, this is your fee...” Many suggested this option avoids the deterrent of joining the exchange by levying a fee on participants only; the “fee should be throughout.”
- Spread Costs Across Non-Participating Insurers. Amidst concerns of insurers opting-out of the exchange, some suggested charging only *non-playing* insurers, citing their failure to participate as putting “strains” on the system.
- Spread Costs Across Participating Insurers. Believing that those insurers that realize the benefits of more efficiency and more business through the exchange should bear the costs, some pushed for just charging participating insurers, using the power of the market to ultimately balance costs.
- Charge the Exchange Enrollees. Some believe that it makes sense for those buying insurance through the exchange to pay a certain amount to make sure it runs efficiently.
- Consider a New Source of Revenue. Some pushed for new sin taxes or another “tax de jour.” Others bristled at a potential provider surcharge.

### ***Considering the Scope of the Exchange and Health Insurance Markets***

Providers wanted to open up the exchange. There was unanimous agreement across providers that New Jersey should open its exchange to more than just the subsidized market, with an eye on spreading risks... “A larger risk pool is the only way to go...maximize the number.” There was also a hope that the exchange could help recapture those higher-income individuals who are currently falling through the cracks or paying deductibles to the point of being underinsured. They would “hope” the exchange would be “attractive” to this group.

Providers also wanted to include firms up to 100 before 2016. There was similar, unanimous agreement on speeding the inclusion of larger small businesses, with an eye toward the “more people, the better.”

Providers suggested merging the small and individual risk pools. When asked about combining the individual and small group risk pools, providers argued for a merging of the two, with some questioning about the Massachusetts experience in doing this and the effects on small groups.

While there were some reservations, a majority wanted to keep a separate market to allow undocumented immigrants a chance to purchase insurance. There were mixed reactions about undocumented immigrants. While many initially suggested that there be no market outside the exchange, this sentiment often shifted when participants were reminded that there were prohibitions on undocumented individuals buying through the exchange. Many argued to keep an outside private market open so that they could still have the chance to purchase insurance. Obviously, we “want them to continue to buy insurance...” Others seemed to question this, citing an argument for a single entity to purchase insurance through and a belief that, “They won’t access it anyway.”

### ***Examining the Overall Functions of the Exchange***

While opinions as to whether the exchange should act as a clearinghouse or active purchaser were mixed, across the forums, a majority of providers believed that the exchange should be an active purchaser. A sizeable minority of participating providers pushed for letting the market, rather than the exchange, decide on plans, citing that the Affordable Care Act already afforded enough “protections” and that another level of bureaucracy [to limit plan participation] was unnecessary. Others strongly disagreed, believing that the exchange “should set more standards” and be allowed to “negotiate” both price and benefits. They cited both benefits for small businesses, as well as the need to protect the “most vulnerable populations” who [especially initially] will need the help of a government structure. Others argued that without a role as an active purchaser, there was little justification for an exchange at all—“It could just be set up on the Web.” Even those providers who argued for a more market-driven, less-active exchange were concerned about plans keeping broad provider networks and ensuring that the coverage included was good coverage. At least one participant wondered about the possibilities for a “hybrid” model.

Providers suggested a range of organizations that could fulfill navigator functions. Many suggested opening the role of navigator to a variety of organizations, talking about the need to “involve different folks for different populations.” Some stressed the important role for “local,” “trusted” faces, like human resources and social services agencies, schools and faith-based organizations. Some mentioned experience with NJ FamilyCare, needing to engage a full range of organizations. Others cited learning from the shift to Medicaid Managed Care, where private companies were initially engaged to help, but ultimately nonprofits and local community-based organizations needed to take on these functions. “Make it an aggressive point-of-service.” Several also mentioned the natural role of providers as navigators, and the need to include providers in the mix. Some participants cautioned how important the role of the navigator was, with the power to either make or break the whole deal. “They could be the deciding factor as to whether this is successful.” Participants also stressed the need for balancing the familiar face

with insurance expertise. “These people also need expertise [in plans].” Some suggested pairing trained consultants who have industry know-how with local agencies. Others suggested the need to ensure centralized training of the navigators.

Providers were skeptical about the use of brokers. When discussing the role of brokers, many providers were cautious and had difficulty seeing a future or evolving role for brokers. We heard, “Isn’t the exchange enough?” “Couldn’t you eliminate the broker?” “There shouldn’t be brokers.” Many talked about the need for brokers to ensure full disclosure about coverage. “Brokers [currently] leave out what’s not covered...They need to be honest about what’s in the plan.” The current broker model is not best, “except for finding more lives.” Several mentioned the issue of conflicts, noting “Any advice offered on a contingency basis is biased.”

There were mixed reactions from providers in using Health Information Technology (HIT) and linking Electronic Health Records (EHRs) with the exchange. When posed with the idea of linking EHR data with the exchange, some raised confidentiality concerns. “Patients still have concerns about privacy” with regard to this, citing patients’ beliefs that the fewer having access to their information, the better. Still, others countered with the need for an adequate system to track quality and outcomes, “People don’t know what they’re buying...if information technology can help guide them...” “If the exchange is ignorant about cost and quality, it can’t provide service in a meaningful way.” “We are a Google nation...information should be used to help make a smart choice.” Others wondered about the overall costs of doing this and cautioned against layering too much on to the exchange, “The more you layer on, the greater its chance of failure.”

Another participant asked how technology could be used generally to help with consumer decision support, rather than providing “just words.” One participant suggested the Web portal have inputs for consumer medical needs and prescriptions and then provide plan options based on those inputs. Some expressed the importance of clarifying what people are expected to pay for their care, wondering if there might be a way to electronically model what people will have to pay and what will and won’t be covered. One mentioned the exchange as being “a forum for uniformity”—providing a system that compares one plan to another and ensures insurers provide “the right information” so buyers can compare price and coverage. They stressed the need to use plain English for understandability and be clear about benefit limits, including limits on supplies, equipment and drugs, as well as clear information on consumer protections.

Providers suggested mass media be among the tools used to engage enrollees. Some suggested looking to the experience with NJKidCare as New Jersey launches the exchange. “We thought...they would be kicking down the doors to get in...only a fraction enrolled early on.”

Some pushed for “casting the net wide” and helping the providers “help them get enrolled.” Many pushed for promotional marketing, and using the power of mass media, “[It’s] everything.” Another suggested employing texting and other social marketing techniques. Some suggested aggressively promoting the benefits of the exchange and advertising penalties as part of the roll-out. Overall, providers echoed the need for easy enrollment, “[It] isn’t going to work unless it’s easy.” ... “Don’t make it cumbersome.”

### ***Benefits Design within the Exchange***

Providers had mixed feelings about limiting plan options. There were two main schools of thought among providers on standardizing products within the exchange—one school leaving the market to decide and another urging the state to limit choices. However, even the group that chose to open the options sought assurance of a good, basic plan for starters.

- Ensure a solid, basic plan and allow add-on options. There was a group that allowed for a market-driven approach after ensuring a good basic plan. These providers wanted to ensure a “rigid minimum,” but then allow for variation. If insurers want to add bells and whistles, they can.
- Keep it simple and standard. The other group opted for simplicity and limiting plans—keep plans standardized for the Web portal, they urged. “There are way too many plans...It’s a nightmare to figure them out.” According to one, that amount of choice sounds like a good idea, but it’s not. We were again reminded of physicians being looked to by patients as the experts on plans. They pushed for simplicity and standardization, citing problems with “large charts” and too much choice. We heard, “it’s supposed to be quick selection...making it ‘overly complex’ will limit the usage...” And again, “Keep it simple.”

Within this discussion and throughout the forums came the plea from providers for the exchange to ensure solid coverage whichever route was taken. “Overall, the exchange shouldn’t exacerbate problems with benefits packages...All plans should have decent coverage.”

As part of this and other discussions, providers in each forum discussed the importance of open and real networks ... “not just on paper.” One complained about “phantom networks” that frequently include dead doctors, “Be sure that doesn’t happen here.” Others suggested the need to regularly audit plan networks.

One participant’s plea included ensuring comprehensive benefits packages for children, saying that children without “real insurance” become dependent adults.

Specific questions centered on ability to change plans and whether there would be any consideration of integrating a long-term care benefit option.

In discussing the role of the exchange in promoting prevention, many moved for preventive incentives. Many providers mentioned positive incentives for good behavior, in the form of benefits and lower co-pays. Others asked if premiums might reflect activity on wellness. “A lot of insurers encourage this, but we need fiscal incentives for widespread adoption of the prevention model.” Along with prevention, some stressed the importance of a benefit design that incentivizes primary care. Cost was cited as a key driving factor in pushing people in the right direction. Providers stressed benefits designed around prevention, and, most importantly, ensuring that enrollees understand these benefits. Some mentioned including both plan- and patient-level outcome measures related to prevention.

To mandate or not remained a question among providers. While many providers expressed regret at the potential of rolling-back state mandates, saying it would be “a step backwards” for New Jersey, others wondered if these were just going to be too expensive and would need to be considered on a case-by-case basis. If New Jersey looked across state lines in considering regional exchanges, some warned there would need to be an “equalizing of mandates.”

Most agreed that dental coverage be integrated within plans. Citing linkages with overall health, like heart health and diabetes, many providers pushed for integrating dental benefits within plans. “If something is wrong dentally,” there are greater effects on overall health. “It’s especially important for children.” On the other hand, some felt it was a failure to not include “dental only” plans, citing difficulties in carriers providing both benefits and the adding of administrative costs in needing to subcontract-out for these benefits. “It’s a huge problem that medical and dental plans can’t talk with one another.” In discussing the linkages with dental health, the need to integrate mental health care also was raised among several providers.

Providers had a range of suggestions for easing transitions and were generally favorable to the idea of creating a Basic Health Plan (BHP). In discussing transitions, some providers stressed that transitions should be “ongoing” and that changes in income should be done in real time. Some suggested that no more than 30 days should lapse between coverage. Others suggested not having any set enrollment period for the exchange, as well as the need for overall “ease” in changing plans (“You should have the option of moving if the network changes”) and the chance for the navigators to help with transitions. Still others pushed for robust networks and good out-of-network benefits as a way to smooth transitions. One participant suggested dually certifying people for Medicaid and the exchange.

Most agreed on creating a Basic Health Plan to help provide stability for that “in between” group that sometimes get lost within the system, though some questioned “how deep” coverage under such a plan would be, with low numbers of providers currently participating.

### ***The Role of the Exchange in Controlling Cost and Improving Quality***

While not getting too involved with specifics, providers suggested a variety of ways the exchange could generally promote quality and control costs. In discussing the exchange’s role in containing costs, some mentioned that if the exchange were taking the route of an active purchaser, it would have a central role in controlling premiums. Incentivizing prevention was also viewed as a key tool in cost control. Still, others mentioned that information-sharing was among the “lowest hanging fruit” in terms of cost savings, reducing duplication without affecting care in any way. Many mentioned the need to move toward more evidence-based medicine.

In terms of measuring and reporting on plan quality, providers wanted to be sure that the exchange’s quality indicators included a detailed consumer survey, including an effective measure to rate denials. Some suggested the navigators would be key in ensuring survey participation among consumers.

Providers were generally favorable of the exchange promoting Medical Homes and Accountable Care Organizations. Many were in favor of the exchange promoting Medical Homes and Accountable Care Organizations, by both encouraging care through them and through providing incentives. One cited experience in transitioning his practice to a Medical Home, “It’s expensive.” Another asked about the possibility of reimbursing for costs associated with becoming an ACO, physicians “don’t get paid to think, we only get paid to do.” Including pharmacies in medical homes was also suggested. Some mentioned the importance of ensuring that ACOs and Medical Homes were represented on the exchange board.

As part of this discussion, however, one participant argued that focusing too much energy on promoting these models would “bog down” the exchange with too much, pushing the need to focus on the “problem of doing one thing well.”

### ***Risk Selection***

Some mentioned the importance of ensuring plans offered within the exchange are also offered outside of the exchange to avoid risk selection. Standardizing the market was viewed as very important. Others mentioned keeping the risk pool big—even having everyone in the exchange.

One provider who viewed himself as attracting very high-risk patients talked about the importance of having these types of providers participate in *all* plans, as insurers can currently “avoid whole [high-risk] populations” by not contracting with them.

### ***Closing Considerations***

There were several recurring themes when providers were asked about their most important priorities for the State to consider in creating the exchange.

- Keep it Simple. There were continued pleas for keeping this simple and easy to use. “Keep it as simple as possible.” To the lay person, insurance is intimidating. “Start simple.”
- Make Sure the Coverage is Real. Again and again, providers wanted to make sure that the coverage was good and that reimbursement was adequate enough that doctors would participate. “Where can people go with this coverage???” ...“We’re talking about a health insurance exchange, but insurance doesn’t mean access. If it’s a good card, there will be a lot of providers there.” And from another, “Regardless of how the exchange is set up, it won’t matter [if the coverage isn’t good].” ...Everyone buys insurance anticipating that they will be covered; an insurance system is needed that mirrors that expectation. Many pushed for reexamining arbitrary limits on sessions and on durable medical equipment (DME), as well as reiterated the need for affordable co-pays and deductibles.
- Include Broad Provider Networks. Again, providers wanted to ensure real networks with lots of providers and “full freedom to choose a physician and hospital.” Ensure adequate networks... “not just on paper,” and without discrimination against provider types.
- Pay Attention to Transparency. Transparency will be critical for both providers and consumers. “We need to understand what we’re paying for.” Transparency was discussed in terms of plans, medical loss ratios (MLRs) and pharmacies. Providers talked about the need to be clear about benefit limits, including limits on supplies, equipment and drugs. There was also a push for clarity in terms of consumer protections.

Lastly, one provider who had been in practice for some time suggested that the word “exchange” leaves a bad taste in the mouth of many who had lived through prior “exchange” experiments. He wondered if New Jersey’s exchange could somehow be renamed.

## Summary of Consumer Forums

Throughout their forums, consumer representatives emphasized that the exchange was established to work for them. While often differing on some of the details of the exchange, consumers nearly universally looked toward it being an active purchaser and, most importantly, a driver of better and more consumer-focused coverage within the state. Oftentimes, in discussing various implementation issues, consumers would focus back on important principles and characteristics associated with a New Jersey exchange—like competency, trustworthiness and transparency.

### ***Exchange Organizational Structure, Governance and Financing***

Nearly across-the-board, consumers argued that New Jersey should establish its own health insurance exchange. Among consumers, there was near universal agreement that New Jersey should establish its own exchange. They cited the state’s forward thinking, but also New Jersey’s ability to address its unique needs and “control [its] own destiny” through creation of its own exchange. While agreeing that New Jersey should probably create its own, one participant noted, but “how it’s *done* is far more important,” citing the need for the exchange to be “good” and “consumer friendly.”

Consumers also believed that one exchange for the whole state made “more sense” to help increase bargaining power and decrease confusion by creating a single, consistent place to go for coverage.

Consumers argued to combine the individual and small group exchange. Consumers cited a number of reasons for combining individual and SHOP exchanges.

- First, it would provide for economies of scale in operating the exchange;
- Second, it would provide a larger number of lives to help boost the exchange’s bargaining power;
- Third, it would help spread risk; and
- Lastly, it would help ease frequent transitions between the individual and small group markets. The markets are quite “closely connected”...It “makes sense to administer them together.”

While opinions were mixed, most consumers preferred a public authority model for the exchange, with broad disagreements on the role of existing agencies in its governance. Most consumers argued that the exchange should not be housed within an existing state agency, believing that these agencies were “overstressed” and that the current “climate” wasn’t right



for the state to take on the responsibility of operating an exchange. They believed the public would feel more of a sense of independence and ownership if the exchange were kept separate. Among the alternatives, there were arguments for both a nonprofit and an independent authority. Some consumers believed that an independent nonprofit would be a more attractive choice for the exchange, providing a “better image” and “more flexibility.” Others countered that a public authority option would ensure many of the necessary consumer protections, like transparency and accountability, along with important linkages with existing programs deemed critical to the exchange’s success. Still, others argued that what was most important were the *characteristics* of the exchange—wanting to ensure the exchange was both transparent and accountable.

There was quite a bit of disagreement on how big a role existing state agencies should play with respect to the exchange, with consumers wanting oversight of the exchange, but not politicization of it. Some argued that these agencies should be represented on the board (if feasible depending on the structure); others suggested the exchange should report to the commissioners. Still, others wanted to shield the exchange from the politics of appointed commissioners altogether—pushing for some sort of “firewall” to avoid any politicization of the exchange.

Consumers believed *they* should play a critical role on exchange board. Some argued that consumers should represent at least a majority of the exchange board. Many spoke of the need to ensure that real consumers (who actually buy insurance) and those with a range of health care needs be included among its members. Some mentioned provider and (especially small) business representatives as well. They mentioned the need for board members to be “very qualified”—understanding insurance markets and knowing the issues. Nearly universally, consumers argued that no one with an interest in the sale or service of exchange products should be on the board. Because of their expertise, however, a number of consumers suggested that these types could serve as consultants or act on an advisory panel to the board. Again, consumers were divided on whether the board should include current agency commissioners (perhaps as ex-officio members), with some citing the need for “direct lines of control,” and others countering that it shouldn’t be politicized. Some stressed the need to keep the size of the board manageable (suggesting it be fewer than ten members) to ensure it can “get consensus” and not become “unwieldy.” Others, with an eye on the possibility that the board would include a number of political appointees, suggested that board member terms be staggered.

Most consumers pushed for insurer-based financing of the exchange. While one consumer suggested a dollar assessment on all tax returns to avoid association with insurers altogether,

most pushed for an insurer assessment to fund the exchange. According to one, “hit” those with “deep pockets and profits”...“Make them more ‘do-gooders’ than they have been.” Consumers were split on whether the fee should be applied to just those insurers participating in the exchange or to all insurers operating within the state to avoid any disincentives for participating. The fee should be as “broad-based as possible.” Several expressed concerns about any proposed insurer fee just getting “passed down” to consumers, pressing for regulations to ensure that the cost doesn’t get put back on the consumer.

Consumers argued a broad pool would help with risk selection. In discussing ways to help with the problem of risk selection, consumers stressed the importance of broadening the exchange pool to the non-subsidized population, creating a “broadly appealing” product that “healthy people will want to buy.” They emphasized the importance of marketing the exchange to the “mandated pool” to make it less expensive for everyone. They also talked about offering the same plans, implementing the same standards, and charging the same fees inside and outside the exchange to “level the playing field.”

Consumers were in favor of creating a single risk pool for individuals and small businesses—again, making the pool “as big as possible.” While some argued that inclusion of the mandated population would improve premiums for everyone, others were cautious about the need to protect prices for small employers with any merging of the pools.

### ***Considering the Scope of the Exchange and Health Insurance Markets***

Across the board, consumers pushed for opening up the exchange. Consumers stressed the benefits of keeping the exchange “open” to spread risk, encouraging its being as “expansive” and “inclusive” as possible. In addition to improving the risk pool, consumers believed that broadening the exchange would help ensure that its market wasn’t in any way “marginalized” and that there was maximum “buy-in” to the exchange.

Consumers also were enthusiastic about including firms up to 100 before 2016, provided the exchange could handle the volume. Consumers were also in favor of speeding inclusion of larger small businesses, provided the exchange could handle the additional work. There is a benefit “of more covered lives in the exchange earlier,” but only if you have a strong exchange—one that “can handle” the volume. Others offered, “Get there (meaning, include the larger smalls) as soon as you can,” even if it isn’t on “day one.” Some suggested initially offering these employers a choice of joining to help ease implementation later on.

Consumers expressed real concerns about helping the undocumented. While consumers talked about keeping an outside market open for the undocumented, there were also many concerns

expressed about not allowing them to be included in the exchange—saying it was “terrible” and would continue to “drive up the cost of charity care.” Some suggested the need to do something more to help, “New Jersey should set up something for them...” and mentioned the need for Federally Qualified Health Centers to at least stay open 24/7 to help avoid “misuse of [ER] services.”

### ***Examining the Overall Functions of the Exchange***

Consumers unanimously pushed for an active-purchaser exchange model. Across the board, consumers were quite adamant that New Jersey’s exchange should be an active purchaser, terming the possibility of a model near the website/clearinghouse end of the continuum “a huge missed opportunity.” They 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. Some felt that taking on these functions would boost consumer “confidence” that the exchange was “working for them.” Some argued that New Jersey already has a clearinghouse—bemoaning that adoption of that model “wouldn’t make any progress at all.” Others went even further... “[It will be a] complete failure if this is going to function as an advertising platform for the health insurance industry. I’ll be out front with a sign.”

Consumers stressed engaging qualified, objective and community-focused organizations as navigators. There were a range of suggestions from consumers about the kinds of organizations that should serve as navigators. They talked about the need to look at *characteristics* important for navigators—with being “free of conflict,” “knowledgeable,” and “know[ing] communities” among the most critical. Consumers stressed the importance of “transparency” and that navigators have “no financial interest” or other interest in steering consumers in a certain direction within the exchange. “Navigators are meant to *really* help people...these folks should be actively, aggressively connecting people to quality programs.” They pushed making navigator services available “where people go.” Some suggested using providers. Others suggested building off of work of existing organizations, including those working on CHIP enrollment. One stressed the need for the state to use the opportunity to engage a range of organizations and get them “bought into” the exchange. A real understanding of and sensitivity to the community was deemed critical for effective navigation, as was the need to be “knowledgeable” about insurance. Some viewed the characteristics of the navigator as being the linchpin toward the overall success of the exchange, “Logic says that will give you a better system...Build a better system through better people.” The consumers suggested that the exchange “certify navigators” to ensure that they are both qualified and free of conflict. Others pressed the importance of having the navigator report back to the exchange “to find out what happens.” Since the ultimate goal is boosting enrollment, the importance of having navigator

“performance standards” that would feed into annual state “enrollment” goals was also discussed.

Many also raised the issue of having the navigator assume a role in transitions and in resolving conflicts and helping with the “innumerable pitfalls” that arise in getting needed services after enrollment.

Consumers believed a broad public awareness campaign and good public image would help boost enrollment. Consumers said that it should seem obvious that the exchange will be “highly publicized” and “broadly understood” with sufficient public announcements and a “broad media campaign.” Some warned that there needs to be “real honesty” in presenting what the program would provide throughout such a campaign.

Others suggested taking lessons from NJ FamilyCare (...“the devil is in the details”). Work to make it “as user-friendly” as possible they urged, including adopting a “one sheet” application, making everything easy to understand with simple language, including weekend hours and targeting “where people go for their care” to expand enrollment.

In connection with building enrollment, Consumers raised the importance of the exchange needing to ensure a “good image” and overcome a “significant headwind” of perceptions of a “government takeover” of health care. More than one group suggested the importance of not allowing brokers and insurers to somehow undermine the exchange. According to one, “Brokers will tell their clients they don’t need this.” And another added, don’t let insurers “bad mouth” the exchange.

Consumers were mixed on a future role for brokers. Some spoke of a “tissue thin” trust relationship with their current brokers, citing the need for future brokers to adhere to “transparency” and “strict ethical standards.” Others suggested the elimination of brokers altogether, believing that the exchange should be easy enough to understand and “consumer-friendly enough” that everyone shouldn’t need a broker. If brokers were kept as part of the navigator mix, as mentioned previously, consumers suggested they assume an additional role as problem-solvers.

Consumers generally wanted an active role for the exchange in marketing, but were unsure about a similar role with respect to billing. Some consumers said that they didn’t have a real opinion on who did the billing (“don’t care where the money goes”), but they did want to ensure that the exchange had an overall role in “billing protections.” Others believed that the exchange having an active role in billing “provide[d] another level of oversight for the industry.”

Still, others raised hesitations about “handl[ing] everything through the exchange—making it an insurance company outside an insurance company,” believing that adding more “layers” of responsibility in the exchange would “slow everything down.” In terms of marketing, consumers were more clear on an exchange role, citing the need for the exchange to ensure insurers “play by certain rules” to be included in the mix. They mentioned the difficulty some, like people with disabilities, will have in making a decision through the portal—thereby underscoring the importance of a marketing-oversight role for the exchange. Many suggested that the exchange has to create standards for marketing in “plain language” so people can really understand their coverage.

There were mixed reactions from consumers in linking Electronic Health Records (EHRs) with the exchange. Some consumers were very enthusiastic about using EHRs, “In this day and age, we’re missing the boat [without them],” even suggesting creating incentives for consumers to use them. However, there was less enthusiasm when posed with the idea of linking EHR information with the exchange portal, with confidentiality concerns raised by some, “*Perhaps* they could be linked with the proper protections...???”

### ***Benefits Design within the Exchange***

Most consumers preferred a limited number of plan options. While one consumer argued that the exchange’s ability to promote comparative quality and outcomes information would suggest experimenting with variation in models, most argued for standardization. Consumers echoed concerns about ensuring a decent benefits package overall. “The bottom has to be good...that is key.” They also cited savings that would accrue from standardization, as well as reduced complexity to help ease the “need for brokers.” Some cited Medigap’s standard options as a model for the exchange.

Consumers wanted the exchange to assume more of a policy role in encouraging prevention and raised the need for a broader discussion on prevention generally. While many discussed incentives for prevention, some suggested that the exchange drive prevention by providing incentives for plans “removing barriers” toward prevention. “The exchange shouldn’t be *the* place where you are told to eat right and exercise but, rather, should highlight plans that promote preventive medicine.” The exchange should be playing a critical role in ensuring plans have the right benefits focused on prevention. Others mentioned that exchange certification should be contingent on high standards for plans encouraging preventive care. Consumers mentioned the exchange needing to ensure that preventive services are available *throughout* the state and that preventive incentives are available across populations, including for people with disabilities. Some pushed for broader state preventive goals “well beyond” ACA standards,

accompanied by a conversation across stakeholders (providers, patients, plans) on moving forward with these goals.

While some consumers pushed for keeping mandates, others suggested a re-look. Some believed it was important to keep the mandates as they are (New Jersey “saw fit to enact the mandates, so we should continue them”). Others believed New Jersey could not afford to subsidize the current set in its entirety. “The reality might be, we can’t afford all these.” While some suggested a cost/benefit analysis of the current set of mandates, others pushed at a complete re-look (especially at the “unusual benefits”), believing that many of these were not part of a rational process, but rather, “who was at the (political) table earlier.” One consumer argued, for example, that people needing rehabilitation from brain injury are no less deserving than women trying to get pregnant.

Most agreed that dental coverage should be integrated within plans. While there was widespread agreement among consumers on integrating dental benefits within plans, some expressed concerns about these benefits increasing small employer premiums (especially for those employers who may not have offered these benefits previously) to the point of making coverage unaffordable.

Consumers viewed information technology, navigators, along with like networks, as being important in easing transitions. They were also generally favorable toward New Jersey creating a Basic Health Plan (BHP). Consumers discussed the importance of information technology and data sharing in easing transitions. “There should be good electronic coordination between the exchange and Medicaid,” including the same form; ensure “uniformity in documentation.” This would allow the “auto populating” of any new documents needed for transitions. “Don’t make them re-fill out the paperwork.” As part of this discussion, the role of improved IT overall was discussed: “The current system is very antiquated”...Medicaid IT needs to be up and running before the exchange. Individuals will go on line to get insurance. [Their] “entire view of the exchange” is going to be based on that one event...If it shuts down, or doesn’t give the right information, it will “alienate” them from the experience. It “has to be done before January...tested, tried and true.”

One participant discussed the importance of the exchange and the navigator in never “dropping the ball” on coverage. “It’s hard enough for Joe and Jane average citizen to find out about programs, much less get themselves enrolled.” Some suggested that the exchange do the homework prior to sending any notice to enrollees indicating that they would no longer qualify for Medicaid, laying out available alternatives.

Others spoke to the importance of making sure “the network of providers is consistent” to help ease transitions. According to one, “Either require providers to do both, or create incentives for doing both.”

Consumers were also generally in favor of creating a basic health plan to further help with transitions for those “just above the line,” again focusing on the need to ensure adequate provider involvement in this plan.

### ***The Role of the Exchange in Controlling Cost and Improving Quality***

Consumers viewed the exchange as having a role in sharing outcomes and in directing patients toward plans that support quality measures. Consumers viewed the exchange as having a key role in promoting information about quality and steering patients toward plans promoting quality. “Highlight products that promote health...Highlight plans that endorse and support quality measures for providers...It would lead to lower costs.”

In further discussing the exchange’s role in containing costs, some believed that the exchange should pursue its role as an active purchaser with an eye on the goal of slowing costs. According to one, the exchange should “highlight plans that not are just the cheapest,” but those that provide “comparisons in costs to consumers over time.” Consumers also mentioned the excessive cost of end-of-life care and the need for the exchange to focus on this area to control costs.

### ***Closing Considerations***

There were a range of issues from consumers when asked about their top priorities for the exchange. Below are some of the recurring themes.

- Make sure consumers and their trust are the focal point of a strong exchange. Again and again, consumers talked about the need for widespread consumer trust in the exchange. They spoke about the need for the exchange to garner consumer “confidence” so they have “a place to go...a place they trust and that has their interest.” They urged that the exchange be “robust,” accountable, and independent. It should be “unbiased and transparent.” “Consumers should be at the center of this.”
- Make sure it’s easy and appealing to use. The exchange will be “the interface for consumers with the health care system...there needs to be a priority on how it should look...how it is accessed.” How “friendly” will it be to consumers? “How to label plans...These all need thought.”

- Make Sure It's An Active Purchaser. The exchange should be more than “just an online billboard”...“Invest in negotiation.” One participant, who cited as a top priority that the exchange act as an active purchaser, did note that, if for some political reason, an “active purchaser model” was somehow “not in the cards” for the state, that the exchange could still serve a role in highlighting plans that work to improve quality and overall health.
- Ensure seamless coordination between Medicaid and the exchange. Consumers echoed the need for “good integration” with Medicaid. “Work for seamless coordination between the exchange and Medicaid—one computer system, one form.” “Transitions will be key; most people will be in and out of this.”
- Ensure Broad Provider Participation. Ensure contracts with sufficient numbers of providers. Ensure “adequacy of networks” and no “phantom networks.” Services may be “covered, but (not if) nobody’s in the networks.”

At the forum’s close, some asked about the format for the report and when it would be available to them.



## Summary of Employer Forums

Employers argued for a robust, market-driven exchange that offers a range of choices and services. While ambivalent about many of the particular attributes of the exchange, the group urged the state to be sensitive to the needs of small employers in the exchange—balancing choice with simplicity and keeping a watchful eye on decisions, like pooling risks that would potentially hold higher cost implications for an already-strained market.

### ***Exchange Organizational Structure, Governance and Financing***

Employers unanimously agreed that New Jersey should create its own exchange. Employers argued that New Jersey needs to be in control of its own exchange destiny. They mentioned the state’s institutional knowledge as one reason to create its own exchange, but were most concerned about “giving over too much regulatory authority” to the federal government by not acting. Leaving the exchange creation to “the feds” with “no idea” about what it would look like, “what degree of control” such an exchange would cede to the states, or whether New Jersey could opt-out of any federally-created exchange once “in,” seemed like a huge “leap of faith” to these employers.

While many believed a multi-state exchange was too cumbersome, some suggested it needed further thought. Several employers argued that the exchange would lose the ability to be nimble and competitive in the marketplace if it needed to coordinate with other states and their laws in implementing the exchange. Another argued for further thought, as state lines constitute “artificial barriers” for insurance, and the “biggest pool” might be the most effective. While not believing that their existence necessarily justified a multi-state exchange, one representative also discussed the need to accommodate employers that cross state lines by creating some sort of coordination across state exchanges.

Most argued for a single New Jersey exchange. Employers believed that a single exchange would work best for the state. For “simplicity sake,” create one. While some suggested the need to accommodate different geographic areas and a “different mix of carriers” within the state through either “different faces” or different back-office functions, most favored “one” place with one set of operations, processes and technologies.

Employers also believed that the SHOP and individual exchange should be combined administratively. Arguing again for “simplification,” “standardization,” and expectations of “no wrong door,” the employers believed that the individual and SHOP administrative functions should be merged.

Employers were a bit ambivalent about the organizational form of the exchange, focusing on arguments for and against various models. Rather than expressing much of a preference, employers argued a good deal about the pros and cons for various organizational models for the exchange. Some believed that the state’s “rightsizing” initiatives, along with potential “conflicts” (of merging the regulator with the distributor), 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 existing infrastructure and the “critical mass of expertise” within the state, others wanted “clear lines” dividing the two. Some specifically mentioned an independent public entity model. Others offered that, although it might be the best choice, many lacked the “taste” for authorities these days. Some mentioned that a nonprofit provided the most flexibility, but others warned to not “get too far out” in giving government powers away, perhaps leaning toward an evolved nonprofit structure that included accountability and transparency.

The employers argued for a balanced board, but cautioned on the need for continuous seats and limited size. Some employers argued for a balanced board to represent key stakeholders interests—like purchasers, providers and carriers. But others warned, “Less is more in terms of board governance,” urging for a smaller-sized board that could move quickly, possibly supplemented by the expertise of a larger advisory committee. Such a committee could include “second tier” or more extended stakeholders. “This is so new,” they will need to “draw on their expertise.” Others talked about New Jersey’s elongated appointments process and the need to ensure continuous seats on the board.

Employers were mixed about financing the exchange. There were a variety of alternatives discussed by employers on financing the exchange, but no real consensus. Some argued that its financing depends on what it’s asked to do—citing the huge difference in Massachusetts’s and Utah’s costs. Others sought some sort of fee, likely insurer-based, but questioned “how realistic it (meaning, the fee) will be to support and sustain a business model.” They wondered if the exchange might need to be able to borrow money and have a credit rating. In arguing for charging participating insurers, some offered, “Carriers participating...are getting the benefit of free marketing...” “But that tends to get pushed onto the consumer,” one countered. Others argued for charging “all health carriers licensed within the state” to push participation. Either way, the employers wanted the exchange’s financing to be independent (meaning, not interlinked with funding for another state agency) and transparent.

Employers argued for ensuring a range of plans and a level playing field to protect from risk selection. Employers believed that spreading risk would allow more plans within the exchange. “Keep options” to protect the risk pool. In addition to a range of offerings, some wondered

about additional incentives to boost participation, “You’ve got to bring healthy people in.” Others spoke of the need to ensure the same plans were offered inside and outside the exchange and having the same rules, including identical group participation rate rules, both inside and outside the exchange.

Employers were not enthusiastic about merging the individual and small business risk pools. While there was some talk about the MLR considerations, most employers opted to keep the markets separate so that the small employers are not subsidizing the individual market. “Small employers are in no position to help subsidize the individuals.” To the extent risk pooling drives up costs for the small employers, it becomes problematic.

### ***Considering the Scope of the Exchange and Health Insurance Markets***

The employers believed that opening up the exchange to the non-subsidized market would improve risks and gain economies of scale. Most employers opted for the “economies” of opening the exchange to the broadest market possible, especially to bring in “healthier risk.” “Everyone should be allowed to join if they want to.”

Most employers, however, were leery of including firms up to 100 before 2016. Employers were generally not enthusiastic about including larger small employers before 2016, with many agreeing that the market changes “a good bit” when you go past 50. Others argued there is “too much happening” initially and that this could possibly be phased-in down the road. While there was some desire to broaden the exchange pool (pushing beyond “impaired markets” and the “uninsured”), there was also caution about attracting the wrong risk type. “If you have a lot of mass, but it’s a lot of bad mass, it doesn’t help you.” Make the SHOP “robust,” “service oriented,” and “affordable” to make it very attractive to the right kind of small businesses.

### ***Examining the Overall Functions of the Exchange***

Employers were mixed on the active vs. passive model for the exchange, with many seeking to balance bargaining considerations with choice. Some talked about having the exchange acting “somewhere in between” on the active/passive continuum. They spoke of “having a robust marketplace...inside of the exchange” but, using the “gravity of the mass” and “bargaining power” to help with pricing and negotiations (though perhaps not excluding carriers on that basis alone). Arguing for the need to balance rate and choice considerations, one offered, “There’s only so much that’s going to be able to be squeezed out of the carriers from a rate perspective.” Others believed that the limited numbers of plans playing in New Jersey’s small employer market *could* enable some leverage on rates.

Still, others very strongly favored an “information portal” and totally “open market model” for the exchange. They believed that the ACA ensured enough protections and that “any qualified plan” should be allowed to participate. Arguing that some smaller insurers are already leaving the market, one participant noted, if you see the exchange has “damaged” the market to the point where the state has only two carriers, “...Not sure who has the power there,” it’s “not a good place to be.”

Employers had questions about the functions of the navigators—pushing for both expectations and deliverables. There were some real questions among employers about the navigator role. Some questioned whether they would serve as marketers of the exchange or whether they would follow through and also act as problem-solvers, easing the “angst” so many small employers have with respect to reform. “They need lots of help.”

Some suggested “harnessing” all disparate entities currently working in this area to help reach populations and boost enrollment in the exchange, offering that existing infrastructure can help fulfill these roles too.

The employers also spoke of the need to license and certify navigators, and ensure “expectations” and “deliverables.”

Others noted the interlinked nature of the definition of the role with decisions about plan standardization.

Still, others were downright skeptical about navigators, admitting they “don’t think it’s going to work,” as many of the organizations people were talking about as potential navigators, like church organizations, didn’t have the needed expertise to likely fill a meaningful role in navigating through the insurance marketplace.

Employers pushed for a strong start as a way to boost enrollment. Some employers pointed to the “launch” as being “very important” in boosting enrollment. “Getting off to a good start” will be key, with a good, simple, and “tested” website going a long way toward the “murmur on the street” as to whether this is a good thing. They also mentioned the importance of making navigator reimbursement based on enrollment, “Navigator grants *have* to be performance-based.” These employers viewed a “centralized place” for enrollment as also being important.

While some employers were doubtful about the need for brokers, others viewed them as being critical to attracting the right risk to the SHOP exchange. Some employers believed brokers will have a “lesser role” with the exchange. Some argued there may not be a role for them at all.

“Unless there’s a true role for that broker to play,” they believed the broker could be bypassed. Some allowed for brokers to be able to serve as navigators and navigators to be able to serve as brokers, reinforcing the “no wrong door” concept. There was also a belief among some that broker buy-in and parity of broker compensation (inside and outside the exchange) was absolutely essential to success. They offered that many brokers hold the keys to driving good risk toward the exchange—in particular, capturing those healthier small employers who already have insurance. The exchange, they believed, without brokers will lose the small employers. It needs “to get mass...” They will not come “if brokers aren’t on your side.”

Employers were mixed on an exchange role in marketing, but viewed an exchange role in billing as critical. While agreeing that there was a need for standardization of marketing materials, some employers wondered if this function might rest with DOBI. On the other hand, many viewed the exchange’s taking an active role in billing as being part of the “perfect world model,” where small employers could just write a check to the exchange. “Aggregation” is needed by small employers. There was also a mention that aggregating billing for part-time employees with multiple employers would be a benefit.

### ***Benefits Design within the Exchange***

Employers were mixed on standardizing plans, wanting simplicity and choice. Some offered that shopping is made easier with standardization—“the more standard offering that’s reasonably responsive to health care needs works best...,” warning that the exchange could “drive people away” with complexity. “There’s a tipping point on choice.” Still, others countered that New Jersey small employers rejected standardization in the early 1990s, “voting with their feet” on a set small number of plans. Others agreed, saying that standardizing would just attract “the same group over and over again.” They believed the exchange needed to be “flexible enough” with its offerings to attract small group business. Experience has shown that opting to standardize *types of plans* or possibly *plan elements* might work best. In addition, the possibility of leveraging technology “filters” to help “cut down on confusion” through narrowing choices was also raised.

Employers were mixed on the exchange’s role in prevention. Some viewed the exchange as having an active role “down the road” in promoting prevention from a centralized point, especially as people switch plans over time. Some suggested the exchange “provide benchmarks” for wellness programs. “Small employers don’t think about wellness because they can’t see a direct savings to them”...Getting small employers invested in prevention through seeing a linkage to costs was termed “the nut that needs to be cracked.” Others saw a more limited role, believing the exchange should “save [its] money” on things like wellness ads, and instead focus on ensuring a transparent portal that makes clear which plans might offer more

innovative wellness programs. They said it's not the role of the exchange to promote these things; it's the role of the *plans*.

Employers were near unanimous in believing New Jersey's mandates needed a re-look. While some suggested that it was hard to weigh in on mandated benefits without knowing what the essential benefits package would look like, others saw the essential benefits as "great political cover" for eliminating the mandates altogether, believing that the State should stay as close to the feds as possible and avoid the "politicking" of opening up mandates. "Let's get out of that and let the market work." One suggested exempting plans in the exchange from the mandates, but most were in favor of mandate parity inside and outside the exchange.

Most employers believed that dental benefits should not be integrated within plans. Employers wanted dental benefits to be kept separate to ensure small employers retained cost options. Some suggested that "small employers cannot take on the burden of additional costs." As further justification, others added that some really good carriers don't have great dental coverage.

Employers were mixed about the exchange being a portal for other types of insurance. Some employers suggested that it would be nice to look at other types of insurance, like long-term care insurance, in one place, and that over time, there might be a role for the exchange to serve as the portal for these other products. Others suggested that this fell "outside the scope" of the exchange.

### ***The Role of the Exchange in Controlling Cost and Improving Quality***

Employers viewed a limited role in the exchange in controlling costs and promoting quality, especially initially. Employers warned that the exchange shouldn't be "overloading" participating plans "with too many requirements" on cost and quality, making it too arduous to participate. While some wanted the exchange to use its leverage on costs, others suggested the exchange stay focused on "facilitating the market." Employers were unanimously cautious of the exchange promoting accountable care organizations (ACOs) or Medical Homes, believing that some of the plans would promote these models.

### ***Closing Considerations***

There were a range of issues from employers when asked about their top priorities for the exchange. Below are some of the recurring themes:

- Keep it simple, simple, simple. Over and over, employers talked about the need to keep it “simple and easy to use.” This will be “unchartered waters” for many. We need to get through to a “distracted market.” “Charlie Sheen is selling out arenas across the country...Those same people don’t even know that this health care law is in place.”
- Balance simplicity with options. Many echoed the need for simplicity, but wanted also to ensure a range of options and choices for small employers. Have an “open market” but use technology to “narrow plan choice.” While there was some push also for employee choice within the exchange, others cautioned on implementing this with an eye toward not making it too easy for the small employers to drop providing coverage altogether.
- Be mindful of small employer needs. Ensure a “robust” SHOP exchange, where small employers see the real benefit of joining. “Meet their needs” so they can focus on their business. Some mentioned that Massachusetts gave “short shrift” to the smalls, and that a strong SHOP in New Jersey was critical to attracting business that will ultimately even out risks and costs.
- Make sure it’s market driven. Employers emphasized the power of the market in driving many exchange decisions. Competition will be a driving force in bringing down costs. Along these lines, some argued about the importance of making the exchange marketplace “look” and “feel” like a private enterprise.
- Don’t neglect the servicing after enrollment. Make sure the exchange is focused on “taking care” of people and small businesses after enrollment. Make sure there’s a “role for someone” to take care of people once they are enrolled. It can’t just be “herding the cattle” ...There needs to be a place for advocacy and help “throughout the year.”
- Avoid politicizing the exchange. Employers reminded that the exchange shouldn’t be politicized in its governance.
- Pay attention to transparency. Transparency was also deemed a key attribute of the exchange. In this context, employers also mentioned the importance of transparency in terms of the exchange costs.

## Summary of Insurance Carrier Forums

Insurance carriers pushed for a vibrant exchange centered on competition, market experimentation and market-driven solutions toward improving service and controlling costs. In considering various questions about the role and functions of the exchange, they argued that the state should be mindful of the undermining effects of redundant regulation and multiple sets of rules on efficiency and costs—arguing over and over again for one set of rules, and one set of regulators. They pushed for the exchange to allow flexibility and get out of the way of plan innovation.

### ***Exchange Organizational Structure, Governance and Financing***

With one exception, carriers were in favor of New Jersey creating its own exchange. While one carrier was skeptical about investing time, energy and resources in the development of an exchange absent more sweeping cost reforms, most believed that New Jersey’s “long and effective history” of being an “early adopter” on reform, along with knowing its own constituents and marketplace best, argued for creation of a New Jersey exchange.

The carriers acknowledged the need for the exchange to recognize the uneven distribution of the population across the state as well as local price differences, but still pushed for a *single* exchange that might perhaps include regional links. They felt “one exchange” would be the best way to serve the population.

Maybe separate, maybe not...While insurers mostly argued for separating the SHOP and individual exchange, they were okay with combining them *administratively*. Carriers mostly opted for separating individuals and the SHOP into “two vibrant exchanges.” That said, most were indifferent to combining the administrative functions of the two, indicating that how the “back office” was set up didn’t matter and that “one set of administrators” could help keep costs down.

As part of this discussion, however, there was considerable concern among carriers about the possibility of the ACA SHOP provisions being implemented following an employee-, rather than employer-choice model. “The jury is out on the SHOP exchange.” If designed for employee choice, they conceded, there might as well be a single exchange for both since everything would effectively operate like an individual market anyway.

While sometimes agnostic on the exchange’s form, carriers were clear on its functions. Some carriers suggested a nonprofit structure for the exchange would maximize revenue-generating opportunities and ensure flexible contracting. Even if it were a nonprofit, they believed the



exchange should adhere to open public records and meetings rules to ensure transparency. Others were much more agnostic on its form, being “fine with whether it’s a new agency or part of an existing agency.” They were less laid back, however, about the exchange’s purview. “Our concern would be just creating another set of regulators. Don’t make it a ‘redundant regulatory body’ ”, they argued; this is “counterproductive” and works against efficiency and costs. Certain functions, they argued, like rate regulation, should remain with DOBI.

Carriers wanted an unpaid board with broad representation. Carriers argued for the exchange board to include a broad array of stakeholders, including plans, providers, consumers and businesses. Some suggested if, not directly, that these stakeholders should participate in an advisory capacity. Some wanted the board to report to the commissioner; others wanted the board to include agency commissioners (like DOBI and Human Services, along with the Medicaid Director) on an ex-officio basis. Some carriers suggested “staggering” appointments and keeping the board to a manageable size of seven, moving quickly on four appointments to get things up and running. Carriers wanted the board’s membership to be “apolitical” and experienced. Across-the-board, they argued that the board should be unpaid, saying that pay will complicate things and that there are enough “affected, interested parties” that compensation didn’t need to be added to the mix. Some offered that out of the state’s 100+ boards, those that are paid “tend to capture newsprint.”

Carriers pushed 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 pharmaceutical providers) and carriers—having a share in its costs. Some suggested charges on all those enrolled in the exchange. Carriers emphasized that if this was envisioned as a broad portal, it shouldn’t just be financed by a “toll” on the “private” carriers. One suggested that the increased volume generated through the exchange could possibly boost revenue from existing insurer assessments to help cover its costs. Another offered looking toward a range of creative, business-based financing ideas, as recommended by the NAIC. Lastly, one reminded that adopting a nonprofit structure for the exchange would offer the most flexibility in its financing.

Insurers looked toward a strong market and range of administrative measures to help mitigate bad risk. Some suggested a strong external market would help in managing risk within the exchange. Carriers also believed that the mandate would be key in attracting a better risk pool, with some suggesting combining a strong public outreach campaign with measures like linking driver’s license renewals with health insurance. The carriers also wondered about easing rating bands to draw more young and healthy consumers to the exchange. The carriers also suggested the exchange adopt a number of administrative measures to help protect the pool, including:

- Adopting a set open enrollment period that would be the same inside and outside the exchange, with late penalties attached;
- Allowing consumers to jump only one precious metal 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 viewed unanimously by carriers as a good idea.

The need to carefully manage the risk pool for dental coverage was also discussed, as carriers indicated that so many of these procedures are deemed “postponable,” that it winds up creating a “terrible risk pool.”

Carriers were nearly universally opposed to offering the same plans inside and outside the exchange. Except for one—who worried about being able to compete and argued for a level playing field on both sides of the exchange—when asked if the same plans should be offered inside and outside, the answer was, “no,” with many arguing for “total flexibility.”

Insurers also voted “no” (with caveats) on creating a single risk pool for the small and individual markets. While, overall, carriers believed that the individual and small group risk pools should not be combined, they indicated that the right answer might ultimately rest with the rules for the SHOP exchange (meaning, again, if it were implemented following an employee-choice model).

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 “upset the pools” by having one subsidize the other, perhaps leading to affordability concerns that ultimately might discourage small employers from continuing to offer insurance.

However, as the possibility of an employee choice model on the SHOP was raised, some indicated that “all vestiges of group insurance will die very quickly in the SHOP exchange, and it really becomes an alternative to a consumer pool.” If this were the case, some argued, it might make sense to put them together. So, employee choice might lead some carriers to opt for a combined risk pool.

### ***Considering the Scope of the Exchange and Health Insurance Markets***

Carriers believed the exchange should open its doors to the non-subsidized market. Carriers were in favor of opening the exchange to the non-subsidized market, provided that enrollees fit the definition for individuals or small groups (not wanting to consider large groups in the mix).

Insurers said that undocumented individuals should continue to be allowed to buy outside the exchange. Some carriers indicated that the need for undocumented individuals to be able to continue to somehow buy insurance forces the need to maintain a market outside of the exchange...“if for no other reason” than this.

Carriers took a pass on speeding inclusion of larger small groups in the exchange and a complete pass on including larger groups. Carriers believed that the exchange should wait on expanding the exchange to larger small groups, suggesting the exchange should “limit” to 50 until 2016 and moving any sooner would be “disruptive.” Some mentioned that the exchange is an “unproven concept” that should ensure the up-to-50 market is working before considering expansion. Some suggested the over-fifty market is “different” in making decisions and it was “not necessary” to include them early on.

The carriers strongly suggested that the exchange not consider including employers with more than 100 employees. Insurers said that the over-a-hundred employers were “a whole different market.” They are “more sophisticated” and “don’t need the exchange.” They also argued that posing an experience-rated pool against a community-rated one, means “death to the pool,” as those less healthy larger groups will get a better deal jumping to the exchange—putting its risk “at the mercy” of any group at any time.

### ***Examining the Overall Functions of the Exchange***

Carriers unanimously voted for the exchange to function as a clearinghouse. The carriers were not in favor of an active purchaser model, believing the exchange should be open to “any qualified plan.” Discussing the rationale behind the vote for a clearinghouse model, some carriers argued that having the exchange have more competitors and acting as a “vibrant marketplace” will, over the long-term, yield improved affordability and access. They believed that having “just a few options” will work against transparency, choice and, ultimately, sustainability.

Carriers were mixed on the role of the navigator. Some suggested that brokers would continue to serve as navigators for small employers. Others flat-out said that navigators and brokers are “very different” and that the traditional broker model wouldn’t work. Some suggested adopting models from the Medicaid market or Medicare State Health Insurance Assistance Programs

(SHIP) —with the navigator as someone who would be “available” to people, but provide “non-biased representation,” “divorced” from financial interest. Carriers agreed that this is “not a simple task” and that navigators need to perhaps be licensed/credentialed to ensure they have the knowledge to educate clients about their options.

Carriers offered a variety of suggestions for boosting enrollment, including their own smart marketing plans. Some carriers mentioned widespread outreach to boost enrollment. Others pushed a range of administrative measures to ensure enrollment: as mentioned above, considering linking an enrollment check with getting a driver’s license or car insurance; implementing penalties for dropping coverage; and requiring quarterly premium payments to ensure an ongoing investment in coverage. At the same time, carriers echoed sentiments to try to make it as “simple as possible” for people, perhaps guaranteeing a year lock-in period for enrollees.

Others suggested making sure about “segmenting eligibles” through a “smart marketing plan”—one that recognizes reaching the Medicaid population requires different techniques and different messaging than reaching small business owners (though, they rhetorically wondered whether this was the job of the exchange or the carriers, offering that the state “typically doesn’t do a great job with marketing”). Others raised concerns about there being a “duplication of effort” with consumers somehow getting caught in the middle. They added that they wanted to make sure it’s “done well.”

As part of the discussion of enrollment, some carriers worried about a “tide” of employers “dumping” their traditional coverage and opting for their employees to go through the exchange, believing that the financial modeling would make sense for some low-wage industries.

Carriers were torn on the question of brokers. Some suggested that there will be “multiple distribution points” and that any regulations adopted as part of the exchange shouldn’t favor any one of these points. Be as neutral as possible, they warned. They mentioned that some consumers may want to bypass brokers and shouldn’t be forced to subsidize those that will continue to prefer “high touch” service. Others admitted that many brokers might need to “reinvent themselves.” Still, some argued that the majority of small employers buy through brokers and they will continue to fulfill a necessary function... “Good advisors will still be advising.” However, how brokers are financed is a question, with some arguing for setting standards for commissions and including transparency as part of the equation. As part of this discussion, some raised the need for the exchange costs to also be transparent, possibly adopting the methods the utilities use to price out.

Some suggested having brokers as certified navigators—“tweak mechanisms” (for their certification) rather than recreate them. Others raised the need to ensure non-duplicative compensation of brokers who might also possibly serve as navigators.

Carriers were generally not enthusiastic about an exchange role in marketing standards. Some suggested that a marketing oversight function already exists within the state and that the exchange doesn’t need to play a role in marketing. Others mentioned that on the Medicaid side, the state has helped with leveling the playing field among plans with respect to marketing and ensuring protections. While conceding that standards need to be met, especially for the disadvantaged, some countered with the need to balance these protections with efficiency (not multiple sets of rules and regulators taking months to turn things around). In discussing marketing, some offered that the exchange should determine eligibility, but that marketing, enrollment and billing should be left with the carriers. Agreeing, another suggested that once the initial phase of eligibility is complete with the navigator, “the plans should be able to offer a hot-link opportunity to show their wares” and let the consumer make a decision from there.

Carriers were skeptical about an exchange role in billing. Some suggested that the exchange should collect billing information up front, but then allow the plans, who are invested in getting paid, to manage the billing process. “Don’t duplicate functions done elsewhere,” they suggested, just creating “additional costs.” Others warned that consumers have developed an expectation about service that might be difficult for the exchange to meet. There is the need for quick turnaround and attention to things like “grace periods” that allow for flexibility on payments. Still, some admitted that there is a “slippery slope” on billing if the SHOP moves toward employee choice, with some open to the possibility for the exchange to take on billing functions if it “deteriorates into that situation.” One mentioned that Medicaid eligibility, enrollment and premium functions currently handled through vendors will probably have to continue that way for some time.

Carriers viewed the exchange pursuing health information technology (HIT) linkages as belonging in the “nice to have” file. While carriers believed that linking HIT with the exchange would be “great,” they did not consider it among items on the critical path for 2014. Given past challenges in HIT integration and the time and resources involved, they suggested this would be “a nice to have.” The more “bells and whistles” added will keep you from implementing, they warned. “It just gets so overwhelming; you’ll never get to the basics.” One mentioned, additionally, that there is still some consumer skepticism about sharing medical information with plans (and the government).

### ***Benefits Design within the Exchange***

Carriers were opposed to limiting product variation. Carriers argued for a “robust free market” and that enough standards would be met through the actuarial values. “Encourage variability for competition...” It will “discourage future innovation” to limit products. They did offer that the exchange could promote standard descriptors to make it easier for consumers to compare plans.

Carriers saw a limited role for the exchange in promoting prevention. Some suggested that the exchange was “going to have a lot to do” without adding prevention to its list. Others said that while the exchange could present some positive messaging to enrollees, most plans already have initiatives around wellness. Some suggested an exchange role in ensuring patients get the right information on wellness programs offered through the plans.

Some viewed the state’s dilemma on mandated benefits as ironic. For many of the carriers who had lobbied against mandates for years, the state’s predicament in terms of mandated benefits presented what they termed a “funny moment,” with many believing that New Jersey has no other recourse than to roll them back. Others talked about the need to not recreate the federal lobbying process at the state. “Let’s live with it.” They indicated that, while blocks of consumers supported each of the mandates, overall, premiums are a much greater concern.

Carriers were somewhat mixed on integrating dental benefits, wanting the market to decide. Some carriers suggested that the market should stay as it is today with respect to dental. Others said to let the market decide on whether these should be integrated, indicating that modest dental benefits are sometimes “crowd pleasers” for consumers. Adding these benefits might also allow some products to make the jump to a different precious metal threshold. Some suggested that if dental benefits were integrated, there should be transparency in the pricing of the benefits.

Carriers were open to the exchange hosting other types of insurance. While, again, not seeing it as a critical component on the to-do list for 2014, carriers were open to the idea of the exchange being a portal for other insurance offerings. “If” the exchange operates extremely efficiently and has a high trust factor (some suggested this is a very “big if”), then why not?

### ***Transitions***

Insurers suggested lock-in periods and good information would be key in easing transitions. Some carriers suggested that “lock-in” periods for both Medicaid enrollees and those with subsidies would be critical to easing transitions. Enrollment rules should also be clear, they noted, with the exchange doing “a bang up job” of presenting people’s rights. Some offered

that the most worrisome transition is the one from Medicaid to private insurance, as the clients are accustomed to high-touch service and a near-platinum plan. Some suggested that having carriers that offer both Medicaid and subsidized products will ease transitions for many, especially for families. While some indicated that creation of a Basic Health Plan would seem to make sense, this was the one area where carriers did not believe they had enough information to weigh in.

### ***The Role of the Exchange in Controlling Cost and Improving Quality***

Carriers expressed a preference for the exchange to promote market solutions to cost control. Indicating that most of the ideas for cost control have been generated from the private market, including the Basic & Essential (B&E) product, the carriers pushed for the exchange to have a “bias for market solutions” rather than regulated ones to help control costs. Don’t “stifle innovation” through regulation. Others were more skeptical, indicating that cost control is not addressed in the law and that an exchange role in controlling costs is “ludicrous.” More than once, carriers complained about a significant cost problem stemming from out-of-network providers, pushing for flexibility in network design and payment.

Carriers didn’t see much of a role for the exchange in promoting ACOs or Medical Homes. According to one, the exchange should “let carriers experiment” and “get out of the way.” Others said that the exchange should encourage product flexibility. Another suggested that the exchange should ensure a level playing field when considering these innovations, imposing the same solvency and other standards throughout the exchange.

Insurers favored adopting the National Association of Insurance Commissioners (NAIC) MLR requirements. Throughout the forums, including in discussing MLRs, the carriers pushed for consistent rules and requirements. While some did not view MLR as an exchange issue, they believed that a consistent set of requirements is administratively simpler and less costly for enrollees.

### ***Closing Considerations***

There were a range of issues from carriers when asked about their top priorities for the exchange. Below are some of the recurring themes:

- Let’s get it started. Many offered that January 1, 2014 will be here before we know it and that the basic structure of the exchange needs to be put in place soon (get people hired, systems built and tested) so that insurers can work on their own systems. Some

expressed concern about passing along information and the systems coming together to reconcile information.

- Consistency is all we ask. As mentioned above, carriers pushed for consistency in definitions and rules (between the federal government and the state) and a lack of duplication in the exchange—not creating two parallel regulatory bodies for the industry.
- No magic bullet. Some carriers expressed concern that there was an expectation that this (the exchange) would be a “silver bullet” on controlling costs and increasing take-up; many warned about affordability and suggested that since New Jersey has already enacted many of the reforms in the ACA, it would be unlikely to recognize the same level of savings as other states.
- Create the exchange with an eye on experience. Some suggested that the state should learn from Massachusetts’s experience and not structure the exchange so as to remove any tools that it might need in the future (exchange 2.0 or 3.0) to address costs (In the words of one, don’t do something you’ll need to “undo”). Others suggested that New Jersey learn from its own auto insurance experience, where lots of competition allowed price and service gains.
- Build it so that carriers will come. Many suggested structuring the exchange to draw a lot of carriers to compete. They also suggested allowing lots of flexibility in product and network design.
- Pay great attention to risks. Some warned that risks really need to be managed, with a weak mandate combining with loss of any pre-existing controls as a real destabilizer.



## Summary of Broker Forums

Not surprisingly, brokers were most concerned about their role not being crowded out by or overlooked in implementation of the exchange. Some constructed a more circumscribed role for the exchange, keeping its focus largely on improving access for the Medicaid and subsidized market, while ensuring the rest of the market stays strong and, largely, as it is.

### ***Exchange Organizational Structure, Governance and Financing***

Brokers believed New Jersey should create its own exchange. The brokers believed that New Jersey was at the forefront in already adopting the makings of an exchange—needing more tweaking than actual creating to move forward with implementation. They also spoke about the need for each state to reflect its “own identity” through its exchange and expressed the desire for the state to have “control” over what they’d like to see as a “New Jersey-branded” program.

Along those lines, brokers were skeptical about the possibility of joining a regional exchange, believing that New Jersey’s better products risked getting “dumbed down” through partnerships with other states. While some pointed out that after 2014, all states would be “vanilla,” others were doubtful about the ability of neighboring states to come together and agree on regulations. They also felt that comparing “apples to apples” in considering a regional exchange vs. private market options would be difficult.

While the brokers pointed to real differences in the northern and southern New Jersey markets that should be considered by the exchange, some believed that adopting subsidiary exchanges could create confusion for consumers in knowing where to go.

Most brokers were okay with administratively combining the SHOP and individual exchange. While many brokers were in favor of combining the SHOP and individual exchange *administratively*, arguing that a single administrative entity would be easier and more cost effective for the state, others believed that even combining the two administratively would be difficult. These are “very, very, very, very different markets,” with different players, different brokers, and sometimes different carriers. Most, however, argued for a single exchange with two separate departments—one to address individual needs, and one to address corporate needs. As part of this discussion, brokers spoke about somehow also addressing the needs of sole proprietors through the exchange with some sort of “bridge” product.

Brokers were mixed on the structure of the exchange. Some brokers argued that DOBI is already doing a good job of managing these markets and that the exchange should reside there

to avoid reinventing the wheel. Others were deferential to a “lot of expertise” residing in DOBI, but wanted the exchange kept outside to avoid politics. Still, others were more clearly in favor of it being “privately run,” suggesting that adopting a nonprofit model (perhaps reporting to DOBI) would shield the exchange from appropriations difficulties.

Brokers wanted a "smart" exchange board with broad representation and limited terms. Brokers looked to the Small Employer Health Board as a kind of model for the exchange board, with a mix of stakeholder representation, but acknowledged the need for providers to be part of that mix. They were clear, however, that members of the board shouldn't stay “forever,” suggesting “term limits” to help ensure the board stays “fresh” on products needed in the marketplace. The board should be filled with experienced and knowledgeable people who know the marketplace, rules, and how insurance is administered. They worried about provisions in the current legislative proposal that excluded industry representatives from the board. One argued that brokers absolutely need to be a part of this, describing their role as the “feet on the street” out there every day with the “end users” of insurance.

Brokers offered a range of suggestions to fund the exchange, with insurance taxes and assessments at the top of the list...but argued that the exchange's budget shouldn't be of the more expensive variety. While some brokers admitted being pressed to put-forth funding suggestions before knowing the full scope of the exchange, they then went forward with a range of alternatives. Some suggested insurer assessments be used to offset the costs. Others suggested a surcharge or tax on premiums sold through the exchange. While many argued that limiting such taxes to exchange-only products was the sensible solution, they believed that the state would ultimately opt for a market-wide tax.

Among other suggestions to help offset the exchange costs were applying steeper penalties than suggested under the ACA to those without insurance, including penalties for those who waited to buy insurance until they needed it.

As part of this discussion, the brokers wanted the exchange to be affordable enough that it wouldn't disadvantage its own business. They were cautious about jumping into a big, high-budget endeavor—urging to start small. They suggested the state make it “de minimus” like Utah vs. robust like Massachusetts.

### ***Risk Selection***

Brokers emphasized the need for a strong non-exchange market to help mitigate risk-selection. First and foremost, 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.” “Use competition to spread risk,” they offered. Some brokers suggested that the rules should be the same inside and outside the exchange to help level the playing field. Others mentioned the exchange should implement a series of measures to try to “stymie” risk administratively by requiring applications 30 days prior to the effective dates and ensuring set “open enrollment” periods. The idea of raising the penalty for those who were not enrolled in the exchange was again mentioned.

Brokers were favorable about offering the same plans inside and outside the exchange. Some brokers mentioned the limited numbers of insurers currently offering plans in the small group market, wanting to ensure that if the exchange drew more carriers to the state, they would be required to offer outside the exchange as well.

Brokers raised concerns about merging the small group and individual risk pools. Brokers advocated for keeping the risk pools separate for small groups and individuals, saying that the two were distinct purchasing entities with very different risk adjustment factors. The cost implication for small groups was a key concern. However, the brokers mentioned the mandate’s potential to also improve the risk in the individual market, possibly making a merger of the two more financially feasible.

### ***Considering the Scope of the Exchange and Health Insurance Markets***

Brokers were mixed on allowing the nonsubsidized market to buy through the exchange. While some brokers agreed that the exchange should be available to the nonsubsidized market, others wanted more clear dividing lines between the exchange and non-exchange market—opting for the exchange to be the place for the Medicaid-eligibles and the subsidized population only and “leav[ing] the private market to handle the non-subsidized market.” Let the rest of the market operate “as it is.” Some felt the exchange would be “busy enough” with its target population without grabbing more of the market, warning that this is going to be a “big, big, big task.” Why start out “throwing everything against the fan?” they wondered. While acknowledging the obvious “self-interest” in leaving the outside market alone, one broker made the linkage to the state’s interest, especially given a potential uncertain future for the level of subsidies...

*...There’s obviously in this room some self-interest just talking about why there should be both and that’s fine...But I think it’s important to connect our self-interest with that of the state. So, the only thing that I think is probably up for some serious jeopardy in Washington is the level of funding for the subsidy...Over time, that’s the part that’s probably unsustainable. New Jersey needs to recognize that 400% of the poverty level may come down to 200% of the poverty level, may come down to 100[%] at some point...Therefore*

*maintaining a viable private market is not just in our interests, but it's in New Jersey's interest. Because as the subsidy gets reduced, more people are going to be outside the subsidy and are going to need a robust private market...You need to have both, because you need it as a back-up.*

Brokers were also not enthusiastic about rushing to include the larger small employers in the exchange. Some brokers said that the state should wait and see how the exchange performs before considering the move to larger small employers. They worried about the “sheer volume” possibly overwhelming the system. “There is not a magic light switch to turn on that this thing is suddenly going to be working.” Others said that the “small group” dynamics are different from the “middle-market group.”

### ***Examining the Overall Functions of the Exchange***

Brokers voted for a clearinghouse-model exchange. Brokers opted for New Jersey to focus on the clearinghouse- rather than the active-purchaser-end of the exchange spectrum. They argued that the state already has a series of regulatory protections in place. They also reminded that past experience shows the trickiness of trying to limit the number of plans in balancing cost, access and selection (remember, five plans grew to twenty-thousand)... Some warned, “Be very careful how you decide to regulate the market...The private market will regulate itself given less intrusion with government oversight.” Another mentioned the cost factor associated with opting for an active purchaser model, offering that building such a “machine” would be “quite expensive,” requiring a “lot of staff, expertise and resources”

Brokers pushed for licensed, certified navigators (who might be brokers). There were at least two schools of broker thought on the role of the navigator. One school flat-out offered that brokers *are* navigators, and wondered why there was a need for such duplication when brokers already serve this function. “There is absolutely no need for navigators...We are navigators.” They viewed themselves as the group best prepared to handle the insurance “woes” of New Jersey’s population. They also offered that New Jersey was not the “Mississippi Delta” and that there were brokers available all across the state to help residents. The second school viewed the navigator as fulfilling a specific role in helping enroll residents in public programs. “...Given the fact that navigators are written into the law...suggests a model that would have them concentrate on enrolling people in public plans that already exist.”

Either way, brokers argued that navigators should be licensed and certified to be able to sell through the exchange—credentialed as “Certified Navigators.” Even if navigators were focused only on underserved populations, they believed that those populations still deserved help from a licensed individual. They warned of potential problems absent navigators having in-depth

knowledge on what's covered, what's not, and why. They also foresaw "turmoil" arising in the event navigators weren't licensed when issues of malpractice might arise. Further, they offered that their own customer service is provided on a continuing basis and the navigators would need to do the same. "They need to be licensed, they need to be certified. They need to be available." They can't close at 5:00. They need to work on Saturdays and Sundays.

When asked about ideas for increasing enrollment, brokers pointed to the power of themselves. In considering ways to boost enrollment in the exchange, the brokers pointed to their own power in driving employer decisions, offering that the exchange needs to provide viable compensation for them so that they can, in turn, drive business there.

Compensate us "fairly," brokers warned. While some brokers had difficulty envisioning an evolvment of their compensation from what it is today, others specifically noted that it was in the interest of the exchange to build "reasonable and acceptable compensation into the program," otherwise the exchange would be inviting problems, similar to those that prompted the state to adopt a no-rebating clause.

Brokers were not in favor of the exchange establishing marketing standards for plans, but were open to a role in billing. Brokers saw no need for the exchange to assume a role in marketing standards, believing that DOBI should continue with its oversight in this area and that it would be "duplicative" for the exchange to take this on. Keep it all done at "one stop" they suggested.

On the other hand, brokers could envision a role for the exchange in billing, with some viewing the ideal scenario involving employers writing a single check to the exchange. Having the exchange assume billing functions might also allow an additional tool in risk management some offered, with the exchange adopting certain premium payment rules in connection with its billing role to avoid "hopping" in and out. However, several brokers warned that taking on billing functions will "exponentially increase costs" for "administering a product that is already drastically challenged in being competitive for the taxpayer." They offered that billing is "tremendously expensive" to do.

### ***Benefits Design within the Exchange***

Brokers were mixed on limiting product variation. On the one hand, brokers spoke about the need to let the market decide on plan options, allowing carriers to add on benefits as needed. On the other hand, they said that experience has taught that "too much variability" and "flexibility" leads to "selection against the carriers—big time." Others suggested limiting plans to a few in each of the precious metal categories to avoid confusion. When posed with this question, some of the brokers pointed to this decision being interdependent on the role of the

broker in the process, "...If you are going to eliminate a broker population or compensate them so small that there is no incentive...to be involved, then...you have to have a very, very vanilla" plan design.

Brokers saw the carriers as taking the lead on promoting prevention. While some brokers suggested that incorporating a wellness education component as part of the exchange application process could ultimately result in reduced costs, most believed that carriers should continue in their current lead role in promoting wellness and health, rather than having the exchange take this on.

Some brokers suggested dropping mandates, others saw this as politically unfeasible. Some brokers said that there "is no money" to pay for the current set of mandates and opted for New Jersey to follow the federal mandates only. Others believed it would be too tough politically for the state to drop all of its mandates, and suggested they be "cost out" by the carriers and charged to the consumer. "The state should give up on all their mandates...", but understanding that's not going to happen, they should enforce the same mandates throughout the state, figure out what the cost is, and charge it to the consumer.

Brokers viewed integration of dental benefits as just adding another mandated benefit. While some brokers admitted to the linkages with overall health, most believed that dental benefits should be kept separate, viewing their inclusion as "just another mandate" that will "increase costs."

Brokers were opposed to the exchange acting as host for alternative types of insurance. Brokers answered, "No" (twice) to the question of whether the exchange should consider acting as a portal for other types of insurance, viewing this as a "big brother" move to control everything. They not-so-gently reminded once again of the difficult "reality of getting this thing up and running."

### ***Transitions***

Brokers argued for lock-in periods and improved IT to help with transitions. Some brokers suggested year-long lock-in periods to help with transitions. They also spoke of the potential role of improved IT (public-private real-time data interface) in helping with transitions. Some suggested that the state would realize a return by investing in understanding which Medicaid clients might be eligible for subsidies (thereby cost-shifting to the feds). When posed with the option of creating a Basic Health Plan, some suggested that this might help increase continuity and decrease churning.

### ***The Role of the Exchange in Controlling Cost and Improving Quality***

Again, brokers viewed a very limited role for the exchange in promoting quality and controlling costs. In considering options for promoting quality and curbing costs, brokers again sought a limited role for the exchange. “The question is whether the exchange should promote this...versus having the insurance carriers...be involved with it...” “The exchange is going to have its hands full.” Along these lines, the brokers saw no role for the exchange in promoting ACOs or Medical Homes, believing that these should just be two of the many options within the exchange that will ultimately prevail if effective.

Brokers favored adopting the NAIC MLR requirements. “Go along with NAIC,” the brokers suggested. As their calculation includes more than New Jersey allows (like disease management), the brokers believed it would be “helpful to New Jersey... [to] defer to their model.” They also reminded that “there’s a cost to maintaining four or five different ways of doing business.”

### ***Closing Considerations***

There were a range of issues from brokers when asked about their top priorities for the exchange. Below are some of the recurring themes:

- Brokers should play a role. The brokers argued that they absolutely need to have a role in the exchange. “Proficient” people are needed to help consumers “wade their way” through navigating the system. They urged that the exchange not displace professionals in the marketplace, reminding that, while paid by carriers, brokers act as the “advocate” and “back office” for consumers. “...The client is who we work for.” It’s “critical that we be allowed to participate.” Others spoke of the broker as a linchpin for success, reminding about the need for the exchange to “work closely” with carriers and brokers, “If you do that, it’s going to be successful.”
- Keep a robust market in and out. Dovetailing with the point above, brokers echoed the need to keep a “robust private marketplace.” They spoke of the importance of the exchange fostering competition among carriers both within and outside. More than one reminded of the need for a level playing field inside and outside the exchange.
- Keep it simple. Brokers first echoed that the state should put in place something that’s “easy to understand” and “simple.” It should not be too confusing. “Keep it simple; keep it stupid...make it easy.” Give the consumer the best chance to understand, but also allow access to a broker if one is needed.

- Keep it small. They also wanted the exchange to be efficient and limited in scope, with the “least bureaucracy involved.” “Skinny down the functions of the exchange.” They reminded that the mandate of the exchange is “access,” and that for New Jersey, solving the problem of access shouldn’t be “an enormous task.” Look at what the mandate is (in their view—access only), and “keep the mission statement focused.”
- Ensure Transparency. Brokers talked about the need for the exchange costs to be transparent, expressing some concerns about the exchange possibly going broke. Brokers also mentioned that the idea of price transparency needs to spread beyond exchange costs, so that consumers begin to understand that a liver transplant costs \$80,000, not \$40.



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