Healthcare Implementation Work Group:
Guiding Principles for an Indiana Health Insurance Exchange - June, 2011

Overarching principle: The Exchange should ensure that all policy and operational choices are considered through the lens of the consumer, and that decisions are made based on the consumer's best interest.

1. **Structure of Exchange Governing Board**
    - Odd number of voting members and staggered terms
    - Must include representatives of key stakeholder groups who are eligible to
    - participate in the Exchange (i.e., consumers; providers; small business); selected based on a slate of potential representatives to be submitted by consumer/business/provider organizations having statewide membership
    - Ex-officio, non-voting members (i.e., OMPP/FSSA, IDOI, Budget Agency)
    - Expertise in at least one of the following areas:
        - Health coverage issues of traditionally uninsured/underinsured populations
        - Provision of evidence-based health care to diverse populations
        - Consumer outreach, education, enrollment and assistance
        - Health coverage issues for small business
        - Health benefits plan administration, financing, design
        - Eligibility, enrollment, retention, claims and appeals procedures
        - Health plan IT/data systems
    - Proportional representation of stakeholders on standing and ad hoc committees
    - Stakeholder Advisory Board that regularly meets, receives reports and provides formal input (i.e., consumers, providers, brokers, agents, employers, insurers)
    - Consideration given to racial, ethnic, gender and geographic diversity on the Governing Board and advisory boards and committees

2. **Transparency and Consumer Input**
    - Meetings of the Board and of any committees must be open to the public and subject to Indiana's Open Door Law (1C 5-14-1.5)
    - Exchange records and other documents must be subject to disclosure pursuant to Indiana's Access to Public Records Act (1C 5-4-13)
    - The Board must be subject to the Indiana's Ethics and Conflicts of Interest Law (1C 4-2-6)

3. **Privacy and Confidentiality**
    - The Board must be subject to all State and federal laws and regulations regarding the privacy and confidentiality of personal information

4. **Conflicts of Interest**
    - Policy prohibiting individuals, entities, and their affiliates who offer a product on the Exchange from serving on the Governing Board
    - Policy requiring annual filing of a conflict of interest statement and a statement of ownership interests by Board and staff members
    - Policy requiring disclosure of an actual or potential conflict of interest and abstention from relevant Board and committee discussions, votes and duties

5. **Key Attributes of the Exchange**

    A. <u>Active Consumer Outreach and Enrollment</u>
    - Promote consumer outreach through a variety of communication streams, including use of media, online tools, toll-free numbers and appropriate staffing levels for one-on-one

- assistance (in-person; phone; online), including tools for diverse populations and those lacking familiarity with health insurance
- Implement and oversee a Navigator Program, develop criteria for selecting qualified entities to serve, and authorize the program to counsel individuals regarding enrollment choices

B. Consumer-Friendly Information
- Maintain an Internet website and a regularly updated list of local, fully accessible, public access sites (i.e., libraries, kiosks at county office buildings, etc.), through which enrollees and prospective enrollees may obtain standardized, consumer-friendly comparative information to select the plan that best fits their needs, including an online calculator to assist in determining the actual cost of coverage after application of any premium tax credits and cost-shares
- Develop standardized procedures to notify participants promptly about premium, benefit or network changes and to assist with disputes or problems regarding coverage, access to care, quality and customer service
- Establish procedures for determining eligibility for premium tax credits, reduced cost-sharing and informing individuals about requirements, penalties, and exemptions

C. Single Point of Entry and Seamless Coverage
- With input from the Stakeholder Advisory Board, develop a single application form regardless of health plan product (including Medicaid and CHIP); seamless transition procedures for individuals and families who experience a change in income that results in a change in the source of coverage; and streamlined enrollment, eligibility determinations and redeterminations (including eligibility for subsidies and for Medicaid and CHIP coverage); require data-sharing agreements with relevant government agencies

D. Affordable. Quality Coverage
- Require comparable rules and terms for plans inside and outside the Exchange to promote competitive pricing and to prevent adverse selection
- Give preference to certified health plans that meet the requirements of Medicaid, CHIP and the Exchange in order to provide continuous coverage and care regardless of changes in source of income or subsidy
- Include certified health plan options that allow for choice of provider
- Establish certification requirements that set high but realistic benchmarks for rates and benefits in order to offer a manageable number of qualified plans
- Establish systems for ongoing monitoring, evaluation, and enforcement to ensure sustained high performance and quality and to improve health outcomes
- Require plans to obtain NCQA accreditation and to report HEDIS and CAPS measures

6. Predictable, Continuous and Equitable Funding
- Ensure that the Exchange has predictable, continuous, and steady sources of funding to facilitate good management and planning
- Require that any fees generated from health plans apply equally to plans inside and outside the Exchange

7. Hiring and Employment
- Establish policies regarding worker protection, non-discrimination, and compliance with occupational health and safety laws