

New York State Health Benefit Exchange SHOP Policy Study

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Executive Summary

Project Background, Objectives, and Methodology

The State of New York (State) Division of the Budget (DOB), on behalf of the New York Health Benefit Exchange, engaged KPMG LLP (KPMG) to assist in planning for the design, implementation, and operation of a Small Business Health Options Program Exchange (SHOP) in accordance with the federal Patient Protection and Affordable Care Act (ACA).

On April 12, 2012, Governor Cuomo issued Executive Order No 42, establishing the State's Health Benefit Exchange (the Exchange). The State began planning for the Exchange soon after the ACA was signed into law March 23, 2010, and plans to have the Exchange operating in time to begin enrolling residents in coverage starting on October 1, 2013.

The scope for this project included assisting the State's analysis to support executive decision making and further planning of requirements related to the SHOP by:

- Conducting a high-level business review of federal and State laws and regulations related to the design and operation of the SHOP, including the State's analyses and planning in order to assist management determine the appropriate, specific starting point for further analysis and assistance;
- Identifying, in conjunction with the State, potential options and decision points related to the design of the SHOP and conducting analyses, assessments, and cost-impact analyses to provide advice to assist executive decision making related to the SHOP's design;
- Providing a summary of how other states are planning for their own SHOP; and
- Advising the State in its efforts to develop a SHOP concept of operations, including identifying key SHOP business processes.

KPMG performed document reviews, conducted focus interviews and SHOP constituency analyses, and facilitated working group discussions to achieve these objectives.

In conjunction with the State's project leadership, we recognized the pivotal role stakeholder experiences will play in the eventual success of the SHOP and therefore crafted an approach that focused on each of the following groups:

- Employers;
- Producers;
- Insurers;
- Employees; and
- The SHOP itself.

For each constituency, KPMG focused discussions by examining pertinent regulations, anticipated challenges and decision points, and other states' precedents through three distinct lenses:

1. *Administrative simplicity* – Making it easier for all constituent parties to shop for, enroll in, and manage coverage.
2. *Cost efficiency* – Seeking to minimize costs to the greatest extent feasible in the near term with the goal of self-sufficiency by 2015.
3. *User experience* – Creating a first class user experience for all SHOP constituents.

Results in Brief

The results of KPMG's SHOP analysis are listed below, organized by key stakeholder and then topic area.

Employers

Registration and Verification

Federal regulations require the SHOP to use a single application which can be submitted online, via U.S. mail, over the phone, or in person to determine employer eligibility and to collect information necessary to purchase coverage.¹ The SHOP should develop a standard employer application that includes the following information, and the Exchange's Web portal should capture the following data:

- Business name;
- Employer identification number (tax ID number);
- Employer address;
- Employer contact information (i.e., name of individual responsible for administering the account on behalf of the employer, e-mail address, and phone number);
- Producer name and license number (optional field);
- Number of employees eligible to participate in employer-sponsored insurance; and
- Copy of most recently filed NYS-45 to verify that the employer is a legitimate New York employer with 50 or fewer full-time employees eligible to purchase coverage in the State's small group market. If a NYS-45 is not applicable, copy of most recent Internal Revenue Service (IRS) tax filing or certification of incorporation.

In the future, the ability of the SHOP to use the NYS-45 database maintained by the NYS Department of Taxation and Finance could help expedite the employer registration and verification process.

¹ Appendix I includes an excerpt from the federal regulations pertaining to SHOP Exchange's employer and employee applications.

Account Setup

This process involves the submission of an employee census, which should include information on all employees eligible for the employer's offer of insurance. The SHOP Web site should have the capability to allow employers to upload a copy of the employee census, which would need to include:

- Name, address, and social security number of all eligible employees;
- An indication as to whether the employee will or will not participate in the employer's health insurance plan;
- For employees that choose not to participate, an indication as to whether the employee is covered through a valid waiver; and
- The likely rate basis type (i.e., single, employee + spouse, employee + child(ren), family) for each employee that will enroll in coverage through the SHOP.

Plan Selection

ACA regulations require the SHOP to offer employers at least one plan selection model in which all qualified health plans (QHPs) in a metallic tier (i.e., actuarial value) are available to employees (all carriers, one plan level). The SHOP may offer other plan selection models, which could include:

- One carrier, one plan;
- One carrier, multiple plans; and
- All carriers, all plans.

The SHOP should offer a broad range of plan selection options along with the business processes and systems to support those offerings. The SHOP's IT systems should be designed to provide flexibility so that different plan selection options can be offered to employers.

The employer plan selection functionality should allow employers to enter a limited amount of data to generate premiums and compare plans, including:

- Zip code of employer;
- Total number of employees participating in the group health plan;
- Number of participating employees purchasing single coverage;
- Number of participating employees purchasing employee + spouse coverage;
- Number of participating employees purchasing employee + child(ren) coverage; and
- Number of participating employees purchasing family coverage.

New York also envisions a process allowing employers or brokers operating on behalf of employers to enter only the minimal amount of information necessary to anonymously generate a premium quote for a prospective SHOP employer.

Premium Contribution Options

The SHOP should offer employers the option of setting their premium contribution based on a percentage of a benchmark plan or as a pure defined contribution. In both scenarios, employers will be allowed to contribute a different amount depending on the rate basis type (i.e., single, employee + spouse, employee + child(ren), family) selected by the employee. Under these scenarios, the employer's monthly contribution would be known in advance of the employee's selection of a health plan. The only potential financial uncertainties from the employer's perspective are the total number of employees that enroll in coverage and the rate basis type chosen by the employees.

Premium Billing and Collection

Federal regulations require the SHOP to issue employers a monthly bill, collect the amount due and make payments to the health insurers for all QHP enrollees, maintain records of these transactions for at least 10 years, initiate termination of an enrollee's coverage in a health plan, and permit a health insurer to terminate such coverage for nonpayment of premiums. The Exchange's premium processing system will need to generate a list bill to accommodate employers whose employees are enrolled in coverage issued by more than one insurer and/or plan. Such list bill must include both the employer and employee contributions towards coverage. The Exchange's centralized customer support unit will also need to be able to address employers' questions regarding premium billing, collection, and remittance.

Producers

Certification and Training

Producers are allowed to assist employers and employees in obtaining coverage through the Exchange. The SHOP will likely rely heavily on this group to support small employers and their employees in purchasing insurance and enrolling in coverage. Accordingly, the SHOP should have staff dedicated to producer relations, including recruitment, training, management, and oversight. In collaboration with DFS, such staff members will need to develop a robust, easily accessible SHOP training program to help educate producers about SHOP functions, policies, and procedures, and the potential opportunities it creates for producers as a new venue to distribute small group insurance. The Exchange may require additional training and certification for producers that serve the individual market, which will include education and training on a range of insurance affordability programs (e.g., Advance Premium Tax Credits, Medicaid).

Account Setup

The SHOP should provide producers a streamlined means to establish a SHOP account so they may enroll groups in coverage. Requiring the producer's DFS license number would give the SHOP the ability to verify their license status with DFS and that they have successfully completed SHOP training and executed an agreement with the Exchange.

Compensation

The Exchange is considering only an indirect role in paying producers. This approach should minimize the administrative responsibilities of the SHOP in this regard, but the Exchange will still need to link the individual producer to his/her employer accounts, and include functionality that links the producer to individual employees within the employer account.

Account Maintenance/Management and Managing Individual Client Accounts

The SHOP will need to provide producers a dedicated Web-based functionality and customer support so they can establish and manage accounts on behalf of clients. A dedicated entry point could be established for producers both online and over the phone to help the SHOP accomplish this. In addition, the SHOP could tailor account management tools to the specific needs of producers.

Customer Support/Referrals

At a minimum, the Exchange call center should have the capability to assist employers or producers to respond to questions about the Exchange and assist in enrollment as required. As an added service, the SHOP Web site could provide a means by which employers could access a list of producers that have registered with the SHOP.

Insurers

Premium Billing and Collection

The SHOP should establish policies and business processes pertaining to key issues such as the collection and transfer of premium payments from employers to carriers, the timing of transfers to effectuate enrollment, the monthly due date for receipt of employer payments and subsequent transfer to carriers, as well as policies, procedures, and notifications regarding late payment and termination for nonpayment of premiums. Insurers should be made familiar with the resultant system and policies in advance of the beginning of open enrollment.

Enrollment

Unlike the Individual Exchange, employers and their employees may enroll in the SHOP throughout the year. The SHOP will directly facilitate employee enrollment in QHPs, establish enrollment time lines and processes for employers and QHP issuers, ensure that issuers adhere to employee enrollment notification standards, and directly notify eligible employers and employees of annual open enrollment periods and applicable off-cycle enrollment periods. The SHOP should work with carriers to establish time lines and processes to facilitate enrollment and premium processing.

Account Maintenance/Management

The SHOP and QHP issuers will need to reconcile enrollment files at least monthly. As the Exchange evaluates its options with regard to the premium processing solution, it needs to integrate this system with the enrollment solution to allow for ongoing account maintenance and management.

Rate Review and Approval Frequency

Federal regulations require SHOP QHP issuers to adjust rates at a uniform time that is either quarterly, monthly, or annually; but prohibit QHP issuers from adjusting rates during the employer's plan year. To provide consistency with the market outside the Exchange, the SHOP should allow for a quarterly update to rates. The Exchange should also defer the review and justification of proposed rate changes to DFS, which currently reviews and approves proposed rates prior to implementation. In concert with DFS, the Exchange should develop a QHP rate justification form that DFS can provide to carriers. Once complete, the justification form can be posted on the Exchange's Web site and the insurer's Web site per ACA regulations.

Employees

Account Setup

The SHOP must use a uniform employee enrollment form, just as is required for employers. Only the minimum information should be collected on this form, including:

- Name, home address, and date of birth of the employee;
- Rate basis type (i.e., single, employee + spouse, employee + child(ren), family); and
- Names and dates of birth of covered spouse and dependents, if applicable.

In the event the employee information does not match that entered by his/her employer, the SHOP must make a reasonable effort to notify the employee and reconcile the information. To ensure the proper notices are sent in a timely manner and can be tracked, the SHOP should maintain the capacity to automatically generate and send template notices which include the information specific to the recipient (e.g., name, address, coverage information, etc.).

Plan Selection and Consumer Decision Support Tools

Plan selection options will directly impact the plan benefit standardization efforts of the State. The SHOP will have to balance a consumer-friendly presentation of plans displaying standardized benefits with the need to accurately display plan differentiation and the full range of consumer choices. The SHOP IT systems and customer support services will need to provide the flexibility for employees to weigh their coverage options while displaying the information in a user-friendly, digestible manner both on the SHOP Web portal and in print format.

Customer Support

In concert with the Exchange's call center staff, the SHOP will have to address many questions or complaints that employees raise. The SHOP should establish a dedicated customer service unit to manage employees' concerns and/or complaints. Many of the same types of online tools and customer supports that will be available through the Individual Exchange should be available to SHOP employees.

SHOP

Oversight and Monitoring

At a minimum, the SHOP is responsible for monitoring changes to federal and/or State laws, regulations, and guidance and incorporating them into its operations. The SHOP should establish a formal process to track, update, and integrate regulatory changes into its system from conception in its business requirements. To stay competitive, the SHOP will also need to reflect changes happening in the commercial insurance market and adjust its plan offerings accordingly.

Reporting

The SHOP has both minimum reporting requirements and an opportunity to create added value for all its constituencies if the appropriate information is collected in an easily retrievable format enabling further analysis and feedback. Federal regulations require the SHOP to produce numerous reports at various frequencies, including reconciling enrollment information with QHP issuers monthly and reporting employer participation and contributions to the IRS at a frequency to be determined. Establishing specific performance metrics assessing public health, employers, issuers,

producers, and the SHOP prior to establishing data collection and storage protocols will help ensure the utility of these data beyond minimum HHS reporting requirements.

Additional Topics

Sample Notifications List

Federal regulations require multiple notifications to be sent and/or received by the SHOP itself, employers, employees, and issuers. Executing the various functions required of the SHOP and its stakeholders will require synchronized business processes and a clear understanding of the dependencies created. A working list of such notifications is included in Appendix 1.

Minimum Participation Requirements

Federal regulations permit the SHOP to authorize group participation rules which will be based on the percentage of eligible employees that enroll in the employer-sponsored insurance, and not based on the percentage of employees that enroll with a particular carrier or the percentage of employees that enroll in a particular health plan.

The State's current statute requires non-HMO insurers to apply a minimum participation rate of at least 50 percent and prohibits HMOs from establishing any minimum participation rate. These regulations will not only affect the SHOP's policy decisions and business processes regarding minimum participation rates, but may also impact the manner by which QHPs are offered to employers under an employee choice model. New York should reconcile the 50 percent minimum participation requirement for non-HMOs and the prohibition on participation requirements for HMOs, which are both set forth in State law, with the federal requirements for Exchanges in a manner that encourages maximum choice and access.

Specifically, the Exchange could apply a fixed participation requirement of 50 percent to all employers purchasing non-HMO coverage through the Exchange. The Exchange could then count enrollment in any of the Exchange products (HMO and non-HMO) towards meeting the 50 percent uniform participation standard. Similarly, enrollment in coverage offered outside of the SHOP Exchange (i.e., spousal coverage, Medicaid, individual or group commercial products) could be counted towards meeting the 50 percent participation requirement applicable to non-HMOs. Determining participation at the SHOP level, rather than at the health plan level, and counting those with other coverage towards meeting participation standards, will reduce the number of employees that fail to meet the Exchange's participation requirement. In the event the group still fails to meet the 50 percent participation standard after employees make an initial selection, the group could be redirected to limit their selections to only HMO options where no minimum participation requirements apply. In this case, HMOs would serve to ensure a level of access for all groups.

Section 125 Plans

A Section 125 plan, also commonly referred to as a cafeteria plan or premium only payment (POP) plan, provides a means by which an employee may choose to pay for certain benefits on a pre-tax basis, significantly reducing the net cost of employer-sponsored health insurance. Employers may also establish a cafeteria plan that allows employees to pay for certain out-of-pocket expenses on a pre-tax basis through a flexible spending account. Section 125 also regulates health savings accounts, which must be paired with a high deductible health plan. At minimum, the SHOP should include on its Web site information on the value of a cafeteria plan or POP plan, how to set one up, and links to additional pertinent IRS resources. The SHOP may also consider developing a Section 125 plan document template for a POP plan that employers could download and complete.

Off-Cycle Enrollment

In addition to mandated annual open enrollment periods, the SHOP must accommodate enrollment of newly eligible employees (e.g., newly hired, expiration of employer's waiting period, change to full-time status, etc.) or employees that experience a change in status. Federal regulations also identify a number of triggering events or circumstances that will permit a qualified employee to enroll in coverage outside an open enrollment period including birth or adoption, marriage, loss of minimum essential coverage, employer sponsored insurance (ESI) becoming unaffordable, permanent move resulting in access to new QHPs, errors, issuer violation of contract, and exceptional circumstances. The SHOP's enrollment and premium billing systems will need to accommodate off-cycle enrollment for employees that experience a qualifying event or are otherwise newly eligible for employer-sponsored insurance. As part of the QHP solicitation, the SHOP should include all of the events that can trigger a special enrollment period for employees and require QHP issuers to accommodate these off-cycle enrollments in order to participate in the SHOP.

Healthy NY

Healthy NY is a public/private insurance program that offers subsidized coverage to low-income working individuals and sole proprietors, and businesses with 50 or fewer employees. As of March 2012, Healthy NY covered almost 180,000 members. In 2013, small businesses comprised 46 percent of Healthy NY enrollees. ² Small business owners apply as a group for Healthy NY directly through one of the 14 participating insurers.

If the State continues the Healthy NY program, offering it through the Exchange could give the SHOP a significant volume of business and give participating employers access to federal tax credits.

Regulations

A sample of federal regulations cited in the report's body are included in full text in Appendix 6.

Glossary

A list of all acronyms and their definitions are included in Appendix 7.

² State of New York Department of Financial Services

Introduction

The State of New York (State) Division of the Budget (DOB), on behalf of the New York Health Benefit Exchange, engaged KPMG LLP (KPMG) to assist in planning for the design, implementation, and operation of a Small Business Health Options Program Exchange (SHOP) in accordance with the federal Patient Protection and Affordable Care Act (ACA). The broad scope of our activities included assisting the State's analysis, decision making, and further planning to specify the requirements and business processes of the SHOP.

Background

On April 12, 2012, Governor Cuomo issued Executive Order No 42, establishing the State's Health Benefit Exchange (the Exchange). The State began planning for the Exchange soon after the ACA was signed into law in March 2010. These efforts have included the development of the Exchange's plan of operations, analyses of the impact of the Exchange on the insurance markets, cost analyses, stakeholder engagement, and the selection of vendors to support the implementation of the Exchange. The State is working to establish a fully functioning Exchange to begin enrolling residents in coverage on October 1, 2013.

Objectives

The scope for this project included assisting the State's analysis to support executive decision making and further planning of requirements related to the SHOP by:

- Conducting a high-level business review of federal and State laws and regulations related to the design and operation of the SHOP, including the State's analyses and planning to assist Exchange management to determine the appropriate, specific starting point for KPMG's analysis and assistance;
- Identifying, in conjunction with the State, potential options and decision points related to the design of the SHOP and conducting analyses, assessments, and cost-impact analyses to assist executive decision making related to the SHOP's design;
- Providing a summary of how other states are planning for their own SHOP; and
- Advising the State in its efforts to develop a SHOP concept of operations, including key SHOP business processes.

Approach

To execute the project work plan, KPMG employed the following data-gathering/analytical techniques in collaboration with the State's SHOP team:

- **Document review.** KPMG requested documents relevant to the State's current planning phase from the Project Sponsor's designated liaison. The team received and read studies commissioned by the State specifically relating to the Exchange's business plan of operations, the role of producers and third-party assistors in the State's Exchange, risk adjustment and reinsurance program recommendations, coverage and cost effects of the ACA, and estimated cost savings for the State.

- **Focus interviews.** KPMG interviewed key personnel involved in planning the State’s SHOP operations. Using an interview questionnaire, KPMG conducted an initial round of five group interviews of stakeholders identified by the State from the Exchange team, the Department of Financial Services (DFS), the Department of Health (DOH), as well as private contractors working with the State. The two goals of these data-gathering sessions were to help identify the issues facing the State departments as they establish the SHOP, and to clarify what discussions had occurred and what decisions had been made to date. We later leveraged the outputs of these sessions by combining them with the baseline data collected via the document review to inform our analytical approach to the latter portion of the project.
- **SHOP constituency analysis.** The team developed a framework to analyze the outstanding decisions and issues facing the SHOP and their potential effects on five major constituencies – employers, insurers, producers, employees, and the SHOP itself. We sought to assess the SHOP’s impact on each of these constituencies in terms of administrative simplicity, cost efficiency, and a positive user experience.
- **Working group facilitation.** In collaboration with the Exchange’s Executive Director and Program Coordinator, the KPMG team prepared and facilitated a series of seven constituent-based discussions. We used this forum to introduce and address key concerns raised during our data-gathering as well as those experienced in other states as part of our multiple workshop series.

Constraints and Limitations

Constraints and limitations present special factors that should be considered in the interpretation of the project results. Key factors to consider include:

- KPMG’s field work and research for this engagement concluded on November 16, 2012.
- The Centers for Medicare and Medicaid Services (CMS) continues to publish guidance on how states should implement the SHOP to meet the requirements of the ACA. The NYS SHOP will have to incorporate new or updated guidance as it becomes available.
- The purpose of this report is to document observations that came to our attention during our work and to offer our comments and recommendations for the State’s consideration. Our procedures consisted of inquiry, observation, and analysis of provided information. Such work does not constitute an audit or attestation. Accordingly, we express no opinion on financial results, processes, other information, or internal controls. The State is responsible for the decisions to implement any recommendations and for considering their impact. This report is meant solely for use by the State and may not be reproduced or shared with any third party without KPMG’s consent, except as may be allowed by the terms of our contract agreement.
- The project was not intended to be a comprehensive and exhaustive review of all practices and activities relating to current or proposed NYS SHOP operations.

Report Organization

KPMG organized this report in the following manner:

- **Methodology:** providing a general overview of the constituency lens and issue-focused approach used during our project fieldwork.
- **Constituency Observations and Recommendations:** identifying the observations and recommendations related to each constituency examined as part of the project scope.
- **Appendices:**
 - **Appendix 1:** Sample List of SHOP Notifications
 - **Appendix 2:** Minimum Participation Requirements
 - **Appendix 3:** Section 125 Plans
 - **Appendix 4:** Off-Cycle Enrollment
 - **Appendix 5:** Healthy NY
 - **Appendix 6:** Regulation Citations
 - **Appendix 7:** Glossary

Methodology

As the participation of issuers (i.e., health insurers) and employers in the SHOP is not required by the ACA, the NYS SHOP must develop an attractive distribution channel for health insurance that encourages issuers to offer products and employers to purchase small group health insurance. KPMG recognized the pivotal role stakeholders will play in the success of the SHOP and crafted an approach based on conversations with the State team that focused on each of the following groups:

- Employers;
- Producers;
- Issuers;
- Employees; and
- The SHOP itself.

These groups are most directly involved in the SHOP and are cited throughout ACA regulations and subsequent guidance published by CMS. They are not, however, fully addressed specifically as constituency groups who will rely on business processes and policies to maintain their relationship with the SHOP. Most federal regulations and guidance currently focus on the functional perspective of the SHOP (e.g., enrollment, plan management, premium aggregation). Breaking our analysis down by these five groups enabled the State team to more fully consider each constituency's potential interactions with the SHOP. Creating a system with the user groups at the fore of policy and procedural decisions should enhance the likelihood that each group will have a more positive experience with the SHOP, therefore attracting more customers. Within each constituency group, KPMG focused discussions by reviewing pertinent regulations, anticipated challenges, and key decision points through three distinct lenses:

1. *Administrative simplicity* – Making it easier for constituents to shop for, enroll in, and manage coverage.
2. *Cost efficiency* – Minimizing costs to the greatest extent feasible while meeting the needs of all participants.
3. *User experience* – Creating a first class user experience for all SHOP constituents.

KPMG presented this approach to the State, which agreed that this dual consideration of constituency groups and the three values critical to the SHOP's success was the most preferable way to proceed. Balancing the occasionally contrasting priorities of these constituencies helped the State compare and contrast SHOP policy options for each identified topic.

For each stakeholder group, KPMG outlined relevant topics for the State to discuss, identified pertinent federal and State regulations, and summarized the specific NYS data gathered to date (via interviews, meetings, and document reviews). Our team then presented open items needing attention and offered key options and recommendations for the State's consideration. KPMG also noted other states' approaches as appropriate and performed additional, in-depth research for specific topics including list billing, special enrollment periods, notification requirements, and the potential value of Section 125 plans.

The following sections recap the discussion and research completed for each constituency group and the topics KPMG identified as pertinent to each over the course of the engagement.

Employers

Introduction

Small businesses comprise 98 percent of all businesses in New York State and employ more than half of the State's private sector workforce.³ The SHOP will be established to serve these employers and their employees, offering the potential to increase the number of employers that offer health insurance to employees. In order to access the small business tax credit that is available to employers offering employer-sponsored insurance to low-wage workers, small business owners must purchase coverage through the SHOP. To attract these business owners, the SHOP must offer easily navigable systems, efficient customer assistance, and an appropriate range of plan choices that meet the coverage and cost needs of small business employers and employees.

Registration and Verification

Background

The first step in facilitating the purchase of insurance by employers through the SHOP is a user-friendly means by which employers – or producers acting on behalf of employers⁴—can register and complete the verification process. While federal regulations require the SHOP to collect a limited amount of information on employers and their employees, insurers in New York's small group market have established employer registration and verification protocols.

Federal regulations require the SHOP to use a single application to determine employer eligibility and to collect the information necessary to purchase coverage.⁵ The regulations direct the SHOP to collect basic information from employers to establish an account, and note that the Exchange must use the “model application” developed by the United State Department of Health and Human Services (HHS) or an “alternative application,” subject to HHS approval. To date, HHS has not issued a model application for either employers or employees.

In addition to the basic information identified in the SHOP regulations, health insurers require applicants to provide various documentation to verify that an employer is a legitimate business and that employees are eligible to participate in the employer's group health plan (e.g., work the requisite number of hours to qualify for coverage). In the current small group market, employers submit materials to establish an account and purchase coverage including state tax forms (e.g., NYS-45, the State's quarterly combined withholding, wage reporting, and unemployment insurance return), IRS documentation, certifications of incorporation, or other organizational documents.

As noted in a recent consulting report on producers and third-party assistors, “NYS-45 is used by virtually all carriers as the definitive list of eligible employees. This is the proof that carriers are looking to make sure that enrollees are employees and not uninsured friends of the owner or other ineligible. Additional documents verifying eligibility may also be required depending on the carrier.”⁶

³ New York State Empire State Development.

⁴ Throughout this report, terms “employers” and “producers” are largely interchangeable. While we refer to employers in this section, producers typically handle the purchase of health insurance on behalf of their employer clients.

⁵ Appendix I includes an excerpt from the federal regulations pertaining to SHOP Exchange's employer and employee applications including 45 CFR 155.730 and 45 CFR 155.405.

⁶ “The Role of Producers and Other Third-Party Assistors in New York's Individual and SHOP Exchanges,” Wakely Consulting Group, June 2012, page 31.

Employers that are subject to unemployment insurance contributions or withholding tax are required to file NYS-45 on a quarterly basis with the Department of Taxation and Finance. The form includes employer and employee information, including employer name, number of employees for each month of the quarter, and employee names and social security numbers.⁷

Because the SHOP will serve as a central point of access to insurance offered by different health insurers, and employees of a single employer may be able to enroll in coverage from multiple insurers, the SHOP will need to establish a standardized registration and verification process that applies to all insurers. Initial discussions between Exchange staff and staff at the Department of Taxation and Finance indicate that the SHOP may be able to access select information from the database housing the NYS-45 filings to help verify an employer's status (and potentially the employee's status). The ability of the SHOP to use the NYS-45 database could help expedite the employer registration and verification process. However, at least in the near term, the SHOP may not have access to the NYS-45 database and will need to accommodate a manual verification process.

Recommendations

The SHOP should develop a standard employer application to enable employers to register with the SHOP. To help verify that the employer is a legitimate New York employer with 50 or fewer full-time employees eligible to purchase coverage in the State's small group market, the SHOP should require employers to submit a copy of their most recently filed NYS-45.

Alternative forms of documentation should be accepted only for those firms that are not required to file NYS-45 or for newly established businesses that have not yet filed NYS-45.

The SHOP employer application should include the following information, and the Exchange's Web portal should make accommodations to capture the following data:

- Business name;
- Employer identification number (tax ID number);
- Employer address;
- Employer contact information (i.e., name of individual responsible for administering the account on behalf of the employer, e-mail address and phone number);
- Producer name and license number (optional field);
- Number of employees eligible to participate in employer-sponsored insurance (will need data on eligible employees, not only those employees who are likely to participate in the employer's group coverage); and
- Copy of most recently filed NYS-45 (if NYS-45 is not applicable, copy of most recent IRS tax filing or certification of incorporation).

⁷ Instructions for NYS-45 indicate that some employers are required to file the form online.

At this stage in the process, the SHOP should not request any information that is not expressly needed to register and verify an employer, such as date of incorporation or industry type. The SHOP should strive to establish a streamlined employer registration and verification process. In light of the fact that HHS has not yet issued a standard employer application, the State should proceed with developing a standard employer registration form and verification process.

Account Setup

Background

Federal regulations require the SHOP to use a uniform employer enrollment form (noted above), which can be submitted online, via U.S. mail, over the phone, or in person. In addition to the information collected as part of the employer registration and verification process, the account setup process involves the submission of an employee census, which should include information on all employees eligible for the employer's offer of insurance, including those employees who may choose not to enroll in the employer's health insurance.

The employee census would need to include:

- Name, address, and social security number of all eligible employees;
- An indication as to whether the employee will or will not participate in the employer's health insurance plan;
- For non-participating employees, an indication as to whether the employee is covered through a valid waiver; and
- The likely rate basis type (i.e., single, employee + spouse, employee + child(ren), family) for each employee that will enroll in coverage through the SHOP.

Just as NYS-45 is used to verify that an employer is a legitimate business, it is also used by insurers to verify that the employee census reflects all eligible employees. Health insurers require submission of NYS-45 and the employee census to establish the employer's account.

Recommendations

The SHOP should develop an account setup process that provides employers with various means to submit their employee census.

The Web portal should allow an employer to upload an employee census or key-enter their employee's information, as well as upload necessary documentation (e.g., NYS-45) to complete the setup process. The SHOP will also need to accommodate paper-based applications. The employee census should include:

- Name, address, and social security number of all eligible employees;
- An indication as to whether the employee will or will not participate in the employer's health insurance offerings;
- For non-participating employees, an indication as to whether the employee is covered through a valid waiver; and
- The likely rate basis type for each employee that will enroll in coverage through the SHOP.

Plan Selection

Background

Pursuant to federal regulations, the SHOP must “allow a qualified employer to select a level of coverage as described in Section 1302(d)(1) of the ACA, in which all QHPs within that level are made available to the qualified employees of the employer”⁸ (i.e., “all carriers, one plan level”). In addition, the SHOP is permitted—but not required—to offer employers other plan selection options. The models described below are not mutually exclusive, nor is this an exhaustive list. New York may choose to allow employers to select from a number of plan selection options.

The range of plan selection choices offered to employers—and by extension their employees—through the SHOP will impact the extent to which the SHOP can effectively meet the needs of the small group market. As employer and employee choice increases, groups may be more likely to find preferable insurance products. While there are a number of plan selection options that could be offered by the SHOP, listed below are four that New York should consider:

- One carrier, one plan;
- One carrier, multiple plans;
- All carriers, one plan level (required); and
- All carriers, all plans.

The “one carrier, one plan” model reflects the traditional way that employers, particularly small employers, purchase health insurance. The employer selects a carrier and a health plan, and employees can choose to enroll in the plan. The Exchange platform could be used by the employer to compare health plans, assess premium contribution options, and select a single health plan to offer to employees. Particularly in light of the requirement that the small employer tax credits will only be available to employers that purchase coverage through the SHOP, offering employers this traditional way to purchase health insurance warrants consideration.

Under the “one carrier, multiple plans” model, the employer selects a health carrier and allows employees to enroll in any of the health plans offered by that carrier through the SHOP. A slight modification to this model would allow an employer to restrict employees’ choices to a subset of the health plans offered by a carrier (e.g., Gold and Silver Level plans, or Silver and Bronze Level plans).

Under the “all carriers, one plan level” model, the employer selects a plan level (e.g., Platinum, Gold, Silver, or Bronze) and employees may select any of the health carriers within that plan level. As noted above, this purchasing model must be offered by the SHOP, pursuant to federal regulations.

Under the “all carriers, all plans” model, employees may enroll in any of the health plans offered on the SHOP.

Each of these models brings with it implications for the SHOP’s attractiveness and sustainability, operational and administrative challenges, the potential for risk selection, as well as potential ramifications for the broader small group insurance market. The plan selection models that the SHOP offers employers and their employees will also need to be supported by customer service

⁸ 45 CFR 155.705(b)(2).

staff, a consideration that also warrants particular attention as New York develops plan selection options for the SHOP.

Recommendations

The SHOP should offer a broad range of plan selection options along with the business processes, systems, and customer service capabilities to support those offerings.

The initial build of the SHOP IT systems should be designed to provide flexibility so that different plan selection options can be offered to employers. While the SHOP may initially choose to limit the plan selection options, it should ensure that a variety of purchasing models can be operationalized and supported. This will enable the SHOP to adapt over time as the market changes and purchasing patterns evolve.

In addition to the ACA-required “all carriers, one plan level” plan selection option, New York should build systems capabilities to allow employers to offer a suite of plans based on a number of different variables, including, but not limited to, health plans offered by a single insurer, health plans of a particular product type (e.g., PPO, POS, HMO), and health plans in two or more actuarial value levels (e.g., Silver and Bronze).

As noted in Appendix 2 regarding minimum participation rates, because HMO and non-HMO products are subject to different requirements in New York, the SHOP will need to take these differences into consideration in structuring its plan selection options.

As employers evaluate different health plans, the SHOP will need to provide plan-specific benefit information as well as plan-specific premiums that are applicable to the employer group. This will require the SHOP’s rating engine to generate premiums and employer contributions based on the size of the group and the rate basis type for each member of the group.

The employer plan selection functionality should allow employers to enter a limited amount of data to generate premiums and compare plans. The following data will need to be captured to allow an employer to review plan options and premiums:⁹

- Zip code of employer;
- Total number of employees participating in the group health plan;
- Number of participating employees purchasing single coverage;
- Number of participating employees purchasing employee + spouse coverage;
- Number of participating employees purchasing employee + child(ren) coverage; and
- Number of participating employees purchasing family coverage.

Because the State uses community rating and does not vary premiums by the ages of enrollees, the generation of rates by the SHOP is greatly simplified compared to other states’ SHOP Exchanges. The premiums for each health plan will vary only by rate basis type.

⁹ These data will also need to be captured for anonymous browsing.

Premium Contribution Options

Background

There are no provisions in the ACA or other pertinent federal regulations requiring employers that purchase coverage through the SHOP to contribute a minimum amount of the employees' premiums. Neither New York State law nor regulations require employers to satisfy a minimum contribution standard. In addition, because New York's small group market uses pure community rating—which means that health plan premiums do not vary based on the age of the employee or any other employee-specific rating factors permitted under the ACA—the premiums for a specific health plan will vary only by geography and rate-basis type.

These key differences in the New York market provide the SHOP with the ability to offer employers a simplified way to compare health plans and to set their premium contribution. The State considered three premium contribution options:

1. The employer provides employees with a defined contribution based on a percentage of a “benchmark plan’s” premiums.
2. The employer offers to contribute a percentage of the premiums for all of the plans offered by the employer.
3. The employer provides a fixed dollar amount (i.e., defined contribution).

In all three scenarios, the employer's contribution may vary based on the rate basis type selected by the employee. While options 1 and 3 are comparable, as described further below, they differ in the manner by which the employer's contribution is established.

Under option 1, the employer establishes the premium contribution based on a percentage of the premium for a specific health plan. The example below—which reflects the “all carriers, one plan level” plan selection option—shows how the employer might set the premium contribution using a “benchmark plan” approach. The employer chooses to offer Silver Level coverage, and the employer selects Carrier B's Silver Level plan as the benchmark plan to base the employer's premium contribution.

Table 1: Option 1 – Benchmark Approach to Employer Premium Contribution

Carrier B's Silver Level Plan			
Rate basis type	Total monthly premium	Employer share as percentage	Employer share as defined contribution
Single	\$300	70%	\$210
Employee + Spouse	\$600	50%	\$300
Employee + Child(ren)	\$700	50%	\$350
Family	\$1,000	50%	\$500

The employer sets the share of the premium contribution as a percentage of the cost of a specific plan, and varies the percentage contribution by rate basis type. Under an employee choice purchasing model, the employees can then take the employer's contribution and select from any of the Silver Level plans offered by the SHOP.

Table 1.A below displays how this would work for an employee selecting single coverage. If the employee selects Carrier B’s Silver Level plan, the employee would pay 30 percent of the cost, but the employees may also choose from any of the other Silver Level plans offered by the SHOP and the employees’ share of the premium will vary depending on the plan selected. The employee could take the employer’s contribution—in this case \$210—and instead purchase a Silver Level plan from Carrier A, Carrier C, or Carrier D. The employer’s share of the premium remains fixed while the employees’ share will vary based on the carrier selected.

Table 1.A: Option 1 – Employee Choice under the Benchmark Approach to Employer Premium Contribution

Silver level plans	Total monthly premium for single coverage	Employer’s share of the premium	Employee’s share of the premium
Carrier A	\$320	\$210	\$110
Carrier B	\$300	\$210	\$90
Carrier C	\$290	\$210	\$80
Carrier D	\$250	\$210	\$40

Under option 2, the employer agrees to pay a fixed percentage of the monthly premium, which could vary by rate basis type, for all of the health plans offered. Using the example above, the employer could offer to contribute 70 percent of the cost for any Silver Level plan selected by the employees. With this premium contribution arrangement, the employer’s monthly liability is unknown until after the employees make their selection.

Table 2: Option 2 – Fixed Percentage Approach to Employer Premium Contribution

Silver level plans	Total monthly premium for single coverage	Employer’s share of the premium (70%)	Employee’s share of the premium (30%)
Carrier A	\$320	\$224	\$96
Carrier B	\$300	\$210	\$90
Carrier C	\$290	\$203	\$87
Carrier D	\$250	\$175	\$75

Option 3 is a defined contribution arrangement in which the employer agrees to contribute a fixed dollar amount—which may vary by rate basis type—and employees can take the employer’s premium contribution and shop for coverage. The only variation between option 1 and option 3 is the method used to set the employer’s contribution. Using the example in Table 1 above, the employer’s contribution would be fixed at \$210 per month for single coverage regardless of the total monthly premium of the carrier selected by the employee.

Recommendations

New York's SHOP should offer employers the option of setting their premium contribution based on a percentage of a benchmark plan (option 1) or as a pure defined contribution (option 3).

In both scenarios, employers will be allowed to contribute a different amount depending on the rate basis type selected by the employee. Under these scenarios, the employer's monthly contribution will be known in advance of employees choosing a health plan. The only potential financial uncertainty from the employer's perspective is the rate basis type chosen by the employees. However, most small employers will know in advance the rate basis type of each of their employees.

Option 2, under which an employer contribution is based on a percentage of the premium for all health plans offered, is not recommended. The State chose not to pursue this option due to the financial uncertainty it creates for employers. However, based on the demonstration of system functionality by New York's IT vendors, CSC and hCentive, a fixed percentage option could be supported by the systems and could be offered if the State chooses to do so at a later date.

Premium Billing and Collection

Background

The need for the Exchange to administer premium billing, collection, and remittance is particularly important, and is a major administrative requirement of the SHOP. Depending on the employee choice model offered by employers, employees may be able to choose coverage from a number of health insurers, requiring the SHOP to centralize premium processing on behalf of employers and insurers.

Centralizing premium billing and collection in the SHOP facilitates a small employer's ability to pursue an employee choice model with employees enrolled in different health plans offered by various insurers. If the premium processing and other administrative functions were not centralized within the SHOP, the employer would need to pay multiple insurers and interact with multiple carriers to address issues such as midyear changes in enrollment, status changes for existing employees, and all of the other administrative tasks that are currently handled through one health insurer.

Federal regulations require the SHOP to:

- Provide each employer with a monthly bill that identifies the employer and employee premium contributions, as well as the total premiums due;
- Collect from each employer the total amount due and make payments to the health insurers for all enrollees;
- Maintain records or accounting procedures and practices of the premium aggregation program for each benefit year for at least ten years; and
- Initiate termination of an enrollee's coverage in a health plan, and permit a health insurer to terminate such coverage for nonpayment of premiums.

Under an employee choice model, with employees enrolled in different health plans offered by various health insurers, the SHOP will need to develop a list bill identifying each employee, the health plan and insurer selected by the employee, the employees' share of the premium, and the employer's share of the premium.

The SHOP will need to establish a process by which employers can remit payments, accept various types of payments (e.g., check, electronic funds transfer), determine the manner to address payment discrepancies, and establish a termination process and timeline for nonpayment of premiums. Health insurers in New York's small group market are required to provide at least 30-days grace period for nonpayment of premiums.

Recommendations

The Exchange's premium processing (i.e., billing, collection, and remittance) system will need to accommodate employee choice and list billing while allowing for enrollment reconciliation monthly and rate changes as needed.

The State will not, however, manage premium processing for enrollees in the Individual Exchange, significantly reducing the administrative burden of the Exchange in this regard. However, it does not affect the SHOP's need to establish a premium processing solution for the small group market.

New York will need to quickly evaluate its options with regard how it will administer premium processing, which could be accomplished by utilizing the functionality and systems available from a vendor with whom the State has an existing business relationship, or, if necessary, exploring other vendors with experience processing premiums.

Since the Exchange decided to centralize customer service—including responding to questions and resolving issues pertaining to premium billing, collection, and remittance—the Exchange's customer support unit will need access to the premium processing solution. This solution must interface with the plan selection and employee enrollment system, which will feed information on employees' plan choices and rate-basis types to insurers. Prior to the effective date of coverage for the group, the SHOP will need to collect premiums from the employers and then remit them to the carriers.

The SHOP's employee choice purchasing model will add some complexity to the premium processing solution's functionality. The systems will need to properly process premiums for a single employer whose employees are enrolled in coverage issued by more than one insurer. The solution will need to generate a list bill that itemizes coverage for each employee, identifies the employer's and employees' share of the premium, provides a total amount due from the employer, collects the employer's payment and distributes the proper amount to the QHP issuers, providing the issuers with detailed information on employers and employees, in addition to administering a premium reconciliation process for employers and insurers.

Carriers will be updating their plan year premiums on a quarterly basis, requiring the Exchange's enrollment and plan selection systems to load the updated rates and apply them to the appropriate accounts, while also maintaining the prior quarters' rates for all of the health plans offered on the SHOP. Maintaining the prior quarters' rates will be necessary to address off-cycle changes in enrollment and plan selection, as discussed in Appendix 4 ("Off-Cycle Enrollment"). Because New York uses pure community rating and does not allow age to be used as a rating factor, the number of rates that the premium processing solution will need to store for each plan will be relatively limited compared to other states' SHOPS.

Producers

Introduction

New York State has a robust network of health insurance producers (i.e., agents and brokers) who help facilitate the enrollment of small business owners and their employees in health insurance in addition to other services. Understanding the current dynamics of this market and leveraging these relationships should help the State increase the number of lives covered by insurance purchased through the SHOP. As a key stakeholder group that plays a significant role in assisting small employers with their health insurance needs, the SHOP will need to develop strong relationships with producers.

Certification and Training

Background

Federal regulations allow Exchanges to permit producers to assist individuals, employees, and employers with enrollment in coverage through the Exchange. If a producer assists individuals in applying for advance premium tax credits and enrolling in coverage through the Individual Exchange, federal regulations require the producer to register with the Exchange, receive training in the range of QHP options and insurance affordability programs, adhere to the Exchange's privacy and security standards, and comply with applicable state laws.¹⁰ The regulations are silent, however, with regard to registration, certification, and training requirements of producers that assist employers and employees in purchasing coverage through the SHOP.

The SHOP will likely rely heavily on producers to facilitate the purchase of insurance by small employers. As noted in the Wakely Consulting Group report, *The Role of Producers and Other Third-Party Assistors in New York's Individual and SHOP Exchanges*, "producers and other intermediaries dominate the small group distribution channel today and are responsible for 88 percent of the small group enrollment of the nine carriers who collectively enroll more than 80 percent of the market across the state."¹¹

The SHOP is a new distribution channel for small group insurance, and producers will need to understand the SHOP's business processes and requirements. Unlike the direct relationship that producers have with health insurers, the SHOP will serve as an intermediary between the insurer and the employer group, handling certain functions (i.e., enrollment, premium billing and collection, notifications) that today are administered by insurers. Producers will need to understand the roles of the various participants (i.e., insurers, the SHOP, employers, producers) in order to best serve their clients: small employers and their employees.

The SHOP will need to develop a training program for producers, which will include, at minimum, the following:

- Information on the QHPs available;
- The manner by which QHPs may be selected by employers and employees;
- Minimum participation rates;

¹⁰ 45 CFR 155.220.

¹¹ Wakely, page 4.

- Premium contribution options for employers and employees;
- Premium payment policies and procedures;
- Availability of tax credits for small employers with low-wage workers; and
- Ongoing account maintenance and management.

DFS regulates, licenses, and oversees producers. The Exchange will need to coordinate with DFS on any Exchange-specific producer education and training requirements. Given DFS's established producer oversight and monitoring, the SHOP should work with DFS' Insurance Division to develop a SHOP producer certification program.

Recommendations

The SHOP should have staff dedicated to producer relations, including recruitment, management, and oversight. Initial staff work should include the development of certification and registration protocols and processes, as well as a producer training program.

In concert with DFS, the SHOP should develop training programs for producers that may be accessed via the Web or in person. In developing this program, the SHOP should work with producer associations and chambers of commerce who have expertise and can offer insight into the development of an effective training program that focuses on the most relevant and meaningful information that a producer will need in order to facilitate enrollment of employers and employees through the SHOP. As the enrollment system and Web portal are being developed, the Exchange should also consider using the system as a training (and perhaps a testing) platform for producers.

The Exchange may require additional training and certification for producers that serve the individual market, which will include education and training on a range of insurance affordability programs (e.g., Medicaid). This level of training and education may not be necessary for producers that serve only the employer group market. Health insurance producers often work with specific segments of the market, and it is likely that many producers manage only small employer accounts and do not service individuals. The Exchange should allow producers that exclusively serve the small group market to opt out of producer training and certification that may be specifically geared toward the individual market.

With regard to producer certification, the SHOP should leverage DFS' producer licensing responsibilities to administer a producer certification program.

The SHOP Web portal and business processes should capture information from DFS on producers that have been trained and certified. This information will then be used to verify a producer's ability to assist employers and employees with the purchase of insurance through the SHOP.

Producer Account Setup

Background

There are no federal or state requirements that pertain to producer account setup. However, given the important role that producers play in the small group market, the SHOP will need to offer an account setup process that allows producers to enter basic information to establish an account, access the Exchange's plan selection and enrollment systems, and enroll groups in coverage. The account setup system will need to include a process to confirm that the producer is licensed by DFS and has been certified to enroll groups in coverage through the SHOP.

Recommendations

The SHOP should establish a streamlined producer account setup process which includes entering the producer's DFS license number.

This process should allow a producer to enter basic information, including his/her DFS producer license number, which will enable producers to easily establish accounts and begin enrolling small employers through the SHOP. The account setup page in the producer Web portal will need to link to the producers' employer accounts, discussed further below.

Compensation

Background

Neither the ACA nor federal Exchange regulations dictate the manner by which producers are compensated for enrolling employers and employees in coverage through the SHOP, nor do they include any explicit restriction on the amount of compensation that may be provided to producers. Carriers in the small group market, however, must meet a medical loss ratio (MLR) of 80 percent, and any producer compensation is counted as part of the maximum 20 percent administrative cost of the carrier. The MLR requirement has resulted in downward pressure on producer compensation across the country.

New York insurance law and regulations limit producer commissions and bonuses for HMO business to no more than four (4) percent of premiums, but there is no limit placed on commissions for non-HMO business. However, the state has an 82 percent MLR requirement in the small group market, which likely affects the amount of compensation provided to producers.¹²

While the focus of this discussion is on the SHOP's general approach to producer compensation and not on the specific amounts of such compensation, the Wakely report on producers and third-party assistors included four models for compensating producers and managing the SHOP's relationship with producers.¹³

1. Carriers pay producers the same rates for coverage sold through the SHOP as they pay for small-group enrollment outside the exchange.
2. The SHOP pays producers directly, the same rates (on average) as carriers pay outside the Exchange for small group business.
3. The Exchange pays producers directly, at a discounted rate from commercial carriers.
4. The Exchange appoints producers as navigators and supports them with grants.

Based on discussions with the State, the Exchange will pursue option 1 above, choosing not to be directly involved in setting producer compensation or paying producers. This approach should minimize the administrative responsibilities of the SHOP with regard to paying producers, but the Exchange will still need to facilitate the transfer of information regarding the "producer of record" to the health insurers.

This transfer of producer of record information is more complicated in an employee choice model, in which individual employees of a single employer may enroll in coverage with different insurers. The producer of record will therefore need to be assigned to each employee, and not only to the employer group. The enrollment file or another data set will need to include information on the

¹² NYS Insurance Law Section 3231

¹³ Additional information on these options can be found in the report, "The Role of Producers and Other Third-Party Assistors in New York's Individual and SHOP Exchanges," Wakely Consulting Group, June 2012.

producer of record associated with each employee, and that information will need to be passed to the appropriate carrier so that the producer can be recorded and compensation credited. This level of detail is materially different from the manner by which the producer of record is typically handled in today's small group market, in which a producer is associated with an employer account, and not with individual employees.

Recommendations

The SHOP will need to link the individual producer to his/her employer accounts, and include functionality that links the producer to individual employees within the employer account.

In an employee choice model, with employees enrolling in health plans offered by multiple insurers, the SHOP will need to pass information on the producer associated with each employee on to the insurer. This is a key difference in the way producer of record information is captured today and the way the SHOP will need to capture the producer of record information.

If the SHOP chooses not to set producer compensation, the Exchange should consider requiring carriers to pay producers using the same schedule of compensation whether the business is placed through the Exchange or through any other distribution channel.

Account Maintenance/Management and Managing Individual Client Accounts

Background

In the small group market, producers often serve as the de facto Human Resources office for their clients and are responsible for more than just providing their clients with insurance enrollment options. As such, producers may want access to all of the functionality that is provided to employers, as well as a producer-focused account maintenance and management system.

Recommendations

The SHOP will need to provide dedicated Web-based functionality and customer support to assist producers to establish and manage their client accounts.

The Web portal and business processes being developed for the SHOP will need to allow a producer to establish an account on behalf of an employer at the point of employer registration and verification. In addition to the information on the employer that is discussed in the "registration and verification" section of this report, the system will need to capture producer of record information and subsequently allow the producer to act on behalf of the employer.

The SHOP will need to establish a dedicated Web and phone entry point as well as account management tools for producers. The Web portal should include a producer tab or page that gives producers access to information on their employer accounts, allows them to update accounts in the same manner an employer is able to (e.g., add new employees, change the rate basis type for employees, terminate employees' coverage, etc.), and includes tools that permit a producer to monitor their accounts (e.g., premium payments, renewals). The system should also include functionality that will allow a producer to assist clients during the plan year with regard to premium payment discrepancies and other employer and employee issues that may arise.

As part of the initial employer account setup and producer of record designation, the SHOP will need to document that the producer has been assigned to the account by the employer. This documentation typically involves a letter from the employer. The SHOP system should allow these letters to be uploaded as part of the employer registration and verification process.

Customer Support/Referrals

Background

As a convenience for consumers seeking assistance with the purchase of insurance, the Exchange may elect to provide information regarding producers on its Web site.¹⁴ The SHOP could refer producers to employers or provide a means by which employers could access a list of producers that are “SHOP certified” or have registered with the SHOP. If the State chooses to offer this service, it will need to establish and consistently update a list of producers and develop a means by which employers can search for producers.

Recommendations

The Exchange call center should initially serve as the main source of producer and employer customer support. The SHOP may consider building a producer referral capacity in the future.

Since the vast majority of small employers that offer health insurance to their employees use the services of a producer, the number of employers that might need a referral or assistance is likely to be quite small. In addition, the SHOP may need to develop a “producer search” tool on its Web site and consider developing an algorithm to list producers in a randomized (non-alphabetical) fashion. Initially, we recommend that the SHOP not devote resources to this effort. The call center for the SHOP should have the capability to assist employers if they need help.

¹⁴ 45 CFR 155.220(c)

Insurers

Introduction

The SHOP offers a new venue for health insurers to generate business in the small group market. However, participation in the SHOP is not mandatory and is subject to numerous regulations per the ACA. Enticing insurers to offer competitive plans and broad choices will require an efficient, business-friendly platform. As the financial intermediary between insurers and small business owners, the SHOP must seamlessly and efficiently administer the premium billing and collection process. The Exchange has already initiated regular policy discussions with insurers operating in New York and will continue to do so to review the responsibilities, requirements, and dependencies the SHOP creates for this key stakeholder group.

Premium Billing, Collection, and Remittance

Background

As noted in the employer section of this report, the SHOP will need to process premiums on behalf of employers and QHP issuers. Premium processing will include:

- Generating itemized monthly bill for employers;
- Establishing premium delivery and payment methods;
- Aggregating premiums across employers and employees;
- Remitting premiums to carriers;
- Managing payment discrepancies;
- Reconciling payments;
- Processing late payments and establishing a termination process for non-payment of premiums;
- Notifying employers and employees;
- Preparing reports for insurers and HHS; and
- Customer service and account management.

The SHOP will need to establish policies and business processes pertaining to the collection and transfer of premium payments from employers to the carriers, the timing of transfers to effectuate enrollment, the monthly due date for receipt of payments from the employers, the transfer of payments to the carriers, as well as policies, procedures, and notifications regarding late payment and termination for nonpayment of premiums.

Neither the ACA nor the federal rules prescribe the manner by which the SHOP must administer these premium processing responsibilities. Unlike the 90-day grace period requirement that applies to the Individual Exchange, regulations pertaining to the SHOP do not require the same three-month grace period for the small group market. However, a 30-day grace period for nonpayment of premiums before coverage is terminated is a common practice for small groups in

New York. Beyond this requirement, the administration of premium processing is not explicitly prescribed by State law or regulations.

Recommendations

The Exchange must develop policies and procedures for premium processing, a critical function of the SHOP. Each of the items noted above will need to have supporting documentation fully developed and vetted with the carriers.

For administration of the premium processing function, New York should develop business requirements for billing, collecting, and remitting payments. The premium processing solution will need to work with the systems integrator and interface with the SHOP's enrollment system used to capture employee enrollment data. The SHOP will also need to establish business agreements with carriers to administer the transfer of payments from employers to insurers.

A review of other states' experience to date, as well as the small group experience from the Massachusetts Connector Authority, suggests that the business processes and technical infrastructure necessary for the establishment of a premium processing component for the SHOP can take a minimum of six to nine months. If New York does not obtain a premium processing solution by the beginning of 2013, it runs the risk of not having a system in place to meet the October 1, 2013 open enrollment period.

Enrollment

Background

Federal regulations¹⁵ require the SHOP to establish open enrollment periods lasting at least 30 days during which qualified employees may enroll in coverage. Unlike the Individual Exchange—which has a defined and limited annual open enrollment period—employers and their employees may enroll in the SHOP throughout the year. The SHOP must:

- Process the employee applications, facilitate the enrollment of qualified employees in QHPs, and transmit enrollment information on behalf of qualified employees to QHP issuers;
- Establish a uniform enrollment time line and process for all QHP issuers;
- Ensure that issuers notify employees of the effective date of coverage and adhere to coverage effective dates;
- Provide notification to a qualified employer and employees of the annual election period in advance of such period;
- Provide an employee who becomes a qualified employee outside of the initial or annual open enrollment period an enrollment period to seek coverage in a QHP beginning on the first day of becoming a qualified employee (discussed further Appendix 4); and
- Initiate termination of an enrollee's coverage in a QHP, and permit a QHP issuer to terminate coverage, if the enrollee is no longer eligible for coverage.

¹⁵ 45 CFR 155.410

Because the SHOP will be responsible for collecting and remitting premiums as well as transferring enrollment information to the QHP issuers, it will need to coordinate these functions. Carriers will require payment prior to the effective date of enrollment, and the SHOP will need to facilitate enrollment and premium payment.

As discussed in the above section on employer enrollment, the SHOP will need to establish a process, applicable to all participating issuers, to validate the eligibility of employers and employees. The continued enrollment of employees and their dependents will also need to be facilitated each month by the SHOP.

Recommendations

The SHOP will need to develop a standard enrollment form and process for employers and their employees to obtain small group coverage.

The SHOP will need to develop an enrollment schedule that accommodates the time necessary for employers and employees to select a health plan, complete the enrollment, and pay premiums—initially to the Exchange, which then must transfer the enrollment data and the payments to the carriers—prior to the effective date of coverage. Accordingly, the SHOP will need to establish deadlines for open enrollment that provide sufficient time to collect and transfer the enrollment data, along with the premium payments, to the carriers. The carriers will need to receive the enrollment data at least 10 to 15 days prior to the effective date of coverage in order to enroll employees and their dependents in coverage.

Assuming a standard 30-day open enrollment period for employees, an employer's open enrollment period will likely need to commence at least 45 days prior to the effective date of coverage. For example, if an employer's health insurance is effective on July 1, 2014, an employer will need to complete the registration, verification and account setup process in early May 2014; open enrollment will need to begin no later than May 15 and close no later than June 15; and the SHOP will need to collect and transfer the enrollment information and premium payments to the carriers no later than June 20. This schedule will need to be adjusted to reflect the ability of the SHOP to transfer the necessary information, along with the premiums, to the carriers in time for coverage to take effect on the first of the month.

The Exchange will need to work with the carriers to establish a standard process and time line for open enrollment, taking into account the role that the SHOP plays as an intermediary in the process. As noted above, the SHOP will also need to coordinate enrollment and premium processing.

Account Maintenance/Management

Background

The QHP issuers and the SHOP are required to reconcile enrollment files at least monthly while accommodating special enrollment periods for employees who become eligible for coverage outside the annual enrollment period. In concert with one another, the SHOP and participating issuers will also coordinate premium processing and address discrepancies that may arise regarding enrollment and premium processing. Regulations also require specific communications and notifications to be sent to employers and/or employees by issuers, including notices of coverage dates, termination of coverage, etc. Please see Appendix 1 for a working list of such notifications.

Recommendations

The New York Exchange’s enrollment and premium processing systems will need to coordinate the transfer of enrollment and premiums to the QHP issuers.

As the Exchange evaluates its options with regard to the premium processing solution, it needs to integrate this system with the enrollment solution (hCentive) to allow for ongoing account maintenance and management.

Rate Review and Approval

Background

Federal regulations require QHP issuers participating in the SHOP to adjust premiums at a uniform interval that is either quarterly, monthly, or annually; and the regulations prohibit QHP issuers from adjusting rates during the employer’s plan year. This means that carriers may update their rates for small group health plans during the course of the year, as is currently allowed in New York, but that rates applicable to a particular employer—once the group is enrolled and coverage is in effect—must remain unchanged during the employer’s plan year.

The Exchange must also ensure that a QHP issuer submits a justification for a rate increase prior to the implementation of such an increase, except for multistate plans, for which the U.S. Office of Personnel Management will provide a process for the submission of rate increase justifications. The Exchange must ensure that the QHP issuer has prominently posted the justification on its Web site. To promote transparency, the Exchange must also provide access to the justification on its own Web site.

Recommendations

To provide consistency inside and outside the Exchange, the SHOP should allow for a quarterly update to QHP issuer rates and work with DFS to streamline the rate adjustment review and approval process.

The Exchange should also defer to DFS the review and justification of proposed rate changes, which currently reviews and approves proposed rates prior to implementation. While the review and approval of rates by DFS requires carriers to justify their rate requests, in general, there is no formal “justification” notification that is posted on DFS’s Web site or the carrier’s Web site. In concert with DFS, the Exchange should develop a rate justification form that can be provided to the carriers by DFS. For plans offered through the Exchange, the Exchange can then post the justification form on its Web site. The form should use plain language to describe the reasons and the justification for the rate change.

The Exchange’s IT systems and business processes will need to accommodate rate changes on the schedule set by DFS—which is currently quarterly—and the system will need to maintain prior quarters’ rates. Maintaining the rates that were in effect in prior quarters is necessary to allow employer groups to add newly eligible employees and employees eligible under the special enrollment rules. For these employees, the rates in effect at the group’s effective date of coverage will apply, not the rates that may be in effect at the time the employees become newly eligible or a special enrollment period is triggered.

Employees

Introduction

Through the SHOP, New York State has the potential to enroll up to 450,000 employees of small businesses.¹⁶ Employees will have the opportunity to choose from a broad range of insurers, plan types, and premiums in a single online platform, via the call center or in person. Ensuring the SHOP is a user friendly, efficient, and attractive portal for employees to browse for and purchase health insurance is crucial to the SHOP's success.

Account Setup

Background

Just as with employer enrollment, federal regulations require the SHOP to use a uniform employee enrollment form, which can be submitted online, via U.S. mail, over the phone, or in person.¹⁷ The enrollment form should collect the minimum information required, consisting of the following:

1. Name, home address, and date of birth of the employee;
2. Rate basis type (e.g., single, employee + spouse, employee + child(ren), family); and
3. Names and dates of birth of covered spouse and dependents, if applicable.

If the information submitted by the employee matches the data entered by the employer in the employee census, the SHOP must notify the employee of their eligibility to purchase coverage. If the data does not agree, it is the SHOP's responsibility to "make a reasonable effort" to determine the cause of the discrepancy. The SHOP must send a notice to the respective employee that their enrollment cannot continue without resolution of the inconsistencies and provide 30 days for a satisfactory response. If this time period elapses without resolution, the SHOP must send a notice of denied eligibility to the employee.¹⁸

Recommendations

The SHOP should develop automated business processes around all required notifications and collaborate with insurers to understand the dependencies these notifications create.

The SHOP will be responsible for issuing notifications to employees for various purposes, including eligibility determinations, coverage termination, etc., at times prescribed by ACA regulations. To ensure the proper notices are sent in a timely manner and can be tracked, the SHOP should maintain the capacity to automatically generate and send template notices, including the information specific to the recipient (e.g., name, address, coverage information). This will decrease the likelihood of human error and provide an audit trail for any programmatic reviews that will take place in the future. As Appendix 1 illustrates, other SHOP stakeholders (issuers, employers, etc.) will also be responsible for sending SHOP-related notifications.

¹⁶ "New York Health Benefit Exchange Detailed Design Review Summary for Section 6.0 SHOP," October 9-10, 2012.

¹⁷ 45 CFR 155.715

¹⁸ 45 CFR 155.715

Plan Selection and Consumer Decision Support Tools

Background

Depending on their employer's decisions, the SHOP may offer employees a level of plan choice they have not generally had to date. The SHOP is responsible for facilitating an employee's enrollment by clearly conveying the choices available in a coherent manner that enables easy comparison between plans and insurers.

The SHOP is tasked with notifying employees in advance of the annual open enrollment period, which must begin at least 30 days prior to the plan year's completion.¹⁹ However, as noted above, the annual open enrollment period will likely need to commence at least 45 days before the end of the employer's plan year in order to facilitate enrollment, premium billing and collection, and the transfer of premiums to issuers.

The SHOP must also be able to accommodate employees who become newly eligible for coverage outside of the annual open enrollment period. Please see Appendix 4 for information on off-cycle enrollment provisions.

As referenced in the discussion of Employer Plan Selection above, the manner by which employees may purchase coverage through the SHOP will impact the extent to which the SHOP can effectively serve the small group market. Plan selection options (e.g., one carrier, one plan; one carrier, multiple plans; etc.) may also directly impact the plan benefit standardization efforts of the Exchange. The SHOP will have to balance a consumer-friendly presentation of plans displaying standardized benefits with the need to accurately display plan differentiation and the full range of consumer choices, which will involve less benefit standardization. The SHOP Web site may utilize numerous criteria to sort available plans, including plan type, monthly premium cost, annual deductible, amounts and types of applicable co-pays, level of prescription drug coverage, provider network, whether a referral is required to see a specialist, etc.

To assist employees in the calculation of costs for prescriptions or anticipated doctor visits, the SHOP Web site could provide the URL for the formularies on carriers' Web sites for the employees to access them directly. The State has decided not to include such calculators directly on the Exchange Web site. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results and health insurer quality ratings will also be made available on the Exchange Web site to facilitate employers' and employees' understanding of plan offerings and encourage competition between insurers to improve their plan offerings and customer experiences.

Recommendations

The SHOP IT systems and customer support services will need to provide the flexibility for employees to weigh their coverage options while displaying the information in a user-friendly, digestible manner both on the SHOP Web portal and in print form.

The broader the choice offered to employers seeking to purchase coverage through the SHOP, the more assistance their employees may need to make decisions about coverage and enrollment for themselves and their families. Short, clear descriptions of the various plan design features (e.g., premiums, co-insurance, co-payments, enrollment period, etc.) should be made available to help educate the consumer as they move through the plan selection process. Including the CAHPS survey and insurer quality ratings is one means by which the SHOP can help employees compare the QHPs offered.

¹⁹ 45 CFR155.725

Customer Support

Background

Just as employers will have access to a customer service hotline staffed by trained professionals who can address their questions and concerns, employees will require similar support. Employees may present needs ranging from understanding basic benefit offerings to addressing off-cycle enrollment. In addition, employees already enrolled in coverage through the SHOP may need assistance transitioning to the Individual Exchange should they lose their employer-sponsored insurance. Although the State will not include a screener on the SHOP Web portal to determine potential eligibility for advanced premium tax credits through the Individual Exchange, customer support services should be available to assist individuals with their transition from the SHOP to the Individual Exchange should this need arise. Considering the specific needs of employees when crafting the SHOP customer service plans will enable staff to appropriately address these situations as they occur.

In concert with the Exchange's call center staff, the State will have to address any complaints or grievances from employees. The SHOP is working to establish a dedicated customer service unit to manage SHOP employees' concerns and to address complaints. The information gathered through this process may eventually inform their QHP management policies as well as their QHP solicitations. Employees may also reach out to navigators, producers, or local chambers of commerce for assistance.

Recommendations

Many of the same types of online tools and customer support mechanisms that will be available through the Individual Exchange should be available to SHOP employees.

The SHOP must determine in advance what specific resources will be offered to employees who seek assistance in-person, over the phone, or through the SHOP Web portal. The State may wish to investigate lessons to be learned from the call center for public health insurance programs or the experience of its Consumer Assistance Program.

As some consumers may not be available to phone the consumer support line during its operating hours, the SHOP may still be able to assist employees with a broad range of online tools, including an FAQ section, video demonstrations, etc. Additional assistance may be offered via e-mail, a live chat functionality, or through in-person seminars. These may also decrease the demands on customer service staff during the call center hours.

All customer supports, regardless of their form, should accommodate various languages and levels of disabilities.

SHOP

Introduction

The SHOP will function as part of DOH per Executive Order 42. SHOP staff and those in other departments (DFS, DOB, etc.) interacting with the SHOP are responsible for effectively and efficiently initiating, monitoring, reporting on, and improving the SHOP systems, policies, procedures, and outcomes.

Oversight and Monitoring

Background

NYS Executive Order 42 of 2010 calls upon the Exchange, DOH, DFS, and other State agencies to “take all necessary steps to effectuate the Exchange.” To do so while remaining a competitive venue to offer and purchase small group health insurance, the SHOP must monitor changes in the commercial insurance marketplace, stay abreast of federal and State regulations, and oversee the implementation of strategic responses to any such changes.

At a minimum, the SHOP is responsible for monitoring changes to federal and/or State laws, regulations, and guidance, and incorporating them into its operations. Before the Exchange can go live, CMS will approve the SHOP’s proposed business processes, rules engines, and Web portal as compliant with all current regulations. This is complicated by the fact that CMS is continuously publishing guidance on Exchange functions, which will require the SHOP’s attention before open enrollment begins and once operations commence.

To stay competitive, the SHOP will also need to reflect changes happening in the commercial insurance market and adjust its plan offerings accordingly. DFS already performs part of this surveillance via their rate and form filing process. As the agency responsible for approving insurance products and rates before they can be offered to the public, DFS has access to product information before it enters the marketplace. However, the State is currently unable to identify trends in enrollment, popularity of different plans, enrollee demographics, etc. as enrollment data is not routinely collected.

The standardization of benefits, which will allow consumers to effectively compare plans and premiums, also poses a challenge to the SHOP’s ability to keep up with the commercial insurance marketplace. In balancing the needs of consumers with the diversity of offered products, the SHOP may consider the experiences of the Massachusetts Health Connector and HealthPass, a private health insurance exchange for small businesses in downstate NY. In Massachusetts, new products are being offered much more frequently in the market outside the Connector than the Connector is updating its plan offerings. This may be one factor contributing to lower than anticipated enrollment amongst small employers in the Connector.

HealthPass initially experienced difficulty keeping pace of product changes because their plan standardization criteria were relatively stringent. HealthPass subsequently altered its approach and now offers a broader range of plans, with new plans made available as the market evolves and new products become popular.

Recommendations

The SHOP must monitor for regulatory updates and changes in the small group market outside the Exchange and establish processes to appropriately respond to both.

The SHOP must remain abreast of both changing regulatory requirements and competing market forces as it begins operations in 2013. Coordinating this effort amongst the numerous State agencies involved and the SHOP's constituent groups (employers, employees, brokers and issuers) will require a thoughtful approach to internal and external oversight and monitoring.

The SHOP should establish a formal process to track, update, and integrate regulatory changes into its system from conception in its business requirements. As federal and/or state laws, regulations, and guidance change or emerge, the SHOP will need to have established mechanisms to ascertain the impact of such changes, perform gap analyses between current and future state needs, and implement required changes. If the SHOP's business requirements are clearly linked to specific regulations or guidance during the planning process, processes or actors impacted by future changes could be more easily discerned.

Identifying the parties responsible for monitoring regulatory changes and clearly outlining their roles could help ensure compliance in an ongoing manner. Creating succession plans and training manuals for those assigned these responsibilities could help mitigate potential compliance gaps if staffing changes occur.

Should the State decide that the SHOP will proceed with a standardized benefit plan with a limited number of alternatives available initially, having the capacity to compare SHOP offerings and related metrics to the outside market will become crucial.

The SHOP must also constantly monitor the small group insurance market to assess new products and plan designs that may be purchased outside of the Exchange. Staying abreast of new products being offered will allow the SHOP to update its own portfolio as appropriate to ensure SHOP's portfolio is reflective of the current market and desirable to customers. If the SHOP offers products being demanded in the market outside of the Exchange, it is more likely to remain competitive and an attractive distribution channel for both issuers and enrollees. As part of the DFS rate and form filing review and approval process, enrollment data by product type should be captured and shared with the SHOP to help inform its product portfolio.

Reporting

Background

Federal regulations require the SHOP to produce numerous reports at various frequencies. For example, the SHOP must reconcile enrollment information and employer participation information with QHP issuers at least monthly. The SHOP must also report to the IRS on employer participation and contributions, and employee enrollment rates at a frequency and format still to be determined. For a minimum of 10 years, the SHOP must retain information on employers participating in the SHOP and employees enrolling in QHPs.²⁰ This must all be done while complying with regulations safeguarding personally identifiable information.²¹

In addition to formal reporting, there are numerous notifications the SHOP is responsible for sending to issuers, employers, etc. Please see Appendix 1 for a list of notifications currently required by federal regulations.

²⁰ 45 CFR 155.720

²¹ 45 CFR 155.260

In meeting these requirements, the SHOP will retain significant amounts of data over extended periods, requiring regular, long-term database maintenance. The types of data collected and the storage format decided upon will help ensure the costs associated with this lead to value above and beyond meeting HHS reporting requirements.

Recommendations

In addition to meeting mandated reporting requirements, the SHOP should define and track progress towards specific performance goals to remain a competitive insurance distribution portal.

As with its oversight and monitoring responsibilities, the SHOP has both minimum reporting requirements and an opportunity to create added value for all its constituencies if the appropriate information is collected in an easily retrievable format.

The SHOP should first determine whether internal State databases, such as those hosted by the State Department of Taxation and Finance, could be appropriately used not only to verify businesses as eligible for the SHOP, but also as sources of information about the businesses. A careful balance should be struck between collecting data for analytical purposes and burdening businesses with reporting requirements as the latter may deter employers from enrolling through the SHOP. If this information already exists in a transferrable format, it should be utilized instead of recreated.

Data sourced from other databases and directly from employers and employees should be easily retrieved, queried, sorted, analyzed, and reported out. The SHOP may utilize a dashboard format to facilitate this and give SHOP staff the opportunity to constantly monitor progress towards established performance goals.

It is highly probable that as more data become available, other government agencies and outside entities such as chambers of commerce, professional associations, issuers, etc. may seek access to the data. Establishing specific performance metrics assessing public health, employers, issuers, brokers, and the SHOP prior to establishing data collection and storage protocols will help ensure the utility of the data to these groups. Anticipating these needs by dialoging with these constituencies now will help the SHOP determine what information to capture (e.g., demographics, whether the enrollee was previously insured, etc.), how to store it, and in what format it might be reported. Effectively communicating with outside entities of any kind will also facilitate the SHOP's transparency.

For each notification the SHOP is required to send, it should develop a standard form and electronic submission process. Business processes dictating responsibility for and tracking of notifications should also be developed in collaboration with issuers and the employers in advance of the beginning of the open enrollment period.

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Appendix 1: Sample Notifications List

The following is a list of SHOP notifications required by ACA regulation to be sent and/or received by the SHOP itself, employers, employees, and issuers. Executing the various functions required of the SHOP and its stakeholders will require synchronized business processes, many of which require notifications to be generated and sent to the pertinent parties. All SHOP stakeholders will need to understand these dependencies and ensure notices they are responsible for sending are done so within the permitted time lines.

Table 3: Sample Notifications List

Notifier	Recipient	Topic	Notice	Contents of notice	CFR Citation
SHOP	Employer	Eligibility	Notify the employer if his application is inconsistent with eligibility standards.	The notice must provide the employer with a period of 30 days from the date on which the notice is sent to the employer to either present satisfactory documentary evidence to support the employer's application, or resolve the inconsistency.	155.715
SHOP	Employer	Eligibility	Notify an employer of approval or denial of eligibility to purchase coverage.	If, after the 30-day period, the SHOP has not received satisfactory documentary evidence, the SHOP must provide an employer requesting eligibility to purchase coverage with a notice of approval or denial of eligibility and the employer's right to appeal such eligibility determination.	155.715
SHOP	Employee	Eligibility	Notify the employee if his application contains information inconsistent with the employer provided information.	The notice must provide the employee with a period of 30 days from the date on which the notice is sent to either present satisfactory documentary evidence to support the employee's application, or resolve the inconsistency.	155.715
SHOP	Employee	Eligibility	Notify the employee of its denial of eligibility.	If, after the 30-day period the SHOP has not received satisfactory documentary evidence, the SHOP must notify the employee of its denial of eligibility.	155.715
SHOP	Employee	Eligibility	Notify an employee seeking to enroll in a QHP of the eligibility determination.	The SHOP must notify an employee seeking to enroll in a QHP offered through the SHOP of the determination by the SHOP whether the individual is eligible in accordance with §155.710 and the employee's right to appeal such determination.	155.715

Notifier	Recipient	Topic	Notice	Contents of notice	CFR Citation
SHOP	Employee	Coverage Termination	Notify each of the employer's employees enrolled in a QHP that the employer is terminating coverage.	If a qualified employer ceases to purchase coverage through the SHOP, the SHOP must ensure that. (2) Each of the employer's qualified employees enrolled in a QHP through the SHOP is notified of the termination of coverage prior to such termination. Such notification must also provide information about other potential sources of coverage, including access to individual market coverage through the Exchange.	155.715
SHOP	Employee via Issuer	Coverage Period	The SHOP must ensure that a QHP issuer notifies an employee enrolled in a QHP of the effective date of coverage.	The SHOP must ensure that a QHP issuer notifies a qualified employee enrolled in a QHP of the effective date of coverage consistent with §156.260(b).	155.720
SHOP	Employer	Coverage Termination	If any employee terminates coverage from a QHP, the SHOP must notify the employee's employer.	(same)	155.721
SHOP	Employer and Employee	Coverage Period	Notify a qualified employer and employees of the annual election period in advance of such period.	(same)	155.725
SHOP	Issuer, Employer, Employees	QHP Decertification	Notify the following of decertification of a QHP: (1) The QHP issuer; (2) Exchange enrollees in the QHP who must receive information about a special enrollment period, as described in §155.420; (3) HHS; and (4) The State department of insurance.	Upon decertification of a QHP, the Exchange must provide notice of decertification to all affected parties, including: (1) The QHP issuer; (2) Exchange enrollees in the QHP who must receive information about a special enrollment period, as described in §155.420; (3) HHS; and (4) The State department of insurance.	155.1080
SHOP	Issuer	Enrollment	Notify QHP issuer that an individual is qualified for coverage.	(1) A QHP issuer must enroll a qualified individual only if the Exchange – (i) Notifies the QHP issuer that the individual is a qualified individual	156.265

Notifier	Recipient	Topic	Notice	Contents of notice	CFR Citation
Issuer	Employee	Coverage Period	Notify employees of effective dates of coverage.	A QHP issuer must notify a qualified individual of his or her effective date of coverage.	156.260
Issuer	Employee	Coverage Termination	Notify employee of termination of coverage.	If an enrollee's coverage in a QHP is terminated for any reason, the QHP issuer must: (1) Provide the enrollee with a notice of termination of coverage that includes the reason for termination at least 30 days prior to the last day of coverage, consistent with the effective date established by the Exchange in accordance with §155.430(d) of this subchapter.	156.270
Issuer	SHOP	Coverage Termination	Notify SHOP of termination of coverage.	Notify the Exchange of the termination effective date and reason for termination.	156.271
Issuer	Employee	Coverage Termination	Notify employee of payment delinquency.	If an enrollee is delinquent on premium payment, the QHP issuer must provide the enrollee with notice of such payment delinquency.	156.272
Issuer	Employer and Employee	Coverage Termination	Notify enrollees of lack of intent to recertify as an issuer on the Exchange.	If a QHP issuer elects not to seek recertification with the Exchange, the QHP issuer, at a minimum, must (4) Provide notice to enrollees as described in paragraph (b) of this section.	156.290
Issuer	Employer and Employee	Coverage Termination	Notify enrollees of lack of intent to recertify a QHP offered through the Exchange.	If a QHP issuer elects not to seek recertification with the Exchange for its QHP, the QHP issuer must provide written notice to each enrollee.	156.290
Issuer	NA	Coverage Termination	Wait on notice from the Exchange to terminate coverage via a decertified QHP.	If a QHP is decertified by the Exchange, the QHP issuer must terminate coverage for enrollees only after: (1) The Exchange has made notification as described in §155.1080 of this subchapter	156.290
Employer	Employee	Enrollment	Notify employees of how to enroll in a QHP through the SHOP.	A qualified employer participating in the SHOP must disseminate information to its qualified employees about the process to enroll in a QHP through the SHOP.	157.205

Notifier	Recipient	Topic	Notice	Contents of notice	CFR Citation
Employer	SHOP	Enrollment	Notify the SHOP of employee and dependent's change in eligibility status.	Qualified employers participating in the SHOP must provide the SHOP with information about dependents or employees whose eligibility status for coverage purchased through the employer in the SHOP has changed, including:	

Appendix 2: Minimum Participation Requirements

Background

Minimum participation levels are used by health insurers in the group market to help maintain a balance of risk—healthy and less healthy, younger, and older workers—within an employer group and across the small employer market. By requiring employers that wish to purchase group coverage to enroll a minimum percentage of eligible employees in the employer’s health plan, minimum participation rates provide some protection against adverse selection, in which older and less healthy workers are more prone to participate in an employer’s insurance plan; while younger and healthier employees may choose to go without coverage.

Because health insurers typically do not know the health status of a group’s members, and an individual’s health status cannot be used as a factor in setting premiums, carriers are unable to adjust prices to account for any selection bias. Requiring a minimum percentage of employees to be covered by the group policy helps mitigate the potential for adverse selection.

Neither the Patient Protection and ACA nor federal regulations require the SHOP to establish minimum participation standards. However, the regulations do permit the SHOP to “authorize uniform group participation rules for the offering of health insurance coverage in the SHOP. If the SHOP authorizes a minimum participation rate, such rate must be based on the rate of employee participation in the SHOP, not on the rate of employee participation in any particular QHP or QHPs of any particular issuer.”²²

This means if the SHOP establishes a minimum participation rate, the rate of participation is calculated based on the percentage of eligible employees that enroll in the employer-sponsored insurance, and not based on the percentage of employees that enroll with a particular carrier or the percentage of employees that enroll in particular health plan.

This distinction is most relevant in an employee choice model, discussed further below, in which employees are allowed to enroll in qualified health plans offered by a range of health insurers. By applying the minimum participation rate at the SHOP level, employers are able to offer their employees a range of health plans without needing to meet carrier-specific or plan-specific participation rates.

While the ACA does not establish minimum participation rates, New York health insurance rules require commercial insurers (i.e., non-HMOs) to apply a minimum participation rate of at least 50 percent if the employee pays any portion of the premium and 100 percent if the employer covers the entire premium.²³ However, HMO plans are statutorily prohibited from applying a minimum participation rate.²⁴

For non-HMO plans, carriers apply different participation requirements that can vary based on the type of plan purchased. HealthPass New York, a nonprofit health insurance exchange that covers (primarily) employers with five or fewer employees, requires 75 percent of eligible employees to enroll in coverage or provide proof of other coverage. The report on producers and third party assistors noted that for some small employers meeting the minimum participation rates has become “an increasingly difficult task as carriers tighten up underwriting guidelines on non-HMO plans.”²⁵

²² 45 CFR 155.705(b)(10)

²³ New York Insurance Law Section 4235

²⁴ 11 NYCRR Section 360.3(a)(1)(ii), Public Health Law 4406.1

²⁵ Wakely, page 24.

In addition to variation with regard to minimum participation standards, the manner by which participation rates are calculated may differ across carriers, with regard to employees that have coverage through another source. Some employees offered employer-sponsored insurance will have coverage through a spouse or parent, Medicare, or Medicaid; and these employees will not want or need the insurance offered by their employer. These employees are typically considered “valid waivers” for the purpose of minimum participation requirements.

In determining whether the employer meets the minimum participation rates, carriers exclude valid waivers. However, there may be different ways that carriers calculate group size in determining whether the employer meets the minimum participation level.

Take, for example, a group of eight eligible employees and a minimum participation rate of 50 percent. If two of eight employees have coverage through a spouse (i.e., valid waivers), the minimum participation rate could apply to the remaining six eligible employees. In this case, three of the remaining six employees would need to enroll in the employer’s coverage to meet the minimum participation level (i.e., three enrolled/six “non-waived” employees = 50%).

Alternatively, a group of eight employees, with two employees covered through valid waivers, might remain a group of eight from the carrier’s perspective, resulting in the need for only two of the remaining six employees to enroll in coverage through the employer. In this case, two employees are covered through valid waivers and two employees enroll in the employer’s offer of insurance (i.e., 2 valid waivers + 2 enrolled employees/8 employees = 50%). HealthPass, for example, uses this approach in determining whether a group satisfies its minimum participate rate; while carriers generally use the former method for calculating participation rates.

Recommendations

The SHOP should consider establishing a minimum participation rate that applies to all employers, regardless of size, that promotes employer and employee access to coverage.

The statutory requirement that non-HMO insurers must apply a minimum participation rate of at least 50 percent and the prohibition on HMOs establishing any minimum participation rate will not only affect the New York SHOP’s policy decisions and business processes regarding minimum participation rates, but may also impact the manner by which qualified health plans are offered to employers under an employee choice model.

Full choice between HMO and non-HMO products could be extended to the small group. Enrollment in HMO products could be counted towards meeting participation standards applicable to non-HMO sales within the Exchange. In this way, HMO enrollees would be treated as enrollees eligible for participation waivers due to spousal coverage. In the event that a given employer still could not satisfy minimum participation requirements due to a lack of employee participation, the employer could then be limited to HMO options which do not carry minimum participation rules. Consistent with New York’s existing market, such an approach would ensure that all employer groups had access to the full range of plan choices in the event minimum participation requirements can be fulfilled and to comprehensive HMO coverage in the event the group falls short of meeting minimum participation requirements.

A second issue involves the minimum participation standard that the SHOP will establish. As noted above, minimum participation rates vary by carrier, product type, size of employer, and geographic location of the employer. The Exchange minimum participation rates should apply to all carriers uniformly, and should not vary based on the geographic location of the employer or the type of health plan (with the possible exception of HMO plans as noted above).

Establishing a single minimum participation rate that applies to all employers, regardless of size, would be most desirable and the SHOP should explore this option with insurers. However, the SHOP must be mindful of the standards that apply in the existing small group market. If the SHOP sets minimum participation rates that are inconsistent with the rest of the market, it could create risk segmentation and market disruption, and the Exchange runs the risk of carriers refusing to participate.

The SHOP will also need to: (1) establish a rule regarding the types of coverage that constitute valid waivers; (2) develop a methodology for calculating the minimum participation percentage for employers that have eligible employees with valid waivers; and (3) create a standard “waiver of coverage” form that employees would need to complete and employers may need to submit to the Exchange to document valid waivers.

Valid waivers should include, at minimum, the following categories of insurance:

- Coverage through another employer’s plan;
- Coverage through a spouse or coverage as a dependent on a parent’s plan;
- COBRA coverage;
- Coverage through a retirement plan;
- Coverage through a veterans program; and
- Coverage through a government-sponsored plan (e.g., Medicare, Medicaid).

Some carriers may also allow valid waivers for individuals who purchase coverage through the individual (non-group) market, as well as employees that do not reside in the carrier’s service area. The SHOP will need to explore these and possibly other situations that may satisfy carriers’ valid waiver requirements as it finalizes the SHOP’s list of valid waivers.

Finally, with regard to minimum participation rates, the SHOP Web portal and associated business processes will need to be able to calculate and administer minimum participation rates—including participation rates that may vary by the size of the employer. As part of the employee census described in the Account Setup section of this report, the system should require an employer to list all eligible employees; indicate whether each employee is expected to enroll in coverage; note whether the employee has a valid waiver; and identify the waiver category. That information will need to be captured by the SHOP and applied to the employer’s account in order to calculate the applicable minimum participation rate.

The SHOP will also likely need to verify, after the employer’s open enrollment period has closed, that the group has satisfied the applicable minimum participation standard. While the account setup process will allow employers to indicate the expected employee enrollment, actual enrollment will need to be confirmed prior to the effective date of coverage.

Appendix 3: Section 125 Plans

Background

A Section 125 plan, also commonly referred to as a cafeteria plan or premium only payment (POP) plan, provides a means by which an employee may choose to pay for certain benefits on a pre-tax basis. Benefits that may be provided on a pre-tax basis include accident and health benefit plans, health savings accounts (HSA), adoption assistance, dependent care assistance, and group term life insurance. From a tax liability perspective, the employee is choosing to forego wages (which are taxable) for certain benefits (which are not subject to federal and state income and payroll taxes). The discussion that follows focuses on the use of a cafeteria plan or POP plan for health benefit plans and health-related accounts.

Using a Section 125 plan, health insurance premiums—both the employer’s share and the employee’s share—can be paid pretax, thereby reducing significantly the net cost of employer-sponsored health insurance. In New York, a Section 125 plan can reduce the net cost of the employee’s share of the premiums by roughly 40 percent; assuming federal marginal rate of 25 percent²⁶, New York marginal rate of 6.85²⁷, as well as the employee’s share of payroll taxes of 7.65 percent. The highest wage earners can reduce their net cost of health insurance premiums by upwards of 50 percent. The employer’s share of the premium is also excluded from the employer’s portion of payroll taxes—including Medicare, Social Security, and federal and state unemployment taxes—and may be excluded from business income taxes, thereby effectively reducing the employer’s net contribution.

In addition to tax sheltering premium contributions, employers may also establish a cafeteria plan that allows employees to pay for certain out-of-pocket expenses on a pre-tax basis. Known also as a flexible spending account or FSA, this benefit enables an employee to forego up to \$2,500 in wages annually, with those monies placed into an account (i.e., FSA) and used by the employee to pay for certain medical expenses. Funds deposited into an FSA are subject to an annual “use it or lose it” provision, with unused funds forfeited by the employee at the end of the plan year.

Section 125 also regulates HSAs, which must be paired with a high deductible health plan (HDHP). Funds in an HSA can be used to pay out-of-pocket expenses incurred by the enrollee. However, unlike an FSA, employees and employers may contribute to an HSA; funds may roll over from year to year; and the HSA is portable, which allows an employee to retain access to the account after leaving an employer. All contributions to an HSA are excluded from the employee’s gross income, and are not subject to income or payroll tax.

While Section 1515 of the ACA prohibits the use of a Section 125 plan for the purchase of health insurance in the Individual (non-group) Exchange, this provision does not apply to employees whose employers offer health insurance through the SHOP. Given the significant savings to employees, as well as the savings to employers, the SHOP should consider how best to promote the use of Section 125 plans.

²⁶ 25 percent marginal rate applies to married filing jointly with income between \$70,700 and \$142,700.

²⁷ New York State marginal rate of 6.85 percent applies to couples with income between \$40,000 and \$200,000.

Recommendations

The SHOP should consider the numerous ways to facilitate the use of Section 125 plans to help employees and employers reduce the net cost of health coverage.

At minimum, the SHOP should include on its Web site information on the value of a cafeteria plan or POP plan. The SHOP should provide basic information on a Section 125 plan, how it can reduce the net cost of coverage, what an employer needs to do to set one up, as well as a “Section 125 plan calculator” that demonstrates the value of paying health insurance premiums on a pre-tax basis. The SHOP could also make available IRS documents and information on Section 125, and the Exchange’s Web portal could include links to the IRS Web site.

A second level of effort for the SHOP could involve the development of a Section 125 plan document template for a POP plan that employers could download and complete. This would involve drafting a plan document that meets the Section 125 requirements, and would likely need to be reviewed by legal counsel to ensure compliance with applicable federal regulations. The Massachusetts Health Connector has already developed a number of Section 125 plan tools and resources that the New York SHOP could update and use. These include a Section 125 Plan Handbook, Employer Adoption Agreement, Implementation Checklist, and Section 125 Plan Document.²⁸

A much more intensive Section 125 plan effort by the SHOP could involve the establishment of a banking relationship to facilitate the use of FSAs and HSAs. As employers are increasingly offering health plans with higher cost sharing, some health insurers have made arrangements with banks to link the health plans with HSAs (which must be offered alongside a HDHP and FSAs. Enrollees are able to pay out-of-pocket expenses with pre-tax funds in their HSA or FSA, thereby lowering the net cost of coverage.

Under an employee choice model, which involves a number of carriers, the SHOP could help employers and employees by providing a centralized banking arrangement that facilitates the reimbursement of employees’ out-of-pocket expenses. This level of involvement would likely require the SHOP to take a more active role in the administration of health coverage for employers and their employees, and may not be feasible in the run-up to open enrollment in October 2013, given all of the other work involved in setting up the Exchange.

²⁸ The MA Health Connector’s Section 125 plan tools and resources can be accessed at the following URL – <https://www.mahealthconnector.org/portal/site/connector/menuitem.5de15e4af5dc94de505da95c0ce08041/?fiShown=default>

Appendix 4: Off-Cycle Enrollment

Background

While the SHOP must establish open enrollment periods during which qualified employees may enroll in coverage, the SHOP must also accommodate enrollment of newly eligible employees (e.g., newly hired, expiration of employer's waiting period, change in status from part time to full time, etc.) outside of the employer's open enrollment period; and qualified employees that experience a change in status must be allowed to enroll in coverage or change health plans outside of the employer's annual open enrollment period.²⁹

In addition to newly eligible employees, federal regulations identify a number of triggering events or circumstances that will permit a qualified employee to enroll in coverage outside of the employer's open enrollment periods. The qualifying events listed in federal regulations include the following:

- **Birth, adoption, or placement for adoption** – A qualified employee that gains or becomes a dependent through birth, adoption, or placement for adoption will become eligible for coverage, with coverage effective on the date of the birth, adoption, or placement for adoption.
- **Marriage** – A qualified employee that marries is eligible to purchase coverage during a special enrollment period.
- **Loss of minimum essential coverage** – A qualified employee or dependent that loses “minimum essential coverage” is eligible for a special enrollment period. The regulations note that a qualified employee or dependent will be eligible for a special enrollment period only if the coverage that is lost meets the requirements of minimum essential coverage, and does not include coverage that may be “substandard” or otherwise not considered minimum essential coverage.

A qualified employee who fails to pay premiums—including premiums for COBRA—or an individual involved in situations allowing for a rescission, as specified in 45 CFR 147.128,³⁰ is not permitted to enroll during a special enrollment period. However, a qualified employee who is offered but does not enroll in COBRA coverage could be eligible for a special enrollment period. For example, an employee whose spouse loses employer-sponsored insurance and is offered—but does not enroll in—COBRA coverage, could be eligible for special enrollment through the SHOP so long as the employer-sponsored insurance that the employee had been enrolled in satisfied the minimum essential coverage requirements. If, however, an employee enrolls in COBRA coverage, the employee would not meet the special enrollment criteria prior to the expiration of COBRA.

- **Employer-sponsored insurance (ESI) is unaffordable or no longer provides minimum value** – A qualified employee may be eligible for special enrollment if coverage offered through an employer-sponsored plan is unaffordable (i.e., greater than 8.0 percent of the individual's modified adjusted gross income) or does not provide minimum essential value (i.e., meets the 60 percent actuarial value standard). This circumstance is most likely applicable to employer's that have coverage through a spouse's plan that becomes unaffordable or is changed such that it no longer provides minimum essential value.

²⁹ 45 CFR 155.420

³⁰ 45 CFR 147.128 is included in the Appendix.

- **Permanent move that results in access to new QHPs** – A qualified employee may be eligible for special enrollment if a permanent move results in their gaining access to new qualified health plans. This provision includes instances in which an individual is already enrolled in a QHP, and a permanent move results in the availability of additional QHPs—for which the individual was not previously eligible.
- **Errors** – A qualified employee whose enrollment or non-enrollment in a QHP is unintentional, inadvertent or erroneous, and is the result of an error, misrepresentation or inaction of an officer, employee, or agent of the Exchange or the Department of Health and Human Services (HHS), as determined by the Exchange, may be eligible for special enrollment.
- **Issuer violation of contract provisions** – A qualified employee who demonstrates that the QHP in which the individual is enrolled violated a material provision of its contract in relation to the enrollee may be eligible for special enrollment.
- **Exceptional circumstances** – A qualified employee may be eligible for a special enrollment under “exceptional circumstances,” in accordance with guidelines issued by HHS and as determined by the Exchange. To date, HHS has not issued guidance or guidelines with regard to this provision of the regulations.

The SHOP’s enrollment and premium billing systems will need to accommodate off-cycle enrollment for employees that experience a qualifying event or are otherwise newly eligible for employer-sponsored insurance. Since several of the federally required qualifying event categories may not be standard practice for New York employers and insurers, the SHOP will need to inform employers and carriers of these requirements, as part of the initial enrollment process (employers) and the QHP solicitation (carriers).

Depending on the type of employee choice model offered by the employer, the SHOP may want to limit the types of health plans that currently enrolled employees may switch to during a special enrollment period. For example, if an employee is enrolled in a Silver level plan and experiences a change in status that triggers a special enrollment period, the SHOP may want to limit the ability of the employee to enroll in a QHP that has a higher or lower actuarial value (i.e., Bronze, Gold, or Platinum level plans).

Recommendation

The SHOP, as part of the QHP solicitation, should include all of the events that can trigger a special enrollment period for employees; and require QHP issuers to accommodate these off-cycle enrollments in order to participate in the SHOP.

The enrollment and premium processing systems of the SHOP will need to allow employers and producers to add newly eligible employees; and modify both the plan selection and coverage (i.e., rate basis type) of employees that are currently enrolled.

Because premiums in the small group market can change more frequently than premiums in the individual market (i.e., quarterly in the small group market vis-à-vis annually in the individual market), the SHOP’s rate generation and premium processing solution will need to capture and retain premiums for the employer that were in effect at the time of the employer’s effective date of coverage. The Exchange systems will then need to apply these premiums to employees that are eligible to enroll during a special enrollment period.

For example, an employer that purchases coverage with an effective date of April 1, 2014 will have premiums in effect for the 12-month period from April 1, 2014–March 31, 2015. If an employee becomes eligible for coverage effective September 1, 2014, the premiums of the QHPs available to the employee will need to reflect the rates that were in effect on April 1, 2014, even though the carriers may have updated their premiums. The employer’s health plans, including plans for those employees who were enrolled after April 1, 2014, will expire at the same time (i.e., March 31, 2015).

Appendix 5: Healthy NY

Background

Healthy NY is a public/private insurance program that offers subsidized coverage to low-income working individuals and sole proprietors, and qualifying businesses with 50 or fewer employees. As of March 2012, Healthy NY covered almost 180,000 members.³¹ Small businesses have increasingly grown as a percentage of Healthy NY enrollees, constituting 27 percent of enrollees in 2006 and rising to 46 percent in 2013.³²

All participants have the choice of four benefit packages but there are distinct eligibility criteria for individuals and sole proprietors and for small businesses. (Due to budgetary restrictions, new enrollment is limited to the HDHP option.) Small business owners must contribute at least 50 percent towards employee premiums (for single coverage only) and must offer coverage to all employees working 20 or more hours per week and earning \$40,000 or less annually. A 50 percent minimum participation rate applies. State law requires all HMOs to offer Healthy NY and allows other insurers to participate as well. Small business owners apply as a group for Health NY directly through one of the 14 participating insurers.

DFS collects information from participating health plans on the medical expenditures paid by Healthy NY enrollees. The State uses this information to determine the dollar amount of reinsurance to be paid to each insurer at the end of the calendar year, which is up to 90 percent of annual medical claims for an enrollee with claims between \$5,000 and \$75,000. In 2010, the State paid issuers \$157 million in reinsurance payments.

The State is currently considering whether to continue this insurance program or transition the enrollees into coverage provided through the Exchange.

Recommendations

The State should consider the administrative and operational implications for the SHOP should Healthy NY continue in 2014 and be offered through the Exchange.

If the State continues the Healthy NY program, offering it through the Exchange could give the SHOP a significant volume of business. Based on the figures from the 2011 Healthy NY Annual Report, the SHOP would be responsible for facilitating the enrollment of the approximately 60,000 small business employers and employees who currently participate in Healthy NY.³³ Those employers who transition with Healthy NY to the SHOP and continue to provide coverage might also be eligible for the federal tax credits available to employers with low-wage workers who purchase coverage through the SHOP.

Migrating Healthy NY to the Exchange might also necessitate the participation of all HMOs in the Exchange as they are required to offer Healthy NY plans under NYS law. This may serve as an incentive for non-HMOs to participate as well so that they may compete in this new venue for enrollees and as a result, broaden the range of choices for both Healthy NY and other SHOP participants. Shifting Healthy NY to the Exchange might also allow the State to consolidate programs and potentially reduce overall administrative expenses.

³¹ http://www.dfs.ny.gov/healthny/pdf_mix/overall_enrollment.pdf

³² "Independent Report on the Healthy NY Program for Calendar Year 2010," Burns & Associates, Inc., December 2010, page ii., Ibid.

³³ Burns & Associates, page ii.

Appendix 6: Regulations

A sample of regulations cited in the document is included in full text below.

§ 155.730 Application standards for SHOP.

- (a) *General requirements.* Application forms used by the SHOP must meet the requirements set forth in this section.
- (b) *Single employer application.* The SHOP must use a single application to determine employer eligibility and to collect information necessary for purchasing coverage. Such application must collect the following –
 - (1) Employer name and address of employer’s locations;
 - (2) Number of employees;
 - (3) Employer Identification Number (EIN); and
 - (4) A list of qualified employees and their taxpayer identification numbers.
- (c) *Single employee application.* The SHOP must use a single application for eligibility determination, QHP selection and enrollment for qualified employees and their dependents.
- (d) *Model application.* The SHOP may use the model single employer application and the model single employee application provided by HHS.
- (e) *Alternative employer and employee application.* The SHOP may use an alternative application if such application is approved by HHS and collects the following:
 - (1) In the case of the employer application, the information in described in paragraph (b); and
 - (2) In the case of the employee application, the information necessary to establish eligibility of the employee as a qualified employee and to complete the enrollment of the qualified employee and any dependents to be enrolled.
- (f) *Filing.* The SHOP must allow an employer to file the SHOP single employer application and employees to file the single employee application in the form and manner described in § 155.405(c).
- (g) *Additional safeguards.* The SHOP may not provide to the employer any information collected on the employee application with respect to spouses or dependents other than the name, address, and birth date of the spouse or dependent.

§ 155.405 Single streamlined application.

- (a) *The application.* The Exchange must use a single streamlined application to determine eligibility and to collect information necessary for:
 - (1) Enrollment in a QHP;
 - (2) Advance payments of the premium tax credit;
 - (3) Cost-sharing reductions; and
 - (4) Medicaid, CHIP, or the BHP, where applicable.
- (b) *Alternative application.* If the Exchange seeks to use an alternative application, such application, as approved by HHS, must request the minimum information necessary for the purposes identified in paragraph (a) of this section.

- (c) Filing the single streamlined application. The Exchange must –
 - (1) Accept the single streamlined application from an application filer;
 - (2) Provide the tools to file an application –
 - (i) Via an Internet Web site;
 - (ii) By telephone through a call center;
 - (iii) By mail; and
 - (iv) In person, with reasonable accommodations for those with disabilities, as defined by the Americans with Disabilities Act.

§ 155.220 Ability of States to permit agents and brokers to assist qualified individuals, qualified employers, or qualified employees enrolling in QHPs.

- (a) *General rule.* A State may permit agents and brokers to –
 - (1) Enroll individuals, employers or employees in any QHP in the individual or small group market as soon as the QHP is offered through an Exchange in the State;
 - (2) Subject to paragraphs (c), (d), and (e) of this section, enroll qualified individuals in a QHP in a manner that constitutes enrollment through the Exchange; and
 - (3) Subject to paragraphs (d) and (e) of this section, assist individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs.
- (b) *Web site disclosure.* The Exchange may elect to provide information regarding licensed agents and brokers on its Web site for the convenience of consumers seeking insurance through that Exchange.
- (c) *Enrollment through the Exchange.* A qualified individual may be enrolled in a QHP through the Exchange with the assistance of an agent or broker if:
 - (1) The agent or broker ensures the applicant’s completion of an eligibility verification and enrollment application through the Exchange Web site as described in § 155.405;
 - (2) The Exchange transmits enrollment information to the QHP issuer as provided in § 155.400(a) to allow the issuer to effectuate enrollment of qualified individuals in the QHP.
 - (3) When an Internet Web site of the agent or broker is used to complete the QHP selection, at a minimum the Internet Web site must:
 - (i) Meet all standards for disclosure and display of QHP information contained in § 155.205(b)(1) and (c);
 - (ii) Provide consumers the ability to view all QHPs offered through the Exchange;
 - (iii) Not provide financial incentives, such as rebates or giveaways;
 - (iv) Display all QHP data provided by the Exchange;
 - (v) Maintain audit trails and records in an electronic format for a minimum of ten years; and
 - (vi) Provide consumers with the ability to withdraw from the process and use the Exchange Web site described in § 155.205(b) instead at any time.

- (d) *Agreement.* An agent or broker that enrolls qualified individuals in a QHP in a manner that constitutes enrollment through the Exchange or assists individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs must comply with the terms of an agreement between the agent or broker and the Exchange under which the agent or broker at least:
- (1) Registers with the Exchange in advance of assisting qualified individuals enrolling in QHPs through the Exchange;
 - (2) Receives training in the range of QHP options and insurance affordability programs; and
 - (3) Complies with the Exchange's privacy and security standards adopted consistent with § 155.260.
- (e) *Compliance with State law.* An agent or broker that enrolls qualified individuals in a QHP in a manner that constitutes enrollment through the Exchange or assists individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs must comply with applicable State law related to agents and brokers, including applicable State law related to confidentiality and conflicts of interest.

45 CFR § 147.128 Rules regarding rescissions.

(a) Prohibition on rescissions

- (1)** A group health plan, or a health insurance issuer offering group or individual health insurance coverage, must not rescind coverage under the plan, or under the policy, certificate, or contract of insurance, with respect to an individual (including a group to which the individual belongs or family coverage in which the individual is included) once the individual is covered under the plan or coverage, unless the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or unless the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage. A group health plan, or a health insurance issuer offering group or individual health insurance coverage, must provide at least 30 days advance written notice to each participant (in the individual market, primary subscriber) who would be affected before coverage may be rescinded under this paragraph (a)(1), regardless of, in the case of group coverage, whether the coverage is insured or self-insured, or whether the rescission applies to an entire group or only to an individual within the group. (The rules of this paragraph (a)(1) apply regardless of any contestability period that may otherwise apply.)
- (2)** For purposes of this section, a rescission is a cancellation or discontinuance of coverage that has retroactive effect. For example, a cancellation that treats a policy as void from the time of the individual's or group's enrollment is a rescission. As another example, a cancellation that voids benefits paid up to a year before the cancellation is also a rescission for this purpose. A cancellation or discontinuance of coverage is not a rescission if –
 - (i)** The cancellation or discontinuance of coverage has only a prospective effect; or
 - (ii)** The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

(3) The rules of this paragraph (a) are illustrated by the following examples:

Example 1.

- (i) **Facts.** Individual A seeks enrollment in an insured group health plan. The plan terms permit rescission of coverage with respect to an individual if the individual engages in fraud or makes an intentional misrepresentation of a material fact. The plan requires A to complete a questionnaire regarding A's prior medical history, which affects setting the group rate by the health insurance issuer. The questionnaire complies with the other requirements of this part and part 146. The questionnaire includes the following question: "Is there anything else relevant to your health that we should know?" A inadvertently fails to list that A visited a psychologist on two occasions, six years previously. A is later diagnosed with breast cancer and seeks benefits under the plan. On or around the same time, the issuer receives information about A's visits to the psychologist, which was not disclosed in the questionnaire.
- (ii) **Conclusion.** In this Example 1, the plan cannot rescind A's coverage because A's failure to disclose the visits to the psychologist was inadvertent. Therefore, it was not fraudulent or an intentional misrepresentation of material fact.

Example 2.

- (i) **Facts.** An employer sponsors a group health plan that provides coverage for employees who work at least 30 hours per week. Individual B has coverage under the plan as a full-time employee. The employer reassigns B to a part-time position. Under the terms of the plan, B is no longer eligible for coverage. The plan mistakenly continues to provide health coverage, collecting premiums from B and paying claims submitted by B. After a routine audit, the plan discovers that B no longer works at least 30 hours per week. The plan rescinds B's coverage effective as of the date that B changed from a full-time employee to a part-time employee.
- (ii) **Conclusion.** In Example 2, the plan cannot rescind B's coverage because there was no fraud or an intentional misrepresentation of material fact. The plan may cancel coverage for B prospectively, subject to other applicable Federal and State laws.

(b) Compliance with other requirements. Other requirements of Federal or State law may apply in connection with a rescission of coverage.

(c) Applicability date. The provisions of this section apply for plan years (in the individual market, for policy years) beginning on or after September 23, 2010. See § 147.140 of this part for determining the application of this section to grandfathered health plans (providing that the rules regarding rescissions and advance notice apply to all grandfathered health plans).

[75 FR 37238, June 28, 2010]

Appendix 7: Glossary

Table 4: Glossary

Term	Definition
ACA	Patient Protection and Affordable Care Act of 2010
DFS	NYS Department of Financial Services
DOB	NYS Division of the Budget
ESI	Employer Sponsored Insurance
The Exchange	The New York Health Benefit Exchange
FSA	Flexible Spending Account
HDHP	High Deductable Health Plan
HHS	United States Department of Health and Human Services
HIICAP	NYS Health Insurance Information Counseling and Assistance Program
HSA	Health Savings Account
IRS	United States Internal Revenue Service
MLR	Medical Loss Ratio
POP	Premium Only Payment
PPO	Preferred Provider Organization
QHP	Qualified Health Plan
SHOP	Small Business Health Options Program Exchange
The State	New York State

