From the perspective of a health insurance consumer, what should the exchange do? How should it look? What kinds of tools, filters, and other features should it have? How much are you willing to pay (per month, for example) for these features?

The Health Care exchange should provide consumers with a one-stop shop to research plan options and enroll themselves, or their families in a health insurance product. The exchange website should include: (following income/citizenship/family size/ geographic location/smoking or non-smoking status for each family member)

1. A tutorial to review/explain to consumers the terminology used on the website, the underlying regulation which created the Exchange and how the process works to enroll – for example: types of information which will be requested, who that information will be shared with, and how to obtain assistance if the consumer has questions related to navigating on the website and ultimately enrolling in an insurance plan. This step could be skipped should the consumer feel they have adequate knowledge of the process, etc.
2. The consumer should have filtering options to use when navigating the website to make their selection as straightforward as possible. The options should include the ability to sort/filter the information by:
    a. Choice of Physician
    b. Choice of hospital
    c. Choice of pharmacy
    d. Premium range (no more than $100.00 per month per range)
    e. Deductible amount
    f. Network type – or simply opt out of HMO type plans
    g. Prescription formularies
    h. Metal level
    i. Plan number – if the consumer has done their research prior to visiting the exchange website OR if the individual is part of an employer group which has been directed to a certain plan/insurance provider
    j. Insurance Provider
    k. An evaluation of the enrollment process to enable the exchange to learn what enhancements may be needed to attract additional consumers to enroll.
3. The site should include the four page summary plan descriptions for each plan offered in the exchange to allow consumers to make comparisons among plans within each metal level.
4. The exchange should have the standard insurance application for enrollment on the website that the consumer can complete. The exchange would then forward this information to carriers on a daily basis. The consumer should have the opportunity to save their information in mid-application should they need to do so.

The value of these service is difficult to determine, however, the request for proposal (RFP) will ultimately determine how many functions the State can afford to offer consumers. The RFP should require potential vendors to list the costs for each of

the services listed in item 3 individually, in addition, the bidders should be required to present any "bundled services" options they could support with the corresponding fees.

The exchange should:

1. Determine eligibility for the various public, subsidized private, and private health insurance plans.
2. Provide consumers basic information on all of the various certified plans – to include benefit plan summaries and premiums.

It will be challenge enough for the Exchange to integrate the delivery of individual coverage through the various public and private issuers – and then to keep the operation financially viable over the long term, given the potential evolution of available funding sources. That said, polls consistently show broad support in providing affordable coverage to individuals who find themselves uninsurable because of pre-existing medical conditions. As well, there is broad support with getting more of the uninsured covered.

Therefore, the Exchange should concentrate on the delivery of affordable, individual coverage to these uninsured and underserved Kansans through the various public and certified private issuers.

We believe that recommendations for the Exchange functionality for the **Public (K-Med/SCHIPS)** market segment can be made to the Exchange Work Group by the K-Med management. We believe there should be good agreement with their recommendations.

We believe that the Exchange should provide the bare essential functionality for the **Individual Private** and **Small Group** market segments, as outlined by the ACA.

We believe that the Exchange should provide minimal functionality for the **Individual Subsidized** market segment. However, since it is necessary for the Exchange to confirm some of the eligibility requirements before coverage can be approved, the Exchange needs to handle some elements of coverage approval process. (i.e. Citizenship and income verification)

The Exchange should:

- Allow for educational opportunities, including ACA, insurance terms, and how to use the website for those less skilled. This should be front end with an opportunity to skip past it if you are comfortable or if you are a navigator/friend helping someone else.
- The next opportunity is for you to choose to apply, or browse the insurance opportunities. The application process should take the least amount of information necessary to determine MCD, subsidize, or non-subsidized coverage

and allow you to complete whatever paperwork is necessary for either vein on line.

- Whether a person chooses just to browse the selections or you get to the "choice" screens following the application process, certain filters are necessary. The information displayed from these filters should be displayed in a randomized order with each display to improve selection bias. Those are:
    - County (to allow for browsing w/o active application)
    - Price points
    - Metal Level
    - Network Physicians
    - Network Hospitals
    - Insurance company
- The person should be able to view with each selection the Name of Insurer and Policy Name, a Health Plan rating indicator, cost of the plan, clear representation of co-pays and deductibles, be able to link to the network providers for the carrier (this would be a hyperlink to a database that is the responsibility of the plan to develop and keep current), and have a hyper link to plan specific information outlining health programs or extra services a plan my offer, plan benefits, ie marketing info.
- If the number of plans is not limited by tier to a manageable amount (5 – 10 plans per tier), then the list of all plans should allow a function to select your top 3 – 5 that dump into a display field to allow for easier side by side comparisons. This would negate the need to scroll between screens or flip between web pages.
- A "what is this" function that allows a person to hover over predefined fields with each selection to get simple definitions. Even if they complete the online tutor at the beginning of the process they may not remember what a co-pay is and it's significance to cost.
- If a person chooses to do so, the website should allow that person to make a selection on-line without approaching the insurer.
- There should be an opportunity just to enter the selection without using the filter. This will help navigators assist families in identifying and choosing plans.
- The website should allow a person to begin the application process, then complete the application at a later date.
- There should be a call center willing to walk a person through the selection process verbally if needs be, in an unbiased way, and complete a transaction for them to assure those without a computer or confused by the website can still efficiently choose their plan.
- The website should be built in such a way to facilitate an open enrollment without having a member have to reapply. A passive enrollment process will negate this need, but this function should not be overlooked.
- Another committee member suggested an short online survey with completion to be able to measure the usefulness of the tool and assess beneficiary website experience.

The Health Insurance Exchange should be consumer-centric in design (i.e., the needs of the consumer, rather than insurers or regulators, should be the foremost design characteristic). The overriding questions in designing the exchange should be how it can drive lower prices and better quality plans for consumers and make the insurance buying experience as simple, seamless, and painless as possible. The exchange should:

- Provide consumer education, describing requirements under the ACA, how the exchange works, and how to use the website. A toll-free help number should be prominently displayed.

- Provide a clear explanation, for each available plan, of covered services, premiums, copays, deductibles, and other out-of-pocket costs, and costs for typical transactions (e.g., physician office visit, name-brand and generic prescriptions). A user should be able to easily determine how much will be spent out-of-pocket before coverage takes effect (e.g., monthly premiums of $300 and a $1,000 deductible require a minimal yearly out-of-pocket commitment of $4,600).

- Allow comparison of a standard benefit package within each tier level. From a consumer perspective, it makes sense to establish a standard plan for each tier to provide a benchmark for comparisons.

- Include filters for monthly premium, annual deductible, plan ratings, name of preferred insurer, providers (at least physicians and hospitals), and prescription drugs. See the health plan selector at Medicare.gov for a model.

- Ensure that consumers are not overwhelmed by a huge number of plan options. Research on the Medicare prescription drug program clearly shows that choice is valued, but too many options is confusing and hinders beneficiaries in selecting the most appropriate plan. This is one reason that few Medicare beneficiaries change plans from year to year even though other plans better fit their needs.

- Allow consumers to enroll in a plan directly from the website, without further contact with an insurer or broker (again, Medicare.gov is a model for this approach).

- Allow users to enter information, save it, and resume the process at another time.

- Provide access in languages other than English (at a minimum, a Spanish language version should be available).

- Include hyperlinks with definitions of terms and other relevant information that can be accessed as a consumer navigates through the website.

- During the development process, test the site and features with a diverse, representative group of consumers (including those representing the low-income population, various age groups, special needs populations, and non-native English speakers).

- Provide a full-service toll-free help line in which trained representatives can answer general questions about insurance coverage and the exchange, provide impartial assistance in comparing and selecting plans, and assist in enrollment. 1-800-Medicare, which operates a call center in Lawrence, provides a well-known and successful model for accomplishing this.

- Establish a mechanism for consumers to provide feedback on their experience in the exchange.

- Provide for regular outside evaluation of consumer experience in the exchange.

- Allow for updates and revisions to the website, as necessary to implement new features, respond to feedback, etc.

PPACA requires that Exchanges perform several activities to support the availability of health plan information and facilitate the distribution of subsidies. We believe that the Exchange functions should include the following to improve value for consumers:

- **Internet web site** - Standardized comparative information on Qualified Health Plans should be searchable by name, metallic level and plan characteristics to promote an efficient shopping experience. Advanced filtering and search technology will help consumers narrow the number of insurance products to those that best meet the particular needs of each consumer. Additionally, the Exchange should consider methods to fairly present all plan options, including randomizing the order of plans that appear at the top of the page.
- **Phone Hotline** - In addition to answering questions regarding the health plan selection process and subsidies, representatives should be trained to further the "no wrong door" approach of the Exchange. For example, representatives should be able to provide a "warm transfer" to the appropriate carrier for customer service if the caller contacts the Exchange for routine plan customer service questions related to their current coverage.
- **Calculator** – The electronic calculator to determine the cost of coverage after the application of premium tax credits and cost sharing reductions should focus on the high-level, monthly cost of coverage. Specific estimates related to medical treatments are more appropriately available through carriers' web sites.
- **Ratings –** The Exchange should allow consumers to learn more about and compare carriers' benefit designs, provider network adequacy and relative quality and price scores, based on a rating system developed by HHS. One national rating standard from HHS is preferred, but if other ratings systems are

considered, they should rely on existing review standards established by national accreditation agencies, such as NCQA.

- **Application and Enrollment –** Technology assessments are currently underway to determine the most efficient means to transfer data and complete enrollment transactions. At this point, we assume that the most efficient means to complete the enrollment process and provide a seamless experience for consumers would be to complete the standard application on the Exchange web site. The transfer between the Exchange web site and the carrier's web site should be at a logical breakpoint for the consumer.
- **Financing –** The services available through the Exchange should be evaluated based on both the cost of building and maintaining these services and the value provided, and the Exchange should consider the tools and information already available in the health care marketplace.

RESPONSE: The KHBE should provide consumers the following information:

- **o** An explanation of the ACA's individual mandate.
- **o** An overview of the KHBE with a special emphasis on how consumers may use it to shop for private health plans or find out if they qualify for a public program or a premium subsidy. In addition to the shopping experience, the KHBE should offer consumers a single enrollment form all plans offered on exchange.
- **o** It should also provide a centralized repository for consumers to submit their payments after enrolling.

In summary, the KHBE should serve as a marketplace and a resource for those wanting to enroll in private or public health care plans as well as those who simply are searching for information.

a. The exchange should look like a "friendly" place with the right mix of graphics, text and links. I personally like the look of the Massachusetts Connector and have found it very easy to navigate. The first page should offer three initial options for consumers as depicted on the next page;

b. The first filter should be the three options described above. The next filter should be the application or screening tool that directs consumers to the correct array of plans for which they qualify. This would include a box for consumers to click on to see if they qualify for a public program or a subsidy to that allows consumers to confirm the identity of the consumer followed by confirmations of location and citizenship status.

c. A reasonable fee for using the website would be a maximum of $3.00 per month. I am unsure whether the preference is to have consumers or health plans responsible for this fee.

d. Carriers should be encouraged to offer enhancements to their plans to ensure their competitiveness. However, I am not sure whether the state needs to mandate any additional benefits be added to any participating plan.

Sample KHBE Website

Just Browsing	Searching for Individual Insurance	Searching for Group Insurance
• What is the ACA?	• Application / Screening Tool	• Application / Screening Tool
• What is the KHBE?	• Preferences / Search Parameters	• Preferences / Search Parameters
• Who Must Have Health Insurance?	• Plan Options	• Plan Options
• How Can I Compare Plans?	• Comparing Plans	• Comparing Plans
• How Can I Purchase a Plan?	• Plan Ratings	• Plan Ratings
• Where Can I Get Help?	• Enrollment Form	• Enrollment Form
• What About Exemptions?	• Purchase Receipt	• Purchase Receipt
• Frequently Asked Questions		
• Terminology Explained		
• Helpful Links		

The Individual and SHOP Sub-Exchanges should have the least amount of decision-support tools, filters/sorts/searches, and other features necessary in order to keep the cost to a minimum. Overall, these features should be robust enough to economically handle the majority of consumer's fundamental needs, i.e. 80% of the needs at 20% of the cost. Sub-Exchanges should provide basic information for educational and plan comparison purposes coupled with hotlinks and contact information for Qualified Health Plans.

Health plan experience has shown that about 95% of purchases require some type of human intervention or assistance before completion of enrollment. Since Navigators, brokers/agents, and Qualified Health Plan professionals will be assisting the vast majority of individuals and small group members with the eligibility, application, and enrollment processes (especially in the first year or two), trying to anticipate every scenario and case-by-case situation would be cost prohibitive and even counterproductive from a complexity standpoint.

Sorts should be used where ever possible instead of filters, since consumers may inadvertently exclude options by improperly setting sophisticated filters or may get frustrated with difficult filtering instructions. In addition, sorts are less expensive to implement and administer. Furthermore, each Qualified Health Plan and each possible benefit plan selection should be assigned a number/suffix so that a user can search and go directly to that QHP or selection, i.e. in cases where the employer has limited the employee's choice or a certain carrier or benefit plan was recommended to an individual.

Fundamental background information on the Sub-Exchanges and process basics, including FAQ's, checklists, helpful tips, and the portal's call center phone number, could be provided to assist first-timers and those renewing coverage. This information should be optional and not require experienced users to incur additional steps.

Research on optimal session time, minimum number of questions, and other consumer experience factors should be reviewed in establishing parameters. Efficient and effective methods to minimize abandonment and maximize first-pass enrollment should be sought. For instance, health plan experience has shown that 15 minutes is the benchmark for the maximum amount of time it should take to complete an application in order to avoid a significant bail out rate by potential applicants. Since individuals have different needs and tolerances for shopping session time, a feature to save information entered and resume the session at a later time should be included to facilitate re-engagement.

The type of network (HMO, PPO, POS, etc.) should be shown for each offering along with the NAIC standard information (gross premium/subsidy/net premium, deductible/copay, etc.) and HHS-specified ratings. A link to provider directories on Qualified Health Plan websites should be provided so physician, hospital, and pharmacy networks and affiliations can be researched real-time; thereby, avoiding the cost and risk of error associated with a central repository of provider information.

All inquiries regarding benefit plans should be directed to the Qualified Health Plans to answer. The Sub-Exchanges should give users QHP-provided contact information (live call, voicemail for call-back, texting code, e-mail address, web chat link, walk-in locations, etc.).

We believe free form text can be misleading and needlessly increase the administrative costs of defining and verifying the information and should be avoided on Sub-Exchange listings. Decision-support tools, such as benefit calculators and chronic disease guides are too costly and generally too complex for the average consumer; therefore, they should not be included in the features of the Sub-Exchanges.

In order to offset the cost of the Sub-Exchanges, health plans may be willing to pay for "qualified leads," i.e. post-enrollment link to other offerings by the already-selected health plan. This would allow the consumer to consider complimentary products and services to the ones he/she selected through a value-added, just-in-time shopping

experience. For small group employees, this simulates their current open enrollment process and could further ease employer administration.