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Commonwealth of Pennsylvania, Pennsylvania Insurance Department

Insurance Exchange Planning

November 21, 2011

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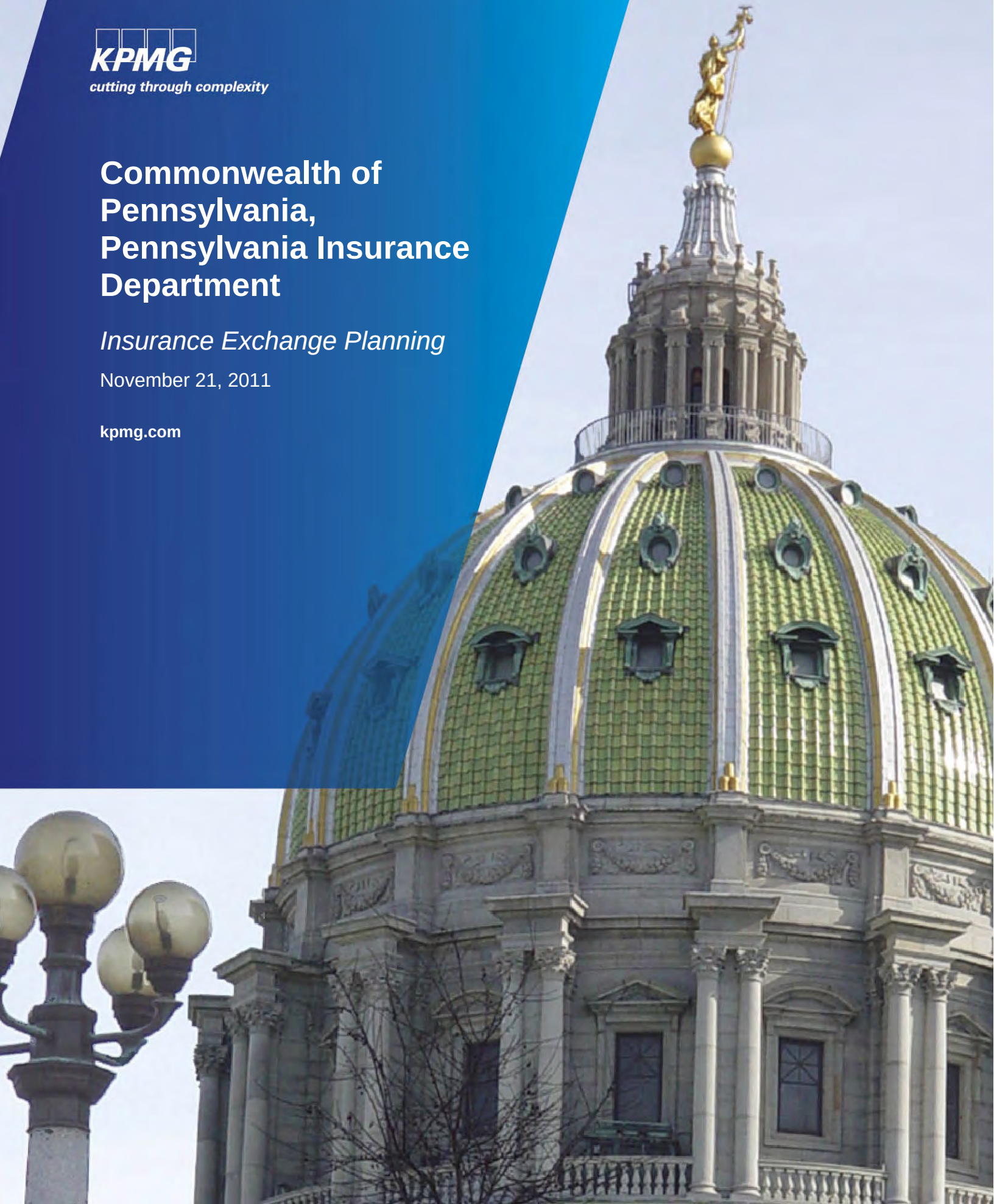

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Overview

Overview of the Affordable Care Act and Exchange Regulations

The Patient Protection and Affordable Care Act, signed into law on March 23, 2010, and the Health Care and Education Reconciliation Act of 2010, signed into law on March 30, 2010 (together referred to as the Act or ACA), covers most facets of the current American healthcare system. The acts propose to significantly revise established components of our healthcare system, such as: Medicaid and other government program eligibility criteria; use of technology to improve healthcare quality and delivery; and creation and administration of Health Insurance Exchanges. Among these, ACA anticipates that a Health Insurance "Exchange" will be operated in each state as a resource for individuals and small employers to access health insurance by January 1, 2014.

KPMG was engaged by the Pennsylvania Insurance Department (PID or the Department) as part of the Commonwealth's ongoing analysis of options to be considered in determining the Commonwealth's plans to comply with the Health Insurance Exchange requirements of the Affordable Care Act. KPMG assisted with identifying, collating, and presenting information for the Commonwealth to consider when making a decision whether to establish and implement its own Health Insurance Exchange. The engagement involved analysis of the Federal Statute, proposed federal regulations, meetings with PID, attendance at stakeholder sessions, review of written stakeholder testimony and consideration of various other publicly available material on the Act and its implementation. The key areas of focus of the work and the resulting analysis were based on the exchange requirements of the Act.

American Health Benefit Exchanges

An "Exchange" is commonly envisioned as an online store that acts as an additional distribution channel where consumers would shop for health insurance. Exchanges are not insurers, but they will qualify plans offered by insurance companies that would like to sell their plans in the Exchange. An Exchange is expected to be in operation in each state by 2014, whether it is a state-operated Exchange or a federal Exchange. Exchanges would be available to those who work for companies with up to 100 or fewer employees (unless a state chooses to reduce the eligibility for employers to those with 50 or fewer employees for the first two years), and to individuals looking to buy insurance for themselves, because they are self-employed, unemployed, not covered by employer coverage, or retired but not yet eligible for Medicare.

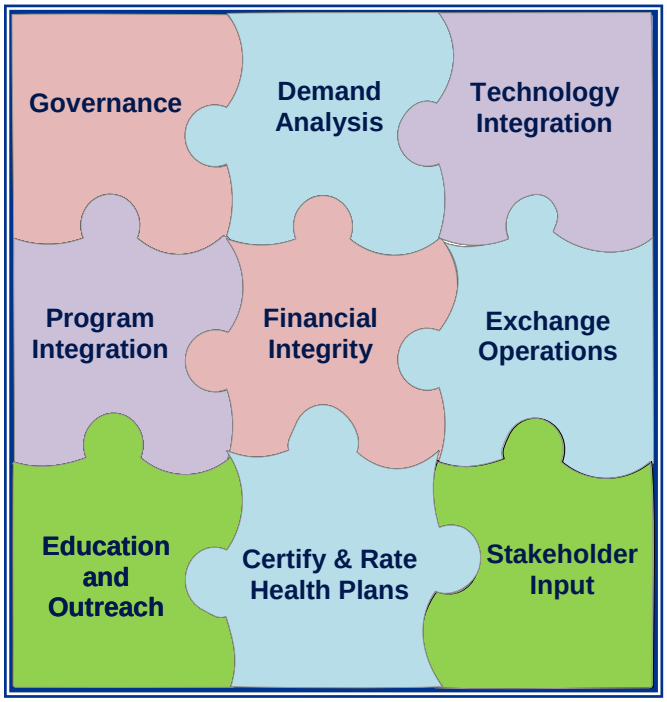
Implementation of an Exchange can take several forms and may be state-wide, multi-state, or regional within a single state; or a federal Exchange may be used by states that either cannot operate their own Exchange or opt into the federal Exchange. In addition, an Exchange will provide both individual and small business coverage. An Exchange may also be implemented within an existing government agency, by a newly created government agency, through a quasi-governmental or by a non-profit entity.

Regardless of whether an Exchange is operated by a state or the federal government or the organizational structure selected, there are a number of core functions that Exchanges are expected to provide under ACA, including:

- **Accessibility:** Certify, recertify, and decertify health plans as qualified, based on established criteria and guidelines; assign a quality rating to each plan; maintain an Internet Website through which individuals may compare standardized comparative information on plans.
- **Eligibility and Monitoring**: Determine eligibility and subsidy levels for insurance through the Exchange; screen applications to determine eligibility and notify individuals if they qualify for other programs such as Medicaid and CHIP; certify that an individual is exempt from the individual mandate to purchase coverage due to affordability or other exemptions permitted under the Act; verify/resolve inconsistent information

provided to the Exchange by applicants; provide and support an electronic calculator to determine the cost of coverage after applicable premium tax credits and cost-sharing subsidies.

- **Support and Assistance**: Provide a toll-free assistance hotline to provide assistance to consumers and businesses; establish a Navigator program – support organizations that will provide information to raise awareness in the community.
- **Communications and Notifications:** Notify the U.S. Department of the Treasury when an employed individual accesses premium tax credits through the Exchange because they were not offered minimum essential coverage by their employer or if the coverage was deemed unaffordable; notify employers when an employee ceases coverage under an Exchange provided Qualified Health Plan (QHP); for verification purposes send applicant citizenship/immigration status information to the Social Security Administration and the Department of Homeland Security; send applicant income-related information to the Internal Revenue Service for purposes of verifying and determining:
  - Income eligibility
  - Tax credit and cost sharing subsidies
  - Eligibility for exemption from individual mandate requirement



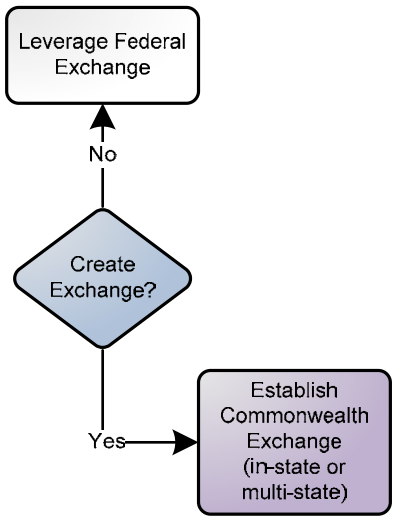
In summary, there will be many integral workstreams that must be carefully planned and executed to establish an insurance Exchange that meets the needs of Pennsylvanians, while also meeting the requirements of the Act.

Stakeholder Feedback

The Pennsylvania Insurance Department (PID) has led the Commonwealth's initiative to seek and obtain input from all interested stakeholders. This was accomplished through several methods including one-on-one stakeholder meetings with the Department, acceptance of written statements from stakeholders and the coordination and execution of three stakeholder forums. These activities were undertaken by PID to gather feedback from the impacted community regarding ACA legislation and the establishment of a Health Insurance Exchange. The Stakeholder Forums were conducted in three locations across the state: Pittsburgh, Philadelphia and Harrisburg. Approximately 800 individuals attended the forums, 75 participants presented testimony, and those who did not want to present at the forum were able to submit their written input to the Department via the website. In addition, a consumer and small business survey administered by the Neiman Group was completed. Stakeholder inputs relevant to several of the key decisions facing the Commonwealth are included in this report.

Demand Analysis

Based on statistical analysis of economic scenarios, shifting in insurance coverage and demand curve participation changes, KPMG developed a range of participation that estimates 2.0 to 2.2 million individuals may participate within a Commonwealth Health Insurance Exchange in 2014. The mean number of estimated participants is approximately 2.1 million participants and the standard deviation of participation is approximately 59,000 participants. These estimates are likely conservative but provide a reasonable foundation for volume expected, and therefore can be used to evaluate systems, resources and process strain. While we have used our best professional judgment in all instances, demand estimates are inherently uncertain because of the random nature of consumer choices. KPMG, therefore, cannot warrant that actual developments will not vary from expectations, perhaps significantly.



Options Analysis

The Commonwealth has many decisions to make in deciding whether, and if so, how, to implement a Health Benefit Exchange. The initial decisions and options to be considered by the Commonwealth are discussed below. With each successive decision, additional considerations are provided including relevant stakeholder input, key risks and potential challenges and benefits. This Options Analysis is intended to provide a framework for the Department's use in working through these first critical steps to determining if and how to establish an exchange.

Federal vs. Commonwealth Exchange

The first decision that the Commonwealth, or any state, is faced with in determining how to provide its constituents with access to the health insurance market is whether to create that marketplace access within the state or to rely on a federal health insurance market or Exchange. Simply put, states have two options for the creation of an Exchange – attempt to create a state-based Exchange by demonstrating adequate progress to the federal government in accordance with milestones in the *Cooperative Agreement to Support Establishment of State Operated Health Insurance Exchanges Funding Opportunity Announcement,* January 20, 2011 (FOA Milestones), or rely on the federal Exchange.

In making this decision, there are several important considerations including costs of establishing and operating an Exchange. While there are many unknowns in the establishment of an Exchange, there are also many risks that should be considered. Several of these risks and considerations are outlined below.

Federal Exchange	State Exchange
Market Risk – The decisions made by a state in leveraging the federal solution as an Exchange may impact the operation of insurance markets within the state and competition in those markets. The potential impacts on the health insurance market should be considered in determining whether or not to use the federally operated Exchange. In addition, the federal Exchange is currently expected to provide only two health insurance plans. The Commonwealth should not only consider the impact on the current insurance market but should also consider whether a limited offering under the federal Exchange will meet the needs of Pennsylvanians. If not, Pennsylvania would need to develop a process to certify qualified plans and work with the federal Exchange to ensure their accessibility through the federal Exchange.	**Market Risk** – The decisions made by a state in implementing an Exchange may have an impact on the insurance markets within the state, including the level of competition fostered. However, a state may be in a better position to manage those impacts by understanding stakeholder concerns and working to address those concerns in the design of the state's Exchange.
Implementation Risk – Interfacing/integrating with a federal-based Exchange is a complex, multi-agency undertaking that will require significant effort by the Commonwealth to answer several information technology (IT) policy and responsibility questions (many of which are still under development by the federal government). At a minimum, Pennsylvania would need to: • Identify what Exchange functional roles may still apply to the Commonwealth (e.g., Medicaid and CHIP) under the federal model. • Identify what IT assets/interfaces may still need to be developed by the Commonwealth. • Review and revise Commonwealth regulatory and policy issues to ensure coordination between the Commonwealth and federal agencies. • Modify the MA and CHIP eligibility systems (these systems will need to be modified regardless of whether the federal Exchange is leveraged to accommodate other changes in these programs). • Integration with the federal Exchange will also require the identification of risks that are associated with any complex system integration and plans to mitigate those risks. There will also be additional risks in this scenario which the Commonwealth may not be able to mitigate due the involvement of parties outside of the Commonwealth's control.	**Implementation Risk** – Establishing a state-based Exchange is a complex, multi-agency project that includes public-facing, government to business, agency to agency, and state to federal government components. This project will require the identification of risks that are associated with any complex system implementation project of this nature and plans to mitigate those risks. In implementing a Commonwealth Exchange, the Commonwealth will have more control and ability to mitigate those risks.

Federal Exchange	State Exchange
Cost Considerations – Interfacing/integrating with a federal-based Exchange will still require resources for, at a minimum, technical staff to support the anticipated core system software modification efforts and policy staff time to review and revise Commonwealth regulatory and policy issues to ensure coordination between state and federal agencies. Depending on the IT assets/interfaces that may still need to be modified or developed, this could be an extensive (and potentially costly) undertaking. A second cost consideration of leveraging the federal Exchange is that federal cost subsidy incentives may result in over-enrollment in the Commonwealth's Medicaid (MA) program. This could add more liability to Pennsylvania for the Commonwealth's unmatched (and uncapped) portion of the MA payments. Another cost consideration the Commonwealth should consider is that by leveraging a federal Exchange model, Pennsylvania could potentially lose out on 90% of federal funds to modify the Commonwealth's core eligibility determination process (to 2015) and the ability to upgrade any associated functionality.	**Cost Considerations** – Implementing a state-based Exchange will require resources for, at a minimum, internal staff and hardware and software. Depending on the governance model chosen and the level of outsourcing the state may consider, the level of internal resources will vary significantly. Establishing an Exchange within an existing agency could help reduce the cost required as the Exchange could leverage existing operational policies, procedures, and systems (such as financial and human resources). Leveraging existing systems could also help reduce the potential cost of establishing an Exchange. In connection with establishing a Commonwealth Exchange, future establishment grants may be requested to upgrade or integrate existing Medicaid systems as a coordinated effort with Exchange establishment. Under this model, such upgrades or integration could receive 100% federal funding.

Stakeholder Feedback on Federal vs. Commonwealth Exchange

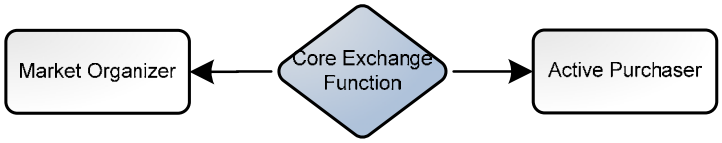
In the feedback obtained through the various activities described above, a large majority of providers, producers, insurers and community representatives alike expressed their desire for Pennsylvania to create its own Exchange. All but one of the stakeholders that spoke at these forums on the topic of establishing a Commonwealth Exchange vs. participation in the federal Exchange indicated that they would prefer a state-run Exchange. The one stakeholder who expressed an interest in the Commonwealth teaming with the federal government to create a federal Exchange suggested it would be a means of promoting efficiencies and minimizing the duplication of efforts required.

Stakeholders expressed a preference for a state-based Exchange because of the flexibility of a state-run Exchange as opposed to a federal Exchange; one stakeholder felt that a Commonwealth Exchange could better support regionally operated plans or subsidiary Exchanges because of the regional differences in health insurance needs of Pennsylvania; while another commented that "an Exchange in PA allows for greater flexibility and reduced federal regulation" and because they believe they would have more input in the creation of such Exchange. Stakeholder investment in any resulting Exchange can be promoted through continued efforts by PID to seek input from stakeholders.

In addition, many of the comments submitted at the Stakeholder Forums include specific concerns that are likely to be more easily addressed if the Commonwealth decides to implement a state Exchange. These concerns include the belief that a regional Exchange within the state will best address the unique needs and attributes of different areas of the state, and the need for ongoing public communication, outreach and transparency.

Active Purchaser vs. Market Organizer Model

Two distinct Exchange operational models are generally believed to currently exist within the United States – the Active Purchaser Model, as implemented in Massachusetts, and the Market Organizer Model, as implemented in Utah.



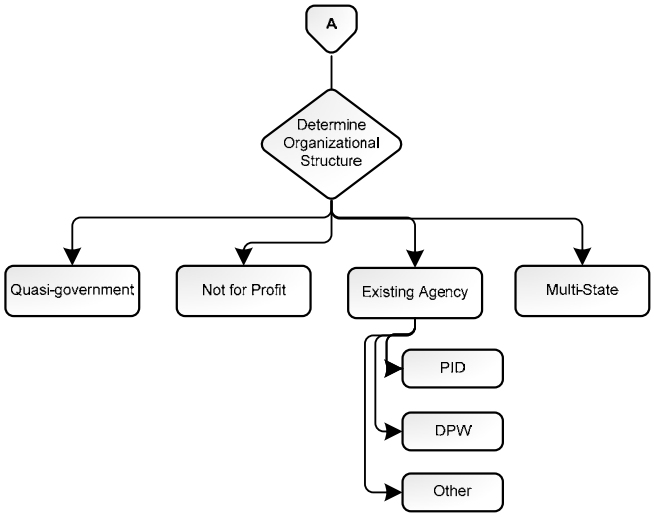
Under the Market Organizer Model, an Exchange acts as a facilitator between consumers and insurance companies to allow for the purchase of insurance. This model supports a laissez-faire environment where consumer needs and budgets will ultimately drive plan selection similar to current market conditions. A Market Organizer Model could support accepting any plan that meets specified pre-defined requirements, while an aggressive Active Purchaser Model could support the authority to limit the number plans participating based upon a bidding or negotiation process. The Commonwealth should consider the costs and benefits of each approach as well as the amount of government involvement within the Exchange under each model.

In both models, an Exchange will need to have the same functionality as required by the Act. For example, under both models all plans offered through the Exchange will have to be qualified and quality ratings will have to be provided. The key attributes of each model are described below.

Market Organizer	Active Purchaser
▪ Less complex technology requirements ▪ Less control over consumer experience ▪ Reliance on carrier websites to collect premiums and fulfill insurance plan enrollment and purchase ▪ May require additional steps to receive operating funds (depending on financing approach)	▪ Exchange selects plans to be offered ▪ Exchange acts as market aggregator ▪ Technology investment is higher ▪ Exchange collects premium payment from enrollee, requiring web-based payment processing capability and enterprise systems capability ▪ Exchange potentially responsible for handling billing and premium questions from members

The decision is not necessarily one or the other. For example, a state can take the Active Purchaser approach while still outsourcing core Exchange operations such as enrollment, consumer assistance, and premium collection and aggregation. On the other hand, a state that takes a Market Organizer approach can also put processes in place to provide consumers with a better “shopping” experience through implmentation of the required quality ratings and easy-to-use comparison tools.

Organizational Options for Establishing a Commonwealth Exchange



Assuming that the Commonwealth moves forward with establishing a Commonwealth Exchange, the next decision will be to determine what organizational structure is most appropriate for the Commonwealth. In assessing the various options outlined throughout this report, the Commonwealth should evaluate each option against an agreed-upon set of criteria. These criteria should be aligned with the long-term initiative of the Commonwealth to sustain a stable and secure economy.

As with most states, the costs of healthcare coverage for the uninsured as well as the state share of Medicaid are significant components of the Commonwealth's budget.

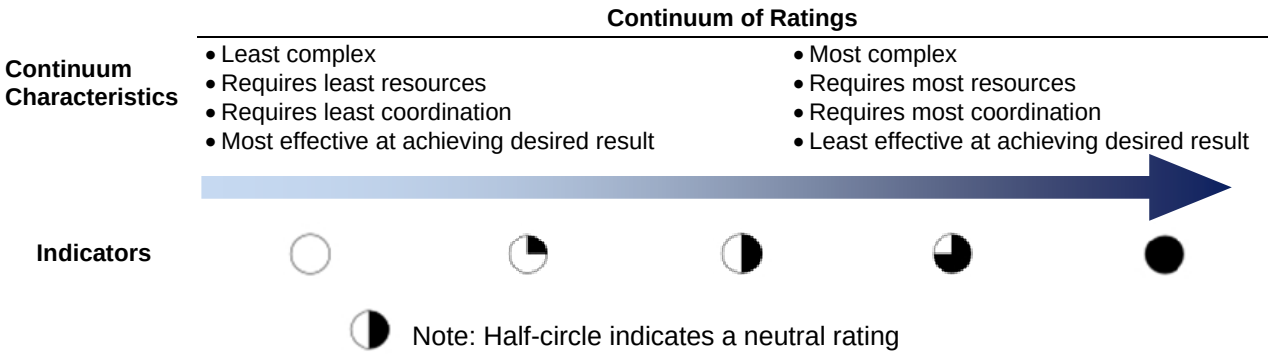
- *Limit the size of government* – In evaluating each option against this criterion, the Commonwealth may wish to consider the degree to which expansion of government may or will need to result. For example, a new quasi-Government agency might require the creation of a new independent board or commission, which may also require oversight from or coordination with existing agencies.
- *Administrative efficiency* – In assessing each option against this criterion, the ease with which the Exchange will be able to operate and make decisions should be considered. In addition, the ability to leverage existing resources (people, process and technology) in establishing the Exchange should be assessed. Options where existing resources can be leveraged will likely create efficiencies in the establishment of a Commonwealth Exchange.
- *Partnering with private industry* – Partnering with private industry, learning from leading practices (within and outside of government), and identifying if there is a possible fit for outsourcing of Exchange functions should be considered for each option.
- *Accountability and transparency* – Stakeholders as well as government leaders across the country are calling for expanded accountability and transparency in government operations, particularly where new operations or programs are implemented. The accountability and transparency of a Commonwealth Exchange are likewise important and expected by all stakeholders and as such, this criterion should be considered when evaluating options for a Commonwealth Exchange. Certain governance structures may provide greater accountability to Pennsylvanians than others. While the level of transparency or "perceived" transparency may be more directly impacted by the operations of the Exchange, certain organizational structures may lend themselves to a greater level of transparency than others.
- *Stimulate and encourage competition* – The current health insurance market is complex with many players and stakeholders. The impact on that market should be considered in assessing options for a Commonwealth Exchange, particularly the impact on competition within that market. A typical goal of an insurance Exchange is to stimulate and encourage competition in the market, thereby resulting in the offering of quality, affordable health care coverage. As a state begins to make decisions with

Governor Corbett's 50 Ways to Rebuild Pennsylvania suggests implementing "healthcare reform by adopting common sense policies that ensure access, quality and affordability."

respect to Exchange operations there can be ripple effects in the market, and certain organizational structures may have greater proclivity than others to consider and address those ramifications.

- *Control and reduce spending – If a* Commonwealth Exchange is established, it must be self-sustaining beginning January 1, 2015. The ongoing costs of operating an Exchange should be considered for each option and the potential costs compared across each option in determining the best fit for the Commonwealth.
- *Accessibility* – A key objective in establishing an Exchange is to create a new avenue of access for health insurance for all Pennsylvanians. When evaluating the options for a Commonwealth Exchange, accessibility was a common concern for stakeholders.

Each organizational structure and the key functions of an Exchange are assessed against these criteria below using the following rating scale.



Note: Half-circle indicates a neutral rating

For example, the full circle under the quasi-government option in the governance focus area for the "limit the size of government" criteria can be interpreted as indicating that establishing a new governance structure within a new entity would not be a desirable result if the goal is to limit the size of government. In contrast, the unfilled circle under the same focus area and critera for the non-for-profit option can be interpreted as an effective option where the goal is to limit the size of government.

Detail Ratings for Each Option and Focus Area by Criteria

Options	Focus Area	Limit the size of government	Efficiency of administration	Partnering with private industry	Accountability and transparency	Stimulate and encourage competition	Control and reduce spending	Accessibility
Quasi-Government	Governance	●	●	◑	◑	◑	●	◑
	Program Integration	◕	●	◑	◑	◑	◕	◑
	Technology	●	◑	◑	◑	◔	◕	◑
	Financial Management	●	●	◔	◑	◑	●	◑
	Certification and Quality Ratings	●	◑	●	◑	◕	◕	◑
	Eligibility and Enrollment	◑	◔	◑	◑	◑	◑	◑

Options	Focus Area	Limit the size of government	Efficiency of administration	Partnering with private industry	Accountability and transparency	Stimulate and encourage competition	Control and reduce spending	Accessibility
Not-for-Profit	Governance							
	Program Integration							
	Technology							
	Financial Management							
	Certification and Quality Ratings							
	Eligibility and Enrollment							
Existing Agency	Governance							
	Program Integration							
	Technology							
	Financial Management							
	Certification and Quality Ratings							
	Eligibility and Enrollment							
Multi-State	Governance							
	Program Integration							
	Technology							
	Financial Management							
	Certification and Quality Ratings							
	Eligibility and Enrollment							

The key considerations driving the ratings assigned above are described below for each focus area.

Governance – From a governance perspective, the Existing Agency and Not-for-Profit options appear to be the most appropriate for the Commonwealth. An existing agency should need less start-up costs and with strategic sourcing of appropriate functions, ongoing costs of operations could also be contained. An established agency would also be able to better communicate with other involved agencies through existing channels. In addition, should an existing agency such as PID lead the Exchange, many of the other stakeholders, especially insurers, already interact and communicate with PID. On the other hand, a Not-for-Profit or Quasi-Government could potentially benefit from greater flexibility in decision making and administration as compared to a "line" agency in such areas a procurement. In addition, at least one stakeholder commented that establishing an Exchange outside of PID would help to avoid any question or perception of conflict given PID's role as regulator. In converse, many stakeholders suggested that the Exchange should be run by PID as they are the existing regulator.

Program Integration – Program integration may be more easily or efficiently achieved in an existing agency where similar programs such as Medicaid and CHIP already exist. Although integration can be achieved in the other organizational options, the ease of administration and incremental costs to integrate will likely be less than optimal. A Not-for-Profit may be the least efficient choice under this category as it may be more difficult for a non-government entity to integrate with the existing government programs – or the government programs may need to remain with the Commonwealth and coordinate with the Not-for-Profit through system interfaces or "hand-offs" of certain processes.

Technology – From a technology perspective, establishing the Exchange in an existing agency is effective at achieving the desired result of leveraging the Commonwealth's existing system assets. While the size of government will not be significantly impacted by placing the Exchange in an existing agency, the efficiency of administration and accountability/transparency are meaningful in this approach. In addition, Pennsylvania's current IT assets can support several of the anticipated Exchange's functional components. Depending on the model selected, the Commonwealth may also be able to partner effectively with private industry to provide required Exchange functionality (e.g., web shopping capability). The Commonwealth may not be able to utilize its existing IT assets as fully if it chooses to establish the Exchange using a Not-for-Profit or Quasi-Governmental model, and some functionality may need to be developed separately. Moreover, the Multi-State Exchange approach may introduce additional complexities regarding "ownership" of data and systems and responsibility for various components of the envisioned Exchange transactions (e.g., help desk support).

Financial Management – A Quasi-Government or Not-for-Profit will need to establish its own financial management and integrity policies, procedures, practices and systems, thus resulting in additional or incremental costs over the existing agency options in which the existing commonwealth systems and processes can be utilized with mimimal incremental cost or effort. In addition, financial management practices may not be as transparent under the Not-for-Profit option. Existing processes and systems may also be leveraged in the Multi-State option; however, agreements between participating states will need to be executed to document each state's responsibilities.

Certification and Quality Rating – A Not-for-Profit or a Multi-State certification and quality rating process may limit the size of government; however, these external agencies may lose the efficiencies of administration gained from maintaining the process within a governmental entity. A Multi-State certification and quality rating process may impede the accountability and transparency of the process and may not encourage competition as well as other choices; however, it may help to control or reduce spending.

Eligibility and Enrollment – Regardless of organizational structure, new processes and systems will be needed to determine eligibilty for premium susbsidies and tax credits and enrollment in qualified health plans. The same processes and systems can be implemented across the various organizational options. Streamlining of

eligibility across government programs (Medicaid and CHIP) and Exchange subsidies and tax credits may be more complex under the Not-for-Profit option.

Summary of Ratings by Option

Criteria	Quasi-Government	Not-for-Profit	Existing Agency	Multi-State
Limit the size of government				
Efficiency of administration				
Partnering with private industry				
Accountability and transparency				
Stimulate and encourage competition				
Control and reduce spending				
Accessibility				

The ratings above were determined by averaging the detailed ratings for each option. The key observations that can be made from the summary ratings chart are provided below by criteria.

Limit the size of government – While a Not-for-Profit organization will require additional resources, these resources are not within a government organization, enabling this option to help avoid increasing the size of government. A Quasi-Governmental organization will require additional government resources to establish the Exchange, hampering the ability to limit the size of government.

Efficiency of administration – A Quasi-Government or Not-for-Profit organization will likely have more administrative flexibility than an existing state agency or Multi-State organization in how operations are established and decisions are made. A Multi-State organization will need to coordinate administrative tasks among the states involved, impacting the administrative efficiency of this Exchange.

Partnering with private industry – An Existing Agency or a Multi-State organization will need to follow the procurement rules in place for the state(s) involved, potentially hampering their ability to quickly partner with private industry and outsource Exchange functions.

Accountability and transparency – An Existing Agency has processes and procedures already in place to support transparency, while a Not-for-Profit organization will need to establish processes to ensure transparency. The other models have mechanisms in place that can be leveraged to support transparency.

Stimulate and encourage competition – Each of the organizational models appears relatively neutral with respect to stimulating and encouraging competition in the insurance market. The decisions that the Commonwealth makes “down the road” with respect to operations of the Exchange will need to take into consideration the potential market impacts with respect to competition – particularly the choice around the Active Purchaser vs. Market Organizer options.

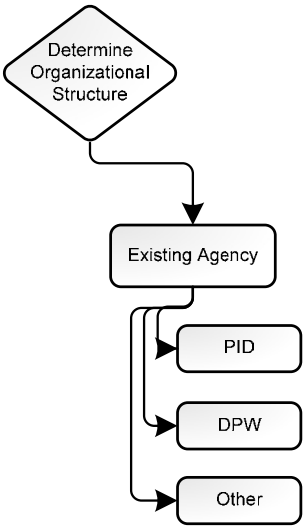
Control and reduce spending – While there are incremental costs in establishing an Exchange within an existing agency, existing processes, systems and infrastructure can be more easily leveraged. This would limit incremental spending to that which is necessary to modify existing systems and put new processes in place that would be required regardless of organizational structure. For the same reasons as described above a Quasi-Governmental structure will have the greatest incremental costs as it represents a new entity that will need its own infrastructure, as would a Not-for-Profit.

Accessibility – As with the previous analysis around the stimulation and encouragement of market competition, the organizational options appear equally able to provide the desired level of accessibility. This is due to the fact that regardless of organizational structure, the Exchange will represent a new channel for access to health benefits. There is a greater possibility that more differences could occur in the "seamlessness" of accessibility under the Quasi-Government, Not-for-Profit and Multi-State options, as the various eligibility determinations (Medicaid/CHIP and Subsidy/Tax Credits) may be more difficult to streamline across multiple entities and supporting technology.

Stakeholder Feedback on Organizational Options for a Commonwealth Exchange

Many stakeholders have commented on their preferred organizational structure for the establishment of a Commonwealth Exchange. One insurer noted that "the governance for the Exchange should sit within the Pennsylvania Insurance Department since the Department currently regulates insurers and has the expertise and relationship with the carriers." These relationships will help to mitigate the transitionary effects of the implementation of the Exchange within the insurance market because insurers already have a direct line of access with the Pennsylvania Insurance Department.Other stakeholders felt that the Exchange should be an independent public authority, perhaps with involvement of key public officers and a stakeholder advisory committee – staffed by consumer representatives. The Exchange will then be in a position to hire assistance more easily, and twenty-nine states have already indicated their consideration of this methodology.

Establishing a Commonwealth Exchange within an Existing Agency



Using the above assessment results, and taking only these factors into primary account, the Commonwealth could conclude that the establishment of a Commonwealth Exchange would best meet the needs of Pennsylvanians if incorporated into an existing agency or agencies of the Commonwealth. If this path is taken, there are several further options to consider. Based on the current processes, systems, regulatory responsibilities and functional responsibilities, two existing agencies may be appropriate candidates for taking on some or all of the Exchange functions. If more than one agency will be involved, a lead agency should be identified. In addition, certain other agencies may only have a temporary role in a Commonwealth Exchange during the establishment phase (through the end of 2013) or may provide support to the lead agency for certain functions.

Also, the Commonwealth may consider outsourcing certain functions of the Exchange to further contain costs of establishing and operating an Exchange as well as potentially transferring risks associated with certain Exchange functions.

The table below reflects what could potentially be outsourced, and/or where existing agency functions could or should be leveraged. In some cases statutory requirements mandate that State agencies retain a certain function such as producer licensing. Under this scenario, the public entities retain the responsibility to establish criteria and rules for operating these functions.

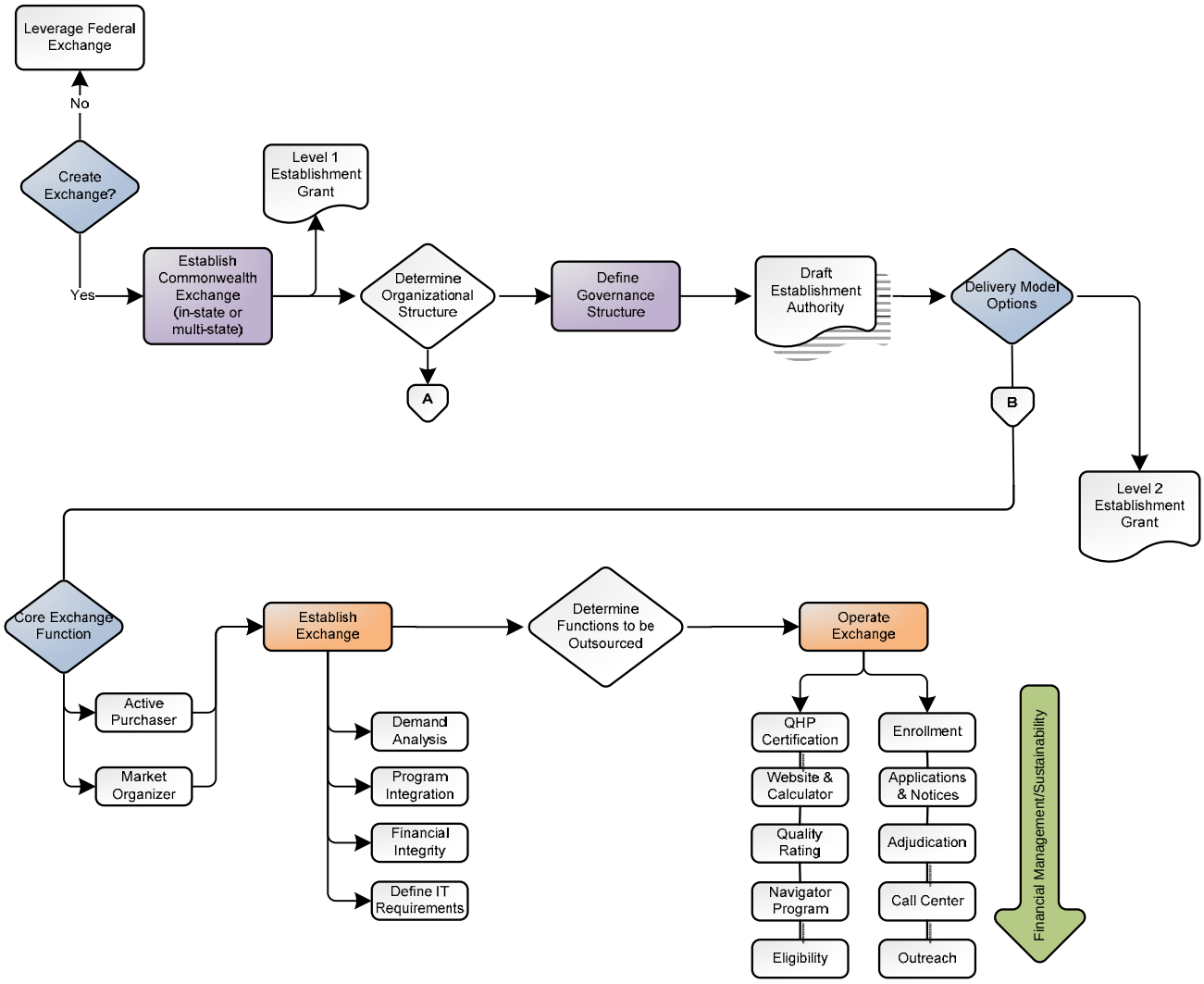
Function	Public Agencies			Private
	PID	DPW	Other	
Establish rules for Eligibility for Medicaid/CHIP, eligibility for subsidy/tax credit, and the related appeals process	✓	✓		
Determine Eligibility for Medicaid		✓		✓
Determine Eligibility for CHIP	✓			✓
Determine Eligibility for Subsidy/Tax Credit				✓
Medicaid/CHIP Eligibility and Tax Credit/Subsidy Appeals Process	✓	✓		✓
Certification of Exemptions	✓			✓
Certification of Qualified Health Plans	✓		✓	
Quality Ratings of the Plans – Develop Criteria for Ratings	✓			
Quality Ratings of the Plans – Evaluate Against Criteria				✓
Oversight and Financial Integrity – Develop Evaluation Criteria	✓	✓	✓	
Oversight and Financial Integrity – Perform Audit			✓	✓
Marketing and Outreach				✓
Customer Service/Call Center		✓		✓
Navigator Management	✓			✓
Producer Licensing	✓			
Premium Processing				✓
Tax Credit Processing				✓
Portal Development		✓	✓	✓
Portal Management/Operation			✓	✓

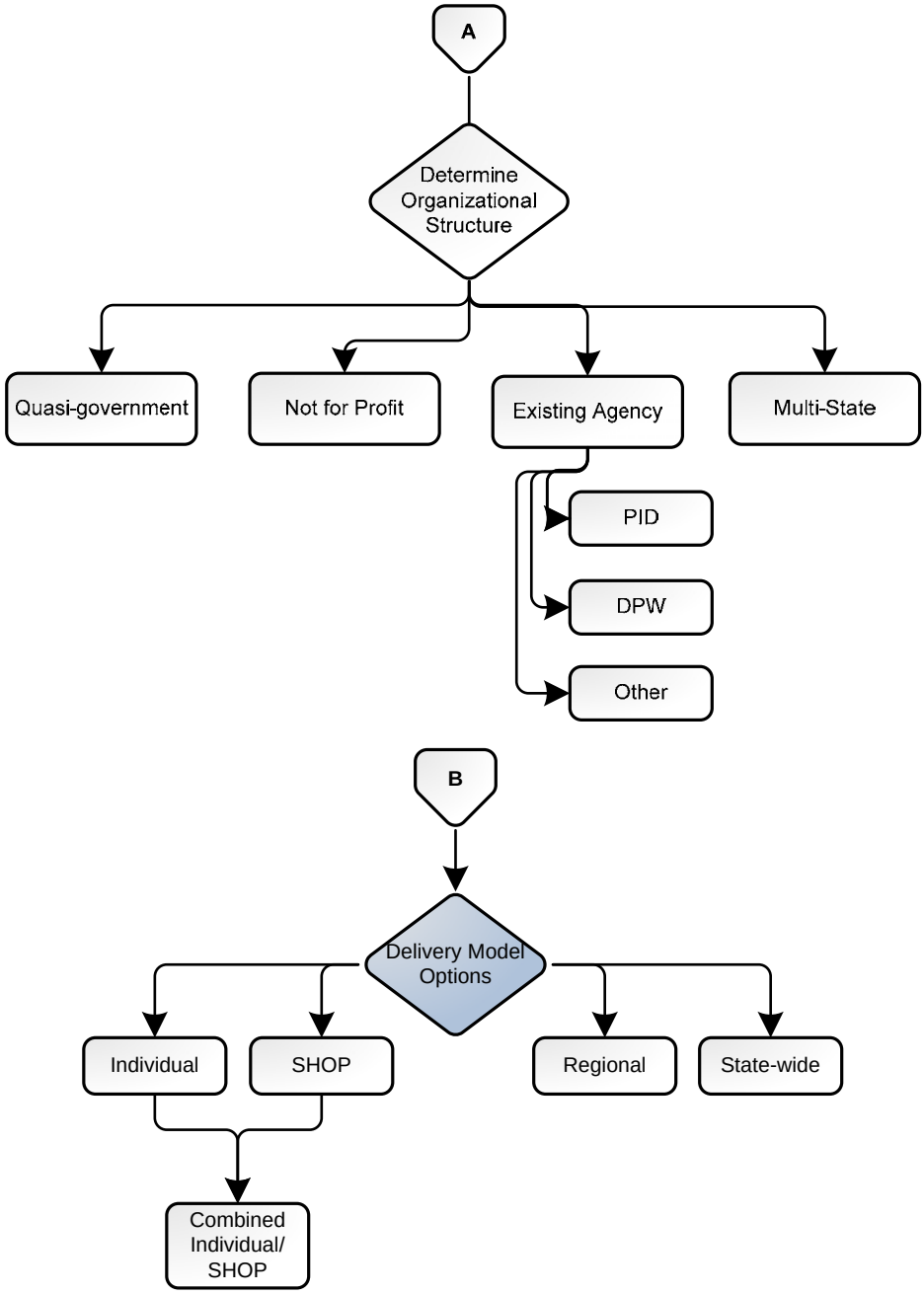
Alternatives for outsourcing could include entering into a public-private partnership (P3). A P3 involves a public sector organization contracting with a private entity to deliver a public service and involves the transfer of risk to the private entity (up to full revenue service). The risk-sharing characteristic of a P3 may be attractive to the Commonwealth; however, contract development can be lengthy as all rules need to be defined in the contract, including penalties and contingencies for the public sector organization to take back the operation. Enabling legislation is also required for P3s.

Moving Forward

The decision tree outlines at a high level the key decisions to be made going forward. It is important to consider the puzzle piece concept presented above and the demonstration of the options rating and analysis – as decisions are made, additional milestones and questions need to be considered in each of the core areas. There are a significant number of possible permutations that can result once the Commonwealth begins to make policy, operational and strategic decisions moving forward.

Health Insurance Exchange Primary Decision Tree





Note to the Reader

The purpose of this report is to present information obtained and observations noted during the course of the engagement for the Commonwealth of Pennsylvania's consideration. The engagement involved analysis of the Federal Statute, proposed federal regulations, meetings with PID, attendance at stakeholder sessions, review of written stakeholder testimony and consideration of various other publicly available material on the Public Protection and Affordable Care Act and its implementation. The gap analysis performed was based on the data and information collected from the Commonwealth over the course of the engagement with the Pennsylvania Insurance Department. It is important to note that the regulations, related guidance and other materials reviewed were current as of August 2011. Health Benefit Exchange requirements are continuing to evolve, and information contained in this report reflects only that data available at the time the work was performed. Future federal guidance may further clarify or modify such information. In this report, KPMG has not expressed an opinion on financial results, processes, other information or internal controls related to PID or the Commonwealth. The Commonwealth of Pennsylvania maintains responsibility for the decisions to implement any aspect of a Health Benefit Exchange, and for considering the impacts of such decisions.

Background

The Affordable Care Act and Exchange Regulations

The Patient Protection and Affordable Care Act, signed into law on March 23, 2010, and the Health Care and Education Reconciliation Act of 2010, signed into law on March 30, 2010 (together referred to as the Act or ACA), covers most facets of the current American healthcare system. The acts propose to significantly revise established components of our healthcare system, such as: Medicaid and other government program eligibility criteria; use of technology to improve healthcare quality and delivery; and creation and administration of Health Insurance Exchanges. Among these, ACA anticipates that a Health Insurance "Exchange" will be operated in each state as a resource for individuals and small employers to access health insurance by January 1, 2014.

KPMG was engaged by the Pennsylvania Insurance Department (PID) as part of the Commonwealth's ongoing analysis of options to be considered in determining the Commonwealth's plans to comply with the Health Insurance Exchange requirements of the Affordable Care Act. KPMG assisted with identifying, collating, and presenting information for the Commonwealth to consider when making a decision whether to establish and implement its own Health Benefits Exchange.The engagement involved analysis of the Federal Statute, proposed federal regulations, meetings with PID, attendance at stakeholder sessions, review of written stakeholder testimony and consideration of various other publicly available material on the Act and its implementation.

The purpose of this report is to present information obtained and observations noted during the course of the engagement for the Commonwealth of Pennsylvania's consideration.

Overall Process and Procedures Performed

During the course of the engagement, KPMG performed the following tasks (among others), which have resulted in this report:

- Produced a project plan identifying key activities to be performed with an estimated timeline;
- Conducted bi-weekly status updates detailing the progress on engagement tasks;
- Submitted a draft mid-project report describing overall project status and including other relevant materials such as an activity crosswalk document, a demand analysis update, discussion document, stakeholder session notes and an options analysis template;
- Developed a preliminary stakeholder communication and outreach plan to solicit participation and feedback from stakeholders during the planning, establishment and operation of a potential Exchange;
- Attended three stakeholder sessions held by the PID and summarized notes by focus area including Exchange structure, roles and responsibilities of stakeholders, consumer considerations, and other Exchange parameters;
- Developed multiple discussion documents and provided them to the PID for review and comment;
- Conducted significant background research and analysis related to core focus areas and presented the information in this report according to a report template agreed upon by PID; and,
- Presented a draft report to PID.

The gap analysis performed was based on the data and information collected from the Commonwealth over the course of the engagement with the Pennsylvania Insurance Department. It is important to note that the regulations, related guidance and other materials reviewed were current as of August 2011. Health Benefit Exchange requirements are continuing to evolve, and information contained in this report reflects only that data available at the time the work was performed. Future federal guidance may further clarify or modify such information. In this report, KPMG has not expressed an opinion on financial results, processes, other information or internal controls related to PID or the Commonwealth. The Commonwealth of Pennsylvania

maintains responsibility for the decisions to implement any aspect of a Health Benefit Exchange, and for considering the impacts of such decisions.

The remainder of this document has been organized to present the following:

- Demand Analysis – includes data sources, limitations, assumptions and step-by-step procedures to obtain results;
- Considerations by Focus Area – includes those areas addressed in the Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges Funding Opportunity Announcement" (FOA) and outlines the related regulatory guidance, key considerations and thoughts for moving forward.
- Decision Tree and Work Plan – discusses decisions to be made and potential work streams to be executed.

Demand Analysis

Commonwealth of Pennsylvania
Insurance Exchange Planning

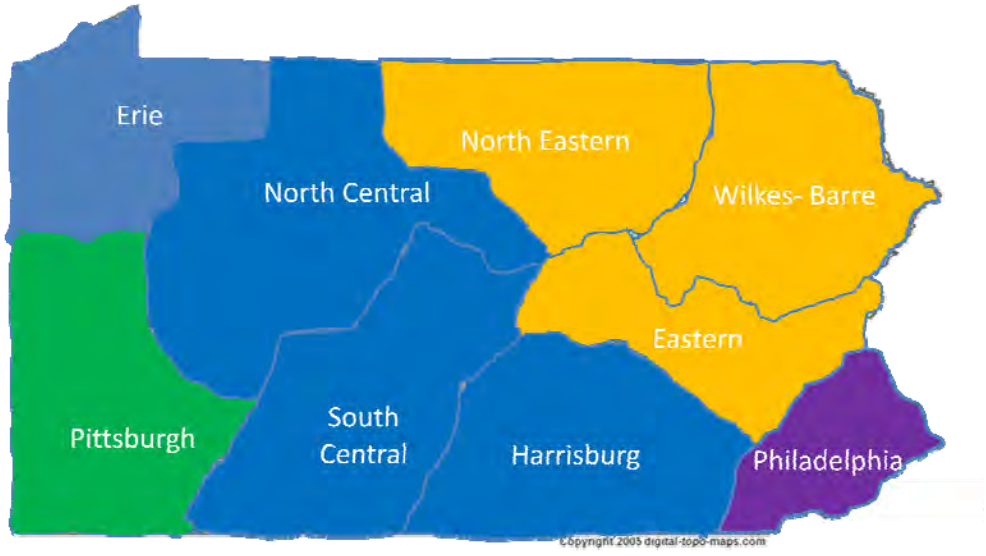
Demand Analysis Overview

KPMG was contracted by the Pennsylvania Insurance Department (PID) to "identify existing background information and what additional background information may be useful concerning the Pennsylvania insured markets (individual, small group and large group), the Pennsylvania uninsured market, and the Pennsylvania self-insured market". As a considerable portion of this background research, KPMG conducted a demand analysis of Pennsylvania's population that will be eligible to purchase health insurance through the Health Insurance Exchange in 2014. KPMG compiled demographic information from the PID, U.S. Census, U.S. Bureau of Labor and Statistics, Pennsylvania State Data Center, Kaiser Family Foundation, and other sources to construct the current picture of Pennsylvania health insurance system. KPMG conducted the analysis by region and developed regional population estimates and key demographics. Employment status and insured status were the key demand drivers considered and we used Neiman Group survey results to derive demand probabilities for each of these demand drivers. Sensitivity tests were then performed to verify the analysis. Based on sensitivity results, KPMG developed three distinct scenario tests for the material assumptions – economic impact, shifting in insurance coverage, and demand curve to help the Commonwealth better understand the demand drivers of the Exchange. Coupling these scenario tests with empirical sensitivity analysis led to a range of participation within the Health Insurance Exchange in 2014.

Regional Definitions

Regional definitions were devised based on the "2008 Pennsylvania Health Insurance Survey" produced by Market Decisions for the PID and the "Blue Cross Plan Service Areas in Pennsylvania" provided by the PID. We utilized the 2008 Pennsylvania Health Insurance Survey as a starting point for our analysis. The survey identified nine regions within the state of Pennsylvania, which were developed by examining the geographic distribution of counties, Labor Market Areas and Metropolitan Statistical Areas. These regional groupings provide a higher level in precision when presenting results and allow comparison to be made between various parts of the state, specifically:

- Erie
- Pittsburgh
- North Central
- South Central
- North Eastern
- Wilkes-Barre
- Harrisburg
- Eastern
- Philadelphia



Using these regions and rate and form information collected from the PID's System for Electronic Rate and Form Filing (SERFF) system to identify statistical difference by geographic region, we analyzed the demand population by the nine regions identified above. Then we summarized the results by the following five regions:

- Erie
- Pittsburgh
- North Central / South Central / Harrisburg
- North Eastern / Wilkes-Barre / Eastern
- Philadelphia

Data Sources

KPMG compiled demographical information from internal and external sources to analyze current population demographics as well as forecasting the Exchange population in 2014. Current estimates for demographic, poverty, Child Health Insurance Program (CHIP) and Medicaid, uninsured rate and unemployment rate are derived from most recent (2010 - 2011) state statistics. Data Sources utilized included:

The Pennsylvania Insurance Department:

- PID CHIP and Child Medicaid Enrollment
- Department of Public Welfare (DPW) Medicaid Enrollment Data
- SERFF National Association of Insurance Commissions (NAIC) Data
- iSite Report
- PA Data Center
- 2008 Pennsylvania Health Insurance Survey

External data sources referenced by the KPMG team:

- US Bureau of Census
- US Bureau of Labor Statistics
- Department of Veterans Affairs
- PA Department of Aging
- E Health Insurance Survey
- Key Stone Research
- Kaiser Family
- Neiman Survey

Data Limitations

KPMG identified data limitations compared to the initial data request while analyzing data provided. We identified the following limitations when analyzing the demand for the Health Insurance Exchange in 2014.

Limited Cross Sections of data – Cross sections (e.g., age by income level by region by insured status) were not available as requested within the KPMG data request. In order to analyze the demographics of Exchange participants, population-based percentages were calculated based on currently available data (i.e., 72.46% of the uninsured population is employed). In order to project our results to 2014, these population-based percentages were multiplied by the 2014 projected population.

No Change in Plan Design – Estimates assume no change in available benefit plan designs offered by the current health insurers, and that the current insured capacity of these insurers remains intact in 2014 (i.e., no insurers abandon the market).

Age Groups – We received data by age group by three distinct groups: less than age 19, age 19 to 64, and age 65 and above. While most data sources were provided by these age bands, some data was provided in slightly different age band (i.e., Medicaid population). The difference in the age band was identified as insignificant and was ignored. Population count of data was requested by 10 - year age bands; however, this information was not readily available. KPMG's analysis excludes individuals age 65 and above, since these individuals will be eligible for Medicare. The analysis in this report assumes that individuals less than age 19 are at least age 18 and are eligible for individual coverage. Furthermore, we assume that no individuals retire from the 19 to 64 age group.

Employer Size – We analyzed the individual market and employers with less than 100 employees within the state to determine the number of eligible individuals within the Exchange. By analyzing employers with less than 100 employees, we have provided an upper bound of eligibility if only employers with less than 50 employees are eligible to join the Exchange in 2014.

Public Coverage – We received data from the PID regarding the state's enrollment data and Medicaid enrollment information from DPW. The 2014 public program population is estimated based on this data, and we analyzed the migration of current public program to the Exchange based on the number of individuals that transition on / off Medicaid on a monthly basis. Our analysis takes into account individuals that may transition from below 133% of the Federal Poverty Level (FPL) that were previously eligible for Medicaid.

Demand Analysis

Assumptions

KPMG compiled population data from the U.S. Census, distribution by income level and age, as well as insured and employed status by county to develop an estimate of the demand for a health insurance Exchange. The following 15 assumptions are the building blocks of the demand analysis:

2014 Population Projection by Region

- Data Source: U.S. Census.
- Description: We collected 2000 - 2009 Census data as of June and 2010 Census data as of April by region. We ignored the two months difference and assume the projection is as of June 2014.

2014 Veteran Population Projection

- Data Source: Department of Veterans Affairs.
- Description: We collected the county-level veteran population projection through 2030. Veterans eligible for VA care in 2014 are excluded from the Exchange population.

Aging Rate

- Data Source: PA Department of Aging and 2010 Census.
- Description: We collected the change in Pennsylvania's elderly by county for 1990, 2000 and 2010.

Young Growth Rate

- Data Source: U.S. Census.
- Description: We collected Pennsylvania-specific data for Pennsylvania's less than 19 years old in 2000 and 2010 by region.

Child Medicaid Enrollment Projection in 2014

- Data Source: PID.
- Description: We collected Medicaid monthly enrollment data from June 1998 to June 2011.

Adult Medicaid Enrollment Projection in 2014

- Data Source: DPW.
- Description: We collected historical enrollment data from 2008 to 2010.

Medicaid Distribution July 2011

- Data Source: DPW.
- Description: We collected Medicaid monthly enrollment data from June 1998 to June 2011.

CHIP Enrollment Projection in 2014

- Data Source: PID.
- Description: We collected CHIP monthly enrollment data by county from June 1998 to August 2011.

2014 Uninsured Rate

- Data Source: U.S. Census.
- Description: We collected 1999 - 2009 health insurance coverage status by age group.

Uninsured Distribution

- Data Source: Key Stone Research.
- Description: We collected the uninsured rate by county and age for the year 2009.

Private Coverage

- Data Source: U.S. Census.
- Description: We collected 13 insurance companies' covered lives by line of business based on SERFF NAIC data collected for the year 2010. Additionally, we collected Pennsylvania specific firm-size data for the year 2008, although this data is not used in the latest analysis.

Unemployment Rate at 2014

- Data Source: U.S. Bureau of Labor Statistics.
- Description: We collected the 2010 population from the U.S. Census and the unemployment rate by county for June 2010 and June 2011 (these rates are not seasonally adjusted). The 2011 population is projected using an annual growth rate determined in the population growth rate by region assumption.

Employment Distribution for Uninsured Population

- Data Source: E Health Insurance Survey.
- Description: We collected the employment distribution for men and women for the uninsured population in 2009.

Probability to Participate

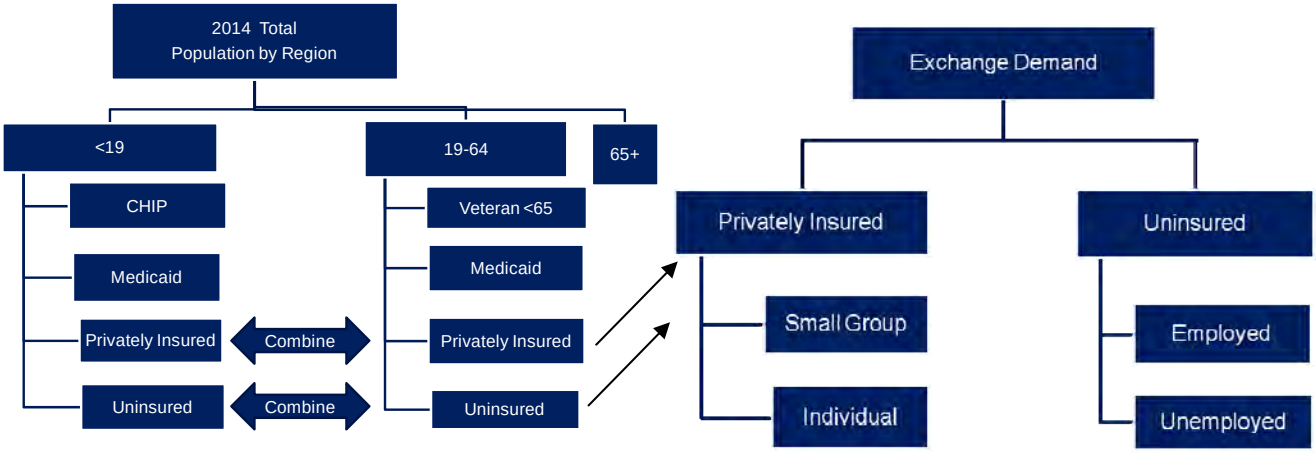
- Data Source: Nieman Survey
- Description: We analyzed consumers' likelihood to participate in an exchange based on initial analysis conducted by the Neiman Group for the State based upon 2011 data. Specifically, we reviewed consumers' satisfaction, need, value, and understanding.

The Effects of Unemployment on Coverage

- Data Source: Kaiser Family Foundation.
- Description: We collected the effect of a one percentage point increase in the unemployment rate on the percentage of children and nonelderly adults with various types of health coverage for 2009.

Analysis Flow Chart

Based on data collected, we devised the following chart to showcase the Exchange participant groups under examination. We grouped the potential Exchange population by age bracket and removed individuals age 65 and above from the analysis, since this group is eligible for Medicare. Then, we analyzed access to public programs, private insurance and uninsured individuals. Based upon available data, we analyzed privately insured and uninsured individuals who were younger than age 65. Next, we split the privately insured population into small groups and individual coverage and uninsured by employment status. Utilizing these subcategories, we were able to directly apply the probability of participation.



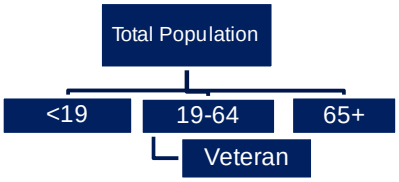
Step-by-Step Analysis

KPMG utilized a multi-step approach to develop a range of participation within the Health Insurance Exchange in 2014. Our analysis began with a review of the total population of Pennsylvania.

Step 1: Calculate the Projected Population in 2014

Step 2: Calculate the Veteran Population in 2014

Step 3: Calculate the Aging Speed and Young Growth Rate



After sorting the aggregate 2014 population by age bands and distinguishing the veteran population, we evaluated projected participation in public programs. Within our analysis, Child and Adult Medicaid were distributed by county based on July 2011 overall Medicaid enrollment by county.

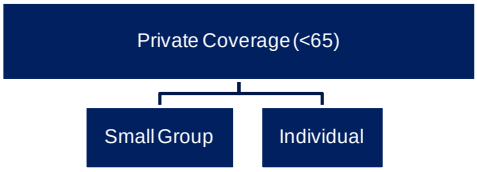
Step 4: Calculate CHIP, Child Medicaid, and Adult Medicaid

Next, we evaluated the largest portion of the population eligible to join the Exchange – the uninsured and currently privately-insured individuals. Building upon previous information, we projected the uninsured population to 2014 using historical uninsured counts by age group. Finally, we calculated the total population covered under private insurance for less than 19 as the compliment of the total population less than 19, public programs and uninsured less than 19. For ages 19-64, we calculated private insurance as the compliment of the total population ages 19-64, public programs and uninsured between ages 19-64.

Step 5: Calculate Uninsured and Privately-Insured Coverage by Age Group

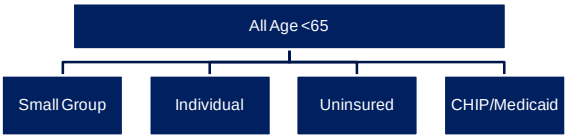
Consequently, we combined the private insured group for ages less than 19 and ages 19-64. We redistributed this population by small group and individual insured status.

Step 6: Combine Age Groups Less Than 65 and Redistribute Private Coverage by Insured Status (Individual and Small Group Coverage)



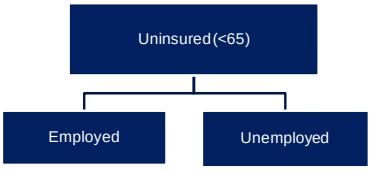
Similarly, we combined CHIP / Medicaid and the Uninsured population to evaluate the effect of unemployment by insurance coverage.

Step 7: Combine Age Groups Less Than 65 and Analyze Unemployment Effect by Insurance Coverage



Next, we separated the uninsured population by employment status. We separated the uninsured population into uninsured / employed, because we believe each of these sub-populations have separate and distinct probabilities of participation.

Step 8: Decompose the Uninsured Population Less Than 65



Combining the analysis of steps 6, 7 and 8, we have identified our sub-populations for the demand analysis. The sub-populations Uninsured / Employed, Uninsured / Unemployed, Small Group Insured and Individual Insured serve as the foundational population of our demand analysis.

Step 9: Demand Analysis Foundational Population

Finally, we reviewed the survey of Pennsylvania's insured population conducted by the Nieman Group. Within the survey, participants were asked to rate their experiences with their current healthcare provider by satisfaction level, need, value and their understanding of benefits. We assigned percentages of participation within the Health Insurance Exchange by evaluating potential survey answers. The percentages are as follows:

Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
95%	85%	50%	20%	0%

For example, for a group of individuals that answered Strongly Disagree to the question "Are you satisfied with your current health insurance plan?" 95% of them would be likely to consider insurance through the Exchange. Prior to using the survey statistics, we tested the statistical significance of satisfaction by insurance plan, marital status, ethnicity, age, and income level using Chi-square tests on the insured population. Satisfaction level by insurance plan was the only statistically significant result. In conclusion, these steps have led to the range of participation within the Health Insurance Exchange in 2014.

Sensitivity Analysis

KPMG identified the following assumptions after conducting sensitivity analysis.

Assumption	Change	Effect on Demand
Uninsured Rate	+1%	+95,000
Individual % of Private Coverage	+1%	-22,000
Small % of Private Coverage	+1%	-30,000
Employed % for Uninsured population	+5%	+15,000
Probability for responses	-5%	-10,000
Unemployment Rate	+2.5%	+12,000
Population Projection	+1%	+26,000
Aging Population	+7,000	-1,600
Young Population	+18,000	No effect
Child Medicaid	+50,000	-7,000
Adult Medicaid	+50,000	-7,000

Data Driven Assumptions

2014 Veteran Population Projection by Region

Uninsured Distribution by Region: Using 2009 Data

Medicaid Distribution: 2011 July

Regional Factor: Relative 2010 regional median income

The Effects of Unemployment on Coverage

Scenario Tests

KPMG considered the following three scenarios tests—economic impact, shifting in insurance coverage, and demand curve participation percentages. Assumptions chosen for each scenario were based upon on historical trends and consistent, external projections.

Scenario Test 1: Economic Impact

Assumptions:

A. Unemployment Rate = 7.25%
Uninsured Rate = 10.54%

B. Unemployment Rate = 8.05%
Uninsured Rate = 15.27%

C. Unemployment Rate = 6.44%
Uninsured Rate = 9.46%

Scenario	Small Group	Individual	Uninsured	Total Demand
A	1.3M	680,000	1.4M	**1.9M**
B	1.2M	617,000	2.0M	**2.2M**
C	1.4M	700,000	1.2M	**1.8M**

In order to test our demand analysis results by economic impact, we considered three separate scenarios. Economic theory and recent market conditions suggest that employment and uninsured rates are leading indicators of current economic conditions. If the economy declines, then unemployment rate and the uninsured rate are likely to increase. However, as the economy improves, the unemployment rate and uninsured rate are likely to decline, but at a much slower pace. Reviewing the results above, scenario B has a more dramatic effect on the overall Exchange population in comparison with scenario A than scenario C, since the unemployment rate and uninsured rate are comparably lower in scenario B. As anticipated, we see that as market conditions decline, higher unemployment rates are a direct consequence to a larger Exchange population. As the economy improves, the Exchange population stabilizes around approximately 1.8 million participants.

Scenario Test 2: Shifting in Insurance Coverage

Assumptions:

A. Individual = 10.64%
Small Group = 21.19%

B. Individual = 9.00%
Small Group = 21.19%

C. Individual = 10.64%
Small Group = 18.01%

Scenario	Small Group	Individual	Uninsured	Total Demand
A	1.3M	682,000	1.4M	**1.9M**
B	1.3M	573,000	1.4M	**1.8M**
C	1.1M	682,000	1.4M	**1.8M**

Next, we considered the effect of shifting in insurance coverage on aggregate demand. We considered three separate scenarios to analyze the effects of small group and individual insured transitions in scenario test 2. As more individuals transition from small group to the individual market, we would anticipate a larger population available for the Exchange. Reviewing the results above, a decrease in the small group population by 3% is approximately equivalent to a 1.6% decrease in the individual coverage on the Exchange population (when comparing scenario B to C in relation to A). These results suggest that the individual market is more likely to contribute Exchange participants than the small group market, which aligns with our assumptions. Comparing scenario test 1 to scenario test 2, we find that the economic conditions are a driver of Exchange participation, while shifting in insurance coverage does not cause significant variation in aggregate demand.

Scenario Test 3: Demand Curve Participation Percentage

Scenario	Small Group	Individual	Uninsured / Employed	Uninsured / Unemployed	Total Demand
A	33%	45%	60%	100%	**1.88M**
B	38%	50%	60%	100%	**2.00M**
C	33%	45%	60%	90%	**1.87M**
D	33%	45%	50%	90%	**1.75M**

Finally, we considered four separate scenarios to analyze the variability of participation percentages within scenario test 3. We identified these four groups of participants because we believe their probabilities of participation are separate and distinct. Intuitively, the Exchange will focus on enrolling the uninsured population or approximately 1.97 million individuals. However, a percentage of the 6 million privately insured individuals are anticipated to participate within the Exchange. While a greater percentage of uninsured individuals are likely to participate, the number of privately insured individuals eligible for the Exchange may drive the larger portion of the Exchange population. In scenario B, we see that a 5% increase in participation in the small group and individual insured markets leads to an additional 120,000 participants within the Exchange, where as a 5% decrease in the uninsured / employed and uninsured / unemployed population decreases the Exchange population by approximately 65,000 participants. From these results, we confirm that the insured population will be a leading participant within the Exchange population.

Demand Analysis Results

Based on statistical analysis of scenarios 1, 2 and 3, KPMG developed a range of participation that estimates 2.0 to 2.2 million individuals may participate within the Health Insurance Exchange in 2014. The mean number of participants is approximately 2.1 million participants and the standard deviation of participation is approximately 59,000 participants. The estimates are likely conservative but provide reasonable foundation for volume expected, and therefore can be used to evaluate systems, resources and process strain. It is important to note that estimates for the Exchange do not include the more than two million individuals currently enrolled in Medicaid and CHIP. While we have used our best professional judgment in all instances, demand estimates are inherently uncertain because of the random nature of consumer choices. KPMG, therefore, cannot warrant that actual developments will not vary from expectations, perhaps significantly.

Focus Areas

Legislative/Regulatory

Governance and Organizational Structure

Program Integration

Technology

Financial Management

Oversight and Program Integrity

Operations

Legislative/Regulatory

The information presented on the following pages addresses the legislative and regulatory considerations the Commonwealth should consider when moving forward with Insurance Exchange Planning.

Regulatory Guidance

Legislation

The Act requires that by January 1, 2014, a state that elects to establish an Exchange must adopt and have in effect the federal standards for Exchanges issued by the United States Department of Health and Human Services (HHS) or that the state have in place a state law, regulation, or other legal mechanism, that implements these standards.

Each state should ensure that it provides its Exchange with the authority necessary to meet all the Exchange requirements of the ACA. Each state must determine the steps necessary to ensure it has legal authority to establish and operate an Exchange that complies with federal requirements; this will require each state to have its own milestones under this Core Area that will correspond to its legislative calendar and the political environment of the state.

Notice of Proposed Rulemaking

The ACA provides that each state has the opportunity to establish an Exchange(s) that: (1) facilitates the purchase of insurance coverage by qualified individuals through qualified health plans (QHPs); (2) assists qualified employers in the enrollment of their employees in QHPs; and (3) meets other requirements specified in the ACA.

Section 1321 of the Act specifically encourages state flexibility in the operation and enforcement of Exchanges and related requirements– within the boundaries of the law. Each state electing to establish an Exchange must adopt the federal standards contained in the law and in the proposed rule, or have in effect a state law or regulation that implements these federal standards. Section 1311(k) specifies that Exchanges may not establish rules that conflict with or prevent the application of regulations promulgated by the HHS Secretary.

ACA Section 1321(c)(1) requires the HHS Secretary to establish and operate such Exchange within States that either: (1) do not elect to establish an Exchange or (2) as determined by the Secretary on or before January 1, 2013, will not have an Exchange operable by January 1, 2014. Section 1321(a) also provides broad authority for the Secretary to establish standards and regulations to implement the statutory requirements related to Exchanges, QHPs, and other components of title I of the Act.

Note that the Commonwealth may also be responsible for addressing forthcoming federal requirements that HHS has not yet announced.

Key Considerations

Emerging Practices

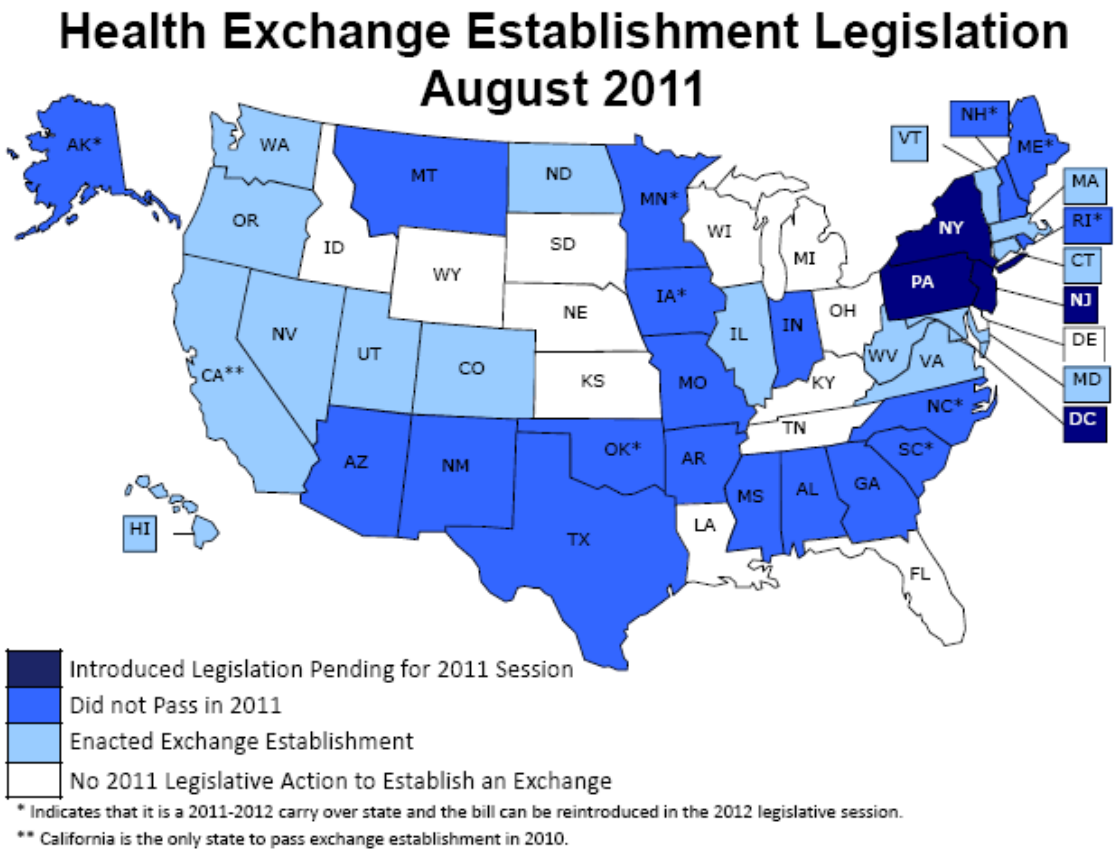
From our review of various consideration documents, we observed that in Maryland, the Maryland Health Benefit Exchange Act of 2011 provides the Exchange the authority to move forward in areas that are critical to implementation. The legislature required multiple policy issues to be studied and delivered in December, in

preparation for the 2012 state legislative session that begins in January 2012. These legislative proposals will be developed through the Exchange Advisory Committee process and considered by the Exchange Board. The final legislative reports may result in additional legislation during the 2012 legislative session. The Exchange Board and staff will continue to build on Maryland's close collaboration with key legislative leaders and stakeholders.

In California, the Level I grant will support staff and consulting capacity within the Exchange to conduct timely review of federal regulations and guidance which may affect Exchange programs or operations. In addition, the grant will expand the capacity of the Exchange to identify and analyze proposed state legislation and regulations. The Exchange will review legislative proposals and advise the state Legislature and the Administration on the impact of specific proposals on the Exchange and recommend legislative directions that will most effectively support Exchange operations and activities. Moreover, California legal and policy staff will help the Exchange to identify and pursue state legislative and regulatory changes necessary for Exchange operations. Exchange staff and consultants will coordinate with the program integration working groups – coordinating with state health and human services programs and with state insurance regulators – to identify legislative or regulatory changes in programs outside of the Exchange that will enhance collaboration, coordination and integration among the Exchange and other programs as envisioned in federal law.

Wisconsin has two distinct efforts in progress to establish governance for their health insurance exchange. Wisconsin's Office of Health Care Reform (OHCR) and Legislative Council's Special Committee on Health Care Reform Implementation are both working on draft legislation to be taken up in the next legislative session. The OHCR drafted a Health Insurance Exchange Governance and Organization options paper describing funding requirements, minimum duties, and powers and then engaged other states (e.g., MA, UT, and CA), national industry experts, and Wisconsin healthcare leaders to review. Currently, there is strong support in the state for an independent public agency modeled after the existing Wisconsin high risk pool insurance authority. The OHCR intends to provide this recommendation via draft legislation for consideration in the next legislative session. Concurrently, Wisconsin's Legislative Council's Special Committee on Health Care Reform Implementation is completing a study and make recommendations on what changes should be made to Wisconsin's statutes and administrative rules in response to recently enacted federal healthcare reform legislation. The committee is directed to study all aspects of the federal legislation that affect Wisconsin including insurance market reforms, coverage for uninsured persons, preventive care, taxation, quality improvement, and health workforce issues.

The following map from the National Conference of State Legislatures website shows their current assessment of the status of each state's health exchange establishment legislation. Note – The Pennsylvania Legislation is pending.



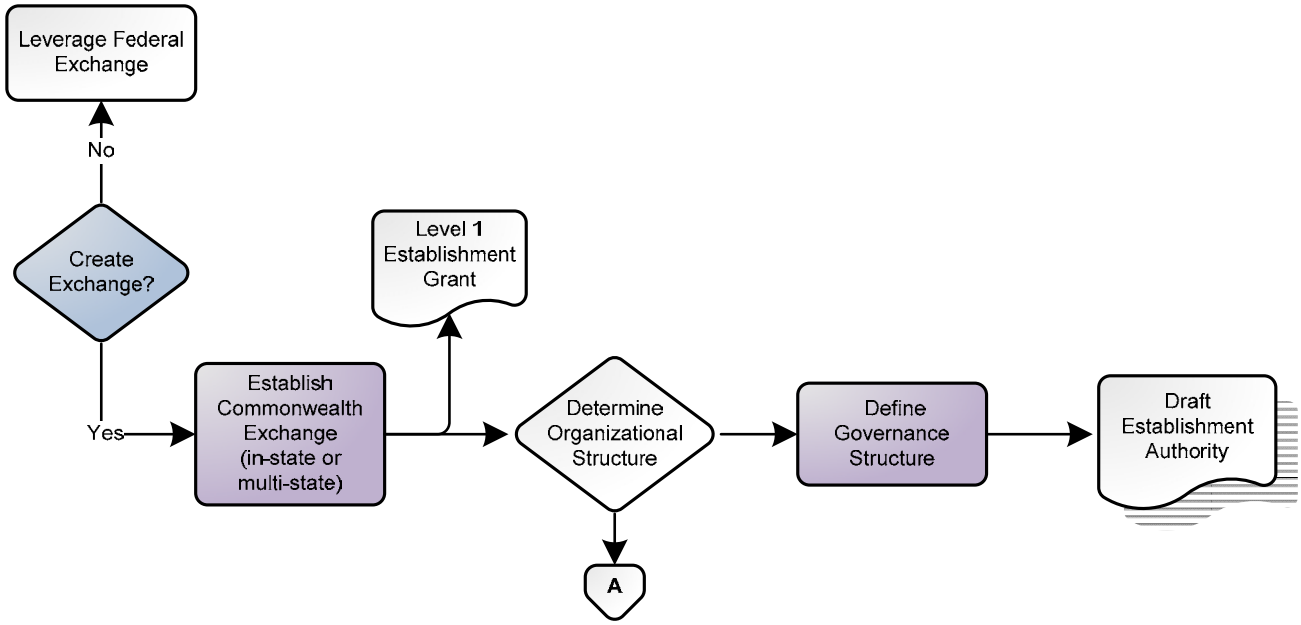
Source – National Conference of State Legislatures website

Also, we noted that the majority of states enacting legislation through August 2011 chose to establish the Exchange as a quasi-governmental body (generally a private entity, with some attributes of government). Of the ten states that have enacted Exchange legislation, seven states created a quasi-governmental entity, two established the Exchange within a state agency, and one will operate its Exchange as a private, nonprofit organization.

Moving Forward

Once the Commonwealth chooses whether or not to implement an exchange, the key decisions will be what kind of exchange organizational structure to leverage (e.g., Quasi-Governmental entity, Not for Profit (NFP), Existing Agency or Multi-State approach) and what kind of governance structure the exchange will have based on the chosen structure (e.g., leverage existing agency structure, create a board, commission, etc). The establishment authority would prescribe these components and several other aspects of the envisioned exchange, like establishing key policies for the exchange or potentially the private insurance market.

Several of the key decisions are illustrated in the flowchart below:



The Commonwealth should consider the following next steps:

1. Determine the form of authority (e.g., Executive Oder, Enabling Legislation); PID believes legislation would be the most effective mechanism to create authority for the Exchange
2. Continue to research other state exchange legislation (e.g., the National Conference of State Legislatives website/database and other sources)
3. Should a decision be made to implement an exchange, decide on a lead agency, PID has direct experience writing legislation and is the best-positioned Executive Agency to strategize and draft an Exchange framework/architecture. Policy details to resolve include:
    - Determining Board/Commission Structure if one is desired and oversight/regulatory processes
    - Determining Exchange Structure
    - Determining Small Business Health Option Program (SHOP) Exchange structure and oversight
4. The legislative time frame should be compressed and not extend too far into 2012 to allow for maximum implementation prior to the 2013 certification process.
5. In the absence of a decision to implement an exchange, PID should continue to refine and execute its outreach process to affected stakeholders, specifically in the carrier community and with Consumer Groups.

It is important to note the annual pressures of the legislative calendar. The budget process begins in February with the Governor's address; appropriations hearings are scheduled through March. Should a decision be made to implement an exchange, the timing of such a decision and other priorities within the 2011 – 2012 legislative calendar will be significant factors to consider and address. In summary, development of legislation should not be pushed back past February 2012.

As the Act states, enacted establishment authority is required in order to submit a Level 2 Establishment Grant application (which accesses federal funds to fund the implementation of the state's exchange). The last level 2 grant application submission deadline is June 30, 2012.

The creation of establishment authority for the Exchange is a key component in securing the funding necessary to develop and implement the chosen solution (i.e., via the Exchange Establishment Grant process). Note that the selected exchange structure, governance approach, degree of outsourcing/ leveraging third parties and several other factors will have a direct impact on the ongoing operating cost and staff resources required to operate, maintain, manage and the eventual sustainability of the Exchange.

Timing Considerations

It is very important that if the Commonwealth makes a decision to create an exchange, that the establishment authority development process start expeditiously. Key milestones may include:

- Receipt of the KPMG Report on 11/21/11; recommendation to Governor and gubernatorial decision thereafter
- November – draft language ready
- Receive stakeholder/industry input on draft prior to bill introduction
- By December 31 – bill introduced
- January/February 2012 – legislative hearings
- January/February – bill being placed on floor calendar in one chamber (i.e.. movement out of committee)
- January/February – floor activity and final passage out of one chamber
- February/March – committee movement in second chamber
- March/April 2012 – floor activity and final passage out of second chamber, signed by Governor

Stakeholder Involvement/Impact

Input and feedback received to date

While we identified no specific stakeholder feedback on the most appropriate method of establishing authority for the creation of a Commonwealth Exchange legislative/regulatory process, the vast majority of stakeholders were interested in having the Commonwealth develop the Exchange (e.g., there was very limited interest in leveraging a federal exchange model) and a significant number or stakeholders advocated for housing it within PID.

Discussion of future plan and communication related to this focus area

If the Commonwealth decides to move forward and implement an exchange, Pennsylvania may need to move quickly to draft establishment authority and establish both organizational and governance structures. In conjunction with this effort, Pennsylvania must initiate and maintain an outreach and communication process with both its key internal and external stakeholders. The outreach process to affected stakeholders is equally important specifically in the carrier community and with the Consumer Groups.

Small Business Health Option Program (SHOP) Considerations

The ACA gives states the option to run separate Exchange offerings for individuals and small businesses, or run a combined Exchange that services both groups. Further, the ACA allows states to determine, for the time period before January 1, 2016, whether a “small employer” is comprised of 50 or fewer employees or 100 or fewer employees. States may open the Exchange to large businesses by 2017. From our review of the consideration documents, we noted that of the 10 states that enacted legislation to create an Exchange, six have specifically indicated what entities will be allowed to purchase in the Exchange marketplace and when. Only Connecticut and Vermont addressed the topic of large employer inclusion, and only Vermont gave a specific time frame for large employers entering the Exchange. Four states will establish separate Exchanges at least in the near term for individuals and small employers. *Note that no states thus far have chosen to include both individuals and employers in one Exchange, and six states have yet to determine the composition of their Exchange.*

There are many factors to consider such as competing issues requiring legislative consideration and PID will be under considerable time constraints to propose, set and gain resolution for the option Commonwealth selects, assuming it moves forward in establishing and Exchange. Another SHOP consideration is determining responsibility for the resolution of invoice disputes between employees and employers in SHOP operations.

Option-Specific Considerations

Unlike other core areas, the Legislative and Regulatory Action area actually helps define the structure that Pennsylvania's Exchange will employ (e.g., Quasi-Governmental entity, Not For Profit, Existing Agency or Multi-State approach). Assuming Pennsylvania decides to implement an Exchange, it is important that the Commonwealth expeditiously create the draft establishment authority (legislation or executive order) and work it through the process. The establishment authority would prescribe the structure chosen by the Commonwealth as well as create a governance approach and leadership model. At the same time, the Commonwealth needs to develop its Level 1 Establishment Grant and submit it by the December 30, 2011 deadline, if it chooses to seek Exchange funding for continued potential implementation efforts.

Other than defining the structure and governance approach for a PA Exchange, there are no other major option-specific concerns for the Commonwealth to consider in the Legislative / Regulatory area.

Governance and Organizational Structure

The information presented on the following pages addresses the governance and organizational structure considerations the Commonwealth should consider when moving forward with Insurance Exchange Planning.

Regulatory Guidance

Legislation

Per the Act, each Exchange must have in place a governance structure that conforms to the requirements of the Act and the regulations to be issued by HHS. The Act provides States with the option of establishing an Exchange within an existing State agency, within a new or existing quasi-governmental entity, or as a separate non-profit. In addition, states could choose to partner with one or more other States to establish a regional Exchange or to create more than one subsidiary Exchange within the State. Regardless of its organizational form, the Exchange must be publicly accountable, transparent, and have technically competent leadership, actions necessary to meet federal standards, including the discretion to determine whether health plans offered through the Exchange are in the interests of qualified individuals and qualified employers.

Level One Establishment grants provide up to one year of funding to states that have made some progress under their Exchange Planning Grants. All states are eligible to apply for Level Two Establishment grants after making sufficient progress – once they are able to meet the Level Two eligibility criteria, including having established a governance structure and having authority established to create the Exchange. Currently the last date to submit a Level 1 Establishment Grant application is December 30, 2011 and the last date to submit a Level Two Establishment Grant is June 29, 2012.

Notice of Proposed Rulemaking

The Act sets forth general standards related to the establishment of a State Exchange and provides a number of areas where States that choose to operate an Exchange may exercise discretion in making decisions about Exchange operations. Under the statute, States have choices regarding the structure and governance of their Exchanges. For example, a state may establish an Exchange as a state agency or as a non-profit organization, and may choose to contract with other eligible entities to carry out various functions of the Exchange. A State may also choose to partner with other States to form a regional Exchange, or may establish one or more subsidiary Exchanges within the State. States may also decide to forgo establishing their own exchange and leverage the exchange functionality provided by the federal government.

In paragraph (b) of §155.100 of the Notice of Proposed Rulemaking (NPRM), HHS proposes to codify section 1311(d)(1) of the Act which requires an Exchange to be a governmental agency or non-profit entity established by the State, specifying that the governance structure of the Exchange must be established and operated consistently with the requirements. Per the NPRM, a governmental agency could be an existing state executive branch agency or an independent public agency. When reviewing the types of governmental agencies that could serve as an Exchange, States should consider the costs and benefits of utilizing the accountability structure within an existing agency versus the need to establish a governing body for an independent public agency or not-for-profit entity.

Additionally, each State will need to follow its own laws related to the establishment of non-profit organizations. A State could operate an Exchange through an existing non-profit that was established by a

State, or by establishing a new non-profit organization or corporation. Under any scenario, the management structure of the Exchange must be accountable for Exchange oversight, transparency and performance.

HHS does not propose to limit the States' discretion to choose any type of entity beyond the minimum standards proposed in §155.110. However, HHS does note that States should consider the relative merits of operating an Exchange through a non-profit entity. Non-profit entities may be able to operate without some of the restrictions that can limit the flexibility of governmental agencies (e.g., procurement rules); however, non-profit entities may face limitations performing functions that are typically governmental in nature. In light of these concerns, HHS notes that States might wish to establish independent public/governmental agencies with flexible hiring and operational practices or establish nonprofit entities with governing bodies that are appointed and overseen by States.

The NPRM highlights that each Exchange is required to publish a set of guiding governance principles that includes ethical and conflict of interest standards and the disclosure of financial interests that are posted for public consumption. To minimize potential conflicts of interest in the oversight and governance of state exchanges, the NPRM requires that an Exchange have procedures in place for disclosure of financial interest by members of the governing body or governance structure of the Exchange.

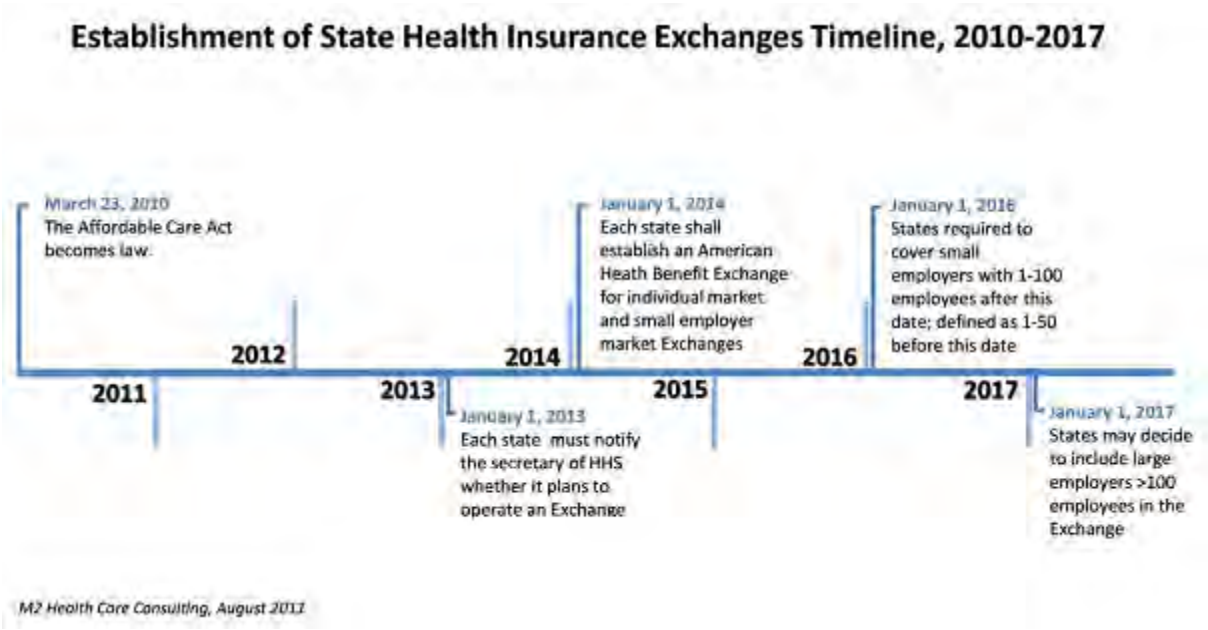
Note – The Commonwealth may need to modify its Exchange strategy and approach when HHS announces new requirements or revises existing requirements in the future (e.g., whether non-profit entities will be prohibited from operating a state Health Insurance Exchange).

Key Considerations

Emerging Practices

Several states have already established health insurance exchanges and have employed various governance structures to support these initiatives. The Massachusetts Commonwealth Connector was established as an independent quasi-governmental agency. The State of Washington established an independent agency for their Exchange, the Washington Health Insurance Partnership, and the State of California have established the California Health Benefits Exchange (CHIX), also as an independent quasi-governmental entity. The Utah Health Exchange, conversely, is administered under an existing state agency, the Office of Consumer Health Services. Wisconsin is in the process of establishing its health insurance exchange governance structure.

The following exhibit from the recently released M2 Health Care Consulting study shows the current Exchange establishment time line.



Source – M2 Health Care Consulting

Also, the M2 Health Care Consulting report (see the Consideration Documentation section) notes that the majority of states enacting legislation through August 2011 chose to establish the Exchange as a quasi-governmental body (generally a private entity, with some attributes of government). Of the ten states that have enacted Exchange legislation, seven states created a quasi-governmental entity, two established the Exchange within a state agency, and one will operate its Exchange as a private, non-profit organization.

Summary of State Exchange Governance Structures

State	Governance
California	Quasi-governmental
Colorado	Quasi-governmental
Connecticut	Quasi-governmental
Hawaii	Non-profit Organization
Maryland	Quasi-governmental
Nevada	Quasi-governmental
Oregon	Quasi-governmental
Vermont	Government agency
Washington	Quasi-governmental
West Virginia	Government agency

Leveraging Current Capabilities

The Commonwealth has conducted preliminary analysis in regard to the feasibility of implementing one of the potential Exchange governance structures. Per PID, each currently existing Pennsylvania quasi-governmental

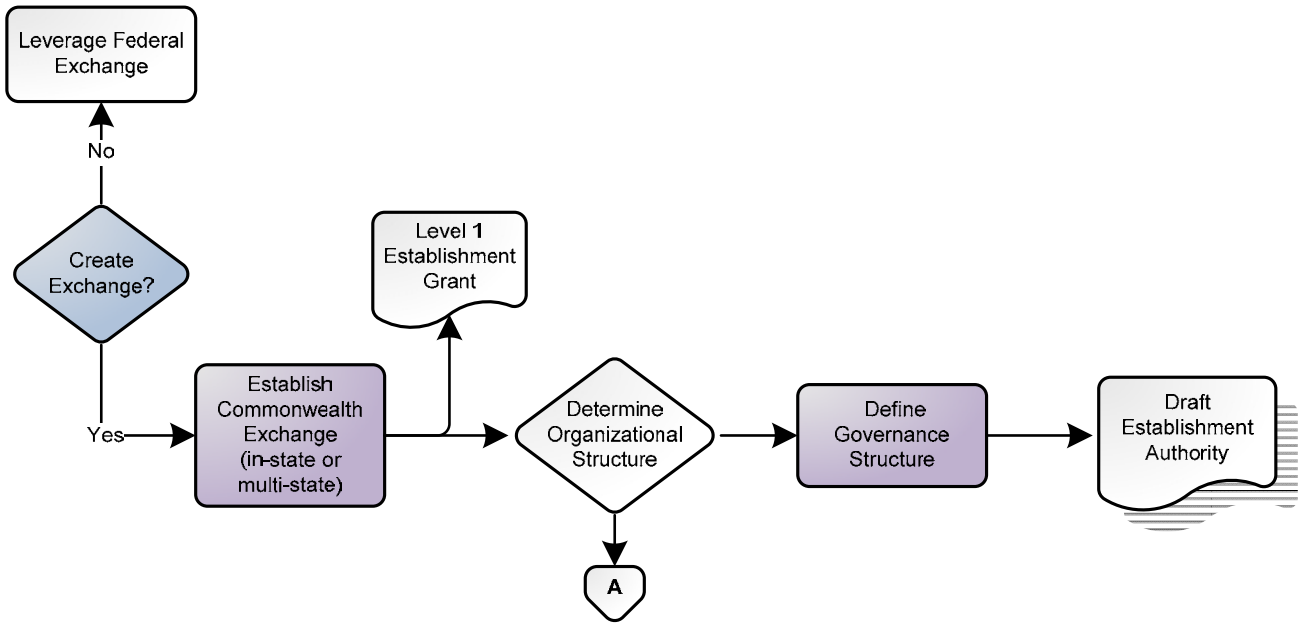
entity is different in terms of the scope of its functions and authorities as identified in their enabling statutes. Some operate more "like" a state agency while some operate less like government – examples such as Pennsylvania High Education Assistance Agency (PHEAA) and Public Utilities Commission (PUC) function much more like state agencies in terms of their size, budgets, procurements, authority, etc.; others such as Pennsylvania Health Care Cost Containment Council (PHC4), Port of Pittsburgh Commission, Milk Marketing Board, PA Council for the Arts, and Philadelphia Regional Port Authority function less like a government entity and serve more of an advisory, research, data collection or revitalization role.

The Commonwealth should have the flexibility required to house the Exchange in a quasi-governmental entity or a not-for-profit should it choose to proceed in that fashion. The administration has stated a priority of creating authority or legislation to allow for public - private partnerships.

Moving Forward

Once the Commonwealth chooses whether or not to implement an exchange, the key governance decision will be what kind of exchange to create (e.g., Quasi-Governmental entity, Not for Profit, Existing Agency or Multi-State approach) and what kind of governance structure the exchange will have based on the chosen structure (e.g., leverage existing agency structure, create a board, commission, etc).

Several of the key decisions are illustrated in the flowchart below:



Under the ACA, States have several options for establishing the Exchange's administrative entity:

A. The Exchange can be established within an existing state agency, such as the PID.

B. The state can create a wholly independent non-profit organization to run the Exchange.

C. The state can create an independent quasi-governmental entity to run the Exchange.

D. If the state does not make enough progress toward creating an Exchange or chooses not to, the federal government will step in to establish and run an Exchange within the state.

Timing Considerations

No specific timing constraints have been identified.

Stakeholder Involvement/Impact

Input and feedback received to date

KPMG reviewed written stakeholder testimony and attended three PID-sponsored stakeholder sessions in Philadelphia, Harrisburg and Pittsburgh. We identified specific stakeholder feedback on how the Commonwealth should establish its governance and organizational structures to support the implementation of a health insurance exchange. The governance/organizational structure feedback we identified from numerous stakeholders is summarized below.

A variety of stakeholders noted that the Commonwealth should consider instituting some form of governing board or steering committee to help set Exchange policy and oversee operations. They specifically noted that any governance board should include healthcare professionals like doctors and nurses, but could also include other key parties including insurance companies, agents, and individuals with public health insurance backgrounds. Many noted that insurers can participate in the governing board or steering committee as long as they did not have any conflicts of interest. Conversely, some felt that insurers, carriers or brokers should not be on any governing or oversight board. Others suggested that people with mental health experience or someone with a family member with a mental health condition be considered for the governing board or steering committee. Still, others noted that the board should contain a representative who knows about low-income insurance issues.

Stakeholders also commented on the structure of the potential Exchange governing board or steering committee, suggesting PID could leverage an Advisory Committee similar to the Medicaid Committee. They went on to suggest that Exchange should also integrate with Medicaid and private insurance and allow out-of network provider coverage without incurring the out-of-network costs.

Regarding the governance structure of an Exchange in Pennsylvania, stakeholders offered many different suggestions for PID to consider. Specifically, they stated that PID should consider establishing an entity like Utah did, or an independent state agency or a non-profit (because it would potentially generate broader financial support). The NJ Small Employers Health Plan Board was cited as an example that works well because of its broad board representation. Many stakeholders perceived that oversight should be provided by a quasi government or private sector organization. Other said that existing governance infrastructure should be leveraged as much as possible. Many felt that the Exchange should avoid duplication of insurance industry functions (e.g., the Commonwealth shouldn't add a whole new regulatory function to operate the Exchange).

Other stakeholders suggested that any Commonwealth Exchange be housed in and managed by PID. It was noted that PID should also continue to serve as the regulator (e.g., not duplicating that role in the Exchange). Setting up the Exchange in PID was perceived as causing the least market disruption by some stakeholders. Others noted that the Commonwealth does not have time to do otherwise. Stakeholders also noted that the Commonwealth should proceed with caution if coordinating an Exchange in partnership with another state because of the different insurance regulations.

Some stakeholders said that if the Exchange is established within a state agency (like PID), there will probably be no governing board. This raised a concern that stakeholders will not have input on how the Exchange or insurers work. In the case of no governing board, stakeholders noted that the Commonwealth should then have an advisory group that can provide input and look at the Exchange as a business.

The notion of ongoing consumer outreach and communication was important to several stakeholders. Per the feedback, PID should require an Annual Performance Report on the Exchange, including metrics such as number of individuals in the Exchange, number still lacking insurance, number moved from employers to the Exchange, etc. They mentioned such an annual report to legislators supports an ongoing dialogue with stakeholders.

The concept of a robust conflict of interest strategy and operational transparency was communicated by numerous stakeholders. Specifically, they suggested that any governing board/steering committee deliberations should be open, transparent and provide the public opportunity to have their comments and opinions heard.

Regarding the structure of the Exchange, stakeholders provided several suggestions. Some feel that PID should consider providing one statewide exchange with the ability to adjust for regional requirements. Conversely, some believed that PID should consider establishing different exchanges in different regions of the state. Others recommend the use of subsidiary exchanges because of the differences across the state. They noted that this could be a single exchange from a governance and IT perspective, but plans/network adequacy would be determined by region. Many noted that a regional Exchange would be preferred over a state-run Exchange, because the Pennsylvania market is regionally unique based on the four Blues plans and commercial insurers footprints. Some felt that one large statewide exchange would have challenges, but certain areas of the state should not be subsidizing other areas. Another theme was to consider structuring the Exchange similar to medicare.gov.

Many carriers noted that after legislation is passed, adequate time should be provided for insurance companies to prepare, test, and help people understand the Commonwealth's Exchange approach. One stakeholder suggested that all Commonwealth residents should be required to purchase health insurance (i.e., implementation could involve proof of medical insurance to get your driver license).

Discussion of future plan and communication related to this focus area

If the Commonwealth decides to move forward and implement an exchange, Pennsylvania needs to move quickly to draft establishment authority and establish both organizational and governance structures. In conjunction with this effort, Pennsylvania must initiate and maintain an outreach and communication process with both its key internal and external stakeholders. The outreach process to affected stakeholders is equally important specifically in the carrier community and with the Consumer Groups/"Future Navigators."

Small Business Health Option Program (SHOP) Considerations

The Commonwealth needs to determine whether the individual and SHOP (e.g., small business exchanges) will be combined or separate. Moreover, Pennsylvania needs to determine whether the individual and SHOP (e.g., small business exchanges) will be administered collectively or separately. Per the ACA, it is the State's option to elect to establish a separate governance and administrative structure for the SHOP exchange. The Act provides each State with flexibility to merge its individual market Exchange and SHOP under a single administrative or governance structure. Note, however, that HHS believes that a single governance structure for both the individual market Exchange functions and SHOP will yield better policy coordination, increased operational efficiencies, and improved operational coordination. If a State does choose to operate its individual market Exchange and SHOP under a single governance or administrative structure, it must ensure that the Exchange has adequate resources to assist individuals and small employers.

Note that no states thus far have chosen to include both individuals and employers in one Exchange, and six states have yet to determine the composition of their Exchange.

Impact and/or specific questions related to focus area

Based on our analysis and meeting with PID, KPMG identified the following impacts and issues to consider: First and foremost, the Commonwealth needs to decide if it plans to create an Exchange or not. Regardless of its decision to create an exchange, if it has not done so already, the Commonwealth should strongly consider applying for a no cost extension of its previously awarded Exchange Planning Grant. This provides the State some flexibility and resources to plan for creating its own exchange or coordinating with the federal exchange as necessary.

If the Commonwealth decides it WANTS TO establish an Exchange it should then decide what type of governance model to establish:

- Within an existing state agency such as the PID, DPW or the Governor's Office of Administration:
  - Need less start-up funding
  - Can leverage existing Commonwealth IT assets
  - Lower ongoing administrative costs
  - Easier communication and data transfer with other agencies such as the DPW
  - Fewer privacy concerns regarding data transfer
  - Already required to be transparent and accountable
  - Large carriers in the state and region are already used to working with the PID
  - Many PA stakeholders noted that housing the Exchange within the Insurance Department would be beneficial

Pennsylvania should note that administering the Exchange within an existing agency can result in perceived conflicts of interest. For example, the PID is responsible for making sure that insurance companies remain solvent and overseeing their operations.

Regardless of the governance structure selected, the Commonwealth should affirm that the Insurance Commissioner, not the Steering Committee or Exchange board, if such is created, has the authority to regulate the business of insurance within Pennsylvania.

Other organizational structures include:

- Create a wholly independent non-profit organization to run the Exchange:
  - Lesser oversight and reduced applicability of state regulations might maximize the Exchange's flexibility
  - Might be able to react more quickly to market changes
  - Able to hire and spend money when necessary with minimal hindrance from purchasing requirements
  - Would be more removed from government regulation and oversight
  - Would be further removed from political influence
  - No known prohibition that would restrict the use of a non-profit/quasi-governmental entity/commissions/authorities/etc for the exchange in PA
- Create an independent quasi-governmental entity to run the Exchange:
  - Would subject the Exchange to only those State rules and laws that the legislature chooses to include in the entity's founding legislation
  - Would provide the Exchange with greater flexibility in personnel, procurement and other matters than is the case with a State agency
  - Distances from existing State agencies would provide less chance of the Exchange being politicized
  - Independence from existing agencies minimizes conflict of interest

- Might allow the Exchange to work more closely with government agencies and politicians than entities not created by State law, facilitating exchange of data, information, and ideas
- No known prohibition that would restrict the use of a non-profit/quasi-governmental entity/commissions/authorities/etc. for the exchange in PA
- The legislature could require the Exchange to comply with State law on transparency, accountability, and related matters

Another key step is for the Commonwealth to identify and develop any other supporting legislation required to establish the Exchange, especially as related to housing the Exchange in a non-governmental entity. Per PID, no prohibition exists with the Commonwealth's ability to "outsource" functions to third parties such as NFPs or quasi-governmental entities. In fact, precedents have been set in regards to leveraging NFPs or Quasi-governmental entities elsewhere in the Commonwealth.

Per PID, each quasi-governmental entity currently existing in Pennsylvania is different in terms of the scope of its functions and authorities as identified in their enabling statutes. Some operate more "like" a state agency while some operate less like government – examples such as PHEAA and PUC function much more like state agencies in terms of their size, budgets, procurements, authority, etc., others such as PHC4, Port of Pittsburgh Commission, Milk Marketing Board, PA Council for the Arts, and Philadelphia Regional Port Authority function less like a government entity and serve more of an advisory, research, data collection or revitalization role.

If the Commonwealth utilizes a quasi-governmental entity or not-for-profit structure, it should have the flexibility required to house the Exchange should it choose to proceed in that fashion.

The Commonwealth would also benefit from creating a high level Steering Committee or governing board to set strategic direction for the possible implementation of an Exchange. Based on discussions with PID and incorporation of stakeholder feedback, the consideration should be given to having the Steering Committee composed of representatives from the following agencies:

- Pennsylvania Insurance Department
- Department of Public Welfare
- Department of Health (DOH)
- Department of Labor and Industry
- Department of Revenue
- Office of Administration
- Office of Administration, Office of Information Technology
- Office of the Budget
- Governor's Policy Office

The Steering Committee should then consider establishing work groups focused on Business and Information Technology aspects of the exchange and subsidiary groups to address specific issues/needs.

To address the 2011 FOA milestone for initiating communication with the State Health Information Technology (HIT) Coordinators, State Insurance Department, the State Medicaid Agency, and the State Human Services Agency and hold regular collaborative meetings to develop work plans.

This group should conduct regular meetings to develop work plans for collaboration that would need to be held with PID, DPW, and DOH (this could be a work group under the proposed Steering Committee). The next task is to determine the structure and establish the governing body that will administer the Exchange.

- Ensure public accountability, transparency and prevention of conflict of interest:
  - This is a major concern of many stakeholders
- Create charter/by-laws that are consistent with state and federal regulations
- Consider the costs and benefits of utilizing the accountability structure within an existing agency versus the need to establish a governing body for an independent public agency or not for profit entity
- Should the Commonwealth decide not to establish an Exchange, the Act requires other health insurance exchange coordination with the federal government

If deferring to the federal Exchange, the Commonwealth must take the steps necessary to coordinate with the federal government. Specifically, Pennsylvania will need to identify what Exchange functional roles may still apply to the Commonwealth (e.g., Medicaid – known in Pennsylvania as Medical Assistance, or MA – and CHIP). PID will also have to address the anticipated federal government bias enrollment issue (e.g., potentially over-enrolling members in Medicaid instead of steering them to the Federal Exchange). Pennsylvania's MA match obligation may grow significantly.

In addition, the Commonwealth will have to take several other steps to effectively coordinate with HHS, including:

- Identify what IT assets/interfaces may still need to be developed the Commonwealth
- Review and revise Commonwealth regulatory and policy issues to ensure coordination between state and federal agencies
- Modify the MA and CHIP eligibility systems because numerous members are potentially coming out of MA and going to be eligible for coverage through the Exchange
- Decide whether, in allowing the Federal Exchange to serve as the primary health insurance selection and enrollment vehicle, PA will simply have their citizens receive insurance through the two plans that the federal government will provide:
  - If PA does this, it will potentially disrupt the Commonwealth's health insurance market and all of the carriers.
  - If not, PA will need to determine how to certify plans and get them on the Exchange.

Option-Specific Considerations

Quasi-Government	Not For Profit	Existing Agency	Federal
Greater flexibility in personnel, procurement and other matters than is the case with a State agency	Lesser oversight and reduced applicability of state regulations might maximize the Exchange's flexibility	May need less start-up funding and could have lower ongoing administrative costs	Federal government would be responsible for making the Exchange self-sustaining by 2015
Independence from existing agencies minimizes conflict of interest	Hire and spend money when necessary with minimal hindrance from purchasing requirements	Fewer privacy concerns regarding data transfer	Might bring economies of scale that could reduce administrative costs
Might allow the Exchange to work more closely with government agencies and politicians than entities not created by State law	More removed from government regulation and oversight, and would be further removed from political influence	Large carriers in the state and region are already used to working with the PID	Might ultimately be more costly for the State, depending on how the start-up costs and ongoing expenses are funded
State regulations and oversight might limit market flexibility	Separation from state agencies might result in less efficient communication and transfer of information with state agencies	Difficult to devote significant state resources to create and staff a new function within an existing agency	State will lose the ability to update/modernize its legacy IT systems
Need to establish base operational support systems that are already in place for an existing agency, like a Human Resources and financial system	Need to establish base operational support systems that are already in place for an existing agency, like an HR and financial system	Commonwealth purchasing rules could inhibit the Exchange's ability to operate efficiently	State would need to determine what data, policies and eligibility determinations can be legally conducted by the Federal government under State law
Will have to establish new working relationships with other agencies and the legislature	The Exchange might have a reduced ability to influence pertinent state legislation	Administering the Exchange within an existing agency has the potential to result in conflicts of interest	State forfeits control over the Exchange

Program Integration

The information presented on the following pages addresses program integration considerations the Commonwealth should consider when moving forward with Insurance Exchange Planning.

Regulatory Guidance

Section 1413 of the Act requires the Exchange to work closely with the Commonwealth's Medicaid, CHIP, and other Health and Human Services Programs to deliver a seamless eligibility verification and enrollment process. Section 1943 of the Act also contains the requirement to implement enrollment simplification and coordination among state health insurance exchanges, CHIP, and Medicaid. This requirement creates a need to have a process to ensure that individuals that are determined to be ineligible for the state's medical assistance plan (or waiver) and ineligible for CHIP are screened for eligibility for enrollment in qualified health plans along with applicable premium assistance, without having to submit another application. The NPRM [CMS-9989-P] further clarifies that this single streamlined application is to collect information to determine eligibility for enrollment for QHPs, advance payments of the premium tax credit, cost-sharing reductions, Medicaid, CHIP, or a state's Basic Health Plan (BHP).

Section 1943 of the Act permits the Exchange to enter into an agreement with the State Medicaid agency and the State CHIP agency to allow either agency to determine if a State resident is eligible for premium assistance to purchase a QHP. The NPRM [CMS-9989-P] further clarifies that the State may authorize the Exchange to enter into an agreement with an eligible entity to carry out one or more of the Exchange's responsibilities. The section referred to in the NPRM defines the criteria for an eligible entity and notes the State Medicaid agency qualifies as an eligible entity.

As noted in the Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges, the Exchange will also need to work closely with the State's Insurance Department. This Department has regulatory oversight over the health insurance insurers and may provide support for the appeals and complaints resolution processes.

In order to meet these requirements, the Exchange, the State Medicaid agency, the State CHIP agency, and the PID will need to work closely together. New system capabilities and new or modified business processes to support a seamless eligibility and enrollment process (including appeals processing and complaints resolution) will need the input and coordination across these agencies.

States are also encouraged to create an Exchange that can be integrated with other health and human services programs. The Exchange could then perform functions such as eligibility determinations and verifications.

In addition to the regulatory guidance specified above, CMS conducts period conference calls. In a September 1, 2011 call in which Pennsylvania CHIP staff participated; CMS representatives have emphasized the need for uniformity in eligibility processes. On the call Ann Marie Costello indicated that this uniformity is needed to "simplify movement among health programs." Future Federal guidance concerning this requirement or other requirements may further clarify or change the information described in this section.

Key Considerations

Emerging Practices

Some states have formed advisory groups to help provide input into Health Care reform initiatives and coordinate between the agencies that may be involved in an exchange. For example, Maryland has formed a Health Care Reform Coordinating Council (HCRCC) that includes participation from the Secretary for the Department of Health and Mental Hygiene (DHMH), Maryland's Medicaid and CHIP agency; The Secretary for the Department of Human Resources (DHR), Maryland's human services and eligibility determination agency; and the Commissioner of the Maryland Insurance Administration.

The composition of Maryland's Exchange Board helps reinforce this coordination with membership including the Secretary of DHMH, the Maryland Insurance Commissioner and the Executive Director of the Maryland Health Care Commission. These agency leaders have established a collaborative working relationship among the agencies to support system and process integration of Medicaid, CHIP, and the Exchange. Examples of coordinated activities include Joint Application Development sessions that were held to document business processes across the agencies and weekly meetings of Maryland's Exchange IT system leadership team that provide guidance to Exchange development, such as the Exchange's IT Architectural and Program Integration Framework.

Another example is Missouri, where the Health Insurance Exchange Coordinating Council (HIECC) is the primary organization responsible for Exchange planning. HIECC includes representation from the:

- Department of Social Services
- Department of Insurance
- Financial Institutions and Professional Registration
- State Medicaid Agency (MO HealthNet)
- Department of Mental Health
- Department of Health and Senior Services
- State Health Information Technology Coordinator

HIECC oversees four work groups comprised of staff members from the involved state agencies. Missouri also developed the "Show-Me Exchange's Vision, Mission, and Principles Statement" that supports integration and alignment of the Exchange and state programs.

In Washington, the Washington State Health Care Authority is merging with the Medicaid Purchasing Agency. This merger is expected to facilitate coordination in support of the Exchange's program integration needs.

In Minnesota, a Program Integration and IT Infrastructure sub-group under the Interagency Exchange work group was created to address program integration needs. A facilitator worked with policy, program, and IT Staff from multiple agencies, along with various stakeholders, to develop object framing, concept and process models related to support operational and technical objectives and specification development. This work involved evaluating existing systems, Exchange requirements, and consumer needs so that Exchange IT specifications would meet coordination needs.

Leveraging Current Capabilities

Pennsylvania is fortunate to have technology in place for the Commonwealth's Medicaid (COMPASS) and CHIP (CAPS) programs that could be leveraged to help establish an Exchange. These systems are accompanied by policies, procedures, and training materials that provide a starting point to develop and support some of the Exchange's portal functions. The Commonwealth also has an infrastructure in place for consumer assistance where portions of that infrastructure can also be leveraged. The Insurance Department also has policies and procedures that provide a starting point for defining how the Exchange can work with insurers that provide QHPs.

The key to program integration is organizing– making the best use of what the Commonwealth has and identifying what needs to be developed. The ideas suggested in the Moving Forward section below provide a structure to get organized if it is determined that an Exchange should be implemented, and how best to integrate the resources to meet the need to provide a seamless eligibility verification and enrollment process.

Moving Forward

In order to make progress toward program integration, the Commonwealth first needs to determine if a State Insurance Exchange will be created for Pennsylvania. This decision needs to be made before progress toward the FOA milestones related to agreements with the Exchange, PID, DPW, and DOH concerning determining responsibilities, strategies, procedures, and cost allocations related to program integration.

To provide leadership and direction for major programs or initiatives, organizations typically establish a Steering Committee to oversee the effort. The Commonwealth may want to consider establishing a High Level Steering Committee to set strategic direction for the possible implementation of the Exchange. This practice is consistent with the other states that are moving toward implementing an Exchange. To facilitate program integration, this committee could include representation from:

- Pennsylvania Insurance Department
- Department of Public Welfare
- Department of Health
- Department of Labor and Industry
- Department of Revenue
- Office of Administration, Executive Office of Health Care Reform
- Office of Administration, Office of Information Technology
- Office of the Budget
- Governor's Policy Office

To support program integration, this committee could establish work groups focused on the business and technology aspects of the Exchange. Regular collaborative meetings to develop work plans could be held with PID, DPW, DOH, and the State HIT Coordinators.

These meetings would help achieve the FOA milestone related to the HIT Coordinators.

A challenge for the Exchange will be to develop a strategy for limiting adverse selection. PID, as a result of the organization's insurance industry knowledge, may need to take a leadership role to establish the "rules of the

game" to limit adverse selection. In Pennsylvania, these rules would require legislation to put them in place and may involve rating rules, risk adjustment, reinsurance, risk coordination, as well as other strategies.

Additional ideas identified by other states include:

- Require all carriers to offer plans in all the metal tiers offered in the Exchange
- For carriers that operate in the Exchange, prohibit them from having affiliates that operate only outside the Exchange
- Prohibit reentry of carriers, for a specified period of time, that choose to leave the Exchange
- Require all health insurance to be sold through the Exchange (this would be counter to the desires of many stakeholders who have expressed an interest in having a robust insurance market in and outside of the Exchange)

Another challenge in creating a seamless eligibility verification and enrollment process will be in handling wrap around programs through the Exchange. An example involves a case where a person has health insurance for himself through his employer, but can't afford to add his family. The wrap around program finds out how much it would cost to add the family and pays the premium for the family if it is more cost effective than medical assistance. These exceptions to a more straightforward eligibility determination and enrollment will most likely continue to involve manual intervention. In creating an Exchange, the Commonwealth will need to determine the processes for the Exchange to work with these exceptions.

PID and DPW have limited resources available to dedicate to establishing an Exchange. Moreover, Program integration will require involvement of key decision makers and Commonwealth staff intimately familiar with the current programs. The Commonwealth may need to engage external resources to help staff a Program Management Office (PMO) to coordinate these program integration activities. Existing funding available on the Planning Grant and future funding in the Level 1 Establishment Grant could be used to fund the additional support. Level 1 Funding can also be used to start to put in place lead operational resources for the Exchange. These resources can also play a key role in program integration.

In the event that the Commonwealth does not implement an Exchange, but relies on a federal-facilitated Exchange, the Commonwealth will need to work with HHS to determine the processes, procedures and interfaces for how data will be made available to Commonwealth agencies. Once the federally facilitated Exchange determines eligibility of the applicant, data collected through that process will be needed by the Commonwealth agency, for example, to administer the Medicaid program for which an applicant may have been deemed eligible. Information about the applicant is also useful for other non-health benefit programs such as the Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF).

Timing Considerations

The decision as to whether or not an Exchange will be implemented for the Commonwealth is a key gating item that needs to be made before progress can be made on many of the FOA milestones. If a Steering Committee is formed as soon as possible, this committee could facilitate making this decision expeditiously.

Stakeholder Involvement/Impact

Input/Feedback

Feedback from the Stakeholder Listening Sessions overwhelmingly supported the idea of Pennsylvania implementing a state-based Health Insurance Exchange. Stakeholders also recognized the need of the Exchange to support eligibility determination and enrollment for QHPs, Medicaid, and CHIP.

The DPW completed the Navigant Study and verified that COMPASS could be used to facilitate eligibility determination for the Exchange and serve as the core Exchange Web portal functionality.

Future Plan and Communication

Input and involvement of existing COMPASS Community Partners on the Exchange design and testing could help validate how well the Exchange is meeting the need to deliver a seamless eligibility verification and enrollment experience.

If the Commonwealth chooses to implement an Exchange, the ability of the Exchange to meet requirements for Program Integration within the time frames established in the Act and NPRMs will depend on leadership to help ensure the agencies involved treat the development of the Exchange as a priority. Leadership direction will need to be effectively communicated to staff that will be involved in the Exchange implementation.

Option-Specific Considerations

Quasi-Government	Not For Profit	Existing Agency	Multi-State
▪ Limited independence from existing state government entities	▪ Greater independence from existing state government entities	▪ Not independent from state government	▪ This alternative involves the introduction of another party (beyond the existing agency option), adding to the complexity of integration. ▪ There will be a need to establish a Memorandum of Understanding (MOU) to establish how program integration will be achieved.

Technology

The information presented on the following pages addresses technology considerations the Commonwealth should consider when moving forward with Insurance Exchange Planning.

Regulatory Guidance

Legislation

Information technology (IT) will be a component of many business functions of the Exchange, including those set forth in Section 1311(d)(4) as well as the requirements in §1411, §1412 and §1413 related to eligibility and enrollment of the Act. This Core Area encompasses the performance of the Exchange in planning for and establishing these systems in these various functional areas. When planning or developing Exchange IT systems, the State should take steps to ensure a modular, flexible approach to systems development, including use of open interfaces and exposed application programming interfaces; the separation of business rules from core programming; and the availability of business rules in both human and machine readable formats. Milestones related to information technology for establishment of an Exchange will be located under each of the Exchange business functions. Exchanges will be required to follow all applicable Federal IT guidance.

Moreover, each Exchange will maintain a website through which applicants and enrollees may obtain standardized comparative information on qualified health plans, apply for coverage, and enroll online. Exchange websites will also need to post required transparency information. Exchanges may choose to provide many more services on their websites. In addition, each Exchange website must provide access to an electronic calculator that allows individuals to view an estimated cost of their coverage once premium tax credits have been applied to their premiums, and the impact of cost-sharing reductions, if they are eligible.

Notice of Proposed Rulemaking

- The Exchange must include an internet website that at a minimum:
  - Presents standardized comparative information on each available Qualified Health Plan (QHP), including:
    - Premium and cost-sharing information
    - Summary of benefits and coverage required
    - The level of coverage of a QHP (bronze, silver, gold, platinum)
  - HHS will establish a standardized format for presenting coverage option information and make available to all Exchanges a model Exchange website template developed by HHS
  - Provides meaningful access to information for individuals with limited English proficiency
  - Publishes key financial information
  - Provides contact information for Navigators and other consumer assistance services
  - Allows for an eligibility determination
  - Allows for enrollment in coverage pursuant to subpart E of the ACA
  - HHS is considering a website requirement that would allow applicants and enrollees to store and access their personal account information and make changes
  - Provides electronic calculator functionality

        - Assist individuals in comparing the costs of coverage in available QHPs after the application of any advance payments of the premium tax credit and cost-sharing reductions.

- Per the NPRM, the key functions of the Exchange include:
  - The Exchange must accept a QHP selection from any applicant who is determined eligible for enrollment in a QHP, notify the issuer of the applicant's selected QHP, and transmit information necessary to enable the QHP issuer to enroll the applicant.
  - The Exchange must use a single streamlined application to collect information necessary for QHP enrollment, calculate and transmit payments of the premium tax credit, calculate cost-sharing reductions, and eligibility for Medicaid, CHIP, and the Basic Health Plan (BHP) if a BHP is operating in the Exchange service area. Note that PA does not currently offer a BHP.
    - Once an applicant is deemed eligible for MA or CHIP, it is envisioned that the Exchange will transfer the application to the existing enrollment information to the Medicaid Agency for MA or PID for CHIP for further processing and fulfillment.
    - There are exceptions to MA eligibility (e.g., blind individuals) such that the Exchange will not be able to calculate eligibility in real–time for 100% of the applicants that utilize it.
      - Some applicants that are eligible for these exceptions will need to be processed via a manual process.
  - The Exchange must accept applications from multiple sources, including the applicant; an authorized representative (we propose this to be defined by State law); or someone acting responsibly for the applicant.

NPRM Guidance on SHOP Exchange

The NPRM proposed regulations set key functions of SHOP Exchanges. States must establish a SHOP that meets minimum requirements and Exchange functions to support SHOP are the same as individual requirements (except where not applicable). The SHOP Exchange must facilitate special enrollment periods outside of open enrollment period and other areas addressed include premium aggregation. Eligibility process will be based on self-certification and then checked against quarterly wage report or other controls.

Applicable Exchange IT Standards

- Federal Information Processing Standards (FIPS)
- ACA Section 1561 Recommendations
- Use NEIM Framework
- NIST account security standards and controls
- Comply with HIPAA Privacy and Security Rules and the ONC standards
- Be accessible for individuals with disabilities
- Must follow standard governing body defined-Systems Development Life Cycle (SDLC) framework and iterative and incremental development methodologies (e.g., Initiation, Planning, Requirements Gathering and Validation, High Level Design, Detailed Design, etc.)
- Leverage a Web Services Architecture (XML, SOAP and WSDL, or REST)
- Use a Services Oriented Architecture (SOA) approach for design and development
- Leverage the concepts of Cloud Computing (e.g., a shared pool of configurable IT resources)
- HHS proposes to apply the HIPAA administrative simplification requirements. To the extent that the Exchange performs electronic transactions with a covered entity, including State Medicaid programs and

QHP issuers, the Exchange must use standards and operating rules adopted by the Secretary pursuant to 45 CFR parts 160 and 162.

Key Considerations

Emerging Practices

In our review of numerous state Level 1 Exchange Establishment grants, we noted that most states are using the funds to plan for the modifications required to its core healthcare eligibility and portal systems. As illustrated in the Level 1 Exchange Establishment grant milestones listed above, HHS expects significant Exchange IT work to take place during 2011, specifically around the areas of IT Gap Analysis and functional and technical requirements planning.

Additionally, some states are using an outsourced approach where they partner with technology vendors to host the development and test environments of the Exchange as it is being developed by a Systems Integrator (SI). The approach calls for the completed Exchange solution to be hosted on the technology vendor's site well after it is developed and implemented. Once the state's IT department and technology infrastructure are mature enough to manage the new Exchange functionality, the vendor will transfer it back to the state for long-term operations and management support. As discussed below, the Commonwealth has several IT assets that can be leveraged and extended to help form the core of an Exchange.

Wisconsin, an early innovator state, structured their exchange IT components in such a way that other states may adopt, modify, and implement their systems. The Badger State embraces building in components in its Exchange model that provide interested states with the assets and tools to quickly and effectively implement their health insurance exchanges, thereby reducing cost, time and risk. Wisconsin's ACCESS self-service site, a system that leverages some of the core components and functionality of Pennsylvania's COMPASS system, demonstrates this approach in action. ACCESS is a frequently transferred and leveraged self-service, human services system because of its modern, table-driven, SOA-based open architecture, and capabilities for expansion. The Commonwealth could leverage some of the technical innovations developed by other states when it finalizes its Exchange approach, especially from Wisconsin due to the similarity of the two state's respective self-service sites.

The following table illustrates the type of exchange several states with enabling authority plan to develop:

Summary of State Exchange Types

State	Exchange Type
California	Active Purchaser
Colorado	Market Facilitator
Connecticut	Active Purchaser
Hawaii	Market Facilitator
Maryland	TBD
Nevada	TBD
Oregon	Active Purchaser

State	Exchange Type
Vermont	Active Purchaser
Washington	Active Purchaser
West Virginia	Market Facilitator

Also, the majority of states enacting legislation through August 2011 chose to establish the Exchange as a quasi-governmental body (generally a private entity, with some attributes of government). Of the ten states that have enacted Exchange legislation, seven states created a quasi-governmental entity, two established the Exchange within a state agency, and one will operate its Exchange as a private, nonprofit organization.

Leveraging Current Capabilities

The following is a brief overview of the Commonwealth's core IT systems. Note that the DPW supports PID's IT operations and maintenance role through various service level agreements (SLA) and interagency agreements.

- COMPASS (Commonwealth of PA Access to Social Services) – COMPASS is a self-service portal for HHS programs, allowing customers to apply for and manage social service benefits in one place. It is the DPW's strategic initiative that allows citizens and business partners to be screened and apply online without knowing all the specifics for the programs they are applying for. COMPASS allows individuals and community-based organizations access to screen for, apply for, and renew a broad range of social programs, including: Healthcare Coverage (Medicaid and CHIP), Food Stamp Benefits, Cash Assistance, Long-term Care, Home and Community-based Services for individuals with intellectual disabilities, and Low-income Home Energy Assistance Program (Seasonal).
- eCIS ─ web-based front end to CIS that provides staff a single location to perform application processing and case maintenance activities. These new Web enabled components are referred to as eCIS.
- CIS ─ Mainframe eligibility information system. CIS is used on a daily basis by over 7,000 DPW caseworkers in 67 counties throughout the Commonwealth. The long-term goal for CIS is to convert it from a legacy-based mainframe architecture to a more fluid and robust open systems architecture. The migration from legacy to open system architecture is a staggered development, and has been underway for some time. Throughout the development of CIS, DPW has implemented several key changes: Implementation of the Master Client Index (MCI); improved use of COMPASS applications; and the development of an automated Medicaid eligibility system (MEDA). The next step is to apply standard filing rules and data collection Cash and Food Stamps as is done for medical categories from DPW's legacy based system to the open system architecture.
- MCI ─ SOA-based application that acts as a central repository for client demographic data. Contains pointers to multiple programs. The MCI is an automated enterprise-wide client identification process that registers and identifies individuals uniquely within DPW. The technical architecture of MCI uses a model that combines a presentation/business tier and a data tier, and provides flexibility for system performance, operating system independence, security, and scalability. Note that the data within the MCI is sometimes duplicated and not tied to any cleansing mechanism. The data integrity within MCI will need to be addressed prior to leveraging it as part of any Exchange solution.

- MPI ─ Master Provider Index. Central repository of provider profiles and demographics. Uniquely identifies providers doing business with DPW.
- CAPS ─ Provides the ability to determine healthcare eligibility, enrollment management, financial obligation management, workload management, application entry, and automated processing for the CHIP program.
- IEVS ─ Income Eligibility Verification System (IEVS) An automated system developed to provide for the exchange of information between DPW and the Pennsylvania Department of Labor and Industry (DLI), Office of Employment Security (OES), the Social Security Administration (SSA), and the Internal Revenue Service (IRS). Information on the IEVS database is compiled from automated matches with the state and federal sources. These matches are referred to as data exchanges.

PA has no existing functional or technical component that is likely to be used "as-is" in any anticipated Exchange design. As such, there needs to be a rapid determination if any remediation of IT assets will be able to be undertaken quickly enough to meet the ACA timelines.

Gap Analysis

KPMG performed a high-level gap analysis between the Commonwealth's current IT asset inventory and the functional and technical requirements associated with a basic individual exchange. Note – that while Commonwealth has not decided to move forward with implementing an Exchange, a benchmark was needed from which to measure the gap. Moreover, PA may not need to implement everything in the model to be compliant with Exchange requirements (which are still evolving). Whatever Exchange model (if any) is finally agreed upon, the Commonwealth may need to modify the plan and budget to account for remediation and integration tasks associated with leveraging its existing IT assets (rather than a simply configuring and building the Exchange with third-party solution components). As such, this high-level assessment will probably adjust based on the Exchange approach, if any, that the Commonwealth selects.

KPMG interviewed PID, DPW and Deloitte staff during our field work and discussed several of the Commonwealth's core eligibility and benefit management systems (described above). The core systems we assessed in the high-level gap analysis include:

▪ COMPASS	▪ eCIS
▪ CIS	▪ MCI
▪ MPI	▪ CAPS
▪ IEVS	

We also leveraged a gap analysis tool to track each core systems' ability to satisfy the specific functional and technical requirements associated with the implementation of a basic individual exchange. These included:

Functional Components	Technical Components
▪ Plan Certification and Risk Management	▪ Information Management
▪ Premium and Tax Credit Processing	▪ Master Person Index
▪ Eligibility Assessment	▪ Knowledge Management
▪ Comparison Shopping	▪ Financial Transaction Processing

Functional Components	Technical Components
▪ Enrollment Processing	▪ Business Process Management
▪ Appeals Management	▪ Privacy and Security
▪ Broker / Navigator Relationship Management	▪ Rules Engine
▪ Marketing & Outreach	▪ Workflow Engine
▪ Customer Service and Account Management	▪ Data Management
▪ Financial Management and Reporting	▪ Service Management
▪ Asset Management	▪ Unified Communications
▪ HR Management	▪ Exchange Portal
▪ Procurement Management	▪ B2B Gateway

Note that this is a high-level gap analysis where KPMG assessed existing core Commonwealth systems against known Exchange requirements. As the ACA prescribes several new functional capabilities that virtually no state currently has in place, it is not surprising for the Commonwealth to have a high initial gap between these requirements and the functionality of its current systems. A primary purpose of this analysis is to give the Commonwealth a sense of the level of IT/systems implementation effort that will be required once a decision is made regarding the approach Pennsylvania wants to pursue.

As discussed elsewhere in this section, the Commonwealth has several core system components (e.g., applications, tools, services and data interfaces) that are robust and mature enough to contribute to an envisioned Exchange architecture. In the section below, KPMG noted several areas where the core Commonwealth systems assessed support some of the following areas (in ***green italics***) and potentially support others (in ***blue italics***).

Functional Gap Highlights

Plan Certification and Risk Management – KPMG noted no areas where the core Commonwealth systems assessed supports any of the following areas:

▪ Plan Certification	▪ Manage Plan Submission Process	▪ Certify / Recertify / Decertify Plan
▪ Form QHP Agreement with Issuer	▪ Manage Issuer and Plan Information	▪ Report Issuer and Plan Information
▪ Assign Plan Quality Rating	▪ Process Change in Plan Enrollment Availability	▪ Manage Rates and Benefits
▪ Monitor Plan Compliance	▪ Administer Transitional Reinsurance	▪ Administer Risk Corridors
▪ Administer Plan Assessments (Surcharges)	▪ Risk Management	▪ Calculate Actuarial Risks
▪ Submit Transparency Information	▪ Manage Plan Certification Business Rules	▪ Manage Plan Certification Workflow Rules

Premium and Tax Credit Processing – KPMG noted no areas where the core Commonwealth systems assessed supports any of the following areas:

▪ Automated Invoice Generation	▪ Automated Invoice Printing	▪ Capture Payment Information
▪ Automated Premium Reconciliation	▪ Determine Eligibility for Tax Credit	▪ Notify Individual of Tax Credit Eligibility Results
▪ Manage Premium and Tax Credit Processing Business Rules	▪ Manage Premium and Tax Credit Workflow Rules	▪ Identification of Delinquent Accounts
▪ Termination of Delinquent Accounts	▪ Manage Communication Business Rules	▪ Manage Communication Workflow Rules
▪ Calculate Member/Employer Premium Contributions	▪ Collect Employer Premium Contributions	▪ Collect Member Premium Contributions

Eligibility Assessment – KPMG noted several areas where the core Commonwealth systems assessed supports some of the following areas (in ***green italics***) and potentially support others (in ***blue italics***):

▪ Process Individual Exemption Renewal Request	▪ Process SHOP Employee Renewal Request	▪ Verify Individual Eligibility of Public Minimum Essential Coverage
▪ ***Verify Individual Eligibility for Employer – Sponsored Minimum Essential Coverage***	▪ ***Determine Eligibility***	• Refer Potentially Eligible Individuals to Medicaid and CHIP for additional Screening
▪ Determine Eligibility for Advance Premium Tax Credit	▪ Determine Category for Cost-sharing Reductions	▪ Qualify Individual for an Enrollment Period
▪ Verify Lawful Presence	▪ Verify Household Income	▪ Calculate Federal Poverty Level
▪ Verify Whether Individual is an Indian	▪ Verify Incarceration Status	▪ Verify Individual Residency Status
▪ Verify Information Required for Exemption	▪ Verify SHOP Employer Identity	▪ Verify Employee Roster
▪ Verify SHOP Employee Application	▪ ***Manage Eligibility Business Rules***	▪ ***Manage Eligibility Workflow Rules***
▪ Determine Insurer Eligibility	▪ Receive Employee List and Employer Options	▪ ***Display Eligibility Rules***

Comparison Shopping – KPMG noted no areas where the core Commonwealth systems assessed support any of the following areas:

▪ Determine Plan Availability and Calculate Plan Cost	▪ Select SHOP Employee Qualified Health Plan	▪ QHP side-by-side comparison tool
▪ Provide Product Comparison Interface		

Enrollment Processing – KPMG noted several areas where the core Commonwealth systems assessed support some of the following areas (in ***green italics***) and potentially support others (in ***blue italics***):

▪ Process Employer Participation Renewal	▪ Accept SHOP Employer Application	▪ Accept SHOP Employer Application Update
▪ Determine SHOP Employer Contribution	▪ Terminate Employer Participation	▪ Validate Application Submission
▪ Review and Adjudicate Alternative Documentation	▪ Accept Individual Eligibility Application	▪ Accept Individual Eligibility Application Update
▪ Accept Individual Exemption Application	▪ Accept Individual Exemption Application Update	▪ Accept SHOP Employee Application
▪ Accept SHOP Employee Application Update	▪ Select Individual Qualified Health Plan	▪ ***Enroll in Medicaid, CHIP or BHP***
▪ ***Enroll in SNAP and TANF***	▪ ***Process Individual Eligibility and Enrollment Renewal Request***	▪ Assess Current Qualified Health Plan Enrollment Status
▪ Disenroll from Qualified Health Plan	▪ Store supporting document image	▪ Interface to Billing System
▪ ***Manage Enrollment Business Rules***	▪ ***Manage Enrollment Workflow Rules***	▪ Process Plan Enrollment Availability and Changes
▪ Enable Employer Product Selection	▪ Enable Employer Contribution Selection	▪ Display Employer Liability Rules (content)

Appeals Management – KPMG noted no areas where the core Commonwealth systems assessed currently support any of the following areas:

▪ Implement Adjusted Eligibility Determination Resulting from Appeal	▪ Conduct Eligibility Appeal	▪ Conduct SHOP Eligibility Appeal
▪ Conduct Employer Liability appeal	▪ Halt Appeals Processing	▪ Manage Appeals Business Rules
▪ Manage Appeals Workflow Rules		

Broker/Navigator Management – KPMG noted no areas where the core Commonwealth systems assessed currently support any of the following areas:

▪ Record / Modify Training	▪ Record / Modify Certification	▪ Record / Modify Compliance
▪ Manage Broker / Navigator Monthly Targets	▪ Manage Broker Sales Objectives	▪ Manage Compensation
▪ Testing of Incentive Returns	▪ Online Training	▪ Broker / Navigator Evaluation
▪ Produce Monthly Paper / E-Statements	▪ Self-service Broker Portal	▪ File Dispute
▪ Manage Dispute	▪ Manage Broker Inquiries	▪ Manage Broker Relationship Business Rules
▪ Manage Broker Relationship Workflow Rules	▪ Manage Navigator Relationship Business Rules	▪ Manage Navigator Relationship Workflow Rules

Marketing and Outreach – KPMG noted no areas where the core Commonwealth systems assessed currently support any of the following areas:

▪ Produce Sales / Marketing Materials	▪ Manage Sales Leads	▪ Manage Marketing and Outreach Business Rules
▪ Manage Marketing and Outreach Workflow Rules		

Customer Service and Account Management – KPMG noted several areas where the core Commonwealth systems assessed support some of the following areas (in ***green italics***) and potentially support others (in ***blue italics***):

▪ ***Manage Account***	▪ Record Inquiry Information	▪ Manage Call Transfer Business Rules
▪ Administer Employer Liability	▪ Manage FAQs	▪ Manage Performance Measures / Measurements
▪ Manage Customer Service and Account Management Business Rules	▪ Manage Customer Service & Account Management Workflow Rules	▪ Receive complaint
▪ Resolve Complaint	▪ Close Complaint	

Financial Management and Reporting – KPMG noted several areas where the core Commonwealth systems assessed support some of the following areas (in ***green italics***) and potentially support others (in ***blue italics***):

Automatic Data Collection (Data Feeds)	Audit Collected Data	Automated Data Mapping
Forecasting	Trend Analysis	Manage Financial Management & Reporting Business Rules
Manage Financial Management and Reporting Workflow Rules		

Asset Management – KPMG noted no areas where the core Commonwealth systems assessed currently support any of the following areas:

Manage Deployment	Manage System Specifications	Monitor Assets
Manage Vendor Contracts		

HR Management – KPMG noted no areas where the core Commonwealth systems assessed currently support any of the following areas:

Manage Recruitment	Manage Compensation	Manage Job Evaluations
Manage Performance	Manage Time and Attendance	Benefits, Pension, and Leave Administration
Salary Administration	Return to Work Administration	Manage Professional Development

Procurement Management – KPMG noted several areas where the core Commonwealth system assessed support some of the following areas (in ***green italics***) and potentially supports others (in ***blue italics***):

Manage Purchase Orders	Manage Inventory	Perform Cost Analysis

Technical Gap Highlights

KPMG noted several areas where the core Commonwealth systems assessed support some of the following areas (in ***green italics***) and potentially support others (in ***blue italics***):

Reporting

Manage Reports	Manage Report Templates	***Review Reports (includes report estimate)***
Manage Report Schedule	Manage Report Delivery Mechanism	***Ad Hoc Reporting***

Business Intelligence

Manage Analytic Templates	Perform Analytics	Portal Integration of Analytics
Manage Data Sources		

Records and Document Management

Manage Surveys	Manage Survey Templates	Review Survey (includes survey estimate)
Manage Survey Schedule	Manage Survey Delivery Mechanism	Publish Survey

General Information Management

Manage Information Management Business Rules	***Manage Information Management Workflow Rules***	National Information Exchange Model (NIEM) http://www.niem.gov/

Master Person Index – KPMG noted several areas where the core Commonwealth systems assessed support some of the following areas (in ***green italics***) and potentially support others (in ***blue italics***):

Deterministic Matching	***Probabilistic Matching***	***Roles Management***
Manage Master Person Index Business Rules	***Role-based access control***	Multiple roles associated with a User ID
Configuration of role-based access control via a standard GUI.	Disable a User ID if the User has not logged on to the system for a predetermined, administrator configurable period of time	Prevent incompatible roles from being assigned to Users
Uniqueness for all User IDs		

Knowledge Management – KPMG noted no areas where the core Commonwealth systems assessed currently support any of the following areas:

▪ Content Management	▪ Store Content	▪ Retrieve Content (Search Features)
▪ Metadata Management	▪ Manage Taxonomy	▪ Tag Content

Financial Transaction Processing – KPMG noted no areas where the core Commonwealth systems assessed currently support any of the following areas:

▪ Payment Processing	▪ Manual Settlements	▪ Batch Settlements
▪ Automate Payments Based on Invoice Data	▪ Electronic Funds Transfer	▪ Payment Reconciliation
▪ Manage Financial Transaction Processing Business Rules	▪ Manage Financial Transaction Processing Workflow Rules	▪ Health Insurance Portability and Accountability Act (HIPAA) adopted transaction standards (e.g., ASC X12N 834, ASC X12N 270, ASC X12N 271) for interfaces
▪ Receipt Processing		

Business Process Management – KPMG noted several areas where the core Commonwealth systems assessed support some of the following areas (in ***green italics***) and potentially support others (in ***blue italics***):

▪ ***Alerting and Notification***	▪ ***Create Notification***	▪ ***Update Notification Content***
▪ Delete Notification	▪ ***Manage Notification Rules***	▪ Communicate to Issuer [including Medicaid for BHP] Regarding Enrollment in Qualified Health Plan
▪ Report Enrollment in Qualified Health Plan	▪ Communicate Individual Eligibility Determination	▪ Report on Individual Exemption Status
▪ Communicate to Employees Regarding Availability of Insurance Through SHOP Exchange	▪ Communicate Training Results	▪ Communicate Certification Results
▪ Communicate Compliance Results	▪ Send Notification	▪ Manage Business Rules
▪ Manage Workflow Rules	▪ ***Document Generation***	

Privacy and Security – KPMG noted several areas where the core Commonwealth systems assessed support some of the following areas (in ***green italics***) and potentially support others (in ***blue italics***):

Identity Management	***Manage Identity / Access Privileges***	***Authentication and Access Control***
Compliance management	Field level security in accordance with RBAC	Digital Certificates using X.509 standard (or most recent version)
History of security profile assignments for a User.	Automatically log, and disable access to any user accounts following a specified, administrator configurable number of unsuccessful log-on attempts	***Prevent concurrent logins for the same User ID unless specifically authorized***
Encrypt any passwords stored in the system	***Enforce standards for password rules***	Utilize encryption algorithms and implementations, in compliance with National Institute of Standards and Technology ─ Special Publications 800-52, 800-77, or 800-113. (http://csrc.nist.gov/publications/PubsSPs.html)
LDAP compliant authentication service(s) for user authentication	Authorized personnel to view all security audit logs	Host-based Intrusion Prevention and/or Detection software (IPS/IDS)
Prevent, detect, and recover from malicious code		

Rules Engine – KPMG noted several areas where the core Commonwealth systems assessed support some of the following areas (in ***green italics***) and potentially support others (in ***blue italics***):

Rules Catalog	***Inference Engine***	***Event Processing Engine***
Modification of business rules via a GUI (Graphical User Interface)	***Automated interfaces through a set of APIs (Application Programming Interfaces)***	***Allow the reuse of the rule repository and rules-driven technology***

Workflow Engine – KPMG noted several areas where the core Commonwealth systems assessed support some of the following areas (in ***green italics***) and potentially support others (in ***blue italics***):

Process Scripting (Business Process Execution Language (BPEL))	Current Status Verification User	Authority Validation
Script Execution		

Data Management – KPMG noted several areas where the core Commonwealth systems assessed support some of the following areas (in ***green italics***) and potentially support others (in ***blue italics***):

Relational database management system (RDBMS)	Referential integrity enforcement	Support data dictionaries with the usage, associated business rule and semantic information on its data elements
Master Data Management functions, including data standardization and deduplication.	***Data Warehousing***	***Extract-Transform-Load***

Service Management – KPMG noted several areas where the core Commonwealth systems assessed support some of the following areas (in ***green italics***) and potentially support others (in ***blue italics***):

Service Registry and Repository	***Service Manager***	***Enterprise Service Bus***
Non-repudiation	Guaranteed Delivery	

Unified Communications – KPMG noted several areas where the core Commonwealth systems assessed support some of the following areas (in ***green italics***) and potentially support others (in ***blue italics***):

Interactive Voice Response	***Fax***	Text Messaging
e-Mail	E-mail interface synchronizing calendar and scheduling data	General Unified Communications
Transmit Report / Notification	Manage Communication Business Rules	Manage Communication Workflow Rules

Exchange Portal – KPMG noted several areas where the core Commonwealth systems assessed support some of the following areas (in ***green italics***) and potentially support others (in ***blue italics***):

▪ ***Web browser based primary interface***	▪ Support the use of mobile devices	▪ ***Multiple views available: Employer, Employee, Consumer, Carrier, Broker, Customer Service Rep, Administrative***

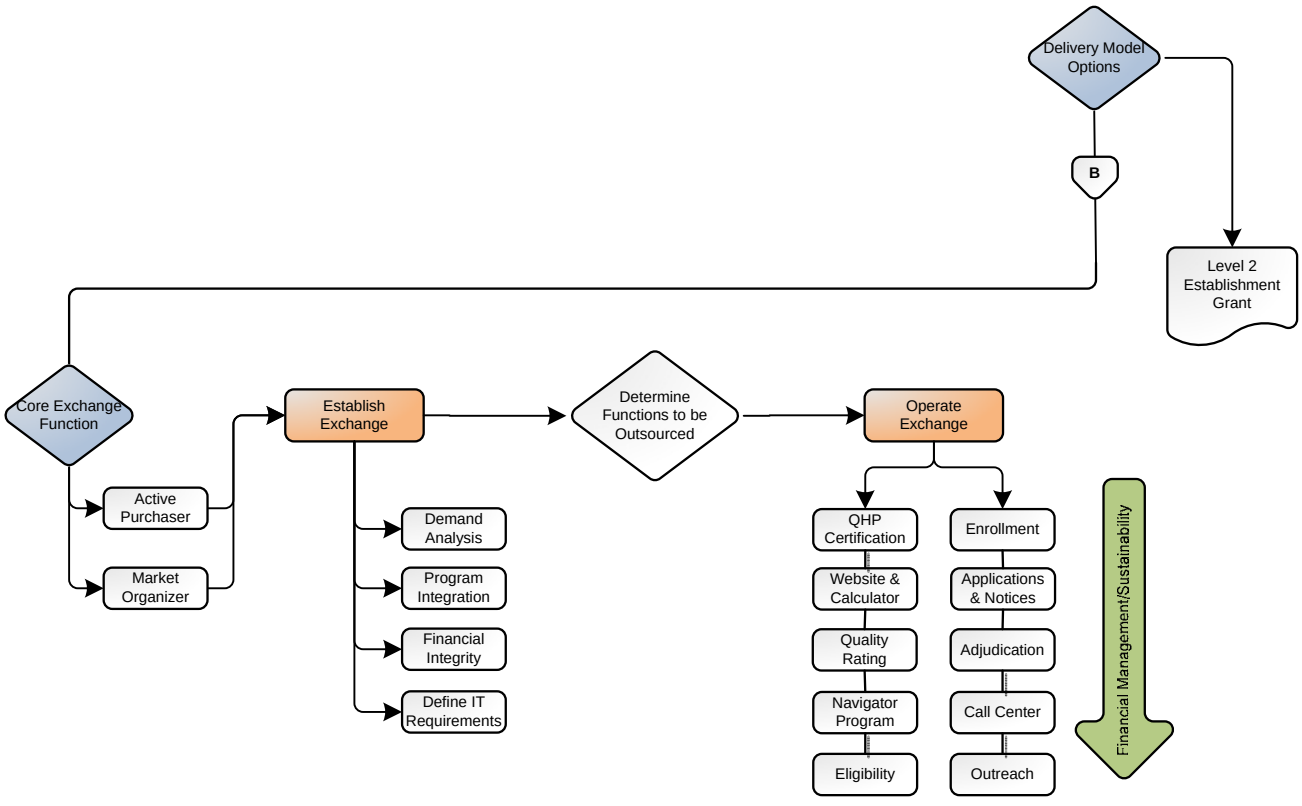
B2B Gateway – KPMG noted several areas where the core Commonwealth systems assessed support some of the following areas (in ***green italics***) and potentially support others (in ***blue italics***):

▪ SFTP	▪ ***EDI***	▪ ***Web Services***

Moving Forward

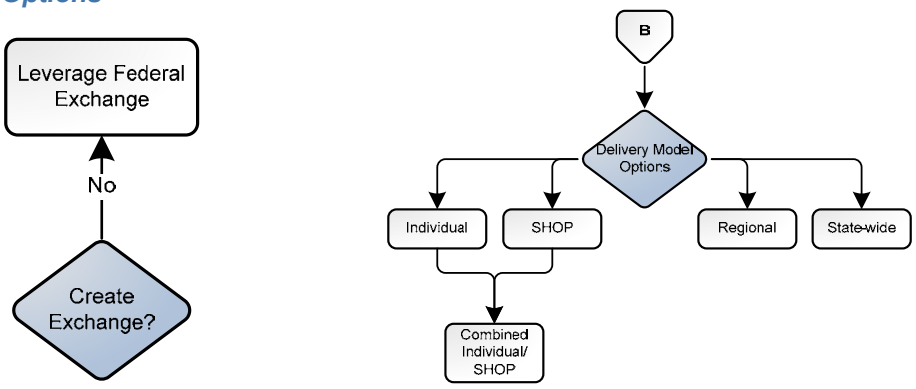
Once the Commonwealth chooses whether or not to implement an exchange, the key decisions will be to identify the appropriate delivery model options (e.g., Separate individual/SHOP, combined individual/SHOP, Regional exchanges or a Multi-State model). After that, Pennsylvania needs to prescribe the core function of the Exchange (e.g., serve as an Active Purchaser or Market Facilitator). The next steps include establishing the Exchange and then operating it.

Several of the key decisions are illustrated in the flowchart below:



Each component of the preceding decision tree is highlighted on the following pages.

Delivery Model Options



The Commonwealth can choose one of several Delivery Model Options:

1. Chooses not to implement a PA Exchange and leverage the Federal Exchange model

- If the Commonwealth does not implement an Exchange, it must:
- Take the steps necessary to coordinate with the federal government. Specifically:
  - Identify what Exchange functional roles may still apply to the Commonwealth (e.g., Medicaid and CHIP)
  - Address the Federal bias enrollment issue (e.g., potentially over-enrolling applicants in MA) – also noted in the *Governance* section of this report.
  - Uncapped liability to PA for the unmatched portion of the MA payment
  - Identify what IT assets/interfaces may still need to be developed in the Commonwealth
  - Review and revise Commonwealth regulatory and policy issues to ensure coordination between state and federal agencies
    - Modify the MA and CHIP eligibility systems because numerous members are potentially coming out of MA and going to be eligible for coverage through the Exchange
    - Decide whether, in allowing the Federal Exchange to serve as the primary health insurance selection and enrollment vehicle, PA will have its citizens receive insurance through the two plans that the federal government is currently expected to provide
      - If PA does this, it will potentially disrupt the Commonwealth's health insurance market and all of the carriers
      - If not, PA will need to determine how to certify plans and get them on the Exchange.
  - The Commonwealth will potentially lose out on 100% federal funds to modify the Commonwealth's eligibility determination process (to 2015) and associated functionality. The federal government is fully funding State-based health benefit Exchange planning and implementation through planning and Establishment Grants. If the Commonwealth pursues a federal Exchange, it will potentially lose out on a significant amount of funding for State infrastructure upgrades.
  - Moreover, Pennsylvania will still be responsible for collecting claims and encounter data from all non-grandfathered health plans for risk adjustment. This claims and encounter data will be provided to the federal government for administration of "risk corridors"
  - Note that the Commonwealth will be responsible for addressing forthcoming federal requirements that HHS has not yet announced

- If PA does not plan to utilize the Federal Exchange, there are several areas where the federal government could help:

- The Federal Exchange may serve as a fall-back solution should PA decide to not develop its own Exchange.
- Either way, PA may use some of the components the federal government develops (e.g., the model Exchange website template and the "black box" interface with SSA, IRS and Department of Homeland Security (DHS).
- PA should not ignore leveraging something provided by the federal government that might have value to the Commonwealth like reducing implementation timelines and cost (e.g., the Commonwealth should remain open to leveraging valuable exchange components that the federal government could build to reduce the effort and expense of implementing a PA-specific exchange)

- Federal Partnership – A new concept whereby a state and the Federal Government work together to jointly implement and operate an exchange. Note that there are no firm details about what services/support the Federal Government would provide a state in this model.
  - Could the State could leverage the Federal partnership to establish the Exchange and then transfer responsibility to a Commonwealth agency/entity once it is stable?
  - Pennsylvania must determine the requirements for interfacing with the Federal data hub if a state elects not be operate an Exchange

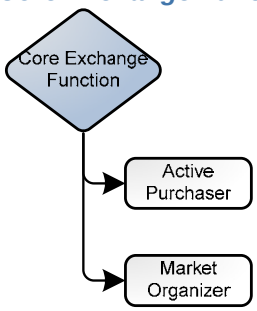
2. Implement a state Exchange in conjunction/partnership with another state

- Partner or leverage the innovations of an early innovator state
  - Maryland
    - Geographically closer
    - Further along in implementation
  - Wisconsin?
    - Wisconsin plans to document and share its approach and design of its health insurance exchange.
    - The state's initial tasks include completing a proof of concept, alternatives analysis, risk analysis, and project plan.
    - Wisconsin will also document its vision, business and system requirements, and system design. The design will include detailed business process flows, screen mockups, and system logic. These planning, requirement, and design deliverables may be used as building blocks that Pennsylvania may use to quickly implement its health insurance exchange in its unique technology environments and programming languages.

3. Create a Commonwealth Exchange/SHOP or regional exchanges:

- One combined statewide Exchange/SHOP
  - No states have plans to implement a combined statewide Exchange/SHOP yet
- One statewide Exchange and a separate SHOP
  - This is the model that most states are leveraging to date
  - The COMPASS system can potentially serve as a robust Exchange portal
  - PA will need to develop functionality to allow for "nearly" real-time determination of MA and CHIP eligibility
- Two or more "regional" Health Insurance Exchanges
  - No states have communicated plans to implement a regional Exchange

Core Exchange Function



4. Determine core Exchange function – Will the Exchange be a Market Organizer (e.g., redirects users to carrier sites for fulfillment and premium billing/collection) or an Active Purchaser (e.g., all in one selection, purchasing and billing)?

- A simple Exchange solution would not process payments or collect funds from users
- In a nonintegrated exchange model (e.g., users are redirected to a carrier's site to complete the plan procurement transaction) for the individual exchange
  - Exchanges must deal with Tax Credit and Cost-Sharing calculations and accounting for individuals and employees with unaffordable care, so there needs to be an eligibility assessment for these options and negotiation with carriers to see if they will deal with payment complexities for these populations.
- Choosing to not collect payments is not the same as not processing enrollment
- PA can outsource payment processing to carriers, but it's different than outsourcing enrollment
- PA may have to collect operating funds from Carriers on the backend if it does not collect it during the plan fulfillment process. Note that there are several options available to states to fund the ongoing operation of the Exchange. Many states are working towards assessing a fee on carriers providing plans in the Exchange, but other funding methods are open to the Commonwealth's consideration.

Core Exchange Functions Supported by IT

- Eligibility
- Enrollment
- Premium Tax Credit Administration
- Cost-sharing assistance administration
- Health Plan Management to support Qualified Health Plans

Systems must be interoperable and integrated with the State's Medicaid/Children's Insurance Program (CHIP) programs and be able to interface with HHS and other data sources in order to verify and acquire data as needed and or permitted by HHS (e.g., any interface with HHS will occur only if the federal government thinks it is reasonable). States are encouraged to achieve interoperability with other health and human services programs for purposes of coordinating eligibility determinations, referrals, verification or other functions. Examples of additional core Exchange functions that could be added, initially or eventually, include Exchange administration, and qualified health plan administration (including data and certification management).

To meet milestones and assure alignment with other critical state and federal programs, the Commonwealth could consider for Exchanges to leverage and re-use services or capabilities available in the State, including those offered by the State health information exchange program such as for provider and patient identity

services (eMPI, ID resolution and authentication). It is unknown how far along the Commonwealth's Exchange program is in creating or providing these services.

Timing Considerations

It is very important that the Commonwealth makes a decision if and then what kind of Exchange it wants to implement. Other timing constraints include:

- Identify procurement constraints
- Exchange planning and development activities must be able ongoing and able to demonstrate progress to the federal government in early 2013
- Exchange must be able to process initial enrollment transactions in the fall of 2013 and be fully functional by January 1, 2014
- System testing

Stakeholder Involvement/Impact

Input and feedback received to date

KPMG reviewed written stakeholder testimony and attended three PID-sponsored stakeholder sessions in Philadelphia, Harrisburg and Pittsburgh. Stakeholder feedback included ideas on how the Commonwealth can leverage IT to support the development and implementation of an Exchange. The IT-centric feedback received from some stakeholders is summarized below:

Many stakeholders perceive COMPASS as a great platform and that the Commonwealth should use existing assets. However, some feel that improvements could be made in electronic income data verifications and building on existing children platforms. Others noted that with the implementation of COMPASS, the Commonwealth was a leader and therefore should maintain the COMPASS platform.

Conversely, some feedback discussed issues with COMPASS, such as its ability to scan and attach documents. They noted that county staff then needs to match up documents that are dropped off or mailed in. (Note – new functionality to allow users to attach documents to cases in COMPASS is in limited production).

A large majority of stakeholders noted that good customer service is a key consideration.

Access to an online tool (Exchange) was cited by some as an issue for low-income people (e.g., a lack of access to or use of computers). In addition, stakeholders said that Exchange must be designed to address the reality that enrollment can change for some families on a monthly basis.

Some carriers noted that the Commonwealth should provide adequate time for insurers to prepare for and test the IT changes needed as a result of any Exchange. Specifically, Independence Blue Cross explained that it was focused on significant immediate reforms and the non-Exchange IT impacts anticipated by the ACA. It also noted that the Exchange model is much more complex, specifically as there will be a focus on the electronic interface and policy fulfillment functionality. As noted elsewhere, the carriers feel they will need significant time to make their internal IT systems changes to support the implementation of an Exchange.

One stakeholder suggested that the Commonwealth review Howell Benefit Services, Inc. The organization has created a multicarrier, Web-based software system that models the insurance needs of sole proprietors and small business owners (patent pending); the application was designed to provide multiple product lines and multicarrier premium invoices via an integrated data engine. The stakeholder thought that the product's data engine could generate HIPAA compliant feeds and includes features and capabilities to support a health insurance Exchange as a single Not-For-Profit.

Stakeholders also mentioned a desire to have a Commonwealth Exchange that provides a single point of entry to get in, with seamless systems to enroll in public or private health plans.

Future Plan and Communication

If the Commonwealth decides to move forward and implement an Exchange, Pennsylvania needs to move quickly to draft establishment authority and establish both organizational and governance structures. In conjunction with this effort, Pennsylvania must initiate and maintain an outreach and communication process with both its key internal and external stakeholders. The outreach process to affected stakeholders is equally important, specifically in the carrier community and with the Consumer Groups. As noted earlier in this section, to implement a Health Benefit Exchange of any type (state or federal), will require an investment in IT functionality., the significance and contents of such investment will be determined on the type of Exchange implemented, and the number and types of functions that are included. Specific outreach efforts will be dependent on type of Exchange pursued, and functional components to be included.

Small Business Health Option Program (SHOP) Considerations

The ACA gives states the option to run separate Exchange offerings for individuals and small businesses, or run a combined Exchange that services both groups. Further, the ACA allows states to determine, before January 1, 2016, whether a “small employer” is comprised of 50 or fewer employees or 100 or fewer employees. States may also open the Exchange to large businesses by 2017. Of the 10 states that enacted legislation to create an Exchange, six have specifically indicated what entities will be allowed to purchase in the Exchange marketplace and when. Only Connecticut and Vermont addressed the topic of large employer inclusion, and only Vermont gave a specific time frame for large employers entering the Exchange. Four states will establish separate Exchanges at least in the near term for individuals and small employers. *Note that no state thus far has chosen to include both individuals and employers in one Exchange, and six states have yet to determine the composition of their Exchange.*

For example, Wisconsin’s systems are individual, user oriented and do not consider employer functionality extensively. Their SHOP exchange will be comprised entirely of new functionality. To support this, Wisconsin will need to develop additional data exchanges, intelligent/intuitive data collection features must be created, and employer registration, employee enrollment, billing, and reporting must be built. In addition, broker/navigator functionality must also be created. Other states like Pennsylvania may be able to leverage the new SHOP designs/functionality that early innovator states like Wisconsin develop.

Impact and/or specific questions related to focus area

Based on our analysis and meetings with PID and DPW, the Commonwealth has several IT assets that *could* be potentially leveraged for a Health Insurance Exchange.

- Specifically:
  1. COMPASS – Portal/Front End – Open architecture
  2. Corticon – Business rules engine
  3. MCI – Master Client Index
  4. IEVS – PA-centric data store for income verification and other data authentication routines
  5. Data Exchanges – Existing or modifiable interfaces to external data sources for authentication/verification:

- Determine information to be reported to federal agencies for purposes of demonstrating an employer's or individual's compliance with requirements of the ACA and/or eligibility for subsidies

6. Per DPW, the Existing HHS Eligibility and Case Management Functionality includes the following core Integrated Eligibility Services:

   - Account Management
   - Registration
   - Intake
   - Data Exchange
   - Integrated Eligibility Rules
   - Confirmation
   - Caseload Management
   - Benefits Issuance
   - Benefit Recovery (possible IRS role)

7. Per DPW, the Existing HHS Eligibility and Case Management Functionality includes the following core Business Support Services:

   - Security
   - Scheduling
   - Online Handbooks
   - Reporting
   - Quality Management and Fraud Detection
   - Master Client Index
   - Master Provider Index
   - Enterprise Information Management
   - Data Warehouse/Reporting
   - Correspondence/
   - Document/Content Management
   - Rules Engine
   - Workload Dashboard

For 6 and 7 above, PA should understand that *no existing functional or technical component will likely be able to be used "as-is."* Per DPW, the following Exchange IT components can potentially be "created" from existing PA IT assets/infrastructure:

- Upfront screening and "interview" process
  - Leverage COMPASS portal and Corticon business rules engine

- Account creation
  - Definition of a household
- Individual and household identify verification
- Income Verification
  - MAGI (both 2010 and future periods)
- Affordability and Assistance Results:
  - Subsidy
  - Premium Tax Credits

While the Commonwealth has several components it could potentially leverage and extend to support the development of an Exchange, there are several other core functional areas that are not currently available to the Commonwealth via its current IT assets. Specifically, PA will need to develop/obtain some technology systems and assets to serve as required components of an Exchange:

- Subsidy/tax credit calculations
- Web shopping experience/market based infrastructure
  - Plan Application management
- Billing/premium collection
- Convert batch to Real-time interfaces (MAGI, etc.)
- A robust Master Provider Index that includes all Exchange providers—including carriers, navigators, brokers, and possible healthcare providers, not just MA and CHIP entities
  - The MPI and MCI have issues with duplicative data and limited mechanisms to maintain integrity. This will have to be addressed before the existing assets are leveraged in any Exchange solution.
- A Master Person Index covering all citizens of the Commonwealth who may consider or choose to use exchange services
- Unified definition of a household
- Broker and Navigator management and support functions
- Support for state's role in advance payments of premium tax credits and cost-sharing reductions
- The ability to collect and display CHIPRA pediatric quality measures from each QHP
- Identifying and tracking eligibility determinations that cannot be promptly made via the Exchange
- The ability to collect and track information needed to assess fees to support ongoing operations of the Health Insurance Exchange
- The ability to resolve invoice disputes between employees and employers in SHOP operations
- The capability to monitor contracts for all Exchange contractors and subcontractors, including collecting, maintaining and processing data needed for contract administration

Additionally, there needs to be a rapid determination if the required remediation of IT assets the Commonwealth controls will be able to be undertaken quickly enough to meet the ACA timelines. Otherwise,

PA needs to consider implementing new technology or leveraging an Early Innovator state's solution or the Federal Exchange. If PA chooses to do so, some components may be able to be leveraged from other sources (and CCIIO will expect it to do so), but not all (i.e., some remediation of PA's IT assets will be required in any situation). Pennsylvania understands that this is not necessarily a cost-driven issue at this point; it hinges upon whether or not PA can hit the timelines defined in the ACA given the specifics of the Commonwealth's decision to move forward, the procurement cycles and other constraints (e.g., ability to outsource tasks/functions/systems, create public / private partnerships, etc.).

Option-Specific Considerations

The following table includes several option-specific IT considerations for Exchange IT system core area.

Quasi-Government	Not For Profit	Existing Agency	Multi-State
Potentially able to leverage existing Commonwealth systems	Potentially need to establish new IT infrastructure.	Able to leverage existing Commonwealth systems	Need to determine which state will serve as the primary IT system provider
Can contract with third-party providers for necessary exchange IT components	Strong business case for outsourcing	Potentially constrained by Commonwealth procurement policies – could inhibit rapid IT planning and deployment tactics	Service level agreements must be negotiated between the two state(s).
	Limited/no ability to leverage existing Commonwealth systems		

Financial Management

The information presented on the following pages addresses the financial management considerations the Commonwealth should consider when moving forward with Insurance Exchange Planning.

This section of the detailed options analysis includes a discussion of both the financial management and oversight and integrity requirements of the Act. The risk adjustment and transitional reinsurance requirements are also discussed in this section as a significant requirement under this focus area is the collection and payment of “assessments” from and to insurers based on risk adjustment factors.

Regulatory Guidance

Financial Management

Section 1313 of the Act indicates that an Exchange shall keep an accurate accounting of all activities, receipts, and expenditures and establish a financial management structure and accounting system that adheres to applicable provisions of generally accepted accounting principles and ensures sound financial management practices. An Exchange must also be subject to annual audits.

Section 155.160 of NPRM CMS-9989-P also provides additional guidance related to funding for continued operations of an Exchange. Primarily, the Exchange must have sufficient funding to support its ongoing operations from January 1, 2015 onwards as no federal funds will be provided for operations after that date.

Oversight and Program Integrity

In addition, an Exchange must also establish oversight and program integrity processes to take steps to prevent waste, fraud and abuse and to ensure compliance with state and federal requirements. The Act and proposed rules also discuss the need to implement integrity measures over eligibility processes.

Risk Adjustment and Transitional Reinsurance

Section 1341 and section 1343 of the Act refer to transitional reinsurance and risk adjustment, respectively. The Exchange must implement a risk adjustment program and a transitional reinsurance program in accordance with federal standards. The Exchange will need to plan for necessary data collection to support risk adjustment, including demographic, diagnostic, and prescription drug data. Qualified health plans may be required to submit encounter data, and therefore, the Exchange needs to develop data and other systems to support risk adjustment. HHS will release more guidance in the future, including information on a risk adjustment model and federal standards for data collection and operations.

More specifically, section 1343 of the Act requires the Exchange to assess a charge on health plans and health insurance issuers if the actuarial risk of enrollees in that plan is less than the average actuarial risk of all enrollees in the state excluding self-insured plans. Furthermore, states will make a payment to those health plans with higher actuarial risks and excludes self-insured plans.

CMS is anticipated to release a proposed rule in September 2012. Based upon current timeline projections, the Exchange will have until October 2012 to release an alternative risk-adjustment approach if the state chooses to deviate from the released guidance. The Exchange should review potential risk adjustment programs in order to make a decision within the small window of opportunity in preparation. If the Exchange chooses to utilize a different risk-adjustment approach from the CMS proposed version, the Exchange should

consider the policy implications of The Freedom of Information Act. The risk adjustment methodology may require additional data parameters to be collected that are not traditionally considered under current HIPAA considerations.

Additionally, CMS has not specified if a concurrent or prospective approach will be utilized to support the risk adjustment process. A prospective approach could provide projected enrollment to help set plan design pricing for the subsequent years. As materiality develops, the risk adjustment would then be applied. A concurrent approach would utilize current year experience and provide risk adjustments based on actual versus expected methodologies.

Section 1341 of the Act requires the Exchange to establish or contract with a nonprofit reinsurance entity for 2014, 2015, and 2016 that will collect payments from all insurers in the individual and group markets and third-party administrators of self-insured group plans amounting to $25 billion in collection from insurers in this time frame. Additionally, the Exchange must make payments to insurers in the individual market and those selling plans through the exchanges that cover high-risk individuals. Amounts remaining unexpended as of December 31, 2016, may be used to make payments under any state's individual market reinsurance program during the two-year period beginning January 1, 2017.

Centers for Consumer Information and Insurance Oversight recently released a discussion document that notes implementation issues and provides potential risk-adjustment scenarios. If the Commonwealth chooses to create an Exchange, the Commonwealth may wish to consider the methodologies presented regarding risk adjustment as well as white papers and studies to be published by the Academy of Actuaries and the Society of Actuaries.

Key Considerations

Emerging Practices

A scan of Level One Establishment Grant Applications from other states and other states' enabling legislation indicate varied approaches and progress toward implementation of financial management regulations and milestones. In particular, California's Accountable Care Act (CA-ACA) created the California Health Trust Fund (the Fund) and requires the Fund to establish and maintain a prudent reserve. In Connecticut, their planned approach to implementing an Exchange includes consideration of "purchase strategy options" to consider for each function the options available through public implementation and operations versus outsourcing of the function with key criteria for evaluating those options being the risks and opportunities associated with each option.

Maryland's Health Benefit Exchange Act (MD-HBEA) not only provides the authority for establishing fees for Exchange revenue generation, but also requires that "any funding mechanisms must be transparent and broad based, and the Exchange must adopt related regulations. Funds collected must be deposited in the Maryland Health Benefit Exchange Fund. The Exchange is prohibited from imposing fees or assessments that would provide a competitive disadvantage to health benefit plans outside of the Exchange. The Exchange must publish on its website the average amounts of any fees or assessments, the administrative costs of the exchange, and the amount of funds known to be lost through waste, fraud, and abuse." Maryland's Department of Health and Mental Health will manage Grants for the Exchange until the Exchange has internal accounting systems, controls, and staff to assume the responsibility for these funds.

California is considering development of a plan that ensures the prevention of waste, fraud, and abuse in Exchange Programs. They will create a Chief Financial Officer position that will offer budgetary oversight to

the Exchange and ensure the operational expenditures, contracts, revenues, and payments of the Exchange occur continuously and in a responsible manner. A Chief Counsel will provide legal oversight for the Exchange, ensuring that all legal agreements are fulfilled and the Exchange entity operates within its legal authority. The Chief Counsel will also provide guidance on any statutes or regulations pertaining to the Exchange.

The State of Washington has indicated that Establishment Grants were targeted to develop the policy and technical details of this area of oversight and program integrity. Washington has determined "that it will be necessary for the exchange to combat waste, fraud and abuse within its financial management system, as well as within the processing of data, information and funds that flow through the exchange."

Leveraging Current Capabilities

For the initial establishment of an Exchange, federal funding is available and can potentially cover 90% of the costs of establishing an Exchange. While the federal government intends to recoup some or all of these costs through future Medicaid taxes (additional.09% on wages over $200,000) and 40% on premiums of excessively high-cost premium plans, states must fund all ongoing operations of an Exchange with other than federal funds starting in 2015.

To meet the self-sustaining operations goal by 2015, a detailed analysis of operating costs, enrollment estimates and other cost drivers will need to be undertaken. Before this additional analysis can begin, the basic decisions as to organizational structure, governance and delivery model of a Commonwealth Exchange should be made to guide the analysis. A summary of potential funding sources is provided below.

Potential Revenue Sources

Description	Fixed or Variable	Application	Considerations
% User Fee	Fixed or Variable	Apply to all premiums for QHP purchased through the Exchange	Use of fee revenue could be used to pay producer commission and for transactions where no producer is involved – that normal share can be used to fund Navigator grants.
Subscriber Fee	Fixed	Employer or Individual purchase of insurance under Section 125	For example, MA charges a $10 Subscriber fee for health insurance purchased through an employer or individual purchasing a health insurance plan and taking advantage of the Section 125 pretax benefit through an employer.
Administrative Cost Reimbursement (MA)	Variable	FFP on eligible administrative costs	▪ Eligibility (performed by DPW, Community Partners, Navigators), Call Center ▪ Cost allocation or indirect rate plans would be required and additional

Description	Fixed or Variable	Application	Considerations
			underlying documentation to support eligibility/allowability (e.g., Time and Effort systems)
Late Fees	Fixed or Variable	Interest and/or penalty on late payment of fees or premiums	Can also be applied to SHOP employer share of premium
Advertising	Fixed or Variable	Sale of Advertising space on portal website	
Broad-based tax	Fixed or Variable	Assess on self-insured employers and providers that do not purchase insurance through the exchange	
Risk-adjustment tax	Fixed or Variable	Assess a tax on risk adjustment payments to those health plans with higher actuarial risks	HHS rules may require the risk adjustment system to be revenue neutral
SHOP Enrollment Fee	Fixed or Variable	Enrollment processing/set up fee for employers	Can be a flat fee per employer or based on number of employees of the employer
SHOP Administrative Fee	Fixed or Variable	Recover cost to administer SHOP. Can be prorated based on number of participating employees for each enrolled employer	Fewer SHOP participating employers drives higher cost per employer

Financial Accounting and Reporting

With respect to establishing accurate accounting practices and application of generally accepted accounting principles, the Commonwealth should leverage existing accounting systems, internal controls and financial reporting processes. The standards and reporting formats may vary depending upon the organizational structure ultimately selected. With respect to annual audits (financial statement audit or other audit required by the Act), Commonwealth law gives the State Auditor General the “first right of refusal” to perform any “statutorily required audit.”

Further, in considering the implementation of any oversight or integrity program, the Commonwealth could take a risk-based approach where several existing functions can be leveraged. These would include the State Comptroller’s Office, the State Auditor General, Office of Inspector General, etc. It is likely that high risk areas will be related to eligibility determination (MA, CHIP, Premium Tax Credits and Subsidies).

Oversight and Program Integrity

The Commonwealth relies on a segregation of duties approach and other checks and balances to help ensure program integrity. Currently, a multiagency approach is taken to program integrity. If an Exchange is pursued, existing oversight and program integrity approaches may be leveraged for the Exchange to help ensure compliance with state and federal requirements and to guard against waste, fraud, and abuse.

Eligibility is considered to be the one of the highest risk area for fraud in Pennsylvania's existing Medical Assistance system. It is expected that the same will be true for subsidy and tax credit eligibility. PA's Medical Assistance system utilizes a systematic Fraud, Waste and Abuse capability to identify potential irregular payments and duplicative beneficiaries. A certain degree of member "self-attestation" is relied upon in the eligibility determination process that is subsequently authenticated. The post-eligibility decision review process will be more critical with the "real-time" benefit/subsidy/eligibility determination requirements of the exchange. Processes and policies will need to be developed that address situations where eligibility was fraudulently or incorrectly given.

There has been some question regarding any potential liability the Commonwealth may have in a case where eligibility was fraudulently or incorrectly given. The Exchange may want to ensure that quality analytics about eligibility are utilized to minimize potential liability, including frequency of spot reviews, consistency checks built into the system verifying against other data sources, field masks for data entered into electronic systems to ensure the accuracy of data.

Moving Forward

Should the Commonwealth decide to implement an Exchange; the organizational structure will help to define the scope and resources necessary to operate its Exchange. That determination, along with the results of a demand analysis, can then be utilized to determine the range of potential funds that will be needed to operate the Exchange. The costs of operating an exchange will vary widely depending on the organizational structure and delivery models chosen. A discussion of key inputs is needed to further assess the financial aspects of an Exchange are summarized below.

Exchange Operating Revenues

Some of the same source data from the Demand Analysis used to estimate the expected size of the exchange (potential numbers of individuals and small employers to enroll in the Exchange) can be used to estimate potential exchange revenues. The next critical data point to allow for revenue estimation is the average monthly premium volume expected within the Exchange. This data element is critical as the most likely and significant revenue stream will be a fee or assessment on premiums of plans purchased through the Exchange. This data will also need to be disaggregated – by market segment and then by age ranges, income levels, etc.

Exchange Operating Expenses

While the start-up costs of an Exchange can be funded by Federal grants, analysis of these costs should be included in developing models of operating costs as such ongoing activities such as systems maintenance, help desk and other continuing services are generally contracted at the time of technology infrastructure procurement. All Exchange functions and operations should also be considered and all related costs included in the analysis. As with the revenue side, the expected size of the Exchange and volume of activity is critical to understanding the technologies, processes, and human resources needed to operate the exchange.

The potential for outsourcing of select functions will also impact the financial management of an exchange. The effect of outsourcing on resources, costs and revenues should continue to be considered as the Commonwealth moves forward with planning. A summary of key exchange functions and potential opportunities for outsourcing, as discussed with PID, is provided in Executive Summary.

Program Integrity

The Commonwealth's policy is to serve as an accountable steward of Taxpayer dollars as well as maintain law and order. Ensuring program integrity is integral to both of these important responsibilities. If the

Commonwealth decides to pursue an Exchange, certain considerations regarding Program Integrity/Oversight will have to be made, including development of continuous monitoring activities over eligibility determinations and financial transactions.

Risk Adjustment and Transitional Reinsurance

The intent of risk adjustment is to minimize adverse selection in the Exchange. Contrary to best efforts, risk adjustment may cause competitive disadvantages in the implementation of the Exchange. Insurers with excessive health insurance rates or excessive risks may need to be reviewed since these insurers are likely to receive many supplemental payments for worse than average risk. Additionally, the Exchange should consider if the balance of risk adjustment subsidies and payments will be revenue neutral or could potentially serve as another source of revenue for the Exchange. If the risk adjustment will generate revenue, an administrative tax per transaction may be a practical option.

The risk adjustment process may also create additional administrative burdens for the Exchange. The determination for risk adjustment utilizes the determination for essential benefits; however, this dependency creates the need for tracking “essential” versus “supplemental benefits. Additional administrative tasks could include data collection and reconciliation/validation, assessments/collections and the disbursement of payouts/adjustments.

Risk adjustment calculations will require a balancing act between administrative complexity and a desire for equitable analysis. Demographic factors, income factors, medical diagnostics and other clinical factors, and the inclusion of credibility adjustments should be considered because of potential significant policy and administrative implications.

Timing implications relative to the reporting of Minimum Loss Ratio (MLR) compliance may cause additional problems for the risk adjustment process. Policy implications could occur as a result of the reporting process and the insurers’ need to determine/accrue premium rebates.

As a result of the risk adjustment process, the Exchange may face technological, administrative, procedural and policy-based implications. In order to help mitigate some of these implications, the Exchange should consider beginning to develop alternative risk adjustment methodologies as part of the Level 1 grant application determinations. Examining the risk adjustment process as soon as possible will help to prepare for the next steps in 2012. Preparatory actions may also provide the Exchange flexibility and knowledge ahead of time in order to adjust or modify the risk adjustment process upon release of CMS guidance.

Similarly, transitional reinsurance could create competitive disadvantages. Insurers with better than average risk may be at a disadvantage compared to companies that receive payments from the reinsurance contract. The Exchange may consider reviewing these contracts on a consistent basis to minimize adverse selection.

The Commonwealth will need to plan for necessary data collection to support risk adjustment, including demographic, diagnostic, and prescription drug data. Qualified health plans may be required to submit encounter data, and therefore, the Commonwealth may need to develop data and other systems to support risk adjustment. HHS is working with insurance plans and experts so that each State does not have to develop a risk adjustment model independently.

Timing Considerations

Without Exchange establishment authority and resolution of key structure and governance decisions, the Commonwealth can only move forward in executing additional planning in areas where generic solutions can

be developed. It is not prudent, efficient or practical to complete the steps suggested in the funding application milestones, without first resolving these key issues.

Stakeholder Involvement/Impact

Input/Feedback

In addition to the implementation of administrative fees, feedback from stakeholders indicates some support for broad-based contribution to fund the Exchange, such as assessment of fees on plans both inside and outside of the Exchange and additional “sin” taxes. Stakeholders also suggested the implementation of defined contribution plans.

Several stakeholders mentioned that “Transparency is Critical,” and stressed the need to incorporate transparency and accessibility into the structure of any Exchange. Also noted were the need for the Exchange board to implement conflict-of-interest rules and the need for open/public meeting. In addition to holding public meetings, stakeholders feel it is important to include consumers on a Board (at least as many as insurance company representatives). Other stakeholders felt that an Exchange Board should include doctors, insurance companies, agents, etc.

Future Plan and Communication

The Commonwealth should continue to seek input from stakeholders on all topics related to the financial management and integrity programs of an exchange and should identify specific milestones within future financial management and oversight and integrity program planning.

Small Business Health Option Program (SHOP) Considerations

Section 155.705(b)(4) of NPRM CMS-9989-P requires a SHOP to perform premium payment activities including premium aggregation to collect employer contributions to premium costs. The Commonwealth can also require employers participating in the SHOP to adopt a defined contribution model for funding their employer contributions. Other states, such as California, plan to do this.

Oversight and integrity will also be important to a SHOP exchange as additional risks will exist in the eligibility area, including potential cross-over between the individual exchange and SHOP.

Option-Specific Considerations

Quasi-Government	Not For Profit	Existing Agency	Multi-State
▪ Follow Governmental Accounting Standards (GASB) and audits in accordance with Generally Accepted Government Audit Standards (GAGAS) ▪ Dependent upon financial dependency of the Commonwealth and governance structure, determine whether the Exchange is a component unit of the Commonwealth for financial reporting purposes	▪ Follow U.S. Generally Accepted Accounting Standards (GAAS) and not-for-profit reporting standards	▪ Follow same accounting and reporting standards as "parent" agency (governmental) ▪ Separate financial statements not necessary; however, unique account codes (revenue, budget, expenditure) should be established for Exchange activity/transactions	▪ Likely follow government standards and issue financial statements ▪ Similar to quasi-governmental structure determination of "parent state" component unit reporting will have to be made
▪ Ability to set user fees and other funding streams will be dependent upon organizational structure and governance model selected and should be addressed in establishment authority.			
▪ Likely most costly option due to creation of new entity, all service delivery, and organizational support functions (HR, procurement, etc) ▪ Certain Commonwealth support and delivery functions could be leveraged under an MoA and allocation of costs for those services to the exchange	▪ Also a costly option, however, certain support functions may be less costly and governance structure may allow for more autonomy from bureaucratic, government processes ▪ Services could be purchased from the Commonwealth under MoA or contract	▪ Least costly as existing support and delivery services can be leveraged ▪ Cost allocation (through indirect cost plans) may also be required where more than one agency is involved ▪ Select functions can be outsourced to reduce the number of new positions required	▪ Sharing of costs (and revenues to cover costs) between participating states must be defined and monitored

Quasi-Government	Not For Profit	Existing Agency	Multi-State
(e.g., DGS could provide procurement services)		to operate the exchange and to transfer risk from the Commonwealth	
▪ Independence from existing agencies minimizes conflict of interest	▪ Lesser oversight and absence of Commonwealth regulations might maximize flexibility. The Exchange could react more quickly to market changes, hire, and spend money with fewer restrictions	▪ State agencies are already required to be transparent and accountable, with systems established to ensure program integrity	
▪ The legislature could require the HBE to comply with State law on transparency, accountability, and related matters	▪ A non-profit would be more removed from government regulation or oversight. It would be more immune to political influence		
	▪ Public accountability and transparency might be reduced		

Oversight and Program Integrity

Please refer to *Financial Management* focus area.

Operations

The information presented on the following pages addresses considerations related to operations the Commonwealth should consider when moving forward with Insurance Exchange Planning. Specifically, this section addresses the following items outlined in the Grant Announcement (IE-HBE-11-004):

- Providing assistance to individuals and small businesses, coverage appeals and complaints
- Certification, recertification and decertification of qualified health plans
- Call Center
- Exchange Website
- Premium Tax Credit and Cost Sharing Reduction Calculator
- Quality Rating System
- Navigator program
- Eligibility determinations for Exchange participation, advance payment of premium tax credits, cost-sharing reductions and Medicaid
- Seamless eligibility and enrollment process with Medicaid and other State health subsidy programs
- Enrollment process
- Applications and notices
- Individual responsibility determinations
- Administration of premium tax credits and cost-sharing reductions
- Adjudication of appeals of eligibility determinations
- Notification and appeals of employer liability
- Information reporting to IRS and enrollees
- Outreach and education
- Free Choice Vouchers
- Risk adjustment and transitional reinsurance
- SHOP Exchange-specific functions

A number of these topics may have been combined for organization purposes and as necessary refer to the applicable sections.

Providing assistance to individuals and small businesses, coverage appeals and complaints

Regulatory Guidance

The Act

The Act establishes a number of ways to protect and assist Individuals and Small Businesses. Many of these are included in Section 1001, *Appeals, External Review, Notice, and Patient Protections,* of the Act (which amends the Public Health Services Act incorporating additional Individual and Group Market Reforms). The Act requires plans or issuers offering Individual or Group coverage to establish an internal appeals process, provide notice to enrollees of internal and external appeals processes and the availability of any Health Consumer Assistance Office or Ombudsman, and to allow enrollees to review their files and participate in the appeals process. Certain patient protections that are required are also identified. Additional insurance market reform considerations are discussed further in the *Health Insurance Market Reform* section of this report, but include provisions in subtitle A, which regulate individual and group market-based reforms that address underwriting methodologies such as removing pre-existing condition considerations and lifetime limits, and subtitle C, which focuses on improvements on quality of care.

The appeals and procedures *for group plans and group offerings* must comply with existing Federal procedures (29 CFR 2560.503-1), and any updates established by the Secretary of Labor. *Individual health coverage plans* must provide an internal claims and appeals process incorporating the claims and appeals procedures required by law, and updated in accordance with any standards established by HHS. Individual and business plans must comply with a State external review process that includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners or implement an effective external review process that meets minimum standards established by HHS guidance.

Patient protections include ensuring that enrollees have the opportunity to choose their primary care provider when a plan requires such designation. Additionally, plans covering services in an emergency department of a hospital must cover emergency services without prior authorization, regardless of whether the provider furnishing health services is a participating provider, and at the same cost whether the services are provided in-network, or out-of-network.

Section 1002 of the Act provides for grants to States or Exchanges to establish, expand, or provide support for offices of health insurance consumer assistance or health insurance ombudsman programs.

Section 1003 of the Act identifies procedures designed to ensure that consumers get value for their dollars. These procedures include an annual review process, continuing premium review, and a required justification for increases and changes in established policies. Additionally, State Insurance Commissioners are required to provide HHS with information about trends in premium increases in health insurance coverage in premium rating areas in the State; and to make recommendations to the State Exchange “about whether particular health insurance issuers should be excluded from participation in the Exchange based on a pattern or practice of excessive or unjustified premium increases.” Beginning in 2014, HHS, with the States, must monitor premium increases of health insurance coverage offered through and outside of an Exchange.

Proposed Rule [CMS-9989 -P] – Small Business Health Options Program (SHOP)

The ACA requires that each State operating an Exchange must establish a SHOP. SHOP is strictly voluntary for small employers, but was designed to enable small employers to offer affordable health plans to their employees.

States operating an Exchange can merge SHOP with the individual market Exchange, or not. The SHOP will provide access to information about plan benefits, quality, and premiums, giving small businesses the types of choices and purchasing power that large businesses typically enjoy. Purchasing employer-sponsored coverage through the SHOP will qualify certain small employers to receive a small business tax credit for up to 50 percent of the employer's premium contributions toward employee coverage pursuant to section 45R of the Tax. The requirements for the small business tax credit applicable for calendar years 2014 and beyond will be addressed in separate rulemaking by the Secretary of the Treasury.

In §155.700, *Standards for the establishment of a SHOP*, HHS proposes that the SHOP does not need to meet requirements related to individual eligibility determinations or the appeals of such determinations. Proposed enrollment requirements are different for SHOPs and for individuals. The enrollment requirements specific to SHOP are outlined in § 155.720. For more information, see the *Options Analysis for Enrollment Process – Shop Considerations section.*

The SHOP does not need to include the calculator described in §155.205(c) given that individuals eligible for affordable employer-sponsored coverage are not eligible for advance payments of the premium tax credit. Because of the employee choice provisions of the Act, SHOPs are encouraged to consider options to calculate and display the net employee contribution to the premium for different plans and different family compositions, after any employer contribution has been subtracted from the full premium amount. Because conveying net premium to the employee for coverage is current market practice and is important to informed employee choice, SHOPs are encouraged to continue this practice.

SHOPs do not need to certify exemptions from the individual coverage requirement. Furthermore, requirements related to the payment of premiums by individuals, Indian tribes, tribal organizations and urban Indian organizations under §155.240 do not apply to the SHOP.

In §155.705, paragraph (b), HHS proposes unique functions of the SHOP. It clarifies that a SHOP must adhere to unique enrollment and eligibility requirements further described in §155.710, 715,720, 725, and 730. In addition, the SHOP must, at a minimum, facilitate special enrollment periods that allow a qualified employee to join or change plans in certain circumstances other than during the employer's annual open enrollment period. HHS proposes that all of the special enrollment periods that apply in the Exchange in connection with individual market coverage apply in the SHOP, with two exceptions:

"(1) Because non-lawfully present individuals employed by a small business are not eligible for the SHOP, there would be no special enrollment period associated with becoming a new citizen, national, or lawfully present individual for the SHOP;"

"(2) There would be no special enrollment period in the SHOP to reflect a change in eligibility or new eligibility for advance payments of the premium tax credit or cost-sharing reductions since neither is available to qualified employees in the SHOP.

Key Considerations

Emerging Practices

A review of other states grant applications shows that some states have taken action to addressing providing assistance to Individuals and Small Businesses.

California enacted legislation in 2010 to establish the California Health Benefits Exchange. The Exchange is a quasi-governmental independent agency within the State Government. California's Department of Managed Health Care (DMHC) has conducted health reform education and training seminars for staff and external stakeholders, updated State website content, developed a new Help Center brochure and provided staff trainings on the Act and the California Affordable Care Act (CA-ACA) and related programs. DMHC and the Exchange are working together to identify next steps and potential longer term collaboration related to consumer assistance in the state. The CA-ACA enacts many of the specific consumer assistance requirements and approaches in the Act, including the requirement that the Exchange operate a toll-free hotline and Internet website, present coverage and benefits in standardized formats, and develop and make available cost of coverage calculators to consumers. The CA-ACA also requires the Board to ensure that the Exchange provides interpretation and language assistance services, including a toll-free hotline for the hearing and speech impaired, and to make Exchange materials available in plainly worded, easily understandable formats and in prevalent languages.

Connecticut enacted a law establishing their Health Care Insurance Exchange as a quasi-public agency, but not a State agency. Connecticut plans to implement a Consumer Assistance and Support project which will cover focus on: General Information assistance, advisory and navigation, call center, self-help, toll-free telephone hotline, etc.; Eligibility and enrollment process; Consumer protections; Grievance and Appeal (coverage, eligibility, etc.); Problem Resolution; Performance Transparency and Reporting on the above, including related data collection.

Maryland enacted the Maryland Health Benefit Exchange act in April 2011, establishing the Exchange as a quasi-governmental entity that is a public corporation and independent unit of state government. Maryland's Medicaid program has many call centers and contracts with outside vendors to assist individuals. Medicaid handles approximately 25,000 managed care enrollments per month. Other significant consumer assistance resources exist at the Maryland Department of Human Resources and the Maryland Department of Aging. Level One Establishment Grant funds will be used for outreach, to ensure that people are aware of the availability of health insurance options and to help to resolve health care billing complaints and insurance appeals.

Missouri has not yet passed legislation establishing a Health Benefit Exchange, but legislation has been introduced. The State has made significant progress in developing and expanding its Consumer Assistance Program (CAP). They will continue to focus on strengthening community partnerships, expanding its strategic outreach and education efforts, integrating consumer assistance, and developing infrastructure to be ready for Show-Me HIE implementation. Community outreach promoting the program and discussing opportunities for collaboration, and collecting information on geographic trends and education needs is planned. They will need to determine whether some or all consumer assistance functions will be provided by the Show-Me HIE, or maintained as an independent program within the Department of Insurance, Financial Institutions and Professional Registration (DIFP). Missouri has made a preliminary decision to maintain and expand consumer assistance functions within DIFP to support consumers in employer-sponsored coverage inside and outside of the exchange, individual coverage inside and outside of the exchange, and Medicaid coverage. The CAP

Ombudsman Program will continue in DIFP and handle complaints related to insurance companies and self-insured employer groups and assistance with the first and second level grievance and appeals process. The State's first priority will be to plan for coordination of CAP services among the Exchange, DIFP and MO HealthNet.

The Washington State Legislature enacted their Health Benefit Exchange law In January, 2011, establishing the Washington Health Benefit Exchange as a non-profit, public/private partnership, making it an entity that does not fall within an existing state agency. To date, Washington State has met with consumer advocates and other stakeholders knowledgeable about the valuable roles producers and navigators can play in an exchange. The State has also begun to evaluate the valuable lessons that can be learned from the Health Insurance Partnership program, which acts as a small business exchange. Those discussions have helped them determine the necessity and scope of their initial review.

Leveraging Current Capabilities

Existing Community Partners ─ The Commonwealth has successfully implemented other programs to provide assistance to consumers. For example, the APPRISE program was created to help Pennsylvanians with Medicare understand their health insurance options and help them make sound decisions about what is best for them. This program includes a variety of methods to train and keep APPRISE coordinators up-to-date on program information. Pennsylvania also has a program to allow organizations to register as COMPASS Community Partners and be granted access to COMPASS in order to assist individuals who need help applying for social programs offered through COMPASS. The Commonwealth could expand the Community Partner program to include those who will help assist applicants related to the Exchange. Please see the *Options Analysis – Navigator Program* section of this document for more information.

Consumer Assistance Program (CAP) ─ The Commonwealth has received a Consumer Assistance Grant which is being utilized to enhance its existing CAP and assist in operating the State Call Center. Grant funding was utilized to expand and support the existing assistance program. The PA Bureau of Consumer Services Health and Human Services Call Center currently operates 11 help lines with over 9,500 calls per month. They process close to 6,000 written health insurance complaints and inquiries, and responds to approximately 5,000 health insurance-related inquiries annually. See the *Options Analysis – Call Center section* of this document for detailed review of the Call Centers.

PID has enhanced its current consumer services division to provide a number of those services that would have otherwise been provided by an Office of Health Insurance Ombudsman, rather than creating an Ombudsman position.

Moving Forward

The Commonwealth already has some programs in effect that provide assistance to Health Insurance Consumers. If the Commonwealth decides to move ahead on the establishment of an Exchange, additional issues regarding providing assistance to Small Businesses and Individuals will have to be addressed. Such issues include:

Call Center/Toll-Free Hotline

The ACA requires that Exchanges operate a toll-free hotline (see the *Options Analysis – Call Center*, for a more detailed review of this issue). How will the Commonwealth provide the necessary resources/support for the required Call Center/CAP? See the *Call Center Options Analysis* for more detailed information.

Appeals Process

Future rulemaking will define the standards for the appeals process, but it is anticipated that some key decisions will need to be made regarding the appeals process. See the Moving Forward subsection in the *Options Analysis – Adjudication of Appeals of Eligibility Determinations & Notification and Appeals of Employer Liability for the Employer Responsibility Payment* section of this document for more information.

Timing Considerations

No specific timing constraints have been identified.

Stakeholder Involvement/Impact

Input/Feedback

In the Stakeholder Listening sessions conducted by PID in August 2011, several stakeholders provided comments on the importance of keeping individuals and small businesses as separate markets/Exchanges. Insurance companies/underwriters commented on the need to keep SHOPs to 50 or under. Evaluation of the success of this initiative and implementation of best practices should be undertaken prior to expanding to 100. One stakeholder indicated that SHOPs should be employer choice models as it is done today.

Future Plan and Communication

The Exchange should continue to consult with small businesses to gather feedback in response to upcoming regulatory action from HHS. Stakeholder forums, similar to those held by the PID, may be an effective way to gather concerns of the stakeholders.

Small Business Health Option Program (SHOP) Considerations

Impact and/or specific questions related to focus area

SHOP participation is voluntary for small businesses, if many businesses fail to participate, will there be significant impacts on State resources?

The requirements for the small business tax credit applicable for calendar years 2014 and beyond will be addressed in separate rulemaking by the Secretary of the Treasury.

The NPRM [CMS-9989 –P] includes proposed rules on the standards necessary to the establishment of a SHOP. Clearly, if these proposed rules are revised there will be impacts on any State plans to implement. Included in these standards are unique requirements for SHOP enrollment. Particular attention will have to be paid to revised rulemaking, and any proposed changes.

As noted above, SHOPs are encouraged to continue in the practice of calculating and displaying the net employee contribution to the premium for different plans and different family compositions. As written, this is a suggestion, not a requirement; Exchanges will have to determine how they will handle this issue.

Option-Specific Considerations

Quasi-Government	Not For Profit	Existing Agency	Multi-State
▪ While providing the formal structure and familiarity that	▪ Flexibility of being outside government might	▪ Existing agencies might be required to provide	▪ Multi-State SHOP would require the integration of provider

Quasi-Government	Not For Profit	Existing Agency	Multi-State
government and consumers may desire, the distance that a quasi-governmental entity provides may facilitate implementation of CAPs, hiring and procurement.	make it easier to implement new policies and procedures, which could take significant time in rulemaking in state agencies.	additional assistance not required by other government structures due to civil service and labor requirements.	networks with out-of-state insurers.
▪ If this Exchange organization wants to leverage any existing consumer assistance mechanisms currently in place, an MoU would need to be established to specify how the Quasi-Governmental entity will work with the agencies that provide this support.	▪ If this Exchange organization wants to leverage any existing consumer assistance mechanisms currently in place, an MoU would need to be established to specify how the Not- For- Profit entity will work with the agencies that provide this support.	▪ Could take advantage of existing CAPs, and utilize existing resources.	▪ SHOP may be subject to multi-state legislation and integration may prove difficult.
			▪ If this Exchange organization wants to leverage any existing consumer assistance mechanisms currently in place, an MoU would need to be established to specify how the multi-state entity will work with the agencies that provide this support.

Certification, recertification and decertification of qualified health plans

Regulatory Guidance

Certification of Qualified Health Plans

Section 1301 of the Act requires all insurance products offered within the Exchange to be Qualified Health Plans (QHP) that provide a set of essential benefits. A qualified health plan is required to have an in effect certification as defined by section 1311 of the Act and provides the essential benefits as defined by section 1302 of the Act. The Act also requires the health insurer to be in good standing to offer health insurance. Health insurance companies offering qualified health plans must offer at least one plan at the silver and gold level within the Exchange, agree to charge the same premium rate for qualified health plans offered within and outside the Exchange and comply with the regulations developed by the secretary as defined by section 1311. According to the Act, "a plan in the silver level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan, while gold level plan provides benefits "that are actuarially equivalent to 80 percent of the full actuarial value of the benefits provided under the plan."

1. The health insurance issuer must provide evidence during the certification process in §155.1010 that it complies with the minimum certification requirements outlined in subpart C of part 156 of this subtitle; and
2. The Exchange must determine that making the health plan available is in the interest of the qualified individuals and qualified employers. The Exchange must not exclude a health plan —
    a. On the basis that such plan is a fee-for-service plan
    b. Through the imposition of premium price control, or
    c. On the basis that the health plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange determines are inappropriate or too costly.

The Exchange must establish a process to certify the qualification of health plans to ensure health plans are meeting federal standards and providing required essential benefits.

Within §155.1010 of the NPRM, a brief description of the certification process is provided:

1. Certification procedures. The Exchange must establish procedures for the certification of qualified health plans consistent with §155.1000(c).
2. Exemption from certification process. Notwithstanding paragraph (a) of this section, a multi-state plan is exempt from the certification process established by the Exchange and deemed as meeting the certification requirements for QHPs.
3. Completion date. The Exchange must complete the certification of the QHPs prior to the open enrollment period as outlined in §155.410.
4. Ongoing compliance. The Exchange must monitor the QHP issuers for demonstration of ongoing compliance with the certification requirements in §155.1000(c).

After receiving certification, qualified health plans will be required to submit additional information to the Exchange (to be further specified by HHS) such as:

1. Rates;

2. Covered benefits; and
3. Cost-sharing requirements.

The NPRM specifies additional requirements for the certification of qualified health plans surrounding transparency of coverage, the accreditation timeline, minimum service areas of the QHP, stand-alone dental plans, decertification and recertification procedures, issuer participation standards and marketing of QHP standards.

Quality Rating System

Section 1311 of the Act defines the quality rating system to support the certification of qualified health plans. The Act states that the Secretary shall develop a rating system that would rate qualified health plans offered through an Exchange in each benefits level on the basis of quality and price. The Exchange shall include the quality rating in the information provided to individuals and employers through an Internet Exchange portal. The law requires an enrollee satisfaction survey system that would evaluate the level of enrollee satisfaction with qualified health plans offered through an Exchange, for each such qualified health plan that had more than 500 enrollees in the previous year, and provide the information through the Exchange's Portal.

Key Considerations

Emerging Practices

Certification of Qualified Health Plans

Three states have enacted legislation related to the Certification of Qualified Health Plans – Maryland, Vermont and Connecticut. While these States are moving forward with proposed legislation, they note that their approach may change pending further guidance from HHS. For example, Maryland has initiated planning to study Exchange issues related to the certification, recertification, and decertification of qualified health plans. As indicated within their level 1 grant, Maryland will "study and make recommendations to the General Assembly regarding the Exchange's approach to contracting with qualified health plans, and the extent to which it should selectively contract to meet the goals identified in the statute. Additionally, Maryland will conduct background research on the policy considerations of the Exchange."

Vermont has also taken the initiative to define state-mandated benefits beyond those required by federal law in the essential health benefits requirements. The Vermont law indicates that qualified health benefits inside the Exchange will be consistent with the requirements of the ACA, but the State will explore whether to include benefits beyond the ACA requirements.

Connecticut enacted Exchange legislation to address the treatment of essential health benefits. The Exchange should receive notice from the state whether qualified health plans are required to provide only the essential benefits or include additional state mandated benefits no later than January 1, 2012. Section 8 of Connecticut Senate Bill 921, Public Act 11-53 provides the certification requirements as currently defined by the state.

Quality Rating System

HHS is expected to release a Quality Rating System and additional regulation defining essential benefits. A handful of states have begun deliberating regarding potential quality rating systems but are awaiting the release of additional guidance from HHS. For example, Maryland plans to use the Quality Rating System to be developed by HHS in the development of draft contracts for qualified health plans. Maryland also plans to analyze quality rating systems as part of its study described above in the certification of qualified healthcare.

In addition, Missouri plans to conduct a study utilizing existing grant funding to support the analysis of forthcoming federal guidance and develop a state-specific quality rating system. Missouri has included quality rating functionality in its system business requirements model for the exchange website and will continue to share information with regard to the development of a quality rating system. The Missouri work plan includes the posting of quality rating information on the state's Exchange Website prior to commencement of open enrollment in 2013.

Leveraging Current Capabilities

The Pennsylvania Insurance Department has well established policies, processes, and communications that support the current rate filing process. Data from the rate filling process could be leveraged to support the certification process. As mandated by the Act, the Exchange will need to review health plans offered both within and outside the Exchange. Insurance companies will have the option to write non-qualified health plans for outside the Exchange and qualified health plans that serve in and outside the Exchange. Potentially, companies could offer non-qualified health plans outside the Exchange providing them a strategic advantage to insurers that only offer qualified health plans within the Exchange. Increased time and resources may also be needed to support additional health plans and rate filings beyond the certification process.

Moving Forward

Many of the key decisions to be made about the certification of qualified health plans / quality rating systems are dependent upon pending guidance from HHS as noted above.

Certification of Qualified Health Plans

As indicated by HHS guidance, "the Exchange should have a process in place to certify, recertify, and decertify qualified health plans that supports the small group and individual market by open enrollment of 2013. The Exchange should begin defining their process and approach to these activities to minimize lag times in the certification process. In order to meet this deadline, Exchanges should begin the process of selection and certification of qualified health plans in 2012."

The Commonwealth may want to consider that nearly all insurance plans could be certified as qualified health plans, since most plans meet the National Committee for Quality Assurance (NCQA) accreditation, geo-access certification as determined by the Department of Health and Healthcare Effectiveness Data, and Information Set (HEDIS) accreditation. Previously, the Commonwealth requested insurers to attest their conformity to the ACA immediate insurance reforms. If the Commonwealth decides to implement an Exchange, requiring an attestation document for the certification of qualified health plans may help to minimize unnecessary additional documentation for the insurers and PID.

If the certification of qualified health plans is housed within PID, this process may require additional resources to support. PID's Accident and Health Bureau rate review team evaluates all health insurance benefit and rate filings for the State of Pennsylvania. The certification process can be included as a component of the review process, but if it is important to maintain current review cycles—additional resources are likely to be needed. Regardless of where the certification process is housed, the Commonwealth will face challenges related to funding the certification of qualified health plans.

Quality Rating System

As indicated by HHS guidance, "the Exchange should assign a quality rating to each plan in accordance with the quality rating system that will be issued by HHS. Also, certification of qualified health plans should include consideration of quality data."

Consideration should be given to creating a quality rating system that provides consumers with information to make an informed decision about their healthcare insurance needs. Multiple rating systems are a potential option. The rating system could be defined in a variety of ways, for example, using a letter grade, a numerical grade or a five-star quality rating similar to the current Medicare ratings. Once established, the quality rating system could also be used by PID as a vehicle to achieve an internal policy goal. This possibility should be considered by the Commonwealth when developing its rating system.

Quality rating factors could include the actuarial value of benefits, network adequacy, and the availability of specialist providers. Bear in mind that the meaningfulness of results decreases when combining these separate indices into a single rating factor. If the rating system becomes too complex, the significance of the ratings may be lost. Due to the nature of Pennsylvania's vast PPO insurance networks, provider networks between carriers are generally similar, which will increase the difficulty of assigning a quality rating that will help consumers decide between available products. Providing the consumer with practical information, such as key results of a HEDIS evaluation, in addition to a simplified quality rating may best serve the consumer and reduce bias.

The Robert Wood Johnson Foundation released an article speaking to quality rating factors named *The Role of Exchanges in Quality Improvement: An Analysis of the Options*. The article addresses potential quality improvement measures similar to those addressed above and addresses four of the nine statutory criteria of the ACA to improve clinical quality and delivery: accreditation, quality improvement, transparency and pediatric quality. The Commonwealth may want to review this article while considering actions on the certification of qualified health plans and a quality rating system.

Timing Considerations

The Quality Rating System within the Exchange will require additional guidance from HHS prior to accomplishing the FOA milestones. In the meantime, the Exchange may consider the following sources of quality metrics to develop a quality rating system:

1. Utilization Review Accreditation Commission (URAC) and quality measurement activities conducted by Department of Health
2. Research conducted by Quality Metric to better understand health outcomes for consumers
3. Utilize stakeholder engagement and ad hoc meetings to ensure that appropriate stakeholder consultation occurs in the development of the quality rating system.
4. Rating system similar to the CMS current Stars system for Medicare Advantage plans, where a quality score will be derived from:
    a. CMS administrative data on plan quality and member satisfaction
    b. Consumer Assessment of Healthcare Providers and Systems (CAHPS)
    c. Healthcare Effectiveness Data and Information Set (HEDIS)
    d. Medicare Health Outcomes Survey (HOS)

Stakeholder Involvement/Impact

Input/Feedback

Certification of Qualified Health Plans

The stakeholder sessions generated no specific comments on the certification of qualified health plans.

Quality Rating System

Stakeholders expressed concern surrounding minimum essential benefits as defined by the ACA. The Pennsylvania Chiropractic Association expressed its concerns regarding individuals' access to chiropractic benefits after the implementation of the Health Insurance Exchange. The association commented that consumers should be provided access to a diverse set of providers including chiropractic providers within the Exchange as part of comprehensive wellness care. In order to do this, the association noted that chiropractic services should be included as an essential health benefit. The Vista Foundation / PA ASERT, a regional autism center, commented on the possible health repercussions that may occur if autism treatment is not considered an essential benefit. The organization estimated that healthcare costs of $1 today may prevent the expenditure of $2.24 a year from now. These stakeholder session comments indicate that healthcare associations are concerned about the impact of pending legislation from HHS on essential benefits.

Future Plan and Communication

Once a process for the certification of qualified health plans and a quality rating system have been established, these processes should be shared with insurance companies who have currently approved health insurance filings with the Department. Identifying issues early in the process will give the Exchange time to develop mitigation strategies. Involvement of these stakeholders may also help define and communicate the role stakeholders will fill related to the Exchange.

Small Business Health Option Program (SHOP) Considerations

Impact and/or specific questions related to focus area

The requirements for the certification of qualified health plans apply both to the individual and SHOP markets. SHOP markets will require employers to be qualified employers in order to offer qualified health plans to their employees through the Exchange. To be certified as a qualified employer, an employer must meet the following qualifications:

1. Be a small employer (fewer than 100 employees); or 50 if state elects until the 2016 deadline;
2. Offer, at a minimum, all full-time employees coverage in a QHP through a SHOP; and
3. Either has its principal business address in the Exchange service area and offer coverage to all its employees through that SHOP, or offer coverage to each eligible employee through the SHOP serving that employee's primary worksite.

Option-Specific Considerations

Four governance options were considered for implementing the certification of qualified health plans—quasi-governmental, not for profit, existing agency and multi-state. Within each option, we provide potential considerations.

Quasi-Government	Not For Profit	Existing Agency	Multi-State
▪ Work in tandem with the current rate filing system to certify qualified health plans	▪ Outsource the certification of qualified health plans to a non-for-profit agency	▪ Implement the certification of qualified health plans as part of the current rate filing process within the PID	▪ Multi-state health plans will not need to be certified as defined under current ACA regulations
▪ Current rate review process could continue to function traditionally	▪ May introduce duplicative work or create silos in the current rate review process	▪ Allows the Department to maintain sole records of certification and approve filings	▪ Multi-state health plans may provide better risk pools and bureaucratic advantages
▪ Additional resources may still be needed to support a larger number of health insurance plans.			

Call Center

Regulatory Guidance

The Act includes several consumer assistance requirements and approaches including the requirement that the Exchange operate a toll-free hotline and Internet website, present coverage and benefits in standardized formats, and develop and make available cost of coverage calculators accessible by consumers.

Proposed Rule [CMS-9989-P] §155.205(b) requires an Exchange to provide consumer assistance tools and programs including a call center to respond to requests for assistance by consumers that is accessible via a toll-free telephone number. To increase accessibility to the call center, it is suggested operation is outside of normal business hours and adjusting staffing levels in anticipation of periods of higher call volumes such as the weeks leading up to and during open enrollment. The Exchange call center should have the capability to provide assistance to consumers and businesses on a broad range of issues, including but not limited to:

- The types of QHPs offered in the Exchange
- The premiums, benefits, cost-sharing, and quality ratings associated with the QHPs offered
- Categories of assistance available, including advance payments of the premium tax credit and cost-sharing reductions as well assistance available through Medicaid and CHIP, and
- The application process for enrollment in coverage through the Exchange and other programs (for example, Medicaid and CHIP)

Key Considerations

Emerging Practices

In their Establishment Grant applications, most states describe efforts or plans to expand or leverage existing help lines to achieve the additional requirements of ACA. Pennsylvania has an existing call center that can likewise be expanded and leveraged.

Leveraging Current Capabilities

A multi-agency Human Services call center, the Health and Human Services Call Center (HHSCC or Call Center) was established in the early 2000s by the Department of General Services on behalf of DPW, PID, DOH and Aging. The primary objective of this call center was to serve as a “one-stop” human services information, referral and application resource.

Since its inception, this Call Center has been outsourced and currently operates 11 help lines with over 9,500 calls per month. Over 85% of all calls for the past six years have been related to CHIP and AdultBasic. In addition to providing live assistance via telephone, the current vendor also provides live online chat assistance. The Call Center operates based on a series of databases that allow operators not only to direct inquiries for services but also to assess both immediate and longer-term needs of callers to coordinate the application/enrollment or referral to all relevant human services across the various human services agencies. They also access COMPASS to assist callers with eligibility determination processes.

The current vendor has been flexible during their contract to add new capabilities, new lines, etc. One example was the new line provided in 2009 for H1N1.

Planned Expansion of Call Center

PID has indicated that, if possible, it is likely to utilize the Call Center for the Consumer Assistance Program grant to enhance PID's delivery of direct assistance to consumers by consolidating the intake of all health insurance consumer calls through the Health and Human Services Call Center (HHSCC). Under this expansion of scope, the contractor will assume responsibility for 100% of the health insurance calls. The HHSCC would take all initial calls and "triage" before forwarding, where appropriate, to PID's Consumer Assistance Unit. HHSCC will directly assist callers with:

- Questions about PA's health insurance high risk pool including information on how to apply
- Explaining the process for filing complaints and appeals against health plans and how to obtain assistance with appeals
- Education consumers about their rights and resources
- Educating consumers about their health insurance options
- Describing health insurance information and tools available on the PID website, and
- Assisting consumers to navigate through the health insurance cost comparison tool on the PID Website

The Contractor would utilize PID's existing web-based Consumer Complaint Tracking System to collect data from each call/caller. This will allow PID to monitor and manage the regulatory data and for management and regulatory reporting purposes. Operators will assist callers to apply for enrollment in CHIP or MA using COMPASS during the call, where applicable.

Comparative Analysis: HHSCC to Exchange Call Center Requirements

Current ACA Guidance	HHSCC Capabilities	Considerations/Comments
Suggested operation is outside of normal business hours	Currently HHSCC operates M-F 7am-7pm and Saturdays 9am-3pm with voicemail/call back procedures in place for after hours calls. Online chat assistance is also available during the same hours.	1. Consider Missouri's analysis (above) of potential market needs for employers and employees accessing the Exchange/Call Center pointing towards need for after-hours operations 2. Consider future individual consumer and small business stakeholder input in assessing need for after-hours operations
Adjusting staffing levels in anticipation of periods of higher call volumes such as the weeks leading up to and during open enrollment	It is unknown whether current HHSCC has identified other peak service times/capacity for existing lines. The current vendor has added capacity in the past to address specific needs such as the H1N1 line and backup support for APPRISE during Medicare open enrollment periods.	3. Determine current capacity for Exchange peak period capacity and impact on costs
Provide assistance to consumers and businesses on a broad range of issues, including but not limited to: (1) The types of QHPs offered in the Exchange	This will be a new functionality to be developed and call center teams trained accordingly.	4. Related specifications will need to be developed for provider of these services whether outsourced or offered internally
(2) The premiums, benefits, cost-sharing, and quality ratings associated with the QHPs offered	This will be a new functionality to be developed and call center teams trained accordingly.	5. Related specifications will need to be developed for provider of these services whether outsourced or offered internally
(3) Categories of assistance available, including advance payments of the premium tax credit and cost-sharing reductions as well assistance available through Medicaid and CHIP	Current HHSCC accesses COMPASS to assist consumers in applying for MA and CHIP. Providing assistance on tax credits and subsidies will be new functionality.	6. Related specifications will need to be developed whether outsourced or offered internally 7. Determine capacity of COMPASS or any future eligibility determination process/system to allow call center access for this purpose

Current ACA Guidance	HHSCC Capabilities	Considerations/Comments
(4) The application process for enrollment in coverage through the Exchange and other programs (for example, Medicaid and CHIP)	Current HHSCC accesses COMPASS to assist consumers in applying for MA and CHIP. Assistance with application process for Exchange offered insurance plan will be a new functionality to be developed.	8. Related specifications will need to be developed whether outsourced or offered internally 9. Determine capacity of COMPASS or any future eligibility determination process/system to allow call center access for this purpose
Exchanges are encouraged to use call centers as conduits to Health Ombudsman, Navigators and any other State consumer programs	Existing HHSCC is currently being expanded to provide additional consumer assistance functions of the PID Consumer Assistance Unit The current vendor also provides outreach and education services to the Commonwealth	10. Consider additional coordination and planning with Navigator program, Ombudsman, etc.

Moving Forward

In proceeding with planning for call center services for an Exchange, we recommend that the governing entity consider the following:

- Assess incremental Call Center functionality to:
  1. Address ACA requirements for the Exchange Call Center
  2. Develop specifications in line with needed function for procurement purposes
  3. Determine peak capacity needs in weeks prior to and during open enrollment
  4. Consider possible expansion beyond typical business hours
- Determine status of Health Ombudsman Program and identify potential areas for coordination with Exchange Call Center function including addition call center needs that might be addressed by the existing or any future HHSCC
- Consider and coordinate Exchange Call Center planning activities and implementation with and across additional consumer assistance offerings and new requirements:
  1. Navigators
  2. Education and Outreach
  3. Consumer Assistance Programs
  4. Online Help Chat
- Consider the appropriate role for a call center — providing guidance on how to use the portal, or directing someone on which option is best for them.

- Consider current capabilities and need for interpretation and language assistance services as well as assistance for consumers with hearing or speech impairment. The current call center vendor provides Spanish and Russian translation services and uses AT&T translation services or other languages.
- Utilize existing HHSCC call data to further assess potential exchange demand, potential impact on cost and operations of call center function, etc.

Timing Considerations

Although no milestones are identified for 2012, the Commonwealth should continue evaluation of the HHSCC, potential vendors and call center needs during 2012. Demand estimates and existing call center data/statistics should be used to assess the potential volume for the call center and online chat functions. An analysis of this data can also be used to develop service level agreements for use in contracting with a call center service provider or Memorandum of Agreement with another Commonwealth agency. These activities should be completed in 2012 to allow for procurement of a call center vendor in 2013, should a new procurement be necessary to put the additional Exchange Call Center services in place.

In addition to the key milestones identified above for the second quarter of 2013, user testing of the call center should be planned and performed specifically to assess capabilities for peak usage.

Stakeholder Involvement/Impact

Input/Feedback

The recent Forums provided support and input for an Exchange call center, comments indicated that a Commonwealth Exchange should:

- Provide multiple avenues to access information regarding the Exchange to support enrollment
- Provide exceptional customer service
- Assist consumers with enrollment questions, complaints and resolution
- Provide hard-copy applications and call centers to assist enrollment as Pennsylvania consumers may not know how to complete online enrollment applications
- Provide documentation for multiple literacy levels and multiple languages

Future Plan and Communication

Stakeholders also suggested that the Commonwealth have a separate forum for streamlining the application, enrollment, appeals processes and a separate statewide conference on the role of Navigators and Producers. Stakeholder input should be sought as the Commonwealth continues to plan for an Exchange particularly to seek input and feedback on customer services beyond the application/enrollment stage as one stakeholder in the Harrisburg Forum pointed out that “customer service does not stop with plan selection.”

Small Business Health Option Program (SHOP) Considerations

The needs of SHOP consumers (employers and employees) may differ during the application/enrollment stages and separate protocols will need to be developed for these consumers for a call center to provide efficient and effective assistance.

Option-Specific Considerations

Quasi-Government	Not For Profit	Existing Agency	Multi-State
Under these structural options, the Exchange entity may implement a new call center or leverage the existing HHSCC through contractual agreements.		An existing Commonwealth agency can leverage the existing HHSCC or implement a new call center. It would be most efficient to expand the existing Call Center. Procurement needs will depend on the outcome of the current assessment of options.	The Commonwealth and other participating state(s) would need to determine responsibility for call center services (which participating state or outsourced vendor). Additional volume from more than one state should be considered in assessing capacity of internal and outsourced providers.

Exchange Website

Please refer to *Technology* Focus Area.

Premium Tax Credit and Cost Sharing Reduction Calculator

Please refer to *Technology* Focus Area.

Quality Rating System

Please refer to the *Certification, recertification and decertification of qualified health plans* section of **Operations.**

Navigator program

Regulatory Guidance

Section 1311 of the Act requires the Exchange to establish a program to award grants to entities that will serve as Navigators. A Navigator is a qualified public or private entity or individual that aids consumers through the process of obtaining and using health insurance. As noted in §155.10 of the NPRM [CMS-9989-P], the minimum duties of a Navigator are:

1. "Maintain expertise in eligibility, enrollment, and program specifications and conduct public education activities to raise awareness about the Exchange.
2. Provide information and services in a fair, accurate and impartial manner. Such information must acknowledge other health programs.
3. Facilitate enrollment in QHPs through the Exchange.
4. Provide referrals to any applicable Office of Health Insurance Consumer Assistance or Health Insurance Ombudsman, or any other appropriate State agency or agencies for any enrollee with a grievance, complaint, or questions regarding their health plan, coverage, or determination under such plan or coverage.
5. Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange, including individuals with limited English proficiency, and ensure accessibility and usability of Navigator tools and functions for individuals with disabilities in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act."

The Exchange must establish a process to monitor the performance of Navigators to ensure they are performing these duties.

Also as noted in the same section of the NPRM, the Exchange must include entities from at least two of the following categories to receive a grant:

1. "Community and consumer-focused nonprofit groups
2. Trade, industry, and professional associations
3. Commercial fishing industry organizations, ranching and farming organizations
4. Chambers of Commerce
5. Unions
6. Resource partners of the Small Business Administration
7. Licensed agents and brokers
8. Other public or private entities that meet the requirements of this section. Other entities may include, but are not limited to, Indian tribes, tribal organizations, urban Indian organizations, and State or local human service agencies."

A Navigator must also demonstrate to the Exchange that it has existing relationships or has the ability to readily establish relations with the individuals or employers/employees that are likely to enroll in a QHP. This requirement does not imply that relationships need to be established with all the types of individuals or employers/employees.

The NPRM indicates that a Navigator cannot have a conflict of interest during the time the entity serves as a Navigator. A Navigator must not be a health insurer or receive directly or indirectly any consideration from a health insurer in relation to assisting individuals or employees to enroll in a QHP. Navigators are also required to meet any licensing or certification requirements established by the State or Exchange; an Exchange is also allowed to establish other required duties.

The Navigator program cannot be supported with federal funds provided to establish the Exchange. Funding must come from nonfederal operational funds. The exception to this rule is in the case where Navigators are required to perform activities related to Medicaid or CHIP. In this case, the contract with the Navigator will need to have a mechanism to identify costs associated with Medicaid and CHIP activities.

All of these requirements apply to both the individual and SHOP markets. Future federal guidance may further clarify or change the requirements included in this section.

Key Considerations

Emerging Practices

Some states have conducted an initial analysis concerning a Navigator Program, but plan to continue studying their options for the program. For example, New York will be conducting a variety of studies, one of which will focus on the criteria for eligibility to serve as a Navigator. Another example is Maryland, where Level One Establishment Grant funds were requested for a Navigator study. In this case the study will:

- Obtain input from potential consumers of the Exchange to perform an assessment of their needs.
- Ascertain if private sector resources may be suitable for the exchange and identify potential organizations that could qualify as Navigators.
- Understand the effect the Exchange may have on private sector employment in the health insurance distribution system, as well as community assistors.
- Understand the role of the producer in the current market.
- Summarize consumer assistance data and Maryland demographic data and coverage.
- Address the following questions as noted in Maryland's Level One Establishment Grant Application:
  - "What functions, in addition to those required by the ACA, should be performed by Navigators?
  - What training and expertise should be required of Navigators?
  - Whether different markets and populations require Navigators with different qualifications?
  - How should Navigators be retained and compensated?
  - How should disparities between Navigator compensation and the compensation of insurance producers outside the Exchange can be minimized or avoided?
  - How can we ensure that Navigators provide information in a manner culturally, linguistically, and otherwise appropriate to the needs of the diverse populations served by the Exchange and that Navigators have the capacity to meet these needs?
  - What other means of consumer assistance may be appropriate and feasible, and how they should be designed and implemented?"

Leveraging Current Capabilities

PID has well-established policies, processes, and communications materials that support current producer licensing. This collection of assets could be leveraged for the creation of the Navigator licensing/certification process once the Navigator program is more fully defined.

Pennsylvania has in place a process to register and manage security for COMPASS Community Partners to gain access to COMPASS. If COMPASS is enhanced to use it as the basis for the Exchange portal, the Commonwealth can leverage these existing processes and functionality to manage security for Navigators.

The Commonwealth has successfully implemented other programs to provide assistance to consumers. One example is the APPRISE program created to help Pennsylvanians with Medicare understand their health insurance options and help them make sound decisions about what is best for them. This program includes a variety of methods to train and keep APPRISE coordinators up-to-date on program information. These methods could be considered for use in Navigator training.

Moving Forward

Many of the key decisions to be made about the Navigator Program are reflected in questions listed above related to the Maryland study. The Commonwealth, in order to collect additional information to support making these decisions, may want to consider performing a Navigator study to further define the role of the Navigator. This study could be used to obtain more demographic information that can be used for further demand analysis related to Navigators. This information can be used to help determine which populations are most underserved. This determination can help prioritize the types of Navigators that should receive grants.

Feedback from NAIC and insurance industry stakeholders in the Stakeholder Listening Session indicated there is a concern that Navigators will cross the line into “soliciting, selling, and negotiating” insurance to consumers. This concern highlights the need to clearly define the Navigator duty to “facilitate enrollment in QHPs.” These stakeholders maintain that if the Navigator crosses the line, then they should be required to be licensed as producers. In order to provide alternatives for how these organizations can assist applicants, consideration could be given to creating two classes of Navigators:

- The first class would perform outreach, but explicitly not walk clients through the enrollment process. In this case, monitoring would need to be put in place to determine if a Navigator “crosses the line.” This class of Navigator may need a certification program.
- The second class would perform outreach and be involved in directly helping clients enroll in QHPs. In this case, as a result of feedback from the insurance industry, the Navigator most likely would need to be licensed. Further work needs to be done to determine if this class needs to be licensed as a producer and certified as a Navigator.

The following is a potential technical requirement for the Exchange that may help verify into which class the Navigator falls: The application needs to capture the identity of the filer. If the filer is a Navigator, the system could require the license number of the Navigator, confirming the Navigator is a class 2 Navigator.

The Navigator study identified above could also be used to further determine if two classes of Navigators should be established. Identification of detailed certification and licensing criteria, as well as the processes to certify and/or license Navigators, could also be a required outcome of the study. The study can also address the complexities related to how a Navigator is formed. An example is if a Navigator entity is formed by combining a community assistance organization and a broker. In this case, if the broker works part time for the

Navigator and part time for a traditional broker, the Exchange will have to determine if any monitoring may need to be in place to discern if the broker is shifting business specifically to the traditional broker's company.

One approach to establishing the Navigator program could be to start small, meeting the minimum requirement of establishing Navigators in two of the eight categories identified in the NRPM. If the Commonwealth chooses to implement two classes of Navigators, the Commonwealth may want to consider community and consumer-focused nonprofit groups and licensed agents and brokers. An outcome of the Navigator study mentioned above may be the identification of the most underserved populations. With this information, the Commonwealth may want to award grants to Navigators that are suited to assist these potential applicants. A potential impact of starting with a small Navigator program would be the need to make sure there is capacity within the other methods to assist applicants during the initial and future open enrollment periods. This assistance may be provided by the Call Center, CAOs, Community Partners, and brokers/producers.

One of the challenges to establishing the Navigator program is determining how the program will be funded. There is a requirement that that funding must be generated by operational funds that are nonfederal. One possible source of funding could be to implement a producer commission for each plan purchased, even if a producer is not involved in the enrollment. In the case where a producer was not involved in obtaining the plan, the commission would be deposited in the fund to support the Navigator program. As mentioned above, the Commonwealth could choose to start with a small Navigator program. A small program would be easier to fund. The Navigator Program study suggested above could also include an outcome of identifying the resources and processes needed to manage the program, including detailed processes for grant advertisements, reviews, awards, payments and other management such as Navigator monitoring.

Timing Considerations

If the Commonwealth decides to proceed with a Navigator study as suggested above, the Navigator study would need to be complete in time to put the processes and procedures in place to implement the grant program required to be operational in the second quarter of 2013. This implementation date is also dependent on identifying non-federal funding sources for the program.

Stakeholder Involvement/Impact

Input/Feedback

The National Association of Insurance Commissioners has authored a document titled "The Comparative Roles of Navigators and Producers in an Exchange – What are the Issues". The paper identifies potential issues with the Navigator program and contains recommendations. Many of the points raised in this paper were also raised in testimony provided for the Stakeholder Listening Sessions PID conducted in August 2011 and are reflected below.

Feedback in verbal and written testimony provided by representatives of the insurance industry as part of the Stakeholder Listening Sessions clearly indicated a concern over what the future role of producers and brokers will be if an Exchange is implemented. A repeated message was that brokers provide a valuable service to their clients before, during, and after enrollment, including help to resolve issues with claims. These speakers stated that the brokers often act as extensions of the human resources departments of small employers. These industry representatives repeatedly requested that if Navigators cross the "solicit, sell, and negotiate" line that they should be licensed as producers. These stakeholders also suggested the Navigators should be required to carry Errors and Omissions Insurance.

Feedback from some consumer assistance groups indicated they already serve as a Navigator of sorts for State programs like Medicaid and CHIP.

Future Plan and Communication

As the Navigator Program is more fully developed, including representation of COMPASS Community Partners, brokers, producers, and other consumer assistance organizations in discussions may help identify issues that may occur during implementation. This early identification will give the Exchange time to develop strategies to mitigate those issues. Involvement of these stakeholders may also help define and communicate the role these stakeholders will fill related to the Exchange.

Small Business Health Option Programs (SHOP) Considerations

Impact and/or specific questions related to focus area

The requirements for Navigators apply both to the individual and SHOP markets. The Navigator program needs to be established in a way to not preclude serving one or the other.

Option-Specific Considerations

Quasi-Government	Not For Profit	Existing Agency	Multi-State
Commonwealth agencies may need or desire to maintain accountability for establishing the rules under which the Exchange will operate. Whichever model is chosen for implementation of the Exchange, the responsibility to establish the rules for the Navigator Program, including certification and licensing criteria and rules for monitoring Navigators, most likely needs to be housed within a Commonwealth agency that will provide oversight to the Navigator program.			

Eligibility

Please note that analysis for the appeals process related to eligibility determinations is included in the *Adjudication of Appeals of Eligibility Determinations & Notification and Appeals of Employer Liability for the Employer Responsibility Payment* Options Analysis section.

Regulatory Guidance

Subpart B of the Act describes the requirements for eligibility determinations.

- Section 1411 defines the requirements for determining eligibility for Exchange participation, premium tax credits and reduced cost-sharing, and individual responsibility exemptions.
- Section 1412 defines the requirements for determination and payment of premium tax credits and cost-sharing reductions.
- Section 1413 defines the requirements for streamlining of procedures for enrollment through an exchange and State Medicaid, CHIP, and health subsidy programs.

More detailed guidance is provided in the NPRM [CMS-9974-P] that proposes the specific standards for the Exchange eligibility process needed to implement the above sections as well as Sections 1311 (Affordable choices of health benefit plans) and 1312 (Consumer choice). This NPRM points out that the ACA requires a simplification of Medicaid and CHIP eligibility policy and rules. This simplification is proposed in NPRM [CMS–2349–P], "Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010." This simplification aligns most of the rules under which individuals will be determined eligible for Medicaid and CHIP with those for advance payments of the premium tax credit and cost-sharing reductions, by generally using modified adjusted gross income (MAGI) as the basis for income eligibility.

NPRM [CMS-9989-P], in §155.230, requires the Exchange to provide a plain language written notice to inform applicants, qualified individuals, and enrollees of their eligibility and enrollment status. These notices must include the reason for the notice and any actions they need to take, including contact information for required follow-up.

Definitions and General Standards for Eligibility Determinations

NPRM [CMS-9974-P], in §155.300, provides definitions and standards for eligibility determinations. Some key items are described in this subsection.

The applicable CHIP MAGI-based income standard will be the income standard applied under the State plan under Title XXI of the Act, or waiver of such plan, and as certified by the State CHIP Agency pursuant for determining eligibility for child health assistance and enrollment in a separate child health program. This standard will also vary from state to state depending on the threshold established by the State CHIP agency.

The Federal Poverty Level (FPL) table used in eligibility determinations for Medicaid and CHIP may be different from that used for advance payments of the premium tax credit and cost-sharing reductions, depending on the date of the eligibility determination; however, for the annual open enrollment period for coverage, the FPL tables for all these programs should be the same.

Attestations that result in authorization of advance payments of the premium tax credit must be made by the primary taxpayer, which is defined earlier in the NPRM.

Eligibility Standards

NPRM [CMS-9974-P], in §155.305, provides eligibility standards. The below information does not cover every standard, but some key items are described in this subsection.

To be eligible to enroll in a QHP:

- The individual must be a citizen, national or a non-citizen lawfully present and expected to be present throughout the period enrollment is sought.
- The individual must not be incarcerated (except in case when pending disposition of charges).
- The individual must reside in the service area of the Exchange that established the Exchange.

The Exchange is to determine the applicant's eligibility for Medicaid and CHIP and enroll eligible applicants. To be eligible for Medicaid, the applicant must:

- Meet citizenship and immigration requirements.
- Meet residency requirements.
- Has a household income at or below the applicable Medicaid MAGI-based income standard and falls into one of the categories of this standard.

To be eligible for CHIP, the applicant must meet the requirements of 42 CFR 457.310 through 457.320 and have a household income within the applicable CHIP MAGI-based income standard.

If a Basic Health Program (BHP) is operating in the service area of the Exchange, the Exchange will determine an individual's eligibility for the BHP.

An applicant is eligible for advance payments of the premium tax credit if the applicant is expected to have a household income of at least 100% but not more than 400% of the FPL for the benefit year for which coverage is requested and one or more applicants for whom the primary taxpayer expects to claim a personal exemption deduction on his or her tax return for the benefit year, including the primary taxpayer and his or her spouse:

- (1) Meets the standards for eligibility for enrollment in a QHP through the Exchange; and
- (2) Is not eligible for minimum essential coverage (which excludes coverage purchased through the individual market, as well as employer-sponsored minimum essential coverage for which the employee's contribution exceeds 9.5 percent (in 2014, and indexed in future years) of household income or for which the plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs, unless an individual is enrolled in such employer-sponsored minimum essential coverage).

A primary taxpayer is also eligible for advance payments of the premium tax credit if:

- (1) The taxpayer meets the standards regarding eligibility for advance payments of the premium tax credit except for a household income of at least 100 percent but not more than 400 percent of the FPL)
- (2) He or she is expected to have a household income of less than 100 percent of the FPL, and

- (3) One or more applicants, including the primary taxpayer and his or her spouse, for whom the primary taxpayer expects to claim a personal exemption deduction on his or her tax return for the benefit year, including the primary taxpayer and his or her spouse, is a non-citizen who is lawfully present and ineligible for Medicaid by reason of immigration status.

A primary taxpayer is ineligible to receive advance payments of the premium tax credit if HHS notifies the Exchange that the primary taxpayer or his or her spouse received advance payments for a prior year for which tax data would be utilized for income verification and did not comply with the requirement to file a tax return for that year. For purposes of determining eligibility to receive advance payments of the premium tax credit, the applicant must provide the Social Security number of the primary taxpayer.

The premium tax credit is paid on an advanced basis and reconciled based on information on the individual's tax return for the entire year. If the individual's reported income is higher than what was used as the basis for the calculation of the advance payment, the individual will be liable to repay, subject to caps on repayment.

An individual is eligible for cost-sharing reductions if the individual:

- (i) Is eligible for enrollment in a QHP
- (ii) Is eligible for advance payments of the premium tax credit
- (iii) Has household income for the taxable year that does not exceed 250 percent of the FPL
- (iv) Is enrolling in a QHP in a silver level plan

An individual is eligible for reduced cost-sharing if the individual's household income exceeds 100 percent of the FPL, but does not exceed 400 percent of the FPL. The exception occurs when the actuarial value of a silver-level QHP without cost-sharing reductions is 70 percent; an individual with household income that exceeds 250 percent of the FPL who is not an Indian is not eligible for cost-sharing reductions. The three eligibility categories for cost-sharing reductions the Exchange should use to send information to the QHP issuer for the QHP issuer to use to determine the correct level of reductions are:

- (1) An individual who has household income greater than 100 percent of the FPL and less than or equal to 150 percent of the FPL
- (2) An individual who has household income greater than 150 percent of the FPL and less than or equal to 200 percent of the FPL, and
- (3) An individual who has household income greater than 200 percent of the FPL and less than or equal to 250 percent of the FPL

Eligibility Determination Process

NPRM [CMS-9974-P], in §155.310, provides guidance on the eligibility determinations process. The below information does not cover all guidance in the section, but some highlights are described in this subsection.

In order to allow an individual to proceed directly to shopping and enrolling in a QHP, bypassing the extra steps needed to enter information and be screened for the insurance affordability programs, the Exchange should allow an individual to decline an eligibility determination for all those programs. Declining an eligibility determination in this case would apply to all programs, including advance payments of the premium tax credit and cost-sharing reductions, Medicaid, and CHIP.

The Exchange is to accept an individual's application and make an eligibility determination at any point in time during the year. The Exchange must accept and process changes reported by the enrollees throughout the year.

Those individuals who are eligible to receive advance payments of the premium tax credit will be allowed to accept less than the expected annual amount authorized. The NPRM goes on to describe attestation steps required and how payments will be split between primary taxpayers when more than one tax household is covered by a policy.

The Exchange must provide a single written notice to the applicant when the eligibility determination has been finalized. Notifications are not required at every step.

The Exchange may determine that an applicant is eligible to receive advance payments of the premium tax credit or cost-sharing reductions if it determines that the individual's employer does not provide minimum essential coverage or provides coverage that is not affordable. In this case the Exchange will notify the employer and identify the employee.

Verification Process Related to Eligibility for Enrollment in a QHP

NPRM [CMS-9974-P], in §155.315, provides guidance on the verification process related to eligibility for enrollment in a QHP. The below information does not cover all guidance in the section, but some highlights are described in this subsection.

The Exchange will rely, first, on sources of electronic data. Data sources described in this section of the NPRM include records of:

- Social Security Administration
- Department of Homeland Security
- Internal Revenue Service (IRS), and
- Data sources maintained by other entities (HHS will approve electronic data sources based on evidence that the sources are sufficiently accurate and are less complex administratively than use of a paper verification process.)

If information required for verification of eligibility cannot be found in available electronic sources, the Exchange will follow specific procedures to request documentation from applicants. The Exchange can also request documentation from the applicant when information provided by the applicant is not reasonably compatible with other information the Exchange has related to the applicant.

HHS will be the intermediary between the Exchange and other Federal agencies that have records required for the verification process. Examples include:

- For an applicant who attests to citizenship and has a Social Security number, the Exchange will verify whether the information matches SSA's records.
- For an applicant who attests to lawful presence or attests to citizenship and for whom SSA records cannot be used to verify citizenship, but has DHS documentation, the Exchange will verify that the information matches DHS's records.

- If SSA or DHS records are unable to verify a claim of citizenship, status as a national, or lawful presence, then the Exchange should determine eligibility in a manner consistent with the process used by the Medicaid agency.

The Exchange is to accept an applicant's attestation as to residency without further verification unless the State Medicaid agency (DPW for PA) or the CHIP agency (PID in PA) does not allow verification based solely on attestation. Here again, the Exchange may examine data regarding residency if the data provided is not reasonably compatible with other data the Exchange has for the applicant and request additional information. Also, if information provided by the applicant about the applicant's incarceration status is not reasonably compatible with other data the Exchange has for the applicant, the Exchange will request additional information.

If approved, electronic data sources are not available to complete verification, the Exchange is to accept the applicant's attestation. If the applicant's attestation is not reasonably compatible with information the Exchange has for the applicant, the Exchange is to follow the processes identified to investigate inconsistencies as described in §155.315(e).

Verification Process Related to Eligibility for Insurance Affordability Programs

NPRM [CMS-9974-P], in §155.320, provides guidance on the verification process related to eligibility for Insurance Affordability Programs. The below information does not cover all guidance in the section, but some highlights are described in this subsection.

This section describes standards related to the verification of eligibility for minimum essential coverage other than through an eligible employer-sponsored plan including:

- Household income and household size
- Enrollment in or eligibility for qualifying coverage in an eligible employer-sponsored plan, and
- Medicaid and CHIP immigration status requirements

If an individual is eligible for minimum essential coverage through sources other than the Exchange and the individual market (such as Medicaid, CHIP, BHP, or an eligible employer-sponsored plan), the individual is ineligible for advance payments of the premium tax credit.

In this section, the Exchange is required to verify both annual and current household income information. This section continues with instructions for calculating household income, requiring only minim information needed to complete verification, obtaining information from Treasury through HHS. This section also includes the process to verify advance payments of the premium tax credit. Here the Exchange is directed to accept the applicant's attestation of family size without further verification unless the information is not reasonably compatible with information the Exchange has concerning the applicant. This direction also applies to the applicant's attestation of the primary taxpayer's household income and whether an applicant is enrolled in an eligible employer-sponsored plan.

Eligibility Redetermination During a Benefit Year

NPRM [CMS-9974-P], in §155.330, provides guidance on the redetermination process that can occur during a benefit year. The below information does not cover all guidance in the section, but some highlights are described in this subsection.

The Exchange is directed to redetermine the eligibility of an enrollee in a QHP during the benefit year when either the enrollee reports updated information that the Exchange verifies or when the Exchange discovers updated information as a result of data matching to identify individuals who have died or have gained eligibility for a public health insurance program. Changes that an enrollee may report include: incarceration status, residency, immigration status, household income or household size, and/or availability of qualifying coverage in an eligible employer-sponsored plan.

If a redetermination of eligibility is performed, the Exchange must provide a notice to the enrollee with the result of the redetermination.

Annual Eligibility Redetermination

NPRM [CMS-9974-P], in §155.335, provides guidance on the annual redetermination process. The below information does not cover all guidance in the section, but some highlights are described in this subsection.

The Exchange must perform an annual redetermination of eligibility for each enrollee in a QHP. In preparation of the redetermination, the Exchange is to send the enrollee an annual redetermination notice, directing the individual to report changes to information included in the notice. The Exchange is to require the enrollee to sign and return the notice and describes the process to be followed if the notice is not returned. The Exchange then needs to redetermine the enrollee's eligibility after completing verification of the information provided. The enrollee will remain in the QHP selected the prior year unless the enrollee has taken action to select a new QHP or terminate coverage.

Coordination with Medicaid, CHIP, the Basic Health Program, and the Pre-Existing Conditions Insurance Program

NPRM [CMS-9974-P], in §155.345, provides guidance on the coordination with Medicaid, CHIP, the Basic Health Program, and the Pre-Existing Conditions Insurance Program (PCIP). The below information does not cover all guidance in the section, but some highlights are described in this subsection.

This section describes the standards to facilitate coordination across these programs needed in order to implement a streamlined process for eligibility determinations and enrollment. Here the requirements include agreements between the Exchange and State Medicaid and CHIP agencies. It also covers requirements for the Exchange to transmit data to these agencies as eligibility determinations are made for Medicaid and CHIP. These agencies then need to provide the individual with choices of available delivery systems. The state may also implement an eligibility system that conducts all eligibility determinations for the Exchange. The Exchange must also coordinate with the State PCIP [PA Fair Care in PA] to ensure that PCIP enrollees do not experience a lapse in coverage.

MAGI-Based Methodologies

In the presentation titled "Medicaid & CHIP in 2014: A Simple Seamless Path to Affordable Coverage, The New World of MAGI," CMS notes that MAGI is a methodology, not a number on a tax return. This methodology is to be used to determine financial eligibility for Medicaid and CHIP. The presentation also points out that eligibility based on being blind or disabled is not affected by MAGI. The presentation continues by highlighting the differences between today's rule and MAGI-based income for income level, household composition and size, budget periods, and income standard conversion. The presentation then delves into the methodology for MAGI. A conversion issue the Exchange will need to handle is highlighted on the slide that discusses protecting Medicaid populations which requires different rules for those who are new enrollees after January 1, 2014 and those who were existing enrollees. Further guidance will be provided in future rulemaking. This issue is discussed in the *Moving Forward* section of this report.

CMS has started to indicate how MAGI calculation methodologies are documented. In "The CMS Medicaid and CHIP Eligibility Changes Under the Affordable Care Act Proposed Rule (CMS-2349-P)" document dated September 27, 2011, CMS notes that the NPRM references require the CHIP state plan to include a description of the State's methodology to determine MAGI for CHIP. This portion of the document referenced §457.300, §457.301, and §457.305 of the NPRM cited.

SHOP

NPRM [CMS-9989-P], in §155.715, provides guidance on the eligibility determination process for employers who wish to offer, through the SHOP, health coverage to qualified employees. The information below does not cover all guidance in the section, but some highlights are described in this subsection.

As for individuals, the information required from both employers and employees is to be limited to only the information needed to determine eligibility. The SHOP does have options for how employer size is determined:

- Allow an employer to self-report and attest to the size of the employer's workforce.
- Require a more stringent determination of size, which may involve the employer providing additional information.

The SHOP must also verify the employer has met the standards specified in §155.710, including:

- Offering all full-time employees access to obtain health coverage via the SHOP.
- Verifying that at least one employee works in the SHOP's service area.

The NPRM indicates self-reporting and attestation for the employer address is sufficient for verification.

Only two application forms should be used – one for qualified employers and one for qualified employees. The SHOP may use the information the employer or employee attests to on the application for purposes of determining eligibility. The SHOP is required to verify that the employee (applicant) is listed on the qualified employer's roster of employees to whom coverage is offered.

The SHOP may deny applications if there is a reason to question the veracity of the information included. The SHOP also may define additional methods to verify information beyond the employee and employer applications. These may include:

- A review of quarterly wage reports (for verification of employer size)
- SHOP records indicating the number of attempts by an employer to enroll employees (to confirm it does not exceed the allowable employer size)

The SHOP must notify the applicant if the SHOP doubts the information provided and make reasonable efforts to address the cause of the doubt, including contacting the applicant and providing a 30-day period for the applicant to resolve the cause of the possible error. The SHOP must then notify the applicant of the eligibility determination at the end of this period. The SHOP must also notify the employees and employers of their right to appeal.

Further Guidance

Further federal guidance may address the following questions states have concerning eligibility determinations and ramifications of the determinations made:

- HHS has not advised whether the state and/or the Exchange and/or the QHP will be held harmless if a benefit is provided in error when all parties have followed the process approved for the state by HHS. An example would be payment of a premium tax credit, based upon the applicant's self-attestation and any authorized use of data exchanges. The indication has been IRS/HHS in this case will hold the applicant harmless. The determination if the submission of inappropriate information to an Exchange by an applicant falls under the state's false claims act needs to be made.
- HHS has not advised whether a state should not allow an applicant to seek a benefit through an Exchange if the applicant has been documented to have recently abused the CHIP program or other benefit programs.

Future federal guidance may further clarify or change information presented in this subsection.

Key Considerations

Emerging Practices

A scan of Level One Establishment Grant Applications from other states provided information for this subsection. Many, if not all, of these states have been in the process of reviewing their existing systems involved in applying for Medicaid and CHIP and determining eligibility in order to determine the gaps between current capabilities and what is required for the Exchange. For example, California has identified gaps such as:

- No online verification of customer submitted information is provided.
- Current systems were not designed for online real-time eligibility determination.
- Medi-Cal eligibility systems function within an integrated welfare eligibility system environment with robust functionality to support client intake, eligibility determination, correspondence, and notifications, financial, reporting, and other functions, but these systems are not online, real-time customer facing systems.

Wisconsin's readiness assessment identified that the State is well-positioned to implement an Exchange as a result of its modern system infrastructure that includes CARES (a web-based integrated eligibility determination system) and ACCESS (a web-based self-services portal) used to report changes, check benefit status for Medicaid, CHIP, and other programs, as well as apply for and select an HMO. Wisconsin indicates these systems provide a foundation for implementing their Exchange. As noted in the Enrollment Process section of this report, Wisconsin has also created a publicly available Exchange prototype to educate potential future applicants and gain feedback from them.

The states applying for these grants have also started coordinating activities of the agencies involved in the eligibility determination processes that are to be covered by the exchange. Examples are:

- Maryland is coordinating activities with the agencies that administer the State Health Assistance Programs, including Medicaid and CHIP (MCHIP) and the State Department of Insurance. They have begun developing requirements using JAD Sessions for topics including integrating or interfacing to support enrollment transactions and eligibility referrals and coordinating applications and notices.
- Washington's Health Care Authority met with owners of the State's eligibility determination systems for health and social services programs (Washington Department of Social Services and Health Services' Automated Client Eligibility System (ACES) and reviewed Washington's self-service portal (Washington Connection) for social and health programs.

A common concern is determining how to make Medicaid eligibility on a real-time basis. In their Level One Establishment Grant Application, Connecticut identified interface challenges as issues they need to address including: “How will the Medicaid eligibility determination take place–automatically upon the entry of information by the consumer, or following worker intervention?”

Some states anticipate the eligibility determination process can be supported by Exchange technology they are already designing, with the Exchange portal designed to support intake and management of eligibility determination and employer liability appeals. For example, Maryland expects their “Technology Platform will be able to provide functionality to support verification and determination of eligibility for qualified health plans.” Maryland also indicates that this platform will also provide functionality for the required applications and notices.

Missouri assessed the eligibility criteria to apply for coverage under MO HealthNet/Chip against exchange requirements and determined that several eligibility requirements for Medicaid/CHIP may be eliminated or continued at state option. Missouri is also planning to form a Notice Work Team to work with the Show-Me HIE on the content for Medicaid notices.

New York has established a central Enrollment Center (EC) for processing Medicaid Renewals by phone, and using state data to expedite renewals. The State is adding 10 positions in the EC to focus on renewal and eligibility determinations. They will help New York further define and validate the existing automated eligibility system tool. Lessons learned will be used in the development of new processes, procedures, and the new MAGI-based rules.

Washington State identified a key activity will be to determine options for handling the “churn” between Medicaid and the Exchange, including coordination among their teams and development of policy options. The Commonwealth will also need to develop similar methods and policies if the Commonwealth moves forward with an Exchange.

Leveraging Current Capabilities

The Commonwealth has in place well-defined and documented procedures for eligibility determinations for the present CHIP and Medicaid programs. These processes, while similar in concept at a high level, are executed via different means. Each is described below:

Current CHIP Eligibility Determination Process

Applicants can apply for CHIP via the Commonwealth of PA Access to Social Services (COMPASS) system. COMPASS is a web site that allows individuals and community-based organizations access to screen for, apply for, and renew a broad range of social programs, including Medicaid and CHIP.

Eligibility determinations for CHIP are then performed by the nine insurance companies in the program. These companies use the CHIP & adultBasic Processing System (CAPS) to determine eligibility. This approach was originally done to build a primary relationship between the insurer and the enrollee. If there is an issue with missing data and all parties on the application have social security numbers identified, then PID’s Central Eligibility Unit (CEU) helps complete the process. Examples are missing income information, and missing citizenship information. If the social security numbers are missing for any parties included in the application, then the insurance company will be responsible to work with the enrollee to resolve. The results of the eligibility determination process can be:

- Incomplete (missing information)

- Enrolled
- Conditionally Enrolled (example – lack of citizenship information)
- ACR (Awaiting Contractor Response) – Case where a premium payment is involved and in the process of generating an invoice and waiting for the payment from the enrollee
- Denied

Upon completing the eligibility determination, CAPS generates a code that indicates what letter should be sent out with the eligibility determination results to the applicant. Instructions concerning how to appeal an eligibility determination are included in the notice sent to the applicant.

Looking to the future, the CHIP eligibility determination processes must be revised because CMS has advised states with stand-alone CHIP programs, of which Pennsylvania is one, that for consistency and coordination purposes, separate CHIP programs must apply the Medicaid eligibility and enrollment provisions. This requirement was summarized in "The CMS Medicaid and CHIP Eligibility Changes Under the Affordable Care Act Proposed Rule (CMS-2349-P)" document dated September 27, 2011. This document referenced §457.300, §457.301, and §457.305 of the NPRM cited. This will necessitate a substantial change in how CHIP eligibility determinations are performed.

Current Medicaid Eligibility Determination Process

The DPW's Office of Income Maintenance (OIM) administers Pennsylvania's public assistance programs. Through the County Assistance Offices (CAOs), OIM is the public face of the Department. These public assistance programs include Medicaid.

An individual who wants to apply for Medical Assistance (MA) benefits can request an application from their CAO or apply online in the COMPASS system. Approximately 30% of the Medicaid applications are submitted online through COMPASS. The individual can complete the application (or apply online) or another individual can complete the application process (such as a medical provider, a representative of a hospital or institution, a child welfare agency for a foster child, or any person acting on behalf of the individual). The completed application form (PA 600 Series) may be submitted to the CAO (who can assist in completing the application). An individual may also apply for MA at a hospital, Federally Qualified Health Center, or any site designated by DPW.

The CAO then determines eligibility based on the application or online submission received. COMPASS can indicate if the individual is likely to be eligible, but the final determination is made and confirmed by manual intervention of the CAO. The application form is not required under certain circumstances such as when adding a newborn or redetermining eligibility.

If the application and the information submitted with it do not provide enough information for the CAO to verify eligibility, the CAO may schedule an interview if the information needed cannot be obtained over the phone or through some other means of contact.

The application process ends when any of the following occurs:

- If an interview is necessary and the applicant does not attend or does not complete it
- The applicant withdraws the application
- The individual is determined ineligible

- The individual is determined eligible and benefits are authorized

The applicant will receive a notice containing the eligibility determination result with information and instructions concerning their right to appeal.

Technology to support the eligibility determination process includes the COMPASS system described above, and the Client Information System (CIS) with its web-enabled components (eCIS) and associated server systems collectively known as iCIS. Medicaid eligibility determination automation was implemented in CIS in 2005. Another significant technology component used in eligibility determination is the iCIS sub-component IEVS. IEVS is an automated system that was developed to provide information to the county eligibility worker to aid in the determination of eligibility and the amount of the benefit. IEVS provides for the exchange of information between DPW and the Pennsylvania Department of Labor and Industry (DLI), Office of Employment Security (OES), the Social Security Administration (SSA), and the Internal Revenue Service (IRS).

Future Eligibility Determination Processes

ACA implies a real-time eligibility determination should be made for Medicaid, CHIP, Advance Payment of Premium Tax Credits, and Cost-sharing Reductions if the information is available. Two significant barriers to enabling real-time eligibility determinations are:

1. The availability of data sources that can provide data to make a real-time determination. HHS has committed to providing Exchanges with access to data from select Federal offices through HHS that can be used for eligibility determinations. The exact details of data to be provided by HHS through data exchanges are not yet known. Also the detailed requirements for the eligibility determination process have not been defined. These requirements may specify the need to use Commonwealth data for verification and the availability of that data cannot be known until the requirements are defined.

2. The current policies/practices require the CAOs to make the final Medicaid eligibility determination. If data sources are found to be available to fully automate the eligibility determination process, policy and practice changes will be needed.

Even if the eligibility determination process is able to be automated, the stakeholders we interviewed envision that a certain percentage of eligibility determinations will not be able to be made during a single session of the applicant using the Exchange portal. These interviewees expect there will be cases where manual intervention will be needed to complete verification of information. They also anticipate, in some cases, manual intervention will be needed to determine the “best” outcome for the applicant’s case. An example of a “best” outcome is a situation where a wraparound program is involved and a determination is made that the program should pay for the individual’s premium because it would be more cost effective than medical assistance.

Moving Forward

The Commonwealth needs to decide whether an Exchange will be implemented or not before significant progress can be made toward FOA Milestones related to coordinating with the Medicaid Agency (DPW), the CHIP Agency (PID) and the State Insurance Department (PID) concerning integrating or interfacing with the agencies involved in eligibility and enrollment processes. In the meantime, some potential key questions or issues with the future eligibility determination process have been identified and included in this subsection.

Organization(s) will be responsible for overseeing eligibility determinations. The approach Exchanges seem to be taking is to enable the online application to make eligibility determinations, in most cases, through the use of rules engines. There may be times when not enough information is provided by the applicant for the system

to make a determination. In these cases, some form of manual intervention will be required. With this online capability, the agencies that are most knowledgeable in the existing programs could continue to oversee the rules that the application would implement and provide a means to perform manual intervention, when required, possibly leveraging present processes. For eligibility determinations that are not done today (such as QHP, advance payments of the premium tax credit, etc.) another organization (possibly the Exchange) would oversee those rules.

One question the Commonwealth may want to consider is this: In the event that the manual intervention is kept in place for Medicaid eligibility determinations and the Exchange system indicates that the applicant does not appear to be eligible for Medicaid (but cannot finalize until manually confirmed), should the system ask the applicant if the applicant wants to decline eligibility determination for all programs and proceed to shop for a QHP? This would allow the applicant to move forward without having to wait for a final eligibility determination. Allowing an applicant to decline an eligibility determination is permitted as noted in the Regulatory Guidance section of this report.

The ability of the Exchange to be able to support real-time determinations may also be impacted by the interfaces that need to be put in place for the Exchange to be able to get information from federal sources through HHS. It is unclear if all this information will be provided on a real-time basis or if some of these data exchanges will rely on batch processing.

The Commonwealth will also need to decide if the Exchange will perform all eligibility determinations for health benefits or if Medicaid eligibility determinations will also be made outside of the Exchange. If the latter approach is taken and the actual systems used to make the eligibility determinations are not the same, the challenge will be to keep these systems in synch as future changes are made to eligibility determination rules.

HHS is seeking feedback on the proposed rules related to redeterminations as well as some options and further issues related to these questions:

- Should an enrollee have the ability to be set up to receive periodic reminders to report changes? The Commonwealth may wish to consider setting up the system so that automatic reminders would be provided and the user could “opt-out” via a feature on their account setup. This could be considered a potential requirement for the Exchange.
- Should changes to income be required to be reported by the enrollee only if they are changes within a certain magnitude? This may be difficult in that the impact to eligibility is really determined by how close the enrollee’s income was to the thresholds in place. (That is if an enrollee was just below 1% of the maximum income for a certain level and the enrollee’s pay went up 3%, should their eligibility be impacted? If the rule is established with a requirement to report changes only in excess of +/- 5% then the enrollee would not need to report it.
- Should there be cut-off dates for changes related to a redetermination, such as September 15th for changes effective October first? Should HHS have to authorize these cut-offs? The private market most likely would request established cutoffs. The determination of who is responsible for the financial impact of the cutoffs may help provide direction as to who could be empowered to authorize the cutoffs.

One of the concerns about implementation of an Exchange is coordination with existing programs as the Exchange is implemented, to ensure there is not a lapse in coverage. Regarding coordination between the Exchange and the Pre-Existing Conditions Insurance Program (known in the Commonwealth as PA Fair Care), facilitating no lapse in coverage is more of a coordination of communications issue. The people

currently enrolled in PA Fair Care will need to understand that they will need to enroll through the Exchange. Stakeholder communications can facilitate this understanding.

Another conversion issue the Exchange needs to consider is the need to protect existing Medicaid populations by implementing a second MAGI calculation for existing Medicaid and CHIP enrollees (prior to January 1, 2014). This second evaluation of MAGI is not needed if the existing enrollee is financially eligible based on the rules implemented for new enrollees. If, however, the existing enrollee is not deemed eligible, a second calculation is needed to determine if the enrollee is eligible using a MAGI calculation with an FPL limit determined by the state to calculate the MAGI equivalent for the income limit prior to the implementation of ACA. The Commonwealth will need to determine the effective percentage of FPL for this second MAGI calculation. The Commonwealth will also need to ensure the eligibility system takes into account the grandfathering clause in Section 2002 of ACA that requires: “An individual who, on January 1, 2014, is enrolled in the State plan or under a waiver of the plan and who would be determined ineligible for medical assistance solely because of the application of the modified adjusted gross income or household income standard, shall remain eligible for medical assistance under the State plan or waiver (and subject to the same premiums and cost-sharing as applied to the individual on that date) through March 31, 2014, or the date on which the individual’s next regularly scheduled redetermination of eligibility is to occur, whichever is later.”

As noted in the Regulatory Guidance section of this report, the NPRMs indicate what must be done to perform verifications to complete the eligibility determination processes. In some instances, the NPRMs recommend that the Exchange accept the attestation of the applicant without further verification unless the Exchange determines the information provided is not reasonably compatible with information the Exchange has concerning the applicant. CMS has indicated that the Secretary of HHS will determine what the states can actually verify. One way to obtain approval may be to include the details concerning what will be verified should be included in the state plan that is reviewed for approval by HHS.

Once a decision has been made to implement an Exchange, work groups under the Exchange Steering Committee described in the Governance and Program Integration options analyses could be established for these work streams:

- **Applications** – This work group could be established to focus on the single streamlined application required. This work group will need to include representation of personnel with Medicaid, CHIP, and other health insurance background to make sure the application and notices address needs for Medicaid, CHIP, and QHPs. As noted in the stakeholder feedback below, some participants in the Stakeholder Listening Sessions indicated a desire to provide input into the future application process. See the section below for more details.
- **Notices** – This work group could be established to focus on the notices required. This work group will need to include representation of personnel with Medicaid, CHIP, and other health insurance background to make sure the application and notices address needs for Medicaid, CHIP, and QHPs.
- **Eligibility Determination Rules** – This work group could be established for developing the requirement and the rules that will be required for the “rules engine” for determining eligibility. The goal would be to ensure the rules required by ACA are established and that PA-specific rules have been developed, reviewed, approved, and included as well. The PA-specific rules include the effective percentage of FPL needed for the second MAGI calculation required to protect existing Medicaid and CHIP populations.
- **Churn Management** – This work group could be established to identify the type of data that could be used to monitor churn between public programs and the QHPS, by tracking individual enrollees across the

programs and using data analytic tools to detect, measure, and manage churn. These tools could also be used to detect fraud and abuse. This group could also help develop methods to understand external impacts that would affect churn and mitigate those impacts.

Each of these work groups would need to consider the policy implications of the changes and actions suggested and work close with a policy work group that coordinates consideration of policy decisions.

Timing Considerations

Activities of the work groups described in the Moving Forward session need to be included in the plan to confirm how they contribute to the milestones above.

Stakeholder Involvement/Impact

Input/Feedback

Feedback in verbal and written testimony concerning eligibility determinations and applications and notices provided for the Listening Sessions conducted by PID in August included a confirmation that stakeholders are looking for a streamlined and modern enrollment process using a single application. Stakeholders also noted that not all consumers have the ability or preference to use an online application, driving the need to provide other means to enroll including use of paper applications and/or a call center. Some stakeholders also noted the need for a process that supports consumers at various literacy levels as well as consumers who do not speak English as their first language.

The Health Insurance Exchange Research Survey conducted by the Nieman Group supports the above feedback. The results identified that consumers surveyed felt that in order for an exchange to be a success, it must allow seamless enrollment in plans.

Future Plan and Communication

As noted above, stakeholder interest was expressed in helping streamline the application process. The work groups tasked with working on the application and eligibility determination processes could benefit from additional stakeholder input concerning details of these processes. Stakeholder input would be especially helpful in confirming that the application and notices can be successfully understood by potential applicants.

As the rules for eligibility determination are finalized, mechanisms to communicate the rules to stakeholders would help facilitate implementation of the Exchange.

Small Business Health Option Programs (SHOP) Considerations

Impact and/or specific questions related to focus area

As noted in the Regulatory Guidance section above, NPRM [CMS-9989-P], in § 155.715, provides guidance on the eligibility determination process for employers who wish to offer, through the SHOP, health coverage to qualified employees. Once a decision has been made to implement an Exchange, a work group under the Exchange Steering Committee described, if such is convened, could focus on SHOP specific functions. This work group could interact with the Applications, Notices, and Eligibility Determination work groups to ensure consistency. Concerning eligibility determinations, a SHOP work group would define the process and requirements for registering employers, develop the SHOP application for employees and the SHOP application for employers, establish the rules for eligibility determination and develop the notices related to eligibility determinations and reenrollment.

Option-Specific Considerations

Quasi-Government	Not For Profit	Existing Agency	Multi-State
▪ An MOU needs to be established to specify how the Quasi-Governmental entity will work with the agencies that will provide support related to policies, procedures, data interfaces and the use of any existing eligibility determination system components this Exchange may want to leverage.	▪ An MoU needs to be established to specify how the NFP will work with the agencies that will provide support related to policies, procedures, data interfaces, and the use of any existing eligibility determination system components this Exchange may want to leverage.	▪ The ability of the Exchange to leverage existing eligibility determination systems and the means to send out notices is least complex in this model, as this will be an agency to agency interaction. ▪ The Exchange agency and the other agencies involved will need to establish an agreement concerning how they will work together to support exchange functions, including identification of a “lead” agency.	▪ An MoU needs to be established to specify how the multi-state entity will work with the agencies that will provide support related to policies, procedures, data interfaces and the use of any existing eligibility determination system components that a multi-state Exchange may want to leverage.

Seamless eligibility and Enrollment process with Medicaid and other State health subsidy programs

Please refer to both *Eligibility* and *Enrollment* sections of **Operations**.

Enrollment process

Regulatory Guidance

Section 1311 of the Act describes the requirements for the enrollment periods the Exchange will need to provide, including an initial open enrollment period, an annual open enrollment period, special enrollment periods specified in section 9801 of the Internal Revenue Code of 1986, and other special enrollment periods under circumstances similar to such periods under part D of title XVIII of the Social Security Act, and special monthly enrollment periods for Indians.

Section 1943 of the Act describes the requirements for enrollment simplification and coordination between the Exchange and the Medicaid/CHIP programs specifying the State will establish procedures for:

- Individuals to use an Internet website to apply for medical assistance under the State plan or under a waiver of the plan, to be enrolled in the State plan or waiver, to renew their enrollment in the plan or waiver, and to consent to enrollment or reenrollment in the State plan through electronic signature.
- If the Exchange determines the individual is eligible for Medicaid or CHIP, enrolling the individual through the website without any further determination.
- Screening individuals determined as ineligible for Medicaid or CHIP for eligibility for enrollment in qualified health plans offered through such an Exchange and, if applicable, premium assistance for the purchase of a qualified health plan. If eligible, the individual should be enrolled without having to submit an additional or separate application. Individuals are also to receive information regarding reduced cost-sharing for eligible individuals and any other assistance or subsidies available through the Exchange.

Section 1943 of the Act also describes enrollment website requirements including allowing an individual who is eligible for Medicaid and who is eligible to receive premium credit assistance for the purchase of a qualified health plan to compare the benefits, premiums, and cost-sharing applicable to the individual for these options. The Act also includes, in the case of a child, comparing the coverage that would be provided for the child through the State plan or waiver with the coverage that would be provided to the child through enrollment in family coverage under that plan and as supplemental coverage by the State under the State plan or waiver.

Section 3021 of the Act describes the standards and protocols for electronic enrollment in the state and federal programs, including:

"(1) Electronic matching against existing state and federal data, including vital records, employment history, enrollment systems, tax records, and other data determined appropriate by the Secretary to serve as evidence of eligibility and in lieu of paper-based documentation.

(2) Simplification and submission of electronic documentation, digitization of documents, and systems verification of eligibility.

(3) Reuse of stored eligibility information (including documentation) to assist with retention of eligible individuals.

(4) Capability for individuals to apply, recertify and manage their eligibility information online, including at home, at points of service, and other community-based locations.

(5) Ability to expand the enrollment system to integrate new programs, rules, and functionalities, to operate at increased volume, and to apply streamlined verification and eligibility processes to other state and federal programs, as appropriate.

(6) Notification of eligibility, recertification, and other needed communication regarding eligibility, which may include communication via e-mail and cellular phones.

(7) Other functionalities necessary to provide eligible's with streamlined enrollment process."

SHOP Specific

NPRM [CMS-9989-P], in §155.720, provides guidance for the enrollment of employees into QHPs under SHOPs. The information below does not cover all guidance in the section, but some highlights are described in this subsection.

The SHOP must process applications for enrollment from employees and facilitate that enrollment. The SHOP is to establish the process and uniform timeline for this enrollment, including:

- Employer eligibility determination to purchase coverage in the SHOP
- Qualified employer selection of QHPs offered to qualified employees
- Timeline for employers to select the level of coverage or QHP offering
- Employee eligibility determination for SHOP enrollment
- Enrollment processing
- Establishment of effective dates for coverage

The time frame for the above activities should be set relative to a plan year as opposed to a calendar year. Please note that the eligibility determination rules for the SHOP are described in the "*Eligibility Determinations for Exchange Participation, Advance Payment of Premium Tax Credits, Cost-sharing Reductions, and Medicaid and Applications and Notices*" Options Analysis section of this report.

The SHOP must maintain information that includes records of qualified employer participation and qualified employee enrollment in the SHOP and report this information to HHS. Reconciliation of enrollment information with QHPs must occur at least monthly, although it could be done on a more frequent basis.

NPRM [CMS-9974-P], in §157.205, provides requirements for qualified employers to share information with their employees including, at a minimum:

- The time frames for enrollment
- Instructions for accessing the SHOP Web site (including tools to compare QHPs)
- The SHOP toll-free hotline

The SHOP may want to provide qualified employers with a toolkit to help with these activities

QHP Specific

NPRM [CMS-9989-P], in §156.260, provides requirements for the QHP issuers to comply with the enrollment periods, including accepting and enrolling qualified individuals during the initial enrollment period and during the annual enrollment periods. QHP issuers must also accept and enroll qualified individuals during the special enrollment period that may be granted to an individual.

This section also includes the requirement that qualified individuals who select a QHP on or before December 22, 2013 would have coverage effective January 1, 2014. It also includes the requirement that qualified individuals who make a QHP selection between the twenty-third and last day of the month for any month between December of 2013 and February 2014 would have coverage effective the first day of the month immediately following the next month.

QHP issuers are also to provide enrollees with notice of their effective coverage date.

NPRM [CMS-9989-P], in §156.265, provides the requirements for QHP issuers to accept and enroll qualified individuals. The information below does not cover all requirements in the section, but some highlights are described in this subsection.

QHP issuers are to:

- Adhere to the Exchange's process, including standards for collecting and transmitting enrollment information
- Use the one single streamlined application developed by HHS
- Electronically send enrollment information to the Exchange, receive information from the Exchange, and acknowledge receipt of information
- Enroll individuals only after the Exchange had confirmed eligibility
- Follow the premium payment process specified by the Exchange
- Provide enrollees with an enrollment package and a summary of benefits and coverage document
- Reconcile enrollment files with the exchange at least monthly

NPRM [CMS-9974-P], in §155.305, requires the Exchange to determine if an applicant is eligible to enroll in a QHP and permitted to enroll in the QHP at the time the applicant seeks coverage.

NPRM [CMS-9974-P], in §155.310, clarifies that the applicant who is determined eligible to enroll in a QHP may select a QHP and be able to receive services.

NPRM [CMS-9974-P], in §155.335, notes that the enrollee, if eligible for coverage at the point of annual redetermination, will remain in the QHP selected the prior year unless the enrollee has taken action to select another QHP or terminate coverage.

Key Considerations

Emerging Practices

A scan of Level One Establishment Grant Applications from other states provided information for this subsection as well as a review of the Wisconsin Health Insurance Exchange prototype.

Enrollment Requirements

Some states have been working to develop requirements for completing their eligibility determination and enrollment processes. For example, Missouri has completed a requirements report titled the "*Show-Me Health Insurance Exchange: Individual Eligibility and Enrollment Requirements and Recommendations.*" As noted in their Level One Establishment Grant Application, "Missouri envisions an individual subsidy eligibility and health plan enrollment process in the Show-Me HIE that is paperless, transparent, real-time, and seamless for all consumers, regardless of the subsidy for which they are eligible." Another example is the work Maryland has been doing to begin developing requirements for providing customized plan information to applicants based on the applicant's eligibility and other information. Maryland is also working to develop the requirements for the rest of the enrollment process.

Enrollment Technology

Some states, like California and Missouri, are participating in the Enrollment User Experience (UX) 2014 project that is working to provide a vision, core design, and interactive design elements to create a first-class user experience. The goal here is to create an experience that will encourage enrollment in the Exchange.

Mississippi plans on including functionality in the Mississippi Exchange for health plan comparison based on consumer selected preferences. This functionality will allow a consumer to model different health plan coverage and costs based on their medical reality (average office visits, type of medication, chronic conditions, etc.)

Maryland expects the technology platform they are designing will meet their needs for facilitating enrollment in QHPs. The platform they will select will be able to support HIPAA/NIEM transformation of data for enrollment.

Wisconsin plans on building on their foundation of applications, including ACCESS (a Web-based, self-services portal) and CARES (a Web-based integrated eligibility determination system), to create Wisconsin's Exchange. Wisconsin also created an initial prototype of a Health Insurance Exchange that includes interactive tools to view information about health plans including premium costs, covered services, and provider networks. Wisconsin plans to expand this prototype to include functionality for small employers, brokers, navigators, and others. This prototype is being used to educate the public about what an exchange may look like and collect feedback from those who visit the site. This site can be found at this address: https://exchange.wisconsin.gov/.

Leveraging Current Capabilities

The Commonwealth has in place well-defined and documented procedures for eligibility determinations/ enrollment for the present CHIP and Medicaid programs. One option for development of an Exchange for Pennsylvania is to build on the current technology in place that supports these programs. This option is noted in the *Technology* section of this report.

Moving Forward

The Commonwealth needs to decide whether an Exchange will be implemented or not before significant progress can be made toward FOA Milestones related to developing system and program operations requirements for providing customized plan information to individuals based on their eligibility and other information, completing the enrollment process and sharing data with HHS. Some key decisions that will need to be made if the Commonwealth chooses to implement an Exchange are included in this subsection.

- Which organization will be responsible to oversee the development of shopping experience needed to help the applicant decide on a plan? Will it be the Exchange (in whatever form the Exchange takes), PID,

DPW, or a private entity to which enrollment is outsourced through a procurement or public/private partnership?

- Regarding payment collections for a QHP, once an applicant selects a plan will the Exchange:
  - Complete the process to enroll them, including collecting the payment, and transmitting that data to the Insurer, or
  - Link the applicant to the Insurer website (transferring the enrollment information collected so far) where the applicant will complete the enrollment process, including paying the insurer.
- How will the Exchange provide for the following, related to electronic enrollment?
  - Electronic matching against existing state and federal data
  - Digitization of documents
  - Reuse of stored eligibility information
  - The ability to apply, recertify, and manage eligibility information online at various locations
  - The ability to expand the enrollment system to integrate new programs, rules, functions and handle increased volume
  - Sending communications, including notifications (may include e-mail and cell phone)
  - Other functions needed to streamline the process
  - Comparison of benefits, premiums and cost-sharing for the individual under QHPs to those under a public program (Medicaid or CHIP)
  - Transmission of eligibility and enrollment information to HHS to begin, end, or adjust advance payments of the premium tax credit and cost-sharing reductions
- Will the Exchange permit a potential applicant to consider QHPs by browsing without registering?

As noted in the stakeholder feedback section below, it appears stakeholders have high expectations for the Exchange to provide a shopping experience that is easy to use and provides a clear comparison of options to help make the decision process quick and easy. This input, and additional input gathered from stakeholders, can be used to help frame the requirements for the user experience for the enrollment function. The Commonwealth may want to consider leveraging the design component outputs of the Enrollment User Experience (UX) 2014 project that is described in the Emerging Practices section above.

Once a decision has been made to implement an Exchange, a work group under the Exchange Steering Committee, if one is convened, (described in the Governance and Program Integration options analyses) could be established for the following work stream:

- **Enrollment** – This work group could be established to focus on the shopping experience to help compare benefits, premiums, and cost-sharing for the individual under QHPs to those under a public program (Medicaid or CHIP) and complete the enrollment process. Initial activities include developing the operational and system requirements for this area. This work group will need to include representation of personnel with Medicaid, CHIP, other health insurance background, and technology skills to work to address the questions listed above. As noted in the stakeholder feedback below, some participants in the Stakeholder Listening Sessions indicated a desire to provide input into the future enrollment process. See the section below for more details. If a make vs. buy analysis indicates that commercially available software could be used for the shopping experience, this work group could be used to perform package selection.

This work group would need to consider the policy implications of the changes and actions suggested and work closely with a policy work group that coordinates consideration of policy decisions.

Timing Considerations

If the Commonwealth establishes an Enrollment work group (described in the Moving Forward section of this analysis), activities of this work group would need to be included in the plan to confirm how they contribute to the milestones above.

Stakeholder Involvement/Impact

Input/Feedback

Stakeholder Listening Sessions

Feedback in verbal and written testimony concerning the enrollment process from the Listening Sessions conducted by PID in August included that the enrollment process should be streamlined and easy to use. As mentioned in the feedback related to eligibility, many stakeholders noted the need to support enrollment online as well as through other avenues such as a paper application and assistance from a call center. This feedback also pointed out the need for the process to support multiple languages and literacy levels.

Health Insurance Exchange Research Survey

The results of the Health Insurance Exchange Research Survey conducted for PID by the Nieman Group provided the following feedback from small businesses related to the Exchange and enrollment:

In order for an exchange to be successful for small businesses, it must:

- Answer questions about available options
- Provide apples-to-apples comparison
- Help small businesses provide reasonably priced care

After being exposed to three different health insurance exchanges, businesses preferred the privately sponsored site because of its simplicity.

- When interacting with the sites, businesses were anxious to get started and compare information – clicking on “Start Now” and “Side-by-Side Comparison”
- They are less likely to engage with information about the exchange or healthcare reform

The survey also solicited feedback from consumers related to the Exchange and enrollment.

The top four objectives in the minds of consumers are:

1. Providing a complete list of options
2. Increasing competition
3. Serving as a negotiator of price
4. Providing cost and quality data for plans

In order for an exchange to be a success, it must:

- Answer questions about options

- Provide apples-to-apples comparison
- Provide contact information for insurance companies
- Allow seamless enrollment in plans

For businesses, consumers prefer a privately sponsored site; they feel it is the easiest to use and will get them started immediately.

Future Plan and Communication

As noted above, stakeholder interest was expressed in helping streamline the application and enrollment processes. The work group tasked with working on the enrollment processes could benefit from additional stakeholder input concerning details of these processes. Stakeholder input would be especially helpful in confirming usability of the process and systems related to enrollment.

As the processes and functionality for enrollment are finalized, mechanisms to communicate to the stakeholders a vision of how the enrollment function will work, including enrollment period deadlines, would help facilitate implementation of the Exchange.

Small Business Health Option Program (SHOP) Considerations

Impact and/or specific questions related to focus area

As noted in the Regulatory Guidance section above, NPRM [CMS-9989-P], in § 155.720, provides guidance for the enrollment of employees into QHPs under SHOPs. The Exchange needs to establish timelines, standardized for a plan year rather than a calendar year, for the following related to SHOP Enrollment:

- Determination of employer eligibility to purchase coverage in the SHOP
- Qualified employer selection of QHPs offered through the SHOP to qualified employees
- Provision of a specific time frame during which qualified employers may select the level of coverage or QHP offering
- Provision of a specific time frame for qualified employees to complete the employee application process
- Determination and verification of employee eligibility for enrollment through the SHOP
- Enrollment processing of qualified employees into selected QHPs
- Establishment of effective dates of qualified employee coverage

The Exchange (SHOP) will also need to define the processes and technology for reconciling enrollment records with QHPs on at least a monthly basis.

If the Commonwealth implements a SHOP, will the Commonwealth provide a toolkit to qualified employers explaining the key pieces of information to disseminate to its employees?

Option-Specific Considerations

Quasi-Government	Not For Profit	Existing Agency	Multi-State
▪ An MoU needs to be established to specify how the Quasi-Governmental entity will work with the agencies that will provide support for related to policies, procedures, data interfaces and any existing Commonwealth components (system frameworks and data sources) this Exchange may want to leverage. ▪ If the Exchange determines it is best to outsource portions of the enrollment function, this Exchange may have more flexibility to complete procurement in a shorter time frame than an existing agency.	▪ An MoU needs to be established to specify how the Not for Profit entity will work with the agencies that will provide support for related to policies, procedures, data interfaces and any existing Commonwealth components (system frameworks and data sources) this Exchange may want to leverage. ▪ If the Exchange determines it is best to outsource portions of the enrollment function, this Exchange may have the most flexibility to complete procurement in a shorter time frame.	▪ The ability of the Exchange to leverage existing system frameworks to develop the enrollment functions is the least complex in this model as this will be an agency to agency interaction. ▪ The Exchange agency and the other agencies involved will need to establish an agreement concerning how they will work together to support enrollment functions, including identification of a “lead” agency. ▪ If the Exchange determines it is best to outsource portions of the enrollment function, existing procurement policies may mean this option would require a longer time period to complete the procurement process.	▪ An MoU needs to be established to specify how the multi-state entity will work with the agencies that will provide support for related to policies, procedures, data interfaces and any existing Commonwealth components (system frameworks and data sources) that a multi-state Exchange may want to leverage. ▪ If the Exchange determines it is best to outsource portions of the enrollment function, this Exchange may have more flexibility to complete procurement in a shorter time frame than an existing agency.

Applications and notices

Please refer to the *Eligibility* section of **Operations**.

Individual Responsibility Determinations

Regulatory Guidance

Individual Responsibility

Section 1501 of the Act describes the need to maintain minimum essential coverage and amends Subtitle D of the Internal Revenue Code of 1986. This amendment requires applicable individuals to ensure the individual, and any dependents of the individual, are covered under minimal essential coverage for each month beginning after 2013. This is commonly referred to as the "individual mandate."

Individual Responsibility Exemptions

Section 1411 of the Act establishes procedures for determining eligibility for individual responsibility exemptions. The individual responsibility requirement and the associated penalty are defined in Section 5000A of the Internal Revenue Code of 1986. An individual responsibility exemption applies to both the requirement and the penalty.

The information required to be provided by applicants seeking an exemption may vary depending upon the reason for requested exemption, and the status of the applicant:

- When an individual seeks an exemption based on the individual's status as a member of an exempt religious sect or division, as a member of a healthcare sharing ministry, as an Indian, or as an individual eligible for a hardship exemption, the information required will be prescribed by the Secretary.
- When an individual seeks an exemption based on the lack of affordable coverage or the individual's status as a taxpayer with household income less than 100 percent of the poverty line, the information required is the information provided to support determining eligibility for tax credits or reduced-cost sharing and/or information concerning employer-sponsored coverage, as applicable.

When the information provided by the applicant is verified as specified in Section 1411(c)(d), the applicant will be issued a certification of exemption.

Exemptions from Requirement to Maintain Minimum Essential Coverage

Section 1501 of the Act amends Subtitle D of the Internal Revenue Code of 1986, providing a religious exemption from the requirement to maintain minimum essential coverage. Individuals eligible for a religious conscience exemption include members of a recognized religious sect or division where the individual is an adherent of established tenets or teachings of the sect or division. Individuals also may be eligible for a religious exemption as a result of being a member of a healthcare sharing ministry which is exempt from taxation and whose members share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs and without regard to the State in which a member resides or is employed. The healthcare sharing ministry must also:

- Have members that retain membership even after they develop a medical condition.
- Have been in existence since December 31, 1999 and continuously shared the medical expenses of it members since that date.

- Have conducted an annual audit which is performed by an independent certified public accountant and be willing to make the audit available to the public on request.

Proposed Rule [CMS-9989]

The NPRM [CMS-9899-P] notes that future rulemakings will address the specific standards and criteria that apply to certifications of exemption consistent with §1311(d)(4)(H) and §1411 of the ACA.

Key Considerations

Emerging Practices

A review of other states grant applications shows that some states are beginning to address Exemptions in their program development assessment and operations.

Maryland enacted the Maryland Health Benefit Exchange act in April 2011, establishing the Exchange as a quasi-governmental entity that is a public corporation and independent unit of state government. They have begun developing requirements for systems and program operations including accepting requests for exemptions, reviewing and adjudicating requests, and exchanging relevant information with HHS. Functional requirements include account/case management, verification of customer information, eligibility determination and reporting. Maryland expects their Technology Platform to automate their process to receive and adjudicate request from individuals for exemptions from the individual responsibility requirements of the Act, and to communicate information on such requests to HHS for transmission to the IRS.

Missouri, which has not yet passed legislation establishing a Health Benefit Exchange, but has introduced legislation, is implementing a demonstration project which provides for an Exchange Portal that will manage individual responsibility exemption applications. Individual responsibility determinations will be performed in cooperation with federal sources and automated to the extent possible. Notification of determination will be an Exchange function as well as management and adjudication of appeals. Missouri will continue to define the detailed business requirements as further CMS guidance and system design occurs. The Exchange will use validated data and responses from federal and non-federal sources to determine and communicate eligibility to individuals. It will include procedures for resolution to data discrepancies, be automated to the extent feasible, and perform the appropriate notifications of exemptions to federal agencies and applicants. The exchange will accept, manage and communicate adjudication of appeals of individual responsibility exemption determinations. The detailed business and functional requirements for these processes will be designed and developed in conjunction with CMS guidance and will be further informed by Missouri's participation in the Enrollment UX 2014 national project.

Leveraging Current Capabilities

The Commonwealth has well-established processes and technology in place to receive online applications for Medicaid and CHIP and process them. If the Commonwealth chooses to leverage this technology for the Exchange, functionality for the intake and processing of individual responsibility exemption applications could be included with the other enhancements needed to extend those systems to cover Exchange requirements.

Moving Forward

If the Commonwealth decides to pursue an Exchange, certain considerations regarding Exemptions from Individual Responsibility Requirement and Payment will need to be considered. These considerations include:

- What data sources does the Commonwealth have to validate data and responses in regard to the eligibility of individuals for exemptions?

- How will the Exchange provide notifications of exemptions to federal agencies and applicants?
- How will the Exchange manage and communicate adjudication of appeals of individual responsibility exemption determinations?

In the *Options Analysis for Eligibility Determinations for Exchange Participation, Advance Payment of Premium Tax Credits, Cost-sharing Reductions and Medicaid, and Applications and Notices*, we described the formation of work groups to focus on specific areas to develop processes and requirements for the Exchange. The requirements for individual responsibility determinations could be covered by the suggested work groups as follows:

- **Applications** – This work group could include defining the requirements of the application for an individual responsibility exemption within their efforts.
- **Notices** – This work group could include defining the requirements of associated notices for an individual responsibility exemption within their effort.
- **Eligibility Determination Rules** – This work group could include defining the rules required for the "rules engine" for determining eligibility for exemptions.

Each of these work groups would need to consider the policy implications of the changes and actions suggested and work closely with a policy work group that coordinates consideration of policy decisions.

Timing Considerations

Activities of the work groups described in the *Moving Forward* section need to be considered as the work plan is developed to explain how they contribute to the milestones above.

Stakeholder Involvement/Impact

Input/Feedback

The Stakeholder Listening Sessions generated no specific comments on Exemptions from Individual Responsibility Requirement and Payment.

Future Plan and Communication

This topic could be covered in any forums used to obtain input from stakeholders concerning eligibility determination processes.

Small Business Health Option Program (SHOP) Considerations

Impact and/or specific questions related to focus area

HHS has clarified that SHOPS do not have to certify exemptions from the individual coverage requirement, as the Exchange will fulfill this requirement.

Option-Specific Considerations

Quasi-Government	Not For Profit	Existing Agency	Multi-State
Concerning the possible outsourcing of Exchange functions, Commonwealth agencies should consider maintaining accountability for establishing the rules under which the Exchange will operate. Whichever model is chosen for implementation of the Exchange, the responsibility to establish the rules for the individual responsibility exemptions process and the process to appeal individual responsibility determinations needs to be housed within a Commonwealth agency. The individual responsibility determination and appeals processes may be monitored/managed by a private entity, but may involve public entity groups.			

Administration of premium tax credits and cost-sharing reductions

Regulatory Guidance

Section 1401 of the Act details premium assistance for coverage under a qualified health plan. Premium assistance is provided to families with household incomes between the federal poverty level tiers:

‘‘In the case of household income (expressed as a percent of poverty line) within the following income tier:	The initial premium percentage is—	The final premium percentage is—
Up to 133%	2.00%	2.00%
133% up to 150%	3.00%	4.00%
150% up to 200%	4.00%	6.30%
200% up to 250%	6.30%	8.05%
250% up to 300%	8.05%	9.50%
300% up to 400%	9.50%	9.50%

Section 1402 of the Act describes the reduced cost-sharing for eligible individuals enrolling in qualified health plans. Eligible insureds are those who enrolled in a qualified health plan in the silver level of coverage in the individual market offered through the Exchange, whose household income exceeds 100 percent but does not exceed 400 percent of the poverty line for a family of the size involved. According to the Act, “a plan in the silver level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan, while gold level plan provides benefits “that are actuarially equivalent to 80 percent of the full actuarial value of the benefits provided under the plan.” The out-of-pocket limitations are shown below:

‘‘In the case of household income (expressed as a percent of poverty line) within the following income tier:	Reduction of Out of Pocket Limit
100% to 200%	66%
200% up to 300%	50%
300% up to 400%	33%

Additional cost benefit reductions are described within the Act and exemptions are defined.

Section 1412 of the Act describes advanced determination and payment of premium tax credits and cost-sharing reductions. Under the Act, employers are required to provide minimum essential coverage. If coverage is not provided, or is considered unaffordable to the employee, the employee is deemed eligible for premium tax credits. Additionally, section 1412 describes eligibility for advanced payments of premium taxes. Health insurance issuers are responsible to reduce the premium charged to the insured for any period by the amount of the advance payment for the period, notify the Exchange and the Secretary of such reduction, and include with each billing statement the amount by which the premium for the plan has been reduced by reason of the advance payment. If non-payment occurs, issuers are required to notify the Secretary of such nonpayment and allow insureds a three-month grace period for nonpayment of premiums before discontinuing coverage.

As noted in §155.340 of the NPRM [CMS-9974-P], the Exchange must simultaneously provide eligible applicants advance payments of premium tax credits and / or cost sharing reductions:

1. Notify the issuer of the applicable QHP
2. Transmit eligibility and enrollment information to HHS, and
3. Transmit information necessary to enable the issuer of the QHP to implement, discontinue the implementation, or modify the level of an individuals' advanced payment

The NPRM requires the Exchange to provide the individual's name and taxpayer identification number to HHS for individuals who are eligible for advance premium payments because the individual's employer does not provide minimum essential coverage, provides minimum essential coverage which is unaffordable or does not meet the minimum value requirement. If the individual changes employers, the Exchange must transmit the enrollees name and social security number to HHS. Finally, if the individual disenrolls from the qualified health plan during a benefit year, the individual's name, social security number and date of coverage termination must be sent to HHS. Additionally, the individual's name and effective date of coverage must be sent to the employer. These metrics will help to minimize unfounded losses for the Exchange.

For more information regarding premium tax credit and cost sharing reductions and SHOP functions, please see the *Options Analyses – Providing Assistance to Small Businesses and Individuals*; §155.700 of the NPRM [CMS-9989-P].

Key Considerations

Emerging Practices

A scan of the Level 1 Grant Applications demonstrates that states are reviewing legislation and considering the administration of premium tax credits and cost-sharing reductions. California has gone as far as to develop an estimate of the number of individuals to be affected by the cost subsidies and number of individuals anticipated to be ineligible. These numbers will help the State understand potential cost pressure points for insureds and predict potential Exchange revenues.

Maryland has begun developing requirements for the premium tax systems and program operations. The State expects the Exchange will be able to notify HHS when an individual reports a change in income level which will trigger a redetermination of eligibility for advance payment of premium.

Missouri has reviewed the ACA requirements and has developed their desired components for the premium tax credit and cost-sharing reduction. Missouri plans to continue this work pending the release of federal guidance on tax credits and subsidies. The State plans to refine processes and systems specifications for providing relevant information to QHPs and HHS to start stop or change subsidy levels.

Similarly, New York is awaiting federal guidance; it plans to study the procedures under which licensed health insurance producers and other organizations may enroll individuals and employers in any qualified health plan in the individual or small group market as soon as the plan is offered by the Exchange. New York plans to provide assistance to individuals applying for premium tax credits and cost-sharing reductions through the Exchange.

Leveraging Current Capabilities

Pending guidance from HHS is anticipated on the topic of premium tax and cost sharing reduction. With this additional guidance, successful subsidy implementation will be heavily dependent upon the eligibility determination system used to support the Exchange. After eligibility is calculated and income information is collected, premium tax and cost-sharing reductions should feed into the Exchange Calculator. Please review the *Eligibility* and *Exchange IT Options Analysis* documents *'Leveraging Current Capabilities'* sections for more information.

Moving Forward

Many of the key decisions to be made about premium tax credits and cost sharing reductions are dependent upon pending guidance from HHS. For many states, the Exchange will serve as the first point of contact for individuals to report a change in income level, which will initiate redetermination of eligibility and transmission of information to HHS. Prior to the release of information by HHS, the Exchange should consider focusing its attention on the eligibility and IT systems needed to support the Exchange.

Timing Considerations

No specific timing constraints have been identified.

Stakeholder Involvement/Impact

Input/Feedback

The stakeholder sessions generated no specific comments on the administration of premium tax credits and cost-sharing reductions.

Future Plan and Communication

Communication with stakeholders on the topic of premium tax credits and cost sharing reduction may be best served after Exchange governance and IT systems are decided by the Commonwealth. By this point, further governance from HHS should be available and more detailed discussions may arise.

Small Business Health Option Programs (SHOP) Considerations

Impact and/or specific questions related to focus area

Individuals eligible for affordable employer sponsored coverage are not eligible for advanced payments of premium tax credit. Therefore, SHOPs are encouraged to calculate and display the net employee contribution to the premium for different plans and different family compositions, after subtracting employee contributions from the full premium employment. Conveying the net premium reflects current market practices and SHOPs are encouraged to continue this practice.

Option-Specific Considerations Option-Specific Considerations

Quasi-Government	Not For Profit	Existing Agency	Multi-State

- Premium tax credit and cost -sharing reduction is highly dependent upon the eligibility and IT Systems of the Exchange. Independent of the systems or governance structure chosen for the Exchange, premium tax credit and cost-sharing reduction implementation will not differ greatly. Pending regulations from HHS may require the premium tax credit and cost-sharing reductions to be reanalyzed by Exchange structure.

Adjudication, Notification and Appeals

Regulatory Guidance

Adjudication of Appeals of Eligibility Determinations

Section 1411 of the Act requires the Exchange to include information explaining the appeals process in notices regarding eligibility determinations. This section also establishes that a process is to be in place to hear and make decisions with respect to appeals of determinations.

The NPRM [CMS-9989-P] indicates that the requirements of the appeals process for individuals and the SHOP will be addressed in future rulemaking.

The NPRM [CMS-9974-P] indicates that a written notice of eligibility needs to include information regarding the applicant's right to appeal. In § 155.355, the requirement is established that an individual may appeal any eligibility determination or redetermination, including determinations of eligibility for enrollment in a QHP, advance payments of the premium tax credit, and cost-sharing reductions. The NPRM indicates the details of the appeals process will be included in future rulemaking.

Notification and Appeals of Employer Liability for the Employer Responsibility Payment

Section 1411 of the Act indicates that a separate appeals process will be established for employers who are notified that they may be liable for a tax imposed when an eligibility determination for an employee identifies that the employer does not provide minimum essential coverage through their employer-sponsored plan or that the coverage they provide is not affordable. This appeals process will allow the employer to provide the Exchange information for consideration in a redetermination process.

The NPRM [CMS-9974-P], in § 155.355, requires the Exchange to notify applicants and employers of appeals processes when the Exchange notifies the applicant or employer of an eligibility determination. This NPRM also indicates that future rulemaking will provide the standards for the process for an employer to appeal a determination that the employer did not offer qualifying coverage to the employee (resulting in the employee being able to obtain advance payments of the premium tax credit or cost-sharing reductions).

Key Considerations

Emerging Practices

As noted above, the standards for the appeals processes will be included in future rulemaking. A scan of Level One Establishment Grant Applications from other states indicate these states are reviewing existing appeals process and waiting for further federal guidance before they can finalize the processes. For example, Missouri plans to evaluate the future federal guidance and confirm whether Medicaid/CHIP eligibility appeals will be referred to MO HealthNet (the State's Medicaid agency) or be adjudicated by Show-Me HIE (the State's Exchange).

Research also revealed that these states are structuring their future work plans to include activities to establish appeals processes related to individual determinations and employer liability for the employer responsibility payment. They plan to use Establishment Grant funding to develop the processes, systems and other infrastructure to manage the appeals processes. For example, Washington has built the State's work plan assuming federal guidance for the appeals process will be provided in November 2011. Some states,

including Maryland and Washington, are doing additional studies that will shape their approach to business operations, including appeals functionality.

Some states anticipate the appeals process can be supported by the Exchange technology they are already designing, with the Exchange portal being able to support intake and management of eligibility determination and employer liability appeals. For example, Maryland expects its Technology Platform will be able to provide functionality for appeals related to individual eligibility determinations and minimum functionality to notify employers when an eligibility determination identified that the employer does not provide minimum essential coverage through their employer-sponsored plan or that the coverage they provide is not affordable.

Leveraging Current Capabilities

The Commonwealth has well-defined and documented procedures in place for appeals of eligibility determinations for the present CHIP and Medicaid programs. These processes, while similar in concept at a high level, are executed via different means. Each is described below:

Current CHIP Appeals Process

Eligibility determinations for CHIP are currently performed by the nine insurance companies in the program. When an insurance company in the program issues a notice of ineligibility, termination, or change in coverage, the parent or guardian of the applicant may request a review within 30 days of the date of the notice by sending the request directly to the insurance company. The best approach, at this time, is if the parent or guardian of the applicant calls the insurance contractor upon getting the notice to discuss it. About 60% of the potential appeals are resolved through this discussion without going into the formal appeals process. If the parent or guardian has filed a request for review, the insurance contractor has two working days to conduct a management review. The contractor then informs PID's Review Officer of the result of the review. If the review results in a determination that the eligibility decision was not appropriate, then the contractor informs the parent or guardian and enrolls the child retroactively to the date they should have been enrolled (or in the case of a termination, re-enrolls retroactively to date of termination). If the review results in a determination that the eligibility decision was appropriate, then PID's Review Officer conducts an interview with the applicant and the contractor's representative and may ask either or both parties for additional documentation. PID's Review Officer then issues a written decision within a reasonable time and sends it to both parties. The contractor then implements the decision upon receipt of that decision. The parent or guardian of the applicant may request reconsideration of the decision, with the Insurance Commissioner, via a written request that must be filed within 15 calendar days from the date of the decision. The Request for Reconsideration will stay the action proposed in the decision. The Commissioner may affirm, amend, or reverse the decision, issuing a reconsideration decision that is sent to the applicant and the contractor. The majority of cases result in the decision being affirmed. The parent or guardian of the applicant may appeal the decision of the Commissioner to Commonwealth Court within 30 days of the reconsideration decision.

An informal appeal process also exists through use of the complaint resolution process. In some cases, applicants file complaints (not appeals) and the issue is dealt with as a consumer issue.

Current Medicaid Appeals Process

An explanation of the right to appeal appears on client notices. Each applicant and recipient has the right to ask for a hearing to appeal a decision or failure to act which affects his benefits. The County Assistance Office (CAO), DPW, or the provider is responsible for helping the client with a hearing request. The client must appeal within 30 days from the date of the written notice of a CAO decision or action. The client may also appeal:

- Within 60 days from the date of the CAO decision or action when the CAO did not send a written notice because the notice was not required.
- Within 60 days from the CAO's failure to act on a request or an application.
- For a period of six months from the date of an action or failure to act if the CAO or agency: failed to send a notice, failed to inform client of the right to appeal, was in error, caused ongoing delay, or failed to take corrective action.
- After six months from the date of an action or failure to act by submitting, with the appeal, an affidavit stating the person in question did not know of the right to appeal, believed the CAO was resolving the problem, believed the CAO erred in its actions, and is making the appeal in good faith.

The CAO forwards the appeal to the Bureau of Hearings and Appeals (BHA) where the BHA designates an Administrative Law Judge (ALJ), who has authority to make a decision on the appeal. The Director of BHA will affirm, amend, reverse, or remand the decision. The CAO, administering agency, or provider agency is bound by the decision, but may request reconsideration by the Secretary of DPW. The CAO/agency will offer the client and his representative the opportunity to have a prehearing conference that may be held by telephone or face to face. This conference is an effort to resolve an issue before going to hearing. If the complaint is resolved, the client should sign a request for withdrawal. If the complaint is not resolved, it will proceed to a hearing. The CAO, client, or provider has the right to request reconsideration by the Secretary of DPW. The request must be in writing and made within 15 calendar days of the BHA's Final Administrative Action Order.

When the CAO makes a request for reconsideration, the CAO will implement the action proposed in the BHA's Order until the Secretary issues a final decision. DPW will review the case within 30 calendar days of the postmark of the reconsideration request. DPW may affirm, amend, or reverse the decision of the Director or remand the case to the ALJ for further findings. When the Client makes a request for reconsideration, the CAO will not implement the action proposed in the BHA's decision (if appeal was filed timely). If the client is dissatisfied with DPW's final decision, an appeal can be made to Commonwealth Court within 30 days of the final decision.

As noted in the Moving Forward section below, these processes or portions of these processes could be leveraged to help establish the appeals processes for the Exchange. Decisions will need to be made if separate processes will be used, combined with a process for the Exchange to track progress of these processes, or if a more consolidated process for appeals will be implemented.

Moving Forward

Future rulemaking will define the standards for the appeals processes, but some of the key decisions that will need to be made regarding the appeals processes include those listed below:

Which agency should be responsible to administer the appeals process of eligibility determinations? Should this be delegated to different agencies based on determination type or should it be centralized with assistance from agencies? Types include:

- Medical Assistance – Should DPW oversee this process?
- CHIP – This process, as noted below, involves the insurance contractors for the early portion of the appeals process. Should the contractors continue to manage this appeals process for CHIP?
- Enrollment in a QHP, advance payment of the premium tax credit and cost-sharing reductions, and employer liability – Should the new Exchange organization manage the appeals process for these types?

Alternatively, should the Exchange organization establish a central unit to manage and track all appeals processes?

Another challenge the Commonwealth must consider is that the current appeals process for eligibility determinations for CHIP is different than for Medical Assistance. The involved agencies report the current processes perform well and they have implemented changes over the years to improve the processes, including use of prehearing conferences that can be conducted over the telephone and improved content for notices to make it easier for the applicant to understand the process. These notices are being piloted in some counties. How much of the existing processes should be leveraged to establish the appeals processes needed? Should a more consistent process be implemented or is it acceptable to have multiple appeals processes associated with the Exchange?

Other states have recognized that once these processes are defined, there will be a need to develop training materials for call center workers, Navigators, producers, eligibility case workers, and others that are involved in eligibility determination processes. Notices sent to applicants will also need to include information to inform individuals and employers about these processes.

A review of future federal rulemaking will be required to finalize decisions on the appeals processes. Identification of the resources needed to support the future appeals processes cannot be determined until federal guidance about the standards for these processes is available.

In the event that the Commonwealth does not implement an Exchange, but relies on a Federal-facilitated Exchange, the Commonwealth will need to work with HHS to determine the processes, procedures and interfaces for how each of the appeals processes will be handled. As noted in the Regulatory Guidance subsection of this section, future rulemaking will define the requirements for these processes.

Timing Considerations

No specific timing constraints have been identified.

Stakeholder Involvement/Impact

Input/Feedback

Feedback in verbal and written testimony for the Stakeholder Listening Sessions included comments requesting that information provided by the Exchange, including the appeals process, be available in multiple languages and literacy levels.

Future Plan and Communication

If the current CHIP and Medicaid Appeals processes are kept basically intact, involvement of stakeholders may not be required to finalize how these processes will work with the Exchange. If major changes are made, stakeholder input would help detect potential issues with the new process before it is implemented. In this case, a session to review the suggested new process with representatives from the agencies involved, as well as CAOs and Community Partners that have assisted applicants with appeals, may be prudent.

New processes will need to be defined for the other eligibility determinations related to QHPs, advance payment of the premium tax credit and cost-sharing reductions, and employer liability. Use of working sessions with stakeholders as described above may be valuable in providing input to the process.

Small Business Health Option Program (SHOP) Considerations

Impact and/or specific questions related to focus area

As noted in the NPRM CMS-9989-P, the appeals standards related to eligibility determinations to participate in a SHOP will be addressed in future rulemaking. An applicant may wish to appeal various determinations including ineligibility determinations resulting from:

- The employee is not listed on the roster of employees that can be covered for the qualified employer.
- The SHOP had a reason to doubt the information provided by the employer or employee based on additional verification performed, such as a review of quarterly wage reports indicating the employer does not meet the definition of a small employer or discovery that the employer is trying to enroll more employees than permitted.

Option-Specific Considerations

Quasi-Government	Not For Profit	Existing Agency	Multi-State
■ Commonwealth agencies will likely need to maintain accountability for establishing the rules under which the Exchange will operate. Whichever model is chosen for implementation of the Exchange, the responsibility to establish the rules for the appeals process will likely need to be housed within a Commonwealth agency. The appeals process may be monitored/managed by a private entity, but may involve public entity groups (such as the Bureau of Hearings and Appeals).			

Information reporting to IRS and Enrollees

Regulatory Guidance

Section 6055 of the Act specifies the requirements of reporting for health insurance coverage. The information collected and reported will include name, address and taxable identification number (TIN). If the coverage provided was minimum essential coverage, then dates of coverage, whether the plan was a qualified health plan, and the amount of advance payments / cost reductions. Additionally, if the individual received coverage through their employer, the required information would include the name and address of employer, employer identification number, portion of the premium required to be paid by the employer and if the health insurance coverage is a qualified health plan in the small group market offered through an Exchange. For all individuals that file a tax return and are not enrolled in at least minimum coverage, each individual will receive information on services available through the Exchange by June 30 of each year beginning in 2013. The information requirements should support consistent, electronic communications between the Exchange and insurance companies in a seamless manner.

Section 9006 of the Act extends the information reporting requirements to corporations that are currently not exempt from tax under section 501(a) of the Internal Revenue Code of 1986.

As noted in §155.305 of the NPRM [CMS-9974-P], it is proposed that the Exchange collects advanced payments consistent with the information reporting on the primary taxpayer's income tax return at the end of the taxable year. Furthermore, the NPRM requires the application filer to provide the Social Security number (SSN) of the primary taxpayer. The primary taxpayer's SSN and filed tax return for the year will be utilized for the verification of household income and family size. However, tax data will only be verified for individuals whom the Exchange provides an SSN or an adoption taxpayer identification number (ATIN). The Exchange will use and disclose SSNs subject to the privacy and security safeguards in §155.260 and §155.270 of NPRM (CMS-9989-P). These safeguards will help the Exchange to verify consumer data and minimize unfounded expenses.

Key Considerations

Emerging Practices

A scan of the Level 1 Grant Applications shows several states that have begun drafting requirements for systems that adhere to the mandatory reporting requirements. California, Maryland and Missouri have all begun developing requirements for the information reporting process. Specific to California, the state plans to enable additional analytical reporting agencies through the data warehouse and support risk adjustment analysis for data received from health plans. Maryland expects that its technology platform will be able to support the IRS and enrollee reporting process each year regarding enrollee's coverage. Missouri has begun developing a means of capturing the required data and drafting specification for building the capacity to communicate the required information to both the IRS and the enrollee.

Leveraging Current Capabilities

Pending guidance from HHS is anticipated on the topic of information reporting to IRS and the enrollee. Insurance companies may currently have access to the name, address and the SSN; however, compliance with consumer privacy and security safeguards must be observed if the Exchange plans to request this information. With the additional regulatory guidance, the Exchange will have a list of required data fields that

need to be collected and reported. These data fields will set the foundation for initial system development and testing for information reporting and will help to prepare Exchanges for open enrollment in 2013.

Moving Forward

Many of the key decisions to be made about information reporting to the IRS and enrollees are dependent upon pending guidance from HHS. For many states, defining regulations and verifying the accuracy of data will be the primary objectives. Prior to the release of information, the Exchange should consider focusing its attention on the eligibility and IT systems needed to support the Exchange.

Timing Considerations

No specific timing constraints have been identified.

Stakeholder Involvement/Impact

Input/Feedback

The stakeholder sessions generated no specific comments regarding information reporting to the IRS and enrollees.

Future Plan and Communication

The Exchange should initiate conversations with insurers planning to participate within the Exchange. Insurance companies have maintained enrollee information databases for internal documentation of membership and are familiar with consumer privacy protection laws. Insurers' experience and resources may help to minimize duplication of information / efforts in order to satisfy mandatory requirements.

Small Business Health Options Program (SHOP) Considerations

Impact and/or specific questions related to focus area

SHOP considerations are not impacted by information on reporting to the IRS and enrollees.

Option-Specific Considerations

Quasi-Government	Not For Profit	Existing Agency	Multi-State
▪ Independent of the systems or governance structure chosen for the Exchange, the information on reporting to IRS and enrollees will not differ greatly by governance structure. Privacy concerns and compliance will need to be addressed since confidential data may need to be transmitted. If data is being transmitted outside of a governmental entity, additional considerations may be necessary. Pending regulations from HHS may require the reporting process to be reanalyzed by Exchange structure.			

Outreach and Education

Please refer to the stakeholder involvement subsection addressed in each focus area as well as the separate *Stakeholder Communication and Outreach Plan*.

Free Choice Vouchers

Please note that there is no longer a requirement for Free Choice Vouchers.

Risk Adjustment and Transitional Reinsurance

Please refer to *Financial Management* focus area.

SHOP Exchange-specific Functions

Please refer to each previous section of **Operations**.

Health Insurance Market Reforms

Commonwealth of Pennsylvania
Insurance Exchange Planning

Health Insurance Market Reforms

Regulatory Guidance

Sections 1311(a)(4)(A)(ii) and 1321 (c)(l)(B)(ii)(II) of the Act, provide that while states have flexibility regarding the scope and operations of Exchanges, the funding grants to establish these Exchanges will be contingent on progress implementing market-focused reforms (specifically the reforms discussed in subtitles A and C of Title I of the Act). FOA grant money as well as certification of the State's Exchange will depend on such progress being made. At this time there is only the vague guidance that progress must be made; HHS is expected to release additional guidance on how progress will be measured or is expected to be demonstrated. Enforcing ACA's consumer-focused protections is an additional requirement to receive certification.

Key Considerations

Progress implementing ACA provisions may include several different activities, including but not exclusively passing legislation and/or regulations, conducting stakeholder consultation sessions, and having a time table and implementation plan.

The provisions of subtitle A of the ACA regulate individual and group market-based reforms that address underwriting methodologies, such as removing consideration of existing medical conditions, prohibiting lifetime limits, implementing guarantee issue and guaranteed renewability provisions, among others, as well as promoting affordability of insurance. Subtitle C concerns improvements in quality of care.

It may be useful for the Commonwealth to consider the nature of federal legislation enacted or regulations promulgated that may have taken effect since March 2010 in light of the various market-based reforms currently being considered. Documenting, to the extent practicable, specific market-based requirements in legislation passed (including but not limited to rating system requirements, guaranteed policy issuance, restriction on factors that can be used for decision making) and undertaking a thorough comparison of existing State laws and regulations to determine where Pennsylvania already meets new/proposed federal requirements, and where changes will be wanted or needed should also be considered. It is important to note that of the date of pertinent legislation may pre-date the passage of ACA.

To the extent that State legislation may have stalled, or not yet passed, PID may want to identify existing obstacles to passage of any desired Exchange legislation, in order to assess the feasibility and timing of future Exchange legislation.

Timing Considerations

The timing for the market-based reforms in the ACA was immediate; many of the required implementation dates have already passed. The expectation implied by the FOA is that state legislative activity has already focused on the various provisions required, and that these provisions are being passed/acted upon. At this point, HHS may be expecting that the longer term components of implementing required reforms (the quality-based metrics) are the focus of current and future state actions.

If the Commonwealth proceeds with an application for additional federal funding, an update or scorecard summarizing the efforts currently underway and those planned by the Commonwealth to meet the various initiatives contemplated under the ACA should also be considered.

Stakeholder Involvement/Impact

The PID held three listening sessions to gauge stakeholder reaction and get a sense of the concerns and impacts consumers expect. The Stakeholder sessions held to date have resulted in feedback on various aspects of creating a Health Benefit Exchange and pending regulations. Stakeholders noted the importance of establishing a rating system, and of making health insurance overall more accessible and affordable for everyone. Incorporating additional stakeholder input into decision making could help to establish voter understanding and appreciation for the various market reforms that have been promulgated per ACA guidance and any that may be proposed by the Commonwealth. It may be important to illustrate how these concerns are driving or influencing Exchange design and consideration of the essential benefits package when applying for additional federal funding.

Shop

Health market reforms are concerned with a variety of issues that are at the insurer-conduct level (e.g., revised acceptable underwriting and rating methods and assumptions) and at the consumer-experience level (e.g., satisfaction, quality of care received, etc.). The small group Exchange, or SHOP, is not directly affected by these requirements.

Option-Specific Considerations

For each of the market conduct and market reforms covered under Subtitles A and C of Title 1 of the ACA, which impact underwriting, policy design, pricing, and quality-based considerations, there are three choices for the PID; omit, wait, or legislate/implement.

Requirements for state-based health markets, as well as the rules and requirements for the Exchange, are continuing to evolve as new regulations and decisions are handed down by HHS, sometimes based upon leading practices from innovator states. Therefore, the wait strategy may be best suited for the provisions which are either achievable operationally but difficult technically, or vice versa, implying the PID would be depending on other states to lead the development and trial implementation. New funding applications may be favorably reviewed even if a wait strategy is chosen, if the Commonwealth does in fact have intent to implement or legislate the reforms contemplated in the ACA. Legislating the implied reforms is the most direct and clear statement of support for the ACA, and is clearly in line with the intent of the FOA language.

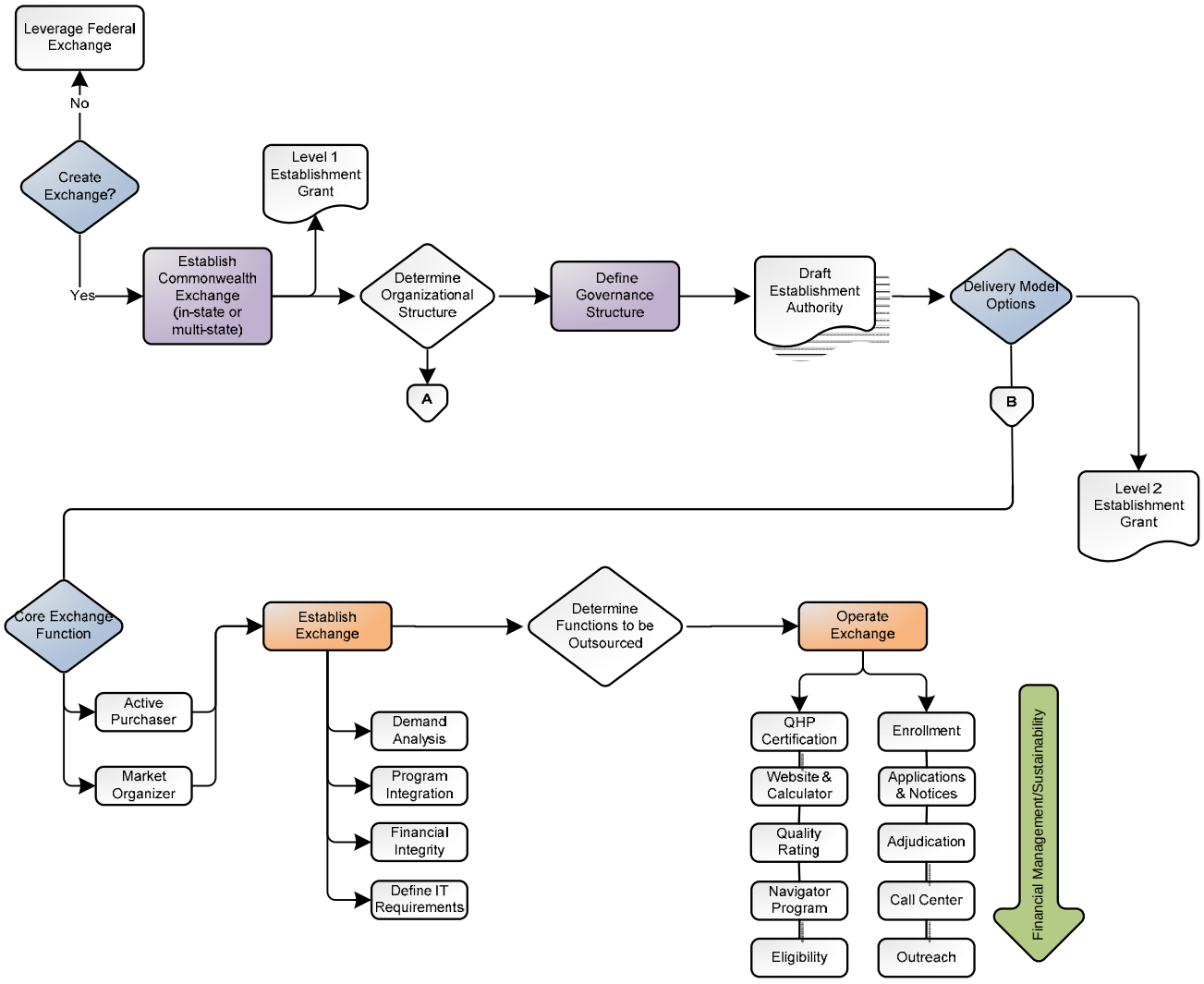
Decision Tree and Work Plan

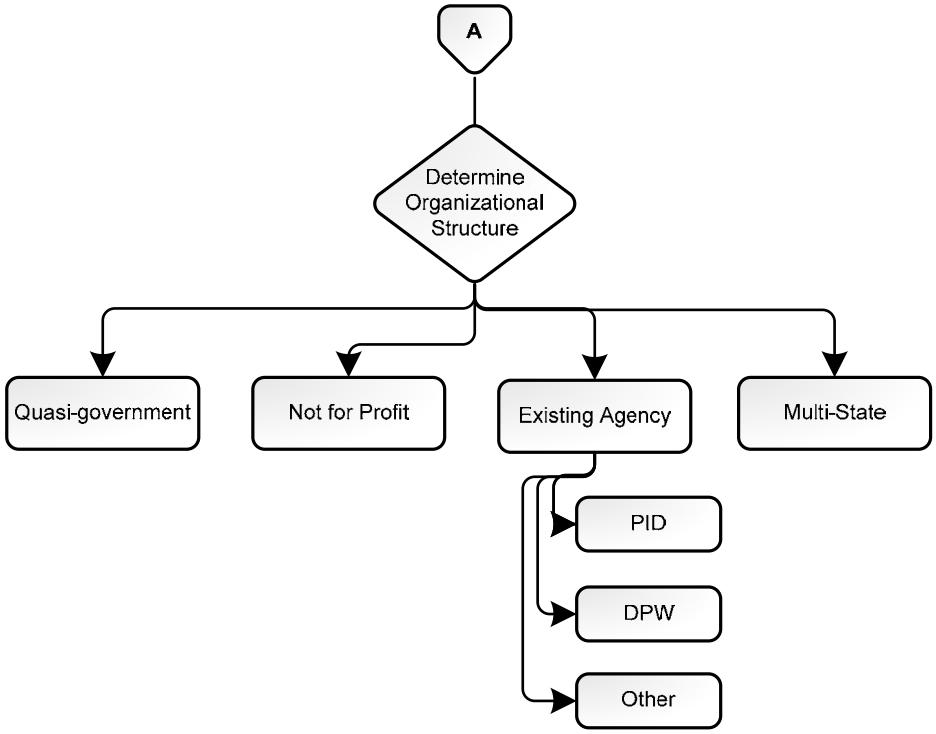
Commonwealth of Pennsylvania
Insurance Exchange Planning

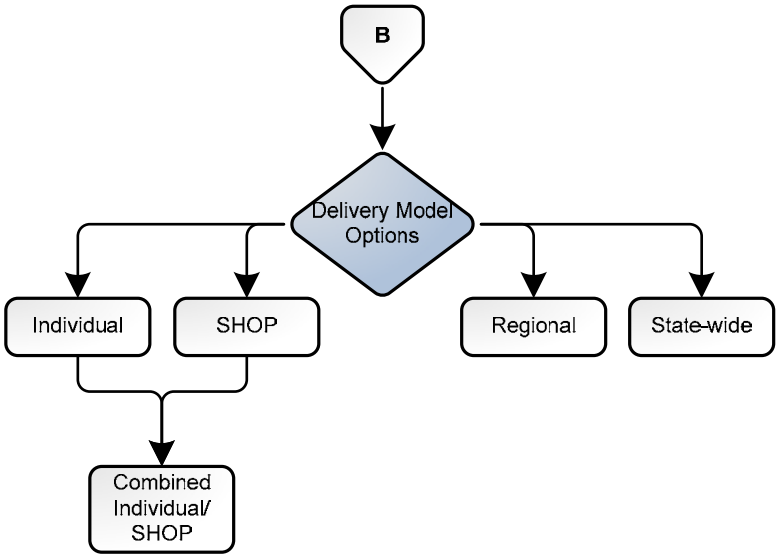
Decision Tree and Work Plan

The information presented on the following pages is for PID consideration and will likely need to be updated as time passes to reflect the decisions made and outdated information.

Decision Tree




A
Determine Organizational Structure
Quasi-government
Not for Profit
Existing Agency
Multi-State
PID
DPW
Other


B
Delivery Model Options
Individual
SHOP
Regional
State-wide
Combined Individual/ SHOP

Preliminary Work Plans by Focus Area

The tables in this section contain an initial broad framework and work plan to establish an Exchange that could be operational to receive applications on October 1, 2013. This work plan in its details and proposed timetables are for illustrative purposes only ─ anything more precise must be made after any decision by the Commonwealth to implement an Exchange. All subsequent decisions by the Commonwealth, including resources allocation, should be expected to impact this illustration and perhaps alter the framework and work plan significantly. In addition, it is important to note that pending guidance from the federal government may change timing of various areas, and changes in any one area will have impacts in other areas as the entire Exchange planning process is highly interdependent.

These work plans are a planning tool for the Commonwealth in an area that is still evolving. They will require regular revisiting and updating as decisions are made, regulations are finalized, and the impacts of decisions are realized.

The activities/milestones in italics are the ones specified in the “Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges” Funding Opportunity Announcement (FOA). Activities containing ** and in bold are mandatory milestones. Additional suggested activities are shown without italics. Activities include timing for review and approval of activities by Exchange leadership as specific steps were not added for this level of detail.

Stakeholder Consultation

Please refer to the *Stakeholder Plan* for the work plan.

Legislative / Regulatory Action

Italics indicate an original FOA milestone that may be a top level task or a sub-task. Tasks include timing for review and approval of activities by Exchange leadership, as specific steps were not added for this level of detail.

Task Level	Activity/Milestone	Recommended Timing	Outcome
1	*Draft enabling legislation, implementing regulations, or other mechanism that provides the legal authority to establish and operate an Exchange that complies with Federal requirements.*	October 2011 – November 2011	▪ Form of authority determined ▪ Sponsors identified ▪ Draft version of authority (Executive Order, legislation, or rule)
1	*Introduce Exchange enabling legislation.*	November 2011	▪ Approved Exchange enabling authority
1	*Hold public hearings on Exchange enabling legislation.*	November 2011	▪ Stakeholder feedback
1	*Q2: Has The necessary legal authority to establish and operate an Exchange that complies with Federal requirements and provides for establishment of governance and Exchange structure?*	May 2012	▪ Defined Exchange Organizational Structure ▪ Defined Exchange Governance Structure ▪ Input for the Level 2 Establishment Grant application to the ▪ Center for Consumer Information and Insurance Oversight (CCIIO)

Governance

Italics indicate an original FOA milestone that may be a top level task or a sub-task. Tasks include timing for review and approval of activities by Exchange leadership, as specific steps were not added for this level of detail.

Task Level	Activity/Milestone	Recommended Timing	Outcome
1	*****Develop a governance model by working with stakeholders to answer key questions about the governance structure of the Exchange:*** ▪ ***Will the State pursue a Regional Exchange?*** ▪ ***Will the Exchange be housed in a State agency, quasi-governmental agency, or non-profit?*** ▪ ***How will the governing body be structured?***	October 2011 – November 2011	▪ A defined governance model ▪ Direction on where the Exchange will be housed (Quasi-Governmental entity, Not for Profit, Existing Agency or multi-state approach) ▪ Input for the Level 1 Establishment Grant application to CCIIO ▪ Direction on the governance model structure
1	*Determine standards for the Exchange governing body that will ensure:* ▪ ***Public accountability*** ▪ ***Transparency*** ▪ ***Prevention of conflict of interest***	December 2011	▪ Standards defined
1	***Q2: **Establish governance structure.***	May 2012	▪ Input for the Level 2 Establishment Grant application to CCIIO ▪ Tied to approved Exchange enabling authority
1	*Appoint a governing board (if applicable) and a management team sufficient to oversee the operations of the Exchange.*	March 2012 – April 2012	▪ Appointed governing board ▪ Public meeting schedule ▪ Management team hired and onboard
1	*Develop a formal operating charter or by-laws that are consistent with State and Federal requirements including public accountability, transparency, and conflicts of interest.*	March 2012 – April 2012	▪ Operating Charter ▪ By-laws ▪ Stakeholder Plan ▪ Communications/Outreach Plan

Exchange IT Systems

Italics indicate an original FOA milestone that may be a top level task or a sub-task. Tasks include timing for review and approval of activities by Exchange leadership, as specific steps were not added for this level of detail.

Task Level	Activity/Milestone	Recommended Timing	Outcome
1	***(Q1) **Conduct a gap analysis of its existing systems and the end goal for systems development by 2014.***	Additional Gap Analysis October 2011 – November 2011 Final Gap Analysis February 2012 – March 2012	▪ Initial/High-level Gap Analysis completed as part of the Options Analysis work ▪ Additional Gap Analysis will be needed for Level 1 Exchange Establishment Grant Application (due by December 29, 2011) ▪ Full Gap Analysis and System Development approach and requested resources are required for Level 2 Exchange Establishment Grant Application (final submittal due by June 29, 2012)
1	***(Q1) **Complete the review of product feasibility, viability, and alignment with Exchange program goals and objectives.***	July – August 2012	▪ This milestone assumes the Commonwealth has identified a technology solution prior to defining the type of Exchange it wants to create and developing its Exchange business and technical requirements
1	***(Q2) **Complete Preliminary business requirements and develop an IT architectural and integration framework.***	November 2011 – January 2012	▪ Dependent on definition of Exchange model and deployment approach ▪ PA's understanding of the high-level business requirements documented ▪ Draft Business Requirements Document ▪ Strategic Architecture Blueprint ▪ Could serve as an input/source document to the IT solution and/or Systems Integrator procurement process
1	Work group completes requirements to support system development.	January 2012 – March 2012	▪ Requirements definition complete

Task Level	Activity/Milestone	Recommended Timing	Outcome
1	Develop Exchange Procurement Approach for: ▪ Systems Integrator ▪ Identified Required Exchange Solution Technical Component(s) ▪ Other third Party Assistance ▪ Planning/IV&V/PMO/QA	December 2011 - February 2012	▪ Procurement Approach/ Tactics formalized ▪ Procurement Vehicle(s) identified ▪ Procurement Documents developed and reviewed ▪ Procurement documents distributed ▪ Degree of procurement required is dependent on definition of Exchange model and deployment approach ▪ Assumes Exchange authority is finalized or well underway – Will require approved and appropriated funds to execute contracts
1	***(Q2) **Complete Systems Development Life Cycle (SDLC) implementation plan.***	November 2011 – January 2012	▪ Dependent on definition of Exchange model and deployment approach (e.g., what in-house assets will be leveraged/modified) ▪ Requires close coordination with DPW ▪ SDLC Plan
1	***(Q3) **Complete security risk assessment and release plan.***	May 2012	▪ IT components assessed are dependent on definition of Exchange model and deployment approach ▪ Includes an assessment of selected third party solution(s) – if any – that the Commonwealth chooses to implement and how they integrate with existing PA IT assets

Task Level	Activity/Milestone	Recommended Timing	Outcome
1	***(Q3) ** Complete Preliminary detailed design and system requirements documentation (e.g. technical, design, etc.).***	January 2012 – May 2012	▪ Dependent on definition of Exchange model and deployment approach ▪ Significant undertaking that will require input from DPW and other stakeholders ▪ Formalized Business Requirements Document
1	***(Q4) **Finalize IT and integration architecture. Complete Final business requirements and Interim detailed design and system requirements documentations (e.g., technical, design, etc.).***	April 2012 – June 2012	▪ Dependent on definition of Exchange model and deployment approach ▪ Will require input from DPW and other Exchange IT and Business stakeholders ▪ Develop Detailed Technical Design Document to satisfy identified Exchange business requirements ▪ This is typically an input into the Level 2 Exchange Establishment Grant Application (final submittal due by June 29, 2012)
1	Begin systems development.	April 2012	▪ System development initiated
1	***(Q1) **Complete Final requirements documentation (including System Design, Interface Control, Data Management, and Database Design).***	May 2012 – August 2012	▪ Usually developed/negotiated in concert with Systems Integrator (SI) and Exchange IT component vendor(s) ▪ Will be used to help ensure SI and IT solution deliver per the Commonwealth's requirements

Task Level	Activity/Milestone	Recommended Timing	Outcome
1	***(Q1/Q2) **Complete Preliminary and Interim development of baseline system and review and ensure compliance with business and design requirements.***	June 2012 – December 2012	▪ Create Requirements Traceability Matrix and ensure all requirements in final Detailed Design Document are included in delivered system components ▪ Determined core Exchange function (e.g., Active Purchaser or Market Facilitator) ▪ Multiple gate reviews with HHS/CCIIO ▪ Coordinate with ongoing DPW core system modernization efforts ▪ Leverage oversight vendor to help manage development effort and hold vendors and Commonwealth accountable to documented project milestones and quality standards
1	Conduct required Exchange development progress assessment with HHS	January 2013	▪ Demonstrate Commonwealth's progress and status against key milestones to CCIIO
1	***(Q3) **Complete Final development of baseline system including software, hardware, interfaces, code reviews, and unit-level testing.***	January 2013 – June 2013	▪ Comprehensive process that will include significant stakeholder, carrier and navigator/broker involvement ▪ Create User Acceptance Test (UAT) plan ▪ Review Requirements Traceability Matrix and ensure all requirements in final Detailed Design Document are included in delivered system and reflected in various use cases, test scenarios and the UAT plan
1	***(Q4) **Complete testing of all system components including data, interfaces, performance, security, and infrastructure.***	July 2013 – September 2013	▪ Test scenarios ▪ Use cases ▪ Execute System Test Plan

Task Level	Activity/Milestone	Recommended Timing	Outcome
1	***(Q3) **Complete final user testing including testing of all interfaces.***	August - September 2013	▪ Test scenarios ▪ Use cases ▪ System Test Plan
1	***(Q3) or pre-open enrollment: ** Complete pre-operational readiness review to validate readiness of all system components. Complete end-to-end testing and security control validations.***	September 2013	▪ Per NPRM, currently Slated for October 2013
1	***As early as mid-2013: **Prepare and deploy all system components to production environment.***	August 2013 – September 2013	▪ Deployment approach dependent on Exchange model chosen
1	***Obtain security accreditation***	September 2013	▪ Should not be a last-minute event ▪ Include security review/assessments at all major system development milestones.
1	Exchange goes live	October 2013	▪ Exchange available for use
1	***Support business operations and maintenance of all systems components.***	October 2013 – Ongoing	▪ Helpdesk is live and staffed up for anticipated high demand during open enrollment period ▪ Process to share consumer queries with carriers enabled

Program Integration

Italics indicate an original FOA milestone that may be a top level task or a sub-task. Tasks include timing for review and approval of activities by Exchange leadership, as specific steps were not added for this level of detail.

Task Level	Activity/Milestone	Recommended Timing	Outcome
1	Establish a Health Insurance Exchange Steering Committee and determine the strategic direction for an Exchange	October 2011 – November 2011	▪ Decision if Pennsylvania will implement an Exchange and what form it may take ▪ An established Steering Committee to oversee Exchange implementation
1	Establish Work Groups that report to the Steering Committee to address core areas	November 2011 – December 2011	▪ Work Groups identified and staff assigned, including lead agency
1	***(Q2)**Perform detailed business process documentation to reflect current State business processes, and include future State process changes to support proposed Exchange operational requirements***	December 2011 – February 2012	▪ Detailed business process documentation for the current state and future state changes
1	*****Initiate communication with the State HIT Coordinators, State Department of Insurance and the State Medicaid agency, and the State Human Services agency as appropriate, and hold regular collaborative meetings to develop work plans for collaboration.***	October 2011 – December 2011	▪ Integration Work Group established ▪ Regular meetings scheduled and initiated
1	*****Execute an agreement with the State Department of Insurance that includes:*** ▪ **Determination of the roles and responsibilities of the Exchange and the State DOI as they relate to qualified health plans offered inside and outside the Exchange.** ▪ **Devise a strategy for limiting adverse selection between the Exchange and the outside market, possibly including legislative changes to level the playing field.**	December 2011 – February 2012	▪ Executed agreement between the Exchange and PID ▪ Established strategy for limiting Adverse Selection
1	*****Execute an agreement with the***	December 2011 –	▪ Executed agreement between

Task Level	Activity/Milestone	Recommended Timing	Outcome
	State Medicaid agency, any other applicable State health subsidy program, and other specific health and human services programs as appropriate, that includes: ▪ **Determination of the roles and responsibilities related to eligibility determination, verification, and enrollment.** ▪ **Identification of challenges in the program integration process, strategies for mitigating those issues, and timelines for completion.** ▪ **Strategies for compliance with the "no wrong door" policy.** ▪ **Standard operating procedures for interactions between the Exchange and OASHSPs.** ▪ **Cost allocation between the Exchange grants, Medicaid Federal Financial Participation (FFP), and other fund streams as appropriate.**	March 2012	the Exchange, DPW, PID, OA, and DOH ▪ Operating procedures to coordinate activities among the Steering Committee, the Exchange, and the involved agencies ▪ Defined roles related to eligibility determination, verification, and enrollment and develop strategies for "no wrong door" ▪ Identification of risks for program integration, including potential mitigating action and plans to implement them ▪ Plan for cost allocation between the Exchange grants, Medicaid FFP, and other identified funding streams
2	▪ Execute inter-agency agreement	December 2011 – January 2012	(subtask)
2	▪ Develop operating procedures and defined roles	January 2012 – March 2012	(subtask)
2	▪ Initiate Risk Management	January 2012 – February 2012	(subtask)
2	▪ Determine cost allocation	January 2012 – February 2012	(subtask)
1	▪ *Collaborate on procurement and development of Exchange and Medicaid IT systems needed to facilitate "no wrong door" for eligibility determinations.*	February 2012 – September 2013	▪ Procurement approach required to develop and implement the Exchange ▪ Development of the Exchange

Task Level	Activity/Milestone	Recommended Timing	Outcome
2	▪ Develop procurement approach and obtain resources required.	December 2011 – March 2012	(subtask)
2	▪ Develop the Exchange systems, including interfaces	April 2012 – September 2013	(subtask)
1	▪ *Collaborate on testing of Exchange and other applicable State health subsidy programs (OASHSPs) systems.*	July 2013 – September 2013	▪ Development of test strategies, test plan, and testing of the Exchange systems and interfaces
1	▪ *Coordinate launch of Exchange open enrollment period with eligibility determinations for Medicaid and OASHSPs.*	June 2013 – October 2013	▪ Plan for launch of Exchange Open Enrollment ▪ Coordinated activities through launch

Financial Management

Italics indicate an original FOA milestone that may be a top level task or a sub-task. Tasks include timing for review and approval of activities by Exchange leadership, as specific steps were not added for this level of detail.

Task Level	Activity/Milestone	Recommended Timing	Outcome
1	*****Adhere to HHS financial monitoring activities carried out for the Planning Grant and under the Establishment Cooperative Agreement***	September 2010 – December 2011	• Quarterly reports within 30 days after each quarter end • Appropriate use of Exchange grants • Note: timing reflects the one Exchange (Planning) grant Pennsylvania Received
1	*Begin defining financial management structure and the scope of activities required to comply with requirements*	November 2011 – April 2012	• Definition of financial management structure initiated • Determine whether State Auditor will perform annual audits of Exchange
1	*****Establish a financial management structure and commit to hiring experienced accountants to support financial management activities of the Exchange, which include responding to audit requests and inquiries of the Secretary and the Government Accountability Office as needed.***	June 2012 – December 2012	• Financial management structure appropriate for organizational structure established
1	*Develop a plan to ensure sufficient resources to support ongoing operations and determine if legislation is necessary to assess user fees*	January 2012 – February 2012	• Resource plan developed • Legislative requirement related to user fees identified
2	Perform staffing analysis for all Exchange functions to estimate human resource needs	March 2012 – April 2012	• Assessed resource needs by Exchange function
2	Assess existing skill sets and capacity to take an incremental Exchange activity	March 2012 – April 2012	• Matrix of existing skills and capacity
2	Using result of analyses above, develop a staffing plan including number, type and estimated cost of anticipated resources	May 2012 – June 2012	• Staffing Plan
1	*Assess adequacy of accounting and financial reporting systems*	October 2012 – December 2012	• Self-assessment of planned accounting and financial reporting systems
1	*Conduct a third-party objective review of all systems of internal control*	December 2012 – April 2013	• Third-party review of all systems of internal control

Task Level	Activity/Milestone	Recommended Timing	Outcome
2	• Procure services of third-party reviewer	December 2012 – February 2013	(subtask)
2	• Conduct third-party review.	March 2013 – April 2013	(subtask)
2	• Address findings and recommendations of third-party Review.	May 2013 – June 2013	
1	*Demonstrate capability to manage the finances of the Exchange soundly, including the ability to publish all expenses, receivables, and expenditures consistent with Federal requirements.*	January 2013 – December 2013	• Exchange financial management capability demonstrated
1	*Post information related to Exchange financial management on its website and identify other means to make financial activities associated with the management of the Exchange transparent.*	January 2014 – December 2014	• Exchange financial information available and accessible for public review
1	*Submit the required annual accounting report to HHS.*	January 2014 – December 2014	• Annual HHS reporting requirements met
2	• If annual financial statement audit is required (separate entity vs. within an agency), determine whether State Auditor will perform the audit, if not procure CPA firm to perform audit.	June 2013	• Identify audit requirement and auditor

Risk Adjustment

Italics indicate an original FOA milestone that may be a top level task or a sub-task. Tasks include timing for review and approval of activities by Exchange leadership, as specific steps were not added for this level of detail.

Task Level	Activity/Milestone	Recommended Timing	Outcome
1	Review concurrent and prospective risk adjustment approaches	November 2011 – January 2012	▪ PA specific risk adjustment program considered
1	Develop data collection processes for the risk adjustment program (i.e., demographic, diagnostic, and prescription drug data)	February 2012 – March 2012	▪ Consistent data to support the risk adjustment process collected
2	Collect encounter data (if required)	February – March 2012	▪ (subtask)
1	Develop / modify current systems to support the risk adjustment program	April 2012 – June 2013	▪ Risk adjustment systems developed
2	Develop / modify current systems to be able to assess a charge on health plans and health insurance issuers if the actuarial risk of enrolees in that plan is less than the average actuarial risk	April 2012 – June 2013	▪ (subtask)
1	Implement a risk adjustment program according to federal standards	June 2013 – December 2013	▪ Risk adjustment program established

Transitional Reinsurance

Italics indicate an original FOA milestone that may be a top level task or a sub-task. Tasks include timing for review and approval of activities by Exchange leadership, as specific steps were not added for this level of detail.

Task Level	Activity/Milestone	Recommended Timing	Outcome
1	Develop / modify current systems to support payments to insurers in the individual market and those through the Exchanges to cover high-risk individuals	April 2012 – June 2013	▪ Transitional reinsurance systems developed
1	Establish or contract a non-profit reinsurance entities for the transitional reinsurance program	July 2013 – August 2013	▪ Non-profit entity identified for transitional reinsurance program
1	Implement a transitional reinsurance program according to federal standards	July 2013 – December 2013	▪ Transitional reinsurance program established

Oversight and Program Integrity

Italics indicate an original FOA milestone that may be a top level task or a sub-task. Tasks include timing for review and approval of activities by Exchange leadership, as specific steps were not added for this level of detail.

Task Level	Activity/Milestone	Recommended Timing	Outcome
1	***** Ensure the prevention of waste, fraud and abuse related to the expenditure of Exchange Planning and Exchange Establishment grants.***	September 2010 – December 2011	• Appropriate use of Exchange grants • (Note timing reflects the one Exchange (Planning) grant Pennsylvania received
1	*Continue planning process and hire staff for oversight and program integrity functions.*	January 2012 – March 2012	• Staff in place to oversee program integrity
1	*Establish procedures for external audit by a qualified auditing entity to perform an independent external financial audit of the Exchange.*	September 2012 – December 2012	• Procedures established for external financial audit of the exchange
1	*Establish fraud detection procedures.*	June 2012 – July 2013	• Fraud detection procedures established • Risk assessment complete • Fraud, waste and mismanagement prevention, detection and remediation program designed • Tools identified to help detect anomalies • Plan and procedures in place for fraud detection
2	Perform risk assessment of Exchange operations considering financial, operations and compliance risks.	June 2012 – September 2012	(subtask)
2	Using results of risk assessment, work with existing Commonwealth authorities (Auditor General, Inspector General) to design a program of fraud, waste and mismanagement prevention, detection and remediation specific to the Exchange, particularly around high-risk areas such as eligibility.	October 2012 – December 2012	(subtask)
2	Identify tools and/or data analytic techniques or queries to identify potential anomalies in data sets indicative of fraud (e.g. false addresses or improper social security numbers.)	January 2013 – February 2013	(subtask)

Task Level	Activity/Milestone	Recommended Timing	Outcome
2	Develop a plan to adequately implement automated tools to supplement existing controls.	March 2013 – July 2013	(subtask)
1	*Develop procedures for reporting to HHS on efforts to prevent fraud, waste, and abuse.*	July 2013 – August 2013	• Procedures established to report prevention efforts to HHS related to fraud, waste, and abuse
1	*Comply with HHS reporting requirements related to auditing and prevention of fraud, waste, and abuse.*	July 2014	• Compliance to HHS requirement related to auditing and prevention of fraud, waste, and abuse

Providing Assistance to Individuals and Small Businesses, Coverage Appeals, and Complaints

Italics indicate an original FOA milestone that may be a top level task or a sub-task. Tasks include timing for review and approval of activities by Exchange leadership, as specific steps were not added for this level of detail.

Task Level	Activity/Milestone	Recommended Timing	Outcome
1	Establish a Consumer Assistance Program (CAP) work group and establish coordination with work groups for core other areas (such as applications, eligibility, notices, and appeals).	November 2011 – December 2011	▪ CAP work group established and aligned with other work groups
1	*Coordinate with existing organizations in the State if applicable; and assure that the following services are available and sufficient to meet State residents' need for assistance: (i) help individuals determine eligibility for private and public coverage and enroll in such coverage; (ii) help file grievances and appeals; (iii) provide information about consumer protections; and (iv) collect data on inquiries and problems and how they are resolved.*	January 2012 – February 2012	▪ Confirmation of available services and identification of any gaps
1	*****Analyze data collected by CAPs and report on plans for use of information to strengthen qualified health plan accountability and functioning of Exchanges.***	February 2012 – March 2012	▪ Data analysis completed ▪ Report available
1	*****If the State chooses to operate these functions within the Exchange, establish protocols for appeals of coverage determinations including review standards and timelines and provision of help to consumers during the appeals process.***	January 2012 – March 2012	▪ Participation in requirements development for appeals function and include requirements for reporting on consumer complaints and appeals
1	*****Draft scope of work for building capacity to handle coverage appeals functions.***	April 2012 – June 2012	▪ Draft scope of work for building capacity to cover the appeals function

Task Level	Activity/Milestone	Recommended Timing	Outcome
-	***Analyze data collected by CAPs and report on plans for use of information to strengthen qualified health plan accountability and functioning of Exchanges.**		Note: Activity was completed above.
1	*Establish a process for reviewing consumer complaint information collected by the State CAP when certifying qualified health plans.*	January 2013 – June 2013	Customer complaint review process developed
1	*Establish process for referrals to CAPs if available in another entity.*	January 2013 – June 2013	Referral process developed
1	*Ensure that any consumer complaints or coverage appeal requests are referred directly to the State program that is designated to process these calls.*	October 2013	Consumer complaint and appeals processes for the Exchange initiated Reporting on Consumer complaints and appeals initiated

Certification of Qualified Health Plans

Italics indicate an original FOA milestone that may be a top level task or a sub-task. Tasks include timing for review and approval of activities by Exchange leadership, as specific steps were not added for this level of detail.

Task Level	Activity/Milestone	Recommended Timing	Outcome
1	*(Q3) Begin developing standards that will be required for certification of a qualified health plan*	January 2012 – February 2012	▪ Initial outline of requirements for the certification process
1	*(Q4) Develop a clear certification policy including a timeline for application submission, evaluation, and selection of qualified health plans*	March 2012	▪ Certification policy / directive to meet legislative requirements ▪ Timeline for application submission, evaluation and selection of QHPs
2	Determine resource needs to support the certification of qualified health plans	March 2012	▪ (subtask)
2	Decide whether the certification process will be housed internally or externally	March 2012	▪ (subtask)
1	*(Q4) Actively engage stakeholders in the development of the solicitation for proposals, through meetings, conferences, webinars, and other forums designed to gather stakeholder input*	April 2012	▪ Gather stakeholder feedback (i.e., insurers) on developing standards
1	*(Q1) Develop a strategy and timeline for the integration of staff and IT systems needed to receive applications, evaluate data from insurers, and notify insurers of the result of the solicitations for applications for qualified health plans*	May – June 2012	▪ Strategic plan for the implementation of the certification of Qualified Health Plans ▪ Notifications sent to insurers indicating the result of the solicitation for applications for QHPs
1	*(Q2) Make significant progress on the development of an RFP for certification of a qualified health plan*	July 2012	▪ Draft RFP for the certification of qualified health plan

Task Level	Activity/Milestone	Recommended Timing	Outcome
1	*(Q2) Draft applicable certification documents (notices/solicitations, applications, agreements, etc.) that will be used in connection with the certification of qualified health plans. Such documents must address Exchange policies relating to the minimum qualifications of a qualified health plan including any user fees, the length of the initial certification, recertification, and terms that may lead to decertification.*	August – September 2012	▪ Draft certification document to support the implementation of the certification of qualified health plans process
2	Consider an attestation document for insurers to verify compliance with certification criteria for QHPs	August – September 2012	▪ (subtask)
1	*(Q2) Complete a solicitation for proposals for qualified health plans*	September 2012	▪ Proposal solicitation written
1	*(Q3) Provide evidence of staff resources (or contracts) to support the plan certification evaluation*	October 2012	▪ Staff resources are named to support the certification process
1	*(Q3) Release the solicitation for the certification of a qualified health plans, conduct bidders conference, and respond to bidder questions on solicitation*	October 2012	▪ Bidders' questions and responses are documented. ▪ Certification process is further refined
1	*(Q4) Begin training health plan issuers to become qualified health plans*	November – December 2012	▪ Health plans are trained to participate within the certification process
1	*(Q1) Collect submissions from the solicitation and begin evaluating proposals*	January 2013	▪ Proposal nears final development
1	*(Q1) Solicit premium quotes from health plan issuers who responded to the solicitation*	February 2013	▪ Premium quotes requested in the solicitation process are compared

Task Level	Activity/Milestone	Recommended Timing	Outcome
1	***(Q1) **Launch plan management and bid evaluation system to allow upload of qualified health plan bids and other required information***	March 2013	▪ Review bids and certify Qualified Health Plans
1	*(Q2) Complete the certification of qualified health plans, complete any negotiations and execute contracts to health plan issuers who applied for qualified health plan issuer status*	April – June 2013	▪ Qualified Health Plans list compiled
1	*Q2: Issue an announcement on the selection of qualified health plans to the public*	June 2013	▪ Notification sent to Insurers who applied for qualified health plans
1	***(Q3) or before open enrollment**: Conduct plan readiness reviews/activities (e.g., test enrollment interfaces with plans, reviews member materials, test financial reconciliation, cross-functional implementation sessions with plans, etc.)*	September 2013	▪ Testing results may require additional adjustments to fine-tune the certification process
1	*(Q1) Begin collecting user fees if the Exchange is utilizing this funding mechanism*	January 2014	▪ User fees documented as revenue for the Exchange
1	*(Q1) Demonstrate capability for the Exchange and/or for the State insurance regulatory body to monitor the practices and conduct, as well as the pricing and benefits of health insurers offering products in the Exchange with regard to their products inside and outside the Exchange*	March 2014	▪ Qualified Health Plans that are inconsistent inside and outside the Exchange may require the State insurance regulatory body to act upon findings

Call Center

Italics indicate an original FOA milestone that may be a top level task or a sub-task. Tasks include timing for review and approval of activities by Exchange leadership, as specific steps were not added for this level of detail.

Task Level	Activity/Milestone	Recommended Timing	Outcome
1	*Collaborate with the State Consumer Assistance Program or Health Ombudsman program if applicable, to determine if call center functionalities can be shared.*	September 2011 – December 2011	• Approach to providing call center services identified
2	Expand analysis call center to consider the additional effort/capacity that may be needed to support an Exchange.	September 2011 – December 2011	(subtask)
2	Determine if there will continue to be a consolidated Health and Human Services Call Center (HHSCC) and if the HHSCC will be expanded to meet the Exchange's call center needs.	December 2011	(subtask)
1	*Q2: Complete call center procurement process and select a vendor to operate the call center*	January 2012 – March 2013	• Call center provider under contract
2	If the Exchange will have its own call center that will be outsourced, develop the requirements and RFP.	January 2012 – September 2012	(subtask)
2	If the Exchange will leverage the central HHSCC, include the Exchange requirements within the procurement vehicle to obtain those services.	January 2012 – September 2012	(subtask)
2	Complete procurement of call center services.	October 2012 – March 2013	(subtask)
1	*Q2: Develop call center customer service representative protocols and scripts to respond to likely requests from healthcare consumers in the State.*	April 2013 – August 2013	• Call center customer service protocols and scripts developed
1	*Q2: Develop protocols for accommodating the hearing impaired and those with other disabilities and foreign language and translation services.*	April 2013 – August 2013	• Protocols defined to accommodating the hearing impaired, individuals with other disabilities, and foreign language translation requirements

Task Level	Activity/Milestone	Recommended Timing	Outcome
1	*Q2: Train call center representatives on eligibility verification and enrollment process, and other applicable areas, so they can facilitate enrollment of individuals over the phone.*	August 2013 – September 2013	• Call center representatives trained
1	***Q3: **Launch call center functionality and publicize 1-800 number. Prominently post information on the Exchange website related to contacting the call center for assistance.***	September 2013	• Call center launched to assist employers entering employee rosters for the SHOP • Call center in place for individuals and employees for the October open enrollment

Exchange Website and Calculator

Italics indicate an original FOA milestone that may be a top level task or a sub-task. Tasks include timing for review and approval of activities by Exchange leadership, as specific steps were not added for this level of detail.

Task Level	Activity/Milestone	Recommended Timing	Outcome
1	***Q1: **Begin developing requirements for systems and program operations, including:*** ▪ ***Requirements related to online comparison of qualified health plans.*** ▪ ***Requirements related to online application and selection of qualified health plans.*** ▪ ***Premium tax credit and cost-sharing reduction calculator functionality.*** ▪ ***Requests for assistance.*** ▪ ***Linkages to other State health subsidy program, and other health and human services programs as appropriate.***	November 2011 – March 2012	▪ Dependent on definition of Exchange model and deployment approach ▪ PA's understanding of the high-level business requirements documented ▪ Draft Business Requirements Document related to online application and selection of qualified health plans ▪ Draft Business Requirements Document related to premium tax credit and cost-sharing reduction calculator functionality ▪ Input to Strategic Architecture Blueprint ▪ Could serve as an input/source document to the IT solution and/or Systems Integrator procurement process
1	***Q1: **Begin systems development.***	April 2012	▪ System development initiated
1	***Q3: **Submit content for informational website to HHS for comment.***	October 2012	▪ Finalized informational website content
1	***Q4: **Complete systems development and final user testing of informational website.***	April 2012 – July 2013	▪ Requirements Traceability Matrix created and requirements in final Detailed Design Document are included in delivered system components ▪ Multiple gate reviews with HHS/CCIIO ▪ Coordination with ongoing DPW core system modernization efforts
1	***Q1: **Launch information website.***	July 2013	▪ Deployed website

Task Level	Activity/Milestone	Recommended Timing	Outcome
			(informational)
1	***Q1: **Collect and verify plan data for comparison tool.***	April 2013 – July 2013	▪ Dependent on definition of Exchange model and deployment approach ▪ Requires input from DPW and other Exchange IT and Business stakeholders
1	***Q3: **Test comparison tool with consumers and stakeholders. Before open enrollment: **Launch comparison tool with pricing information but without online enrollment function.***	June 2013 – September 2013	▪ Test scenarios ▪ Use cases ▪ System Test Plan
1	***As early as mid-2013: **Launch fully functioning comparison tool with pricing information and online enrollment functionality on the first day of open enrollment.***	October 2013	▪ Plan comparison functionality ▪ Interface/plan data coordination approach with carriers finalized

Quality Rating System

Italics indicate an original FOA milestone that may be a top level task or a sub-task. Tasks include timing for review and approval of activities by Exchange leadership, as specific steps were not added for this level of detail.

Task Level	Activity/Milestone	Recommended Timing	Outcome
1	Pending additional guidance from HHS defining the Federal Quality Rating System	December 2011	▪ Federal Quality Rating System will be defined
2	*Utilize the Federal quality rating system developed by HHS in development of draft contract for qualified health plans*	December 2011	▪ Federal Quality Rating System adapted to Pennsylvania
1	*Include quality rating functionality in system business requirements for the Exchange website*	January 2012 – March 2012	▪ Quality Rating System outlined in the framework of the Exchange website
2	Survey consumers to obtain a list of quality rating indicators	January 2012	▪ (subtask)
2	Choose quality rating indicators.	February 2012 – March 2012	▪ (subtask)
1	*Complete system development of quality rating functionality*	April 2012	▪ Quality Rating System operational for testing phase
1	*Complete testing and validation of quality rating functionality.*	May 2012 – April 2013	▪ Testing and validation bugs fixed.
1	*Before open enrollment: Post quality rating system information on the Exchange website*	May 2013 – June 2013	▪ Quality Rating System requirements posted to the Exchange website
1	*Continually update quality rating information on the Exchange website and for call center representatives so they have the most u- to-date information on qualified health plans*	July 2013 – December 2014	▪ The Exchange website serves as a reliable source for call centers and insurers on the Quality Rating System

Navigator Program

Italics indicate an original FOA milestone that may be a top level task or a sub-task. Tasks include timing for review and approval of activities by Exchange leadership, as specific steps were not added for this level of detail.

Task Level	Activity/Milestone	Recommended Timing	Outcome
1	Receive Federal guidance on the Navigator Program	November 2011	▪ Receive guidance that may impact the tasks and schedule below
1	Conduct a Navigator Study, including obtaining demographic data to determine which populations are most underserved and further define the role and certification or licensing required	December 2011 – April 2012	▪ Demographic data to determine which populates are most underserved ▪ Role of Navigator defined including certification and licensing requirements ▪ Identification of milestones for establishment of the program ▪ Method to monitor Navigator performance is defined
2	▪ *Conduct preliminary planning activities related to the Navigator program including developing high level milestones and time frames for establishment of the program*	December 2011 – January 2012	(subtask)
2	▪ *Determine targeted organizations in the State who would qualify to function as Navigators.*	January 2012 – April 2012	(subtask)
1	***Q2: **Determine Navigator grantee organizations and award contracts or grants (funded from the operational funds of the Exchange)***	April 2012 – March 2013	▪ Navigator grant program established ▪ Grant availability advertised, responses received, and grants awarded
2	▪ Establish the Grant Program for Navigators.	April 2012 – July 2012	(subtask)
2	▪ Advertise availability of grants	August 2012 – October 2012	(subtask)
2	▪ Select Grantees and award contracts	October 2012 – March 2013	(subtask)

Task Level	Activity/Milestone	Recommended Timing	Outcome
1	*Q2: Train Navigators*	December 2012 – July 2013	▪ Navigator training delivery approach defined ▪ Navigator training materials prepared ▪ Navigators scheduled for training and training completed
2	▪ Identify training delivery approach and secure resources to implement	December 2012 – March 2013	(subtask)
2	▪ Develop training materials, identify potential organizations to receive training	April 2013 – June 2013	(subtask)
2	▪ Deliver Navigator Training	July 2013	(subtask)
1	*First quarter before open enrollment: Begin operations of Navigators*	August 2013 – September 2013	▪ Navigators begin operations ▪ Navigator monitoring begins

Eligibility Determinations

Italics indicate an original FOA milestone that may be a top level task or a sub-task. Tasks include timing for review and approval of activities by Exchange leadership, as specific steps were not added for this level of detail.

Task Level	Activity/Milestone	Recommended Timing	Outcome
1	*Q1: Begin coordination with agencies administering other Applicable State Health Subsidy Program, including Medicaid and CHIP agencies and other health and human services agencies as appropriate, and create institutional structure to support future work*	July 2011 – November 2011	▪ Organization to coordinate efforts is put in place ▪ Decision to implement an Exchange for Pennsylvania is made
2	Complete initial planning effort	July 2011 – September 2011	(subtask)
2	Establish a Health Insurance Exchange Steering Committee and determine if Pennsylvania will implement an Exchange	October 2011 – November 2011	(subtask)
1	*Q1: Begin coordination with the State Department of Insurance on Exchange planning effort*	July 2011	▪ Planning activities initiated
1	***Q1: **Begin developing requirements, including requirements on the Exchange side and in other Applicable State Health Subsidy Programs (OASHSPs) as appropriate, including:*** ▪ ***Integrating or interfacing with OASHSPs to support enrollment transactions and eligibility referrals*** ▪ ***Coordinating appeals*** ▪ ***Coordinating applications and notices*** ▪ ***Managing transitions*** ▪ ***Communicating the enrollment status of individuals***	November 2011 – December 2011	▪ Establish work groups to start requirement development ▪ Initiate work on requirements

Task Level	Activity/Milestone	Recommended Timing	Outcome
1	Work groups complete requirements to support system development	January 2012 – March 2012	▪ Requirements definition complete
1	***Q1: **Begin system development, including any systems development needed by OASHSPs. (and other programs as appropriate)***	April 2012	▪ System development initiated
1	***Q4: **Complete system development and prepare for final user testing, including testing of any systems within OASHSPs. (and other programs as appropriate)***	May 2012 – April 2013	▪ System development complete ▪ User Acceptance Test (UAT) plan and test scripts/test cases completed and testers identified
1	***Q1: **Begin final user testing, including testing of all interfaces***	May 2013	▪ UAT initiated ▪ Interface testing initiated
1	***2013 Q3 or before open enrollment: **Complete user testing, including full end-to-end integration testing with all other components***	June 2013 – September 2013	▪ All testing completed
1	***As early as mid-2013: **Begin conducting eligibility determinations for OASHSPs, coordinating all relevant business functions, and receiving referrals from OASHSPs for eligibility determination***	August 2013 – October 2013	▪ Final preparation for coordination with involved agencies ▪ Start eligibility determinations in October 2013

Enrollment Process

Italics indicate an original FOA milestone that may be a top level task or a sub-task. Tasks include timing for review and approval of activities by Exchange leadership, as specific steps were not added for this level of detail.

Task Level	Activity/Milestone	Recommended Timing	Outcome
1	***Q1: **Begin developing requirements for systems and program operations, including:*** ▪ ***Providing customized plan information to individuals based on eligibility and QHP data*** ▪ ***Submitting enrollment transactions to Qualified Health Plan (QHP) issuers*** ▪ ***Receiving acknowledgements of enrollment transactions from QHP issuers*** ▪ ***Submitting relevant data to HHS***	November 2011 – December 2011	▪ Establish Enrollment work group to start requirements development ▪ Initiate work on requirements
1	Work group completes requirements to support system development	January 2012 – March 2012	▪ Requirements definition complete
1	System development		▪ System development initiated ▪ System development completed ▪ User Acceptance Test (UAT) plan and test scripts/test cases completed and testers identified
2	▪ ***Q1: **Begin systems development***	April 2012	(subtask)
2	▪ Enrollment work group participates in package selection or development of enrollment functionality	April 2012 – April 2013	(subtask)
2	***Q4: **Complete systems development and prepare for final user testing***	May 2012 – April 2013	(subtask)
1	***Q1: **Begin final user testing, including testing of all interfaces***	May 2013	▪ UAT initiated ▪ Interface testing initiated

Task Level	Activity/Milestone	Recommended Timing	Outcome
1	***2013 Q3 or before open enrollment: **Complete user testing, including full end-to-end integration testing with all other components***	June 2013 – September 2013	▪ All testing completed
1	***As early as mid-2013: **Begin enrollment into qualified health plans***	October 2013	▪ Start enrollment processing

Applications and Notices

Italics indicate an original FOA milestone that may be a top level task or a sub-task. Tasks include timing for review and approval of activities by Exchange leadership, as specific steps were not added for this level of detail.

Task Level	Activity/Milestone	Recommended Timing	Outcome
1	Establish work groups to focus on processes and requirements for Applications and Notices	November 2011 – December 2011	▪ Establish work groups to start requirement development
1	*Review federal requirements for applications and notices, begin customizing federal applications and notices as allowable, and begin developing requirements for Exchange-created applications and Notices*	December 2011 – January 2012	▪ Initiate work on requirements ▪ Plan is completed for how stakeholders will be involved to provide input to and validate requirements
1	Complete defining requirements for Applications an Notices	February 2012 – March 2012	▪ Requirements definition complete
1	Develop format and actual content for Applications and Notices (system generated and paper form)	April 2012 – April 2013	▪ Applications and Notices developed
1	*2013 Q3 or before open enrollment: Finalize all applications and notices including stakeholder review, testing, translation of content, etc. prior to open enrollment*	May 2013 – August 2013	▪ Applications and Notices finalized
1	***As early as mid-2013: **Begin utilizing applications and notices to support eligibility and enrollment process***	September 2013 - October 2013	▪ Initiate use of Applications and Notices

Exemptions from Individual Responsibility Requirement and Payment

Italics indicate an original FOA milestone that may be a top level task or a sub-task. Tasks include timing for review and approval of activities by Exchange leadership, as specific steps were not added for this level of detail.

Task Level	Activity/Milestone	Recommended Timing	Outcome
1	***Q1: ** Begin developing requirements for system and program operations, including:*** ▪ ***Accepting requests for exemptions*** ▪ ***Reviewing and adjudicating requests*** ▪ ***Exchanging relevant information with HHS***	November 2011 – December 2011	▪ Engage work groups to start requirement development ▪ Initiate work on requirements
1	Work groups complete requirements to support system development	January 2012 – March 2012	▪ Requirements definition complete
1	***Q1: **Begin systems development***	April 2012	▪ System development initiated
1	***Q4: **Complete systems development and prepare for final user testing***	May 2012 – April 2013	▪ System development complete ▪ User Acceptance Test (UAT) plan and test scripts/test cases completed and testers identified
1	***Q1: Begin final user testing, including testing all interfaces***	May 2013	▪ UAT initiated ▪ Interface testing initiated
1	***Q3 or before open enrollment: **complete user testing, including full end-to-end integration testing with other components***	June 2013 – September 2013	▪ All testing completed
1	Develop and communicate instructions for applying for an Individual Responsibility Exemption	July 2013 – September 2013	▪ Instructions developed ▪ Instructions communicated to individuals, Navigators, and Community Partners
1	***Begin processing exemptions from individual responsibility requirements and payment and reporting to HHS on outcome determinations***	October 2013	▪ Exemption processing initiated

Premium Tax Credit and Cost-Sharing Reduction Administration

Italics indicate an original FOA milestone that may be a top level task or a sub-task. Tasks include timing for review and approval of activities by Exchange leadership, as specific steps were not added for this level of detail.

Task Level	Activity/Milestone	Recommended Timing	Outcome
1	Receive pending guidance from HHS	November 2011 – December 2011	▪ HHS regulation that establishes baseline standards for premium tax credits and cost-sharing reductions
1	***(Q1) **Begin developing requirements for systems and program operations, including providing relevant information to QHP issuers and HHS to start, stop, or change the level of premium tax credits and cost-sharing reductions***	November 2011 – December 2011	▪ Initial eligibility and redetermination requirements for premium tax credits and cost-sharing reductions defined, including requirements for: – The Premium tax credit and cost-sharing reduction calculator – Notification to employers when one or more of their employees is determined to be eligible for advance payment of a premium tax credit because the employer does not meet certain conditions
1	Work groups complete requirements to support system development	January 2012 – March 2012	▪ Requirements definition complete
1	System development	April 2012 – April 2013	▪ System development completed ▪ User Acceptance Test plan and test scripts/test cases completed and testers identified
2	***(Q2) **Begin systems development***	April 2012	(subtask)
2	***(Q4) **Complete systems development and prepare for final user testing***	May 2012 – April 2013	(subtask)
1	***(Q1) **Begin final user testing, including testing all interfaces.***	May 2013	▪ UAT initiated ▪ Interface testing initiated
1	***2013 Q3 or before open enrollment: **Complete user testing, including full end-to-end integration testing with other components.***	June 2013 – September 2013	▪ All testing completed

Task Level	Activity/Milestone	Recommended Timing	Outcome
1	***As early as mid-2013:*** *****Begin submitting tax credit and cost-sharing reduction information to QHP issuers and HHS.***	August 2013 – October 2013	▪ Final preparation for coordination with involved agencies/QHPs ▪ Start eligibility determinations in October 2013

Adjudication of Appeals of Eligibility Determinations

Italics indicate an original FOA milestone that may be a top level task or a sub-task. Tasks include timing for review and approval of activities by Exchange leadership, as specific steps were not added for this level of detail.

Task Level	Activity/Milestone	Recommended Timing	Outcome
1	*Q2: Begin developing business processes and operational plan for appeals functions*	April 2012 – July 2012	▪ Appeals process development, including defining the roles each participating organization has in the appeals process ▪ Operational Plan for appeals
1	*Q4: Establish resources to handle appeals of eligibility determinations including training on eligibility requirements*	April 2013 – July 2013	▪ Resources put in place for the appeals process ▪ Appeals training developed and delivered
2	▪ Identify resources to support the appeals process	April 2013 – May 2013	(subtask)
2	▪ Develop training materials, schedule and conduct training	May 2013 – July 2013	(subtask)
1	*Q3 or before open enrollment: Initiate communication with HHS on process for referring appeals to the Federal appeals process*	July 2013 – October 2013	▪ Initiation of communication with HHS on process to refer appeals to the Federal process
1	***As early as mid-2013: **Begin receiving and adjudicating requests***	October 2013 – January 2014	▪ Initiation of process to adjudicate appeals

Notification and Appeals of Employer Liability for the Employer Responsibility Payment

Italics indicate an original FOA milestone that may be a top level task or a sub-task. Tasks include timing for review and approval of activities by Exchange leadership as specific steps were not added for this level of detail.

Task Level	Activity/Milestone	Recommended Timing	Outcome
1	***Q1 ** Begin developing requirements for systems and program operations including:*** ▪ ***Coordination of employer appeals with appeals of individual eligibility*** ▪ ***Submission of relevant data to HHS***	April 2012 – June 2012	▪ Development of system requirement and program operation needs
1	***Q1 ** Begin systems development.***	April 2012	▪ System development initiated
1	***Q3 ** Complete systems development and prepare for final user testing***	May 2012 – April 2013	▪ System development complete ▪ User Acceptance Test (UAT) plan and test scripts/test cases completed and testers identified
1	***Q1 ** Begin final user testing including testing all interfaces.***	May 2013	▪ UAT initiated ▪ Interface testing initiated
1	***Q3 ** Complete user testing, including full end-to-end integration testing with all other components***	June 2013 – September 2013	▪ All testing completed
1	***As early as mid-2013 ** Begin notifying employers in coordination with eligibility determinations***	August 2013 – September 2013	▪ Communication to employers developed and implemented

Information Reporting to IRS and Enrollee

Italics indicate an original FOA milestone that may be a top level task or a sub-task. Tasks include timing for review and approval of activities by Exchange leadership, as specific steps were not added for this level of detail.

Task Level	Activity/Milestone	Recommended Timing	Outcome
1	Receive pending guidance from HHS.	November 2011 – December 2011	▪ HHS regulation that establishes baseline standards for information reporting
1	***(Q1) **Begin developing requirements for systems and program operations, including:*** ▪ ***Capturing data used in enrollment process to enrollees*** ▪ ***Submitting relevant data to HHS for later use in information reporting.*** ▪ ***Capacity to generate information reports to enrollees.***	November 2011 – December 2011	▪ Enrollment work group starts requirement development for information reporting ▪ Initial work on requirements
1	Work group completes requirements to support system development	January 2012 – March 2012	▪ Requirements definition complete
1	System development	April 2012 – April 2013	▪ System development complete ▪ User Acceptance Test (UAT) plan and test scripts/test cases completed and testers identified
2	***(Q1) **Begin systems development.***	April 2012	(subtask)
2	Enrollment work group participates in package selection or development of enrollment functionality that includes reporting requirements.	April 2012 – April 2013	(subtask)
2	Design functionality for communicating information on Individual Responsibility exemptions to HHS for transmission to IRS.	April 2012 – April 2013	(subtask)
2	***(Q3) **Complete systems development and prepare for final user testing.***	May 2012 – April 2013	(subtask)
1	***(Q1) **Begin final user testing including testing all interfaces***	May 2013	▪ UAT initiated ▪ Interface testing initiated
1	***(Q3) ** Complete user testing, including full end-to-end integration testing with all other***	June 2013 – September 2013	▪ Includes test of information reporting to IRS and

Task Level	Activity/Milestone	Recommended Timing	Outcome
	components		Enrollees
1	*Confirm that systems are prepared to generate information reports to enrollees*	September 2013	▪ Report / interface testing complete

Outreach and Education

Please refer to the *Stakeholder Plan* for the work plan.

SHOP-specific Functions

Italics indicate an original FOA milestone that may be a top level task or a sub-task. Tasks include timing for review and approval of activities by Exchange leadership, as specific steps were not added for this level of detail.

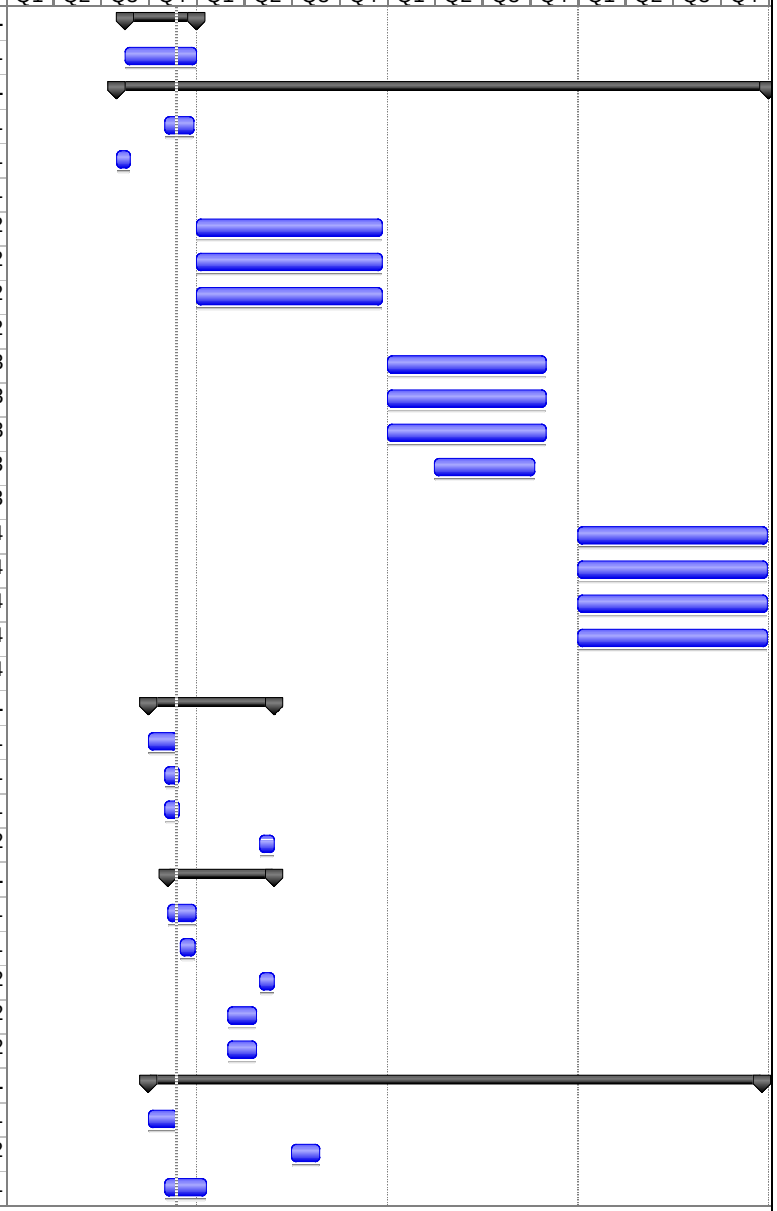
Task Level	Activity/Milestone	Recommended Timing	Outcome
1	*Research the design and approach of the SHOP Exchange and whether it will be merged with the individual market Exchange*	October 2011 – November 2011	▪ Decision made as to a separate SHOP market or merged with individual market
1	***Q1: ** Begin developing requirement for systems and program operations***	November 2011 – December 2011	▪ Establish work group to start requirement development ▪ Initiate work on requirements
1	Work group completes requirements to support system development	January 2012 – March 2012	▪ Requirements definition complete
1	***Q1: **Begin systems development***	April 2012	▪ System development initiated
1	***Q4: **Complete systems development and prepare for final user testing***	May 2012 – April 2013	▪ System development complete ▪ User Acceptance Test (UAT) plan and test scripts/test cases completed and testers identified
1	***Q1: **Begin final user testing, including testing of all interfaces***	May 2013	▪ UAT initiated ▪ Interface testing initiated
1	***2013 Q3 or before open enrollment: **Complete user testing, including full end-to-end integration testing with all other components***	June 2013 – September 2013	▪ All testing completed
1	Open SHOP to accept employer rosters	September 2013	▪ Employer roster registration process initiated
1	Begin SHOP enrollment	October 2013	▪ SHOP enrollment

Source Documents

Type	Document Name	Organizing Agency	Date
Consideration Document	Health Benefit Exchanges: An Implementation Timeline for State Policymakers	State Coverage Initiatives: Robert Wood Johnson Foundation	July 2010
	The Comparative Roles of Navigators and Producers in an Exchange – What are the Issues	National Association of Insurance Commissioners	May 19, 2011
	North Carolina Health Benefit Exchange Study	Milliman	July 18, 2011
	State Efforts to Enact Health Insurance Exchanges	M2 Health Care Consulting	August 15, 2011
	CMCS Eligibility conference – MAGI breakout session	Centers for Medicaid and Medicare Services	September 13, 2011
	CMCS Medicaid CHIP Eligibility NPRM Section by Section Summary	Centers for Medicaid and Medicare Services	September 27, 2011
Funding Opportunity	Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges	Office of Consumer Information and Insurance Oversight – Department of Health and Human Services	January 20, 2011
Law	Compilation of Patient Protection and Affordable Care Act	Office of the Legislative Counsel – U.S. House of Representatives	March 23, 2010
Level 1 Grant	Washington Level 1 Establishment Grant	Washington State Health Care Authority	April 5, 2011

Type	Document Name	Organizing Agency	Date
	Missouri Level 1 Establishment Grant	State of Missouri	June 24, 2011
	New York Level 1 Establishment Grant	New York State Department of Health	June 27, 2011
	Maryland Level 1 Establishment Grant	Maryland Department of Health and Mental Hygiene	June 28, 2011
	Mississippi Level 1 Establishment Grant	Mississippi Insurance Department	June 29, 2011
	California Level 1 Establishment Grant	California Health Benefit Exchange	June 30, 2011
	Connecticut Level 1 Establishment Grant	State of Connecticut	July 27, 2011
	Minnesota Level 1 Establishment Grant	Minnesota Department of Commerce	August 16, 2011
Notice for Proposed Rulemaking	CMS-9989-P	Department of Health and Human Services	July 15, 2011
	CMS-9974-P	Department of Health and Human Services	August 17, 2011

ID	Task Name	Start
1	**Background Research**	**Wed 8/17/11**
2	Analysis of Insurance Market	Wed 8/17/11
3	**Stakeholder Consultation**	**Mon 8/1/11**
4	Establish Advisory Committee	Tue 11/1/11
5	Regional Stakeholder Meetings	Mon 8/1/11
6	Indian Tribal Government Meetings **	Fri 12/30/11
7	Provide Publicly Available Minutes to HHS	Sun 1/1/12
8	Work groups under the Steering Committee document minutes (add)	Sun 1/1/12
9	Work groups collect documented minutes and submit to HHS (add)	Sun 1/1/12
10	Continue Indian Tribal Government Meetings **	Mon 12/31/12
11	Complete stakeholder meetings	Tue 1/1/13
12	Work groups under the Steering Committee document minutes (add)	Tue 1/1/13
13	Work groups collect documented minutes and submit to HHS (add)	Tue 1/1/13
14	Public Outreach work group provides HHS with outreach materials (add)	Mon 4/1/13
15	Continue Indian Tribal Government Meetings **	Tue 12/31/13
16	Post Evidence of regular consultation with stakeholders	Wed 1/1/14
17	Summarize feedback received (add)	Wed 1/1/14
18	Conduct quarterly open forums (add)	Wed 1/1/14
19	Provide feedback to HHS (add)	Wed 1/1/14
20	Continue Indian Tribal Government Meetings **	Wed 12/31/14
21	**Legislative / Regulatory Action**	**Sat 10/1/11**
22	Draft Exchange Legislation	Sat 10/1/11
23	Introduce Exchange Legislation	Tue 11/1/11
24	Public Hearings on Exchange Legislation	Tue 11/1/11
25	Legal Authority to Operate Compliant Exchange	Tue 5/1/12
26	**Governance**	**Mon 11/7/11**
27	Develop a Governance Model **	Mon 11/7/11
28	Determine Exchange Governing Standards	Thu 12/1/11
29	Establish Governance Structure **	Tue 5/1/12
30	Appoint Exchange Governing Board	Thu 3/1/12
31	Develop Formal Charter/ By-Laws	Thu 3/1/12
32	**Exchange IT Systems**	**Sat 10/1/11**
33	Gap Analysis of existing systems **	Sat 10/1/11
34	Review product alignment with Exchange goals **	Sun 7/1/12
35	Preliminary Business Requirements/ IT Framework **	Tue 11/1/11



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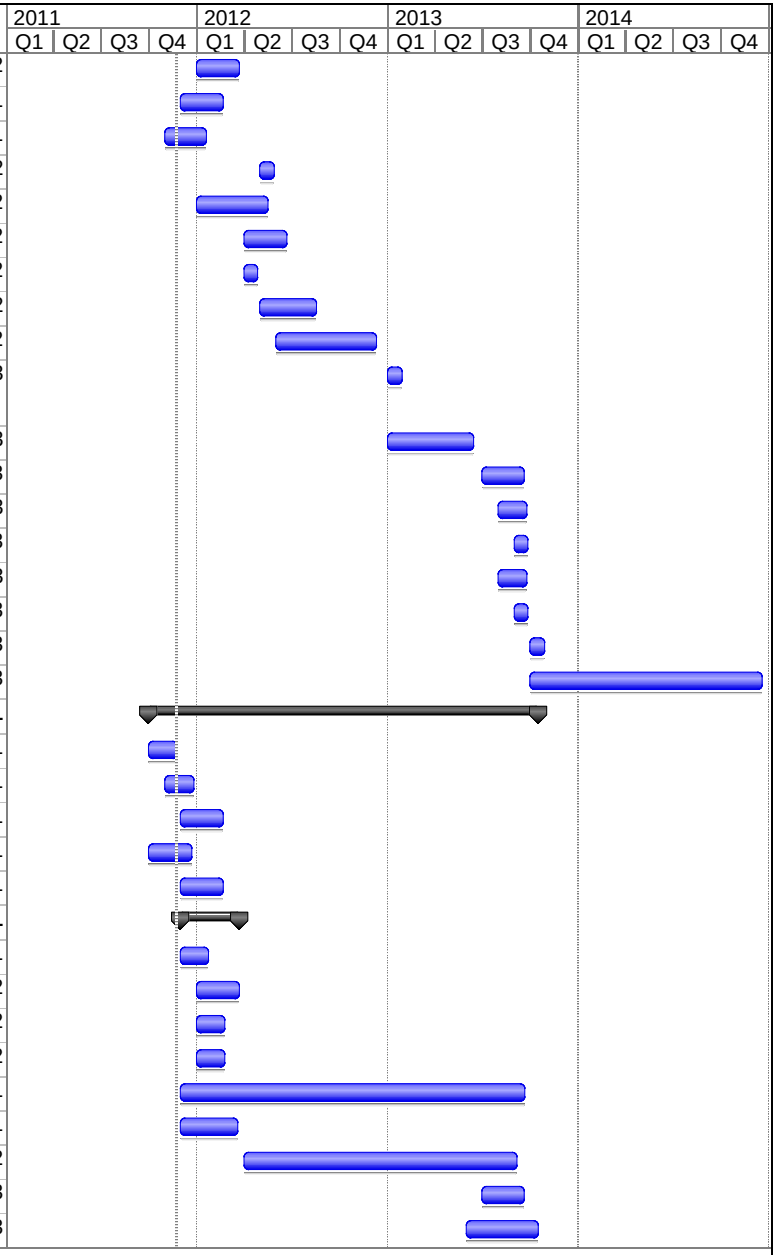
ID	Task Name	Start
36	Work group completes requirements to support system development (add)	Sun 1/1/12
37	Develop Exchange Procurement Approach (add)	Thu 12/1/11
38	SDLC Implementation Plan **	Tue 11/1/11
39	Security Risk Assessment and Release Plan **	Tue 5/1/12
40	Preliminary System Documentation **	Sun 1/1/12
41	Finalize System Documentation **	Sun 4/1/12
42	Begin systems development (add)	Sun 4/1/12
43	Complete Final requirements documentation **	Tue 5/1/12
44	Preliminary Baseline System Review **	Fri 6/1/12
45	Conduct required Exchange development progress assessment with HHS (add)	Tue 1/1/13
46	Complete Final Baseline System Development **	Tue 1/1/13
47	Complete System Testing **	Mon 7/1/13
48	Complete final user testing **	Thu 8/1/13
49	Pre-Open Enrollment **	Sun 9/1/13
50	Prepare and Deploy all system components to production environment **	Thu 8/1/13
51	Obtain security accreditation **	Sun 9/1/13
52	Exchange goes live (add)	Tue 10/1/13
53	Support Business Operations and maintenance of all systems components **	Tue 10/1/13
54	**Program Integration**	**Sat 10/1/11**
55	Establish a Health Insurance Exchange Steering Committee (add)	Sat 10/1/11
56	Establish Work Groups that report to the Steering Committee (add)	Tue 11/1/11
57	Detailed Business Process Documentation **	Thu 12/1/11
58	Communicate with State Agencies to Promote Collaboration **	Sat 10/1/11
59	Execute Agreement with State Dept. of Insurance **	Thu 12/1/11
60	**Execute Agreement with State Health Agencies / Programs ** **	**Thu 12/1/11**
61	Execute inter-agency agreement (add)	Thu 12/1/11
62	Develop operating procedures and defined roles (add)	Sun 1/1/12
63	Initiate Risk Management (add)	Sun 1/1/12
64	Determine cost allocation (add)	Sun 1/1/12
65	Collaborate on Eligibility Medicaid IT Systems	Thu 12/1/11
66	Develop procurement approach and obtain resources required (add)	Thu 12/1/11
67	Develop the Exchange systems, including interfaces (add)	Sun 4/1/12
68	Collaborate on testing of Exchange and OASHSPs	Mon 7/1/13
69	Coordinate open enrollment period with Eligibility determinations	Sat 6/1/13



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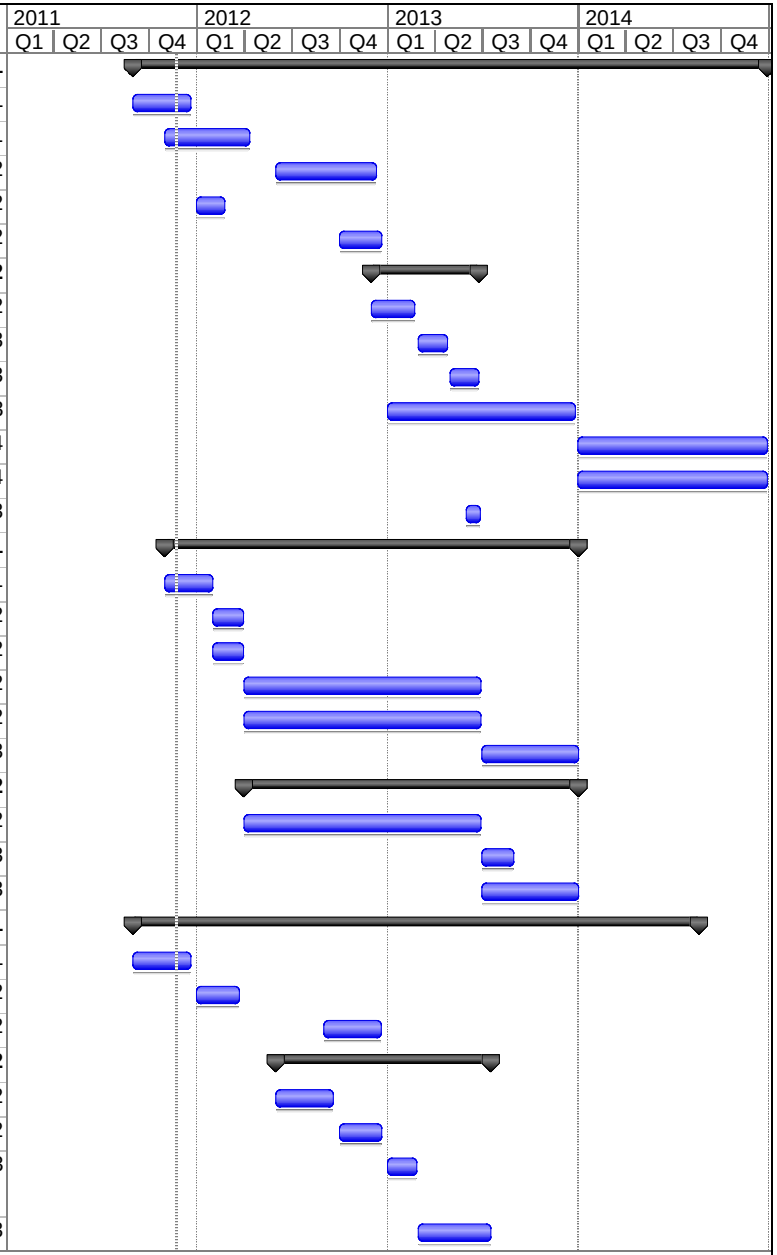
ID	Task Name	Start
70	**Financial Management**	**Thu 9/1/11**
71	Adhere to HHS Financial Monitoring Activities **	Thu 9/1/11
72	Define Structure and Scope of Financial Management activities	Tue 11/1/11
73	Establish Structure/ Hire Accountants **	Fri 6/1/12
74	Develop Plan to Determine Resource and Legislation Needs	Sun 1/1/12
75	Assess Adequacy of Financial Systems	Mon 10/1/12
76	**Third Party Review of Internal Control Systems**	**Sat 12/1/12**
77	Procure services of third party reviewer (add)	Sat 12/1/12
78	Conduct third party review (add)	Fri 3/1/13
79	Address findings and recommendations of third-party review (add)	Wed 5/1/13
80	Demonstrate capability to manage the Exchange finances	Tue 1/1/13
81	Post information related to Exchange financial management on its website	Wed 1/1/14
82	Submit the required annual accounting report to HHS	Wed 1/1/14
83	Determine whether State Auditor will perform the audit (add)	Sat 6/1/13
84	**Risk Adjustment**	**Tue 11/1/11**
85	Review concurrent and prospective risk adjustment approaches	Tue 11/1/11
86	Develop data collection processes for the risk adjustment program	Wed 2/1/12
87	Collect encounter data (if required)	Wed 2/1/12
88	Develop / modify current systems to support the risk adjustment program	Sun 4/1/12
89	Develop / modify current systems to be able to credit / debit health plans	Sun 4/1/12
90	Implement a risk adjustment program according to federal standards	Mon 7/1/13
91	**Transitional Reinsurance**	**Sun 4/1/12**
92	Develop / modify current systems to support debits / credits to insurers	Sun 4/1/12
93	Establish or contract a non-profit reinsurance entities	Mon 7/1/13
94	Implement a transitional reinsurance program according to federal standards	Mon 7/1/13
95	**Oversight & Program Integrity**	**Thu 9/1/11**
96	Ensure Prevention of Grant Misuse **	Thu 9/1/11
97	Continue Planning/ Hire Oversight and Integrity Staff	Sun 1/1/12
98	Establish Procedures for an External Audit	Sat 9/1/12
99	**Establish fraud detection procedures**	**Fri 6/1/12**
100	Perform risk assessment of Exchange operations (add)	Fri 6/1/12
101	Design a program of fraud, waste and mismanagement prevention (add)	Mon 10/1/12
102	Identify tools and/or data analytic techniques to identify data anomalies (add)	Tue 1/1/13
103	Develop a plan to adequately implement automated tools (add)	Fri 3/1/13



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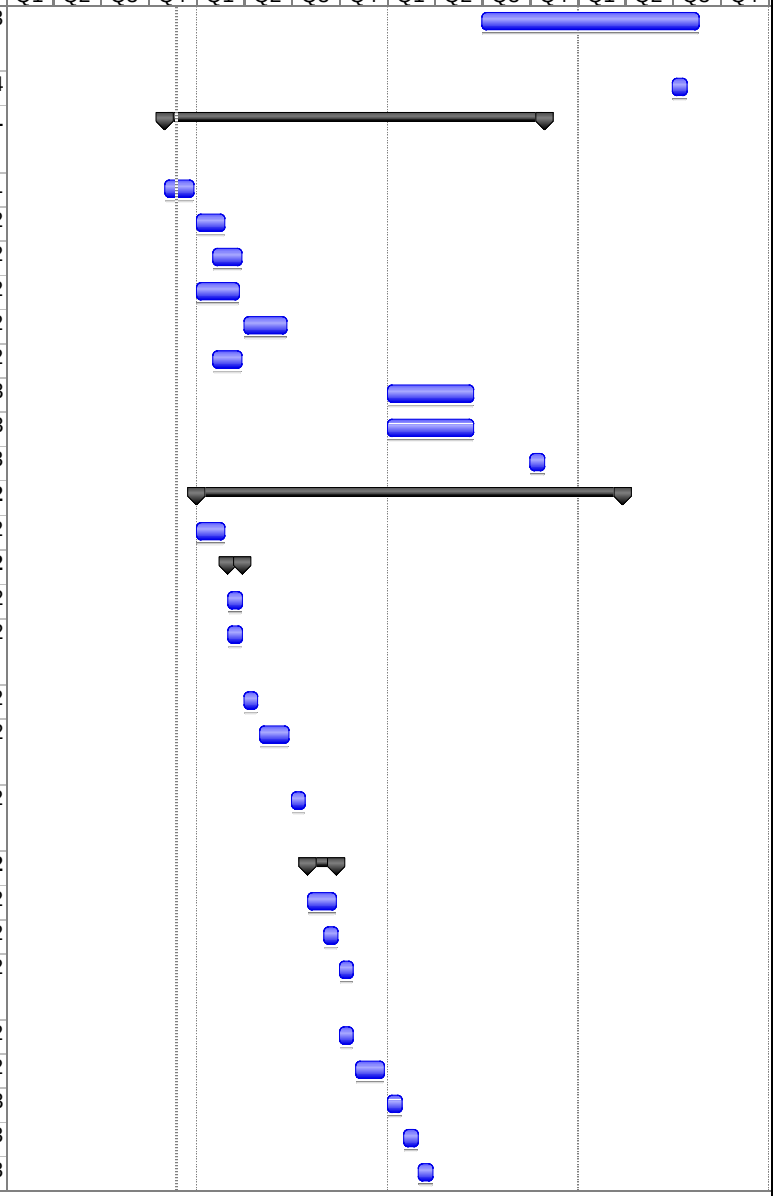
ID	Task Name	Start
104	Develop procedures for reporting to HHS on efforts to prevent fraud, waste, and abuse	Mon 7/1/13
105	Comply with HHS reporting requirements	Tue 7/1/14
106	**Proving Assistance To Individuals And Small Businesses, Coverage Appeals, And Complaints**	**Tue 11/1/11**
107	Establish a Consumer Assistance Program work group (add)	Tue 11/1/11
108	Coordinate with State Organizations to Ensure Service Availability	Sun 1/1/12
109	Analyze and Report on Collected Data to Strengthen Exchange **	Wed 2/1/12
110	Establish Protocols for the Appeals of Coverage Process **	Sun 1/1/12
111	Draft a Scope of Work for Building Capacity to Handle Appeals Functions **	Sun 4/1/12
112	Analyze and Report on Collected Data to Strengthen Exchange **	Wed 2/1/12
113	Establish a process for reviewing consumer complaints	Tue 1/1/13
114	Establish process for referrals to consumer assistance programs	Tue 1/1/13
115	Ensure any consumer complaints or appeals are referred properly	Tue 10/1/13
116	**Certification of Qualified Health Plans**	**Sun 1/1/12**
117	Begin Developing Standards for Certification of Health Plans	Sun 1/1/12
118	**Develop a Certification Policy**	**Thu 3/1/12**
119	Determine resource needs (add)	Thu 3/1/12
120	Decide whether the certification process will be housed internally or externally (add)	Thu 3/1/12
121	Communicate with Stakeholders to Gather Input	Sun 4/1/12
122	Develop a Strategy and Timeline to Integrate Staff and IT Systems in Application Process	Tue 5/1/12
123	Make significant progress on the development of an RFP for certification of a qualified health plan	Sun 7/1/12
124	**Draft Applicable Documents for Certifying Health Plans**	**Wed 8/1/12**
125	Consider an attestation document for insurers to verify compliance (add)	Wed 8/1/12
126	Complete a solicitation for proposals for qualified health plans	Sat 9/1/12
127	Provide evidence of staff resources (or contracts) to support the plan certification evaluation	Mon 10/1/12
128	Release Solicitation / Conduct Bidders Conference	Mon 10/1/12
129	Begin training health plan issuers to become qualified health plans	Thu 11/1/12
130	Collect submissions from the solicitation and begin evaluating	Tue 1/1/13
131	Solicit premium quotes from health plan issuers who responded	Fri 2/1/13
132	Launch plan management and bid evaluation system **	Fri 3/1/13



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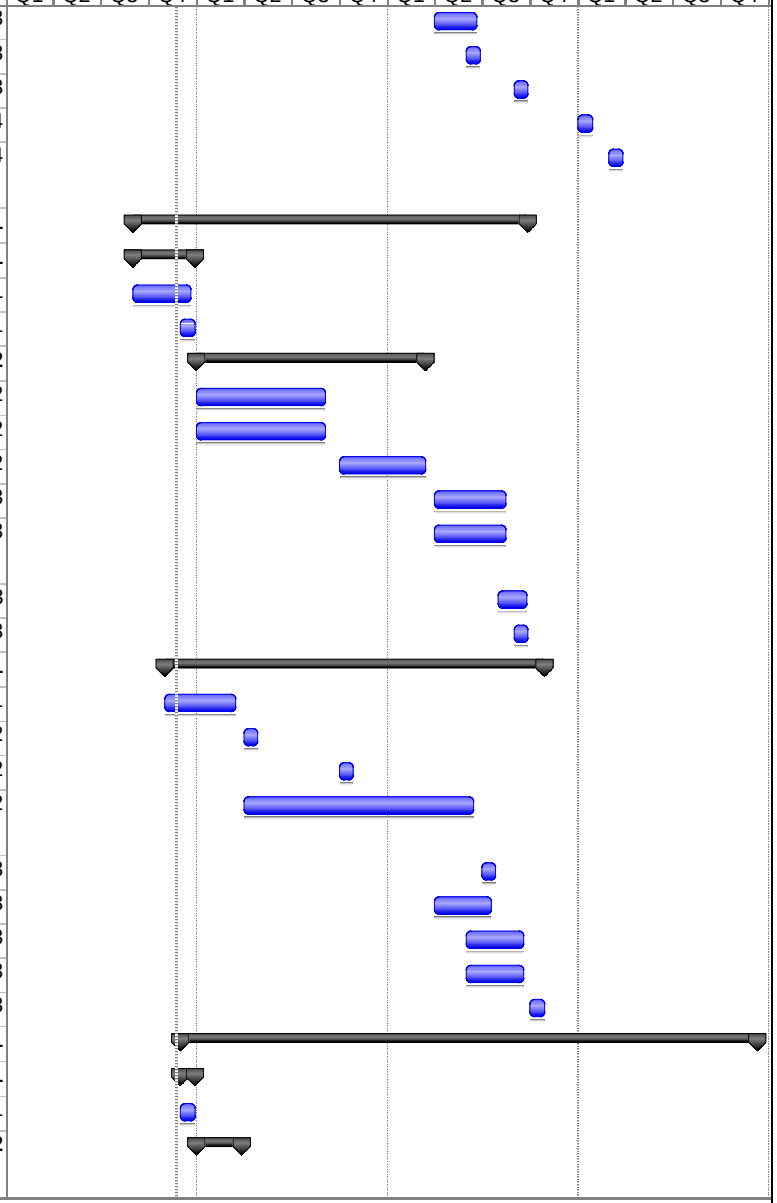
133	Complete the certification of qualified health plans	Mon 4/1/13
134	Issue an announcement on the selection of qualified health plans	Sat 6/1/13
135	Conduct plan readiness reviews/activities	Sun 9/1/13
136	Begin collecting user fees	Wed 1/1/14
137	Demonstrate capability for the to monitor practices and conduct of health insurers	Sat 3/1/14
138	**Call Center**	**Thu 9/1/11**
139	**Determine if Call Functionalities can be Shared**	**Thu 9/1/11**
140	Expand current DGS analysis (add)	Thu 9/1/11
141	Determine if there will continue to be a consolidated HHSCC (add)	Thu 12/1/11
142	**Complete call center procurement process**	**Sun 1/1/12**
143	Develop the requirements and RFP for call center (add)	Sun 1/1/12
144	Develop the requirements for HHSCC (add)	Sun 1/1/12
145	Complete procurement of call center services (add)	Mon 10/1/12
146	Develop call center customer service representative protocols	Mon 4/1/13
147	Develop protocols for accommodating the hearing impaired and other special services	Mon 4/1/13
148	Train call center representatives	Thu 8/1/13
149	Launch call center functionality and publicize 1-800 number **	Sun 9/1/13
150	**Exchange Website and Calculator**	**Tue 11/1/11**
151	Begin developing requirements for systems and program operations **	Tue 11/1/11
152	Begin systems development **	Sun 4/1/12
153	Submit content for informational website to HHS for comment **	Mon 10/1/12
154	Complete systems development and final user testing of informational website **	Sun 4/1/12
155	Launch information website **	Mon 7/1/13
156	Collect and verify plan data for comparison tool **	Mon 4/1/13
157	Test comparison tool with consumers and stakeholders **	Sat 6/1/13
158	Launch comparison tool with pricing information **	Sat 6/1/13
159	Launch fully functioning comparison tool **	Tue 10/1/13
160	**Quality Rating System**	**Thu 12/1/11**
161	**Pending additional guidance from HHS (add)**	**Thu 12/1/11**
162	Utilize the Federal Quality Rating System	Thu 12/1/11
163	**Include quality rating functionality in system business requirements for the Exchange website**	**Sun 1/1/12**



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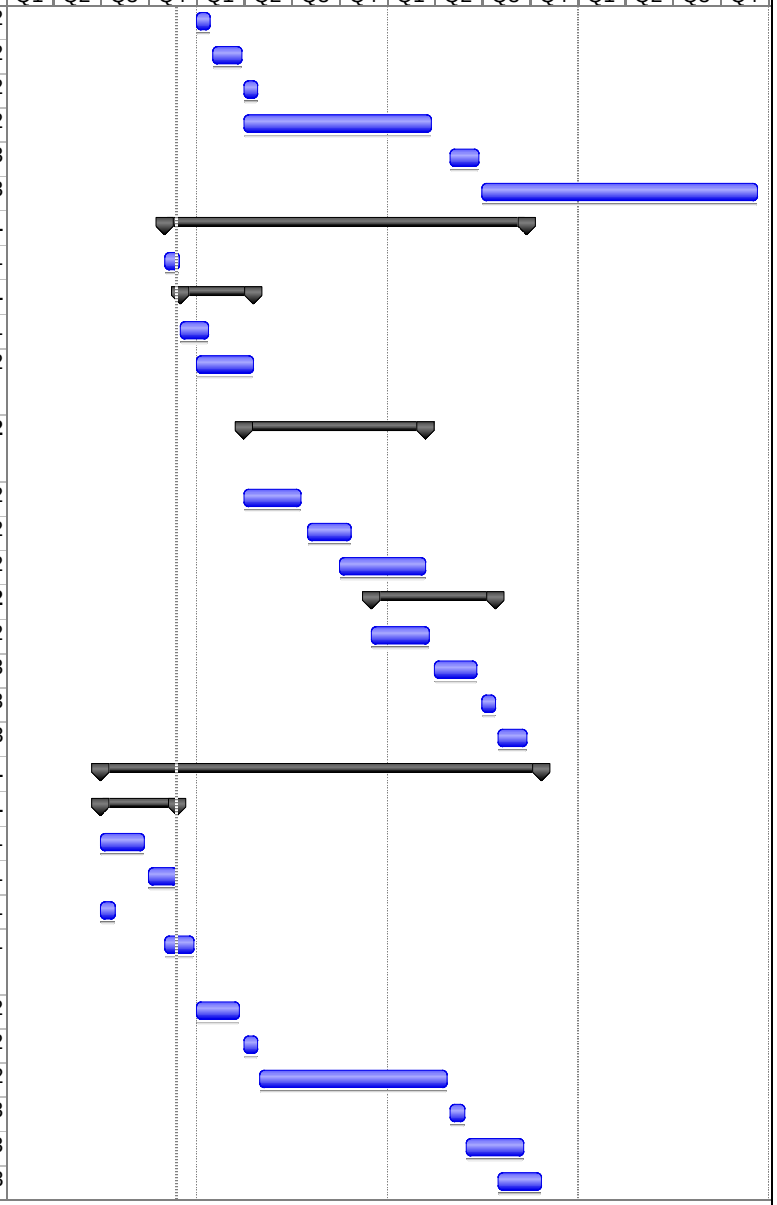
ID	Task Name	Start
164	Survey consumers to obtain a list of quality rating indicators (add)	Sun 1/1/12
165	Choose quality rating indicators (add)	Wed 2/1/12
166	Complete system development of quality rating functionality	Sun 4/1/12
167	Complete testing and validation of quality rating functionality	Sun 4/1/12
168	Post quality rating system information on the Exchange website	Wed 5/1/13
169	Continually update quality rating information on the Exchange website	Mon 7/1/13
170	**Navigator Program**	**Tue 11/1/11**
171	Receive Federal guidance on the Navigator Program (add)	Tue 11/1/11
172	**Conduct a Navigator Study (add)**	**Thu 12/1/11**
173	Conduct Preliminary Planning Activities	Thu 12/1/11
174	Determine targeted organizations in the State who would qualify to function as Navigators	Sun 1/1/12
175	**Determine Navigator grantee organizations and award contracts or grants ****	**Sun 4/1/12**
176	Establish the Grant Program for Navigators (add)	Sun 4/1/12
177	Advertise availability of grants (add)	Wed 8/1/12
178	Select Grantees and award contracts (add)	Mon 10/1/12
179	**Train Navigators**	**Sat 12/1/12**
180	Identify training delivery approach and secure resources (add)	Sat 12/1/12
181	Develop training materials, identify potential organizations (add)	Mon 4/1/13
182	Deliver Navigator Training (add)	Mon 7/1/13
183	Begin operations of Navigators	Thu 8/1/13
184	**Eligibility Determinations**	**Fri 7/1/11**
185	**Coordinate with agencies administering other OASHSPs**	**Fri 7/1/11**
186	Complete initial planning effort (add)	Fri 7/1/11
187	Establish a Health Insurance Exchange Steering Committee (add)	Sat 10/1/11
188	Coordinate with State Department of Insurance	Fri 7/1/11
189	Begin developing requirements, including requirements on the Exchange side and in OASHSPs **	Tue 11/1/11
190	Work groups complete requirements to support system development (add)	Sun 1/1/12
191	Begin Systems Development **	Sun 4/1/12
192	Complete System Development and Prepare for final user testing **	Tue 5/1/12
193	Begin final user testing **	Wed 5/1/13
194	Complete user testing **	Sat 6/1/13
195	Begin conducting eligibility determinations for OASHSPs **	Thu 8/1/13



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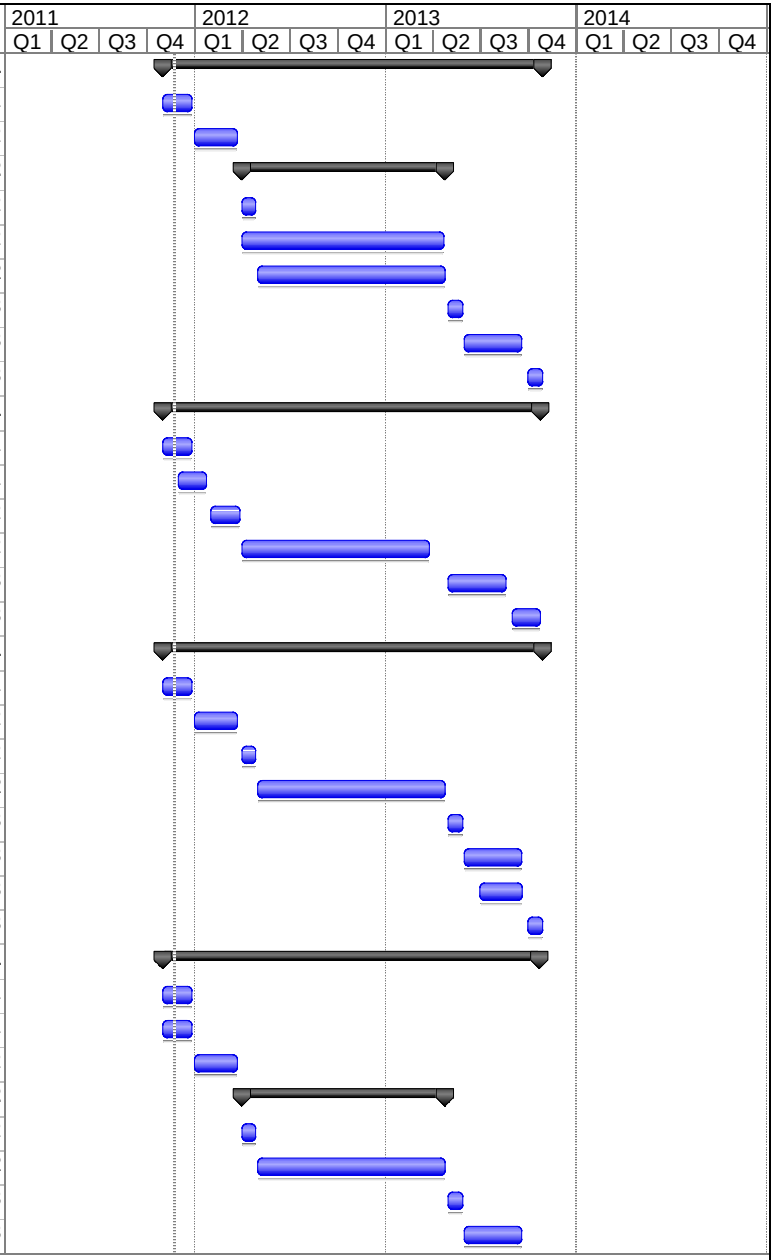
196	**Enrollment Process**	**Tue 11/1/11**
197	Begin Developing Requirements for systems and program operations **	Tue 11/1/11
198	Work group completes requirements to support system development (add)	Sun 1/1/12
199	**System development (add)**	**Sun 4/1/12**
200	Begin systems development **	Sun 4/1/12
201	Enrollment work group participates in package selection (add)	Sun 4/1/12
202	Complete systems development and prepare for final user testing **	Tue 5/1/12
203	Begin final user testing **	Wed 5/1/13
204	Complete user testing **	Sat 6/1/13
205	Begin Enrollment into qualified health plans **	Tue 10/1/13
206	**Applications and Notices**	**Tue 11/1/11**
207	Establish work groups to focus on processes and requirements (add)	Tue 11/1/11
208	Review Federal requirements for applications and notices	Thu 12/1/11
209	Complete defining requirements (add)	Wed 2/1/12
210	Develop format and actual content (add)	Sun 4/1/12
211	Finalize all applications and notices	Wed 5/1/13
212	Begin utilizing applications and notices **	Sun 9/1/13
213	**Exemptions from Individual Responsibility Requirement and Payment**	**Tue 11/1/11**
214	Begin developing requirements for systems and program operations **	Tue 11/1/11
215	Work groups complete requirements to support system development (add)	Sun 1/1/12
216	Begin systems development **	Sun 4/1/12
217	Complete systems development and prepare for final user testing **	Tue 5/1/12
218	Begin final user testing **	Wed 5/1/13
219	Complete user testing **	Sat 6/1/13
220	Develop and communicate instructions (add)	Mon 7/1/13
221	Begin processing exemptions **	Tue 10/1/13
222	**Premium Tax Credit and Cost Sharing Reduction Administration**	**Tue 11/1/11**
223	Receive pending guidance from HHS (add)	Tue 11/1/11
224	Begin developing requirements for systems and program operations **	Tue 11/1/11
225	Work groups complete requirements (add)	Sun 1/1/12
226	**System development (add)**	**Sun 4/1/12**
227	Begin systems development **	Sun 4/1/12
228	Complete systems development and prepare for final user testing **	Tue 5/1/12
229	Begin final user testing **	Wed 5/1/13
230	Complete user testing **	Sat 6/1/13



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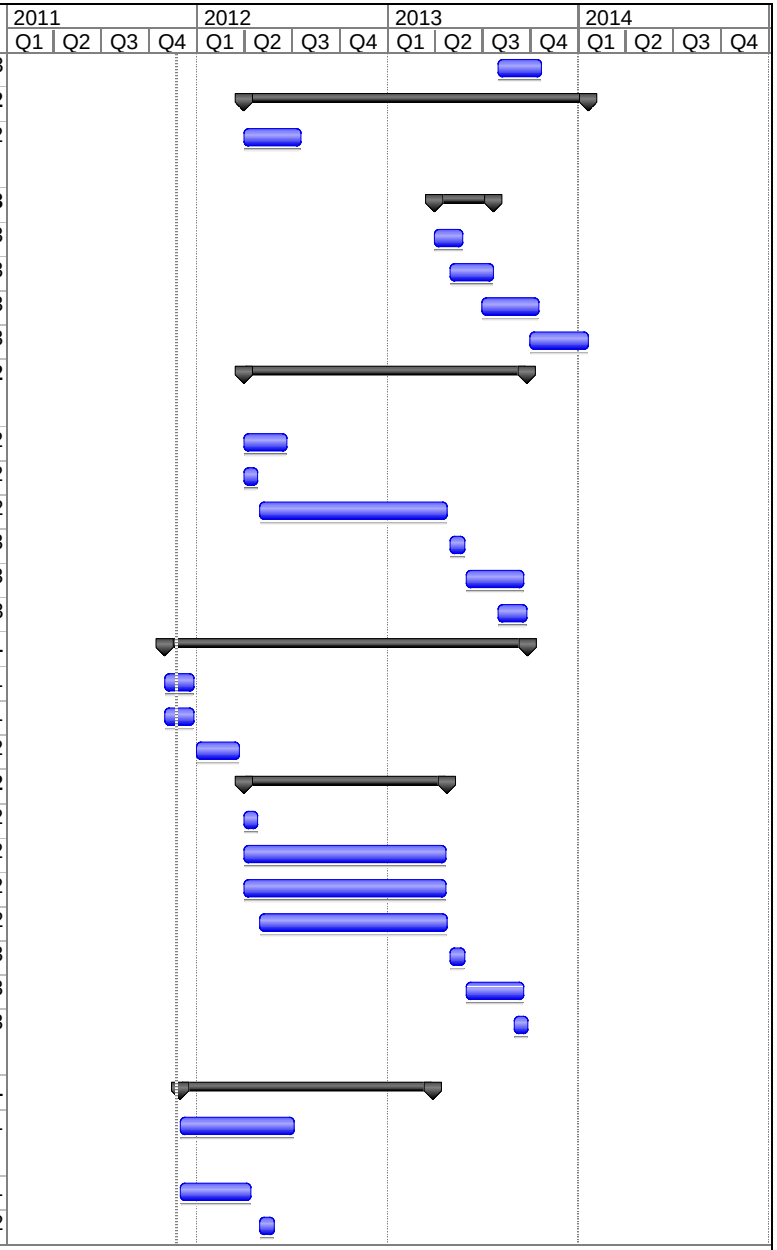
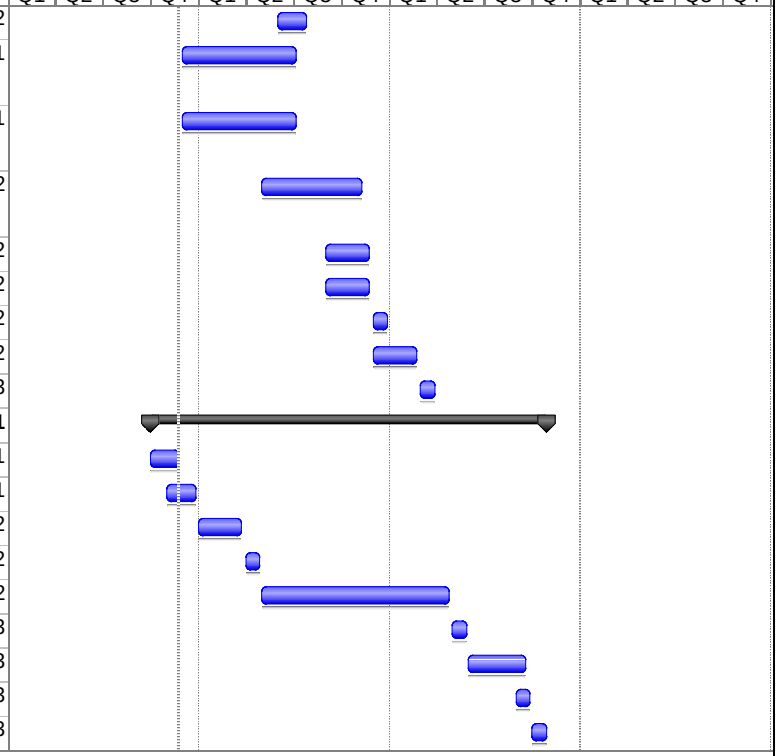
231	Begin submitting tax credit and cost-sharing reduction information **	Thu 8/1/13
232	**Adjudication of Appeals of Eligibility Determinations**	**Sun 4/1/12**
233	Begin developing business processes and operational plan for appeals functions	Sun 4/1/12
234	**Establish resources to handle appeals of eligibility**	**Mon 4/1/13**
235	Identify resources to support the appeals process (add)	Mon 4/1/13
236	Develop training materials, schedule and conduct training (add)	Wed 5/1/13
237	Initiate communication with HHS on process for referring appeals	Mon 7/1/13
238	Begin receiving and adjudicating requests **	Tue 10/1/13
239	**Notification and appeals of employer liability for the employer responsibility payment**	**Sun 4/1/12**
240	Begin developing requirements for systems and program operations **	Sun 4/1/12
241	Begin systems development **	Sun 4/1/12
242	Complete systems development and prepare for final user testing **	Tue 5/1/12
243	Begin final user testing **	Wed 5/1/13
244	Complete user testing **	Sat 6/1/13
245	Begin notifying employers in coordination with eligibility determinations **	Thu 8/1/13
246	**Information reporting to IRS and enrollee**	**Tue 11/1/11**
247	Receive pending guidance from HHS (add)	Tue 11/1/11
248	Begin developing requirements for systems and program operations **	Tue 11/1/11
249	Work group completes requirements to support system development (add)	Sun 1/1/12
250	**System development (add)**	**Sun 4/1/12**
251	Begin systems development **	Sun 4/1/12
252	Enrollment work group participates in package selection (add)	Sun 4/1/12
253	Design functionality for communicating information (add)	Sun 4/1/12
254	Complete systems development and prepare for final user testing **	Tue 5/1/12
255	Begin final user testing **	Wed 5/1/13
256	Complete user testing **	Sat 6/1/13
257	Confirm that systems are prepared to generate information reports to enrollees **	Sun 9/1/13
258	**Outreach and Education**	**Thu 12/1/11**
259	Perform market analysis/environmental scan to assess outreach/education needs	Thu 12/1/11
260	Coordinate with Navigator study (add)	Thu 12/1/11
261	Develop outreach and education plan (add)	Tue 5/1/12



Project: Commonwealth of PA All Tasl
Date: Mon 11/21/11

Task
Split
Progress
Milestone
Summary
Project Summary
External Tasks
External Milestone
Deadline

ID	Task Name	Start
262	Distribute outreach and education plan to stakeholder and HHS (add)	Fri 6/1/12
263	Develop outreach and education plan to include key milestones and contracting strategy	Thu 12/1/11
264	Distribute outreach and education plan to stakeholders and HHS for input and refinement	Thu 12/1/11
265	Develop a "toolkit" for outreach to include educational materials and information	Tue 5/1/12
266	Develop performance metrics and evaluation plan	Sat 9/1/12
267	Design a media strategy and other information dissemination tools	Sat 9/1/12
268	Submit final outreach and education plan	Sat 12/1/12
269	Focus test materials with key stakeholders and consumers	Sat 12/1/12
270	Launch outreach and education strategy	Fri 3/1/13
271	**SHOP-specific Functions**	**Sat 10/1/11**
272	Research the design and approach of the SHOP Exchange	Sat 10/1/11
273	Begin developing requirements for systems and program operations **	Tue 11/1/11
274	Work group completes requirements to support system development (add)	Sun 1/1/12
275	Begin systems development **	Sun 4/1/12
276	Complete systems development and prepare for final user testing **	Tue 5/1/12
277	Begin final user testing **	Wed 5/1/13
278	Complete user testing **	Sat 6/1/13
279	Open SHOP to accept employer rosters (add)	Sun 9/1/13
280	Begin SHOP enrollment (add)	Tue 10/1/13



Project: Commonwealth of PA All Tasl
Date: Mon 11/21/11

Task
Split
Progress
Milestone
Summary
Project Summary
External Tasks
External Milestone
Deadline

KPMG
cutting through complexity

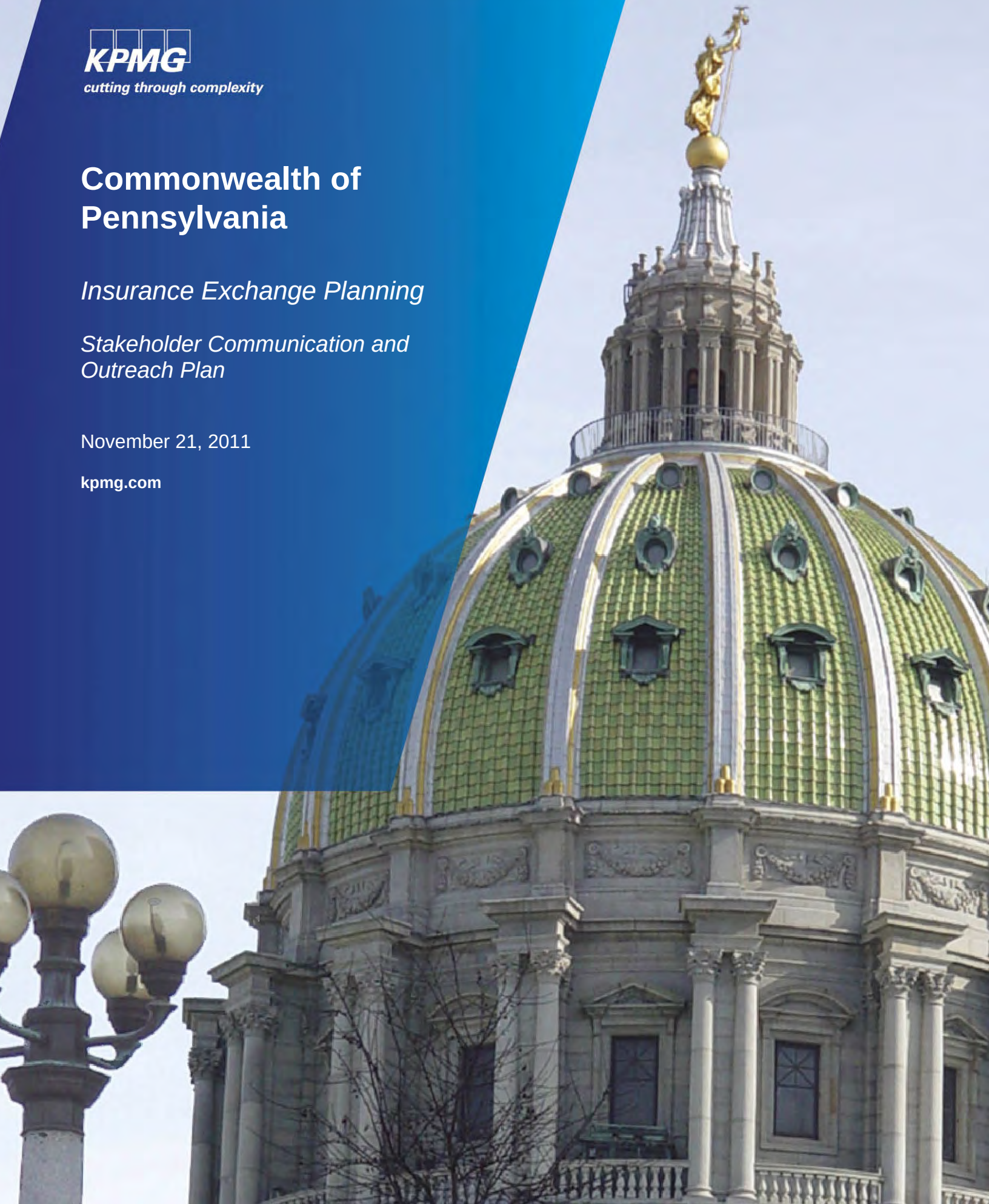
Commonwealth of Pennsylvania

Insurance Exchange Planning

Stakeholder Communication and Outreach Plan

November 21, 2011

kpmg.com



Introduction

Stakeholder involvement and effective communication of information relating to the Commonwealth of Pennsylvania's potential Health Benefit Exchange (Exchange) must be successfully managed. Section 1311(d)(6) of the Patient Protection Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010 (together, referenced as the Act or ACA) requires that each Exchange consult with a variety of key stakeholders in the planning, establishment and ongoing operation of Exchanges. This Stakeholder Communication and Outreach Plan (the Plan) is designed to assist the Pennsylvania Insurance Department (PID or the Department) to:

- Identify core stakeholders impacted by the development or use of an exchange
- Outline the various issues to be discussed and subsequently addressed based on stakeholder input
- Encourage specific and relevant information about the Exchange to be communicated in a timely manner
- Suggest varied methods of communication to help facilitate clear messaging and ensure sufficient coverage; communication and outreach
- Provide an avenue for stakeholders to resolve concerns and generate Exchange support

Additionally, this plan will provide parameters and guidance on key messages as well as indicate the vehicles may be used under differing circumstances and various audiences to obtain feedback as well as communicate information. Finally, the Plan may also be used as a means of establishing accountability and setting some of the timing of communications to users involved and affected by the Exchange.

Guiding principles incorporated throughout this Plan include:

- Create opportunities for PID leadership to communicate effectively with stakeholder groups on a continuous basis
- Balance the use of face-to-face communications with the use of technology to maximize message coverage and minimize time commitments and expenses
- Promote the credibility of the processes involved with contemplating, planning, establishing, operating and monitoring an Exchange through visible leadership support
- Understand the impact on various stakeholder groups and work to address concerns
- Be consistent in the tone and content of the messages related to the Exchange

The remainder of this document is comprised of the following sections:

1. **Anticipated Stakeholders** – outlines the internal and external stakeholders to be considered for future communication and outreach.

2. **Efforts to Date** – presents the Commonwealth's recent activities aimed at obtaining stakeholder input.

3. **Stakeholder Considerations by Focus Area** – presents a summary of stakeholder issues by focus area that the Commonwealth may wish to consider in its Exchange decision making process.

4. **Moving Forward** – presents possible messages, suggested timing and various vehicles for obtaining input and disseminating information related to the planning, establishment and operation of an Exchange with consideration given to "Cooperative Agreement to Support Establishment of State Operated Health Insurance Exchanges Funding Opportunity Announcement" (FOA) milestones.

NOTE: Elements of this Plan, especially the suggested efforts for moving forward, will likely change and require updating as the Commonwealth makes policy and operational decisions and additional federal guidance is released.

Anticipated Stakeholders

The following table presents a list of anticipated stakeholders. This list should be revisited on a regular basis to help ensure additional stakeholders are included as appropriate as decisions are being made.

Groups	Members
PID and Exchange Team Members	Michael Consedine, Commissioner Randolph Rohrbaugh, Executive Deputy Commissioner Franca D'Agostino, Director of Special Projects Matthew O'Donnell, Policy Director Sandra Ykema, Department Counsel for Insurance Rosanne Placey, Press Secretary Kimberly Bathgate, Communications Manager Brad Harker, Department Counsel (Contracts) Peter Adams, Executive Director, Office of Chip & adultBasic Kenneth Kitch, IT Generalist, Bureau of Information Systems Ronald Gallagher, Deputy, Office of Market Regulation
Additional Stakeholders	Commonwealth of Pennsylvania Citizens Agents, Brokers and Producers Insurance Companies Healthcare Providers (including dental) Hospital Associations Consumer Advocates Patients Employees Unemployed Individuals Self Employed Individuals Small Business Employers and Related Associations Medical Society, Medical Professionals National and Community-based Insurers Legislators Pharmaceuticals Actuaries Academia Other Relevant Commonwealth Departments and Agencies

Efforts to Date

PID has been actively engaging stakeholders in the discussion around Exchanges. The table below presents the activities performed through the end of August 2011.

Activity	Description	Delivery Method / Timing
PID Website	Website contains various related articles, statements, letters and other documentation for the public to view.	Ongoing
Health Insurance Exchange Forums	PID executed three stakeholder meetings during the month of August in three separate locations. Published questions PID posed to potential participants in advance of the sessions included: ■ Should Pennsylvania establish and run an Exchange or should Pennsylvania allow the federal government to establish and run the Exchange? ■ Should the Exchange function as a market organizer or as an active purchaser? ■ How should the Exchange be organized and governed? Sessions enabled the Commonwealth to: ■ Provide a forum for stakeholders to share their input and public ideas on the exchange ■ Outline critical areas where stakeholder input is needed ■ Further identify and enhance the network of interested parties to involve in Exchange Plan. To the extent attendees wanted to speak publicly during the session, they were requested to register and provide a written copy of their comments. Testimony submitted as well as videos of each session are accessible online to the public.	In-person at the following locations: ■ Pittsburgh (8/9) ■ Philadelphia (8/11) ■ Harrisburg (8/23) Recordings available online
Individual Meetings	PID has met with individual stakeholder groups to discuss particular issues/concerns as it relates to the planning, establishment and operations of a potential Exchange.	Ongoing as requested of PID or initiated by PID

Activity	Description	Delivery Method / Timing
Health Insurance Exchange Research/ Survey	A survey was administered by the Neiman Group on behalf of PID to explore: ■ Awareness and understanding of Exchanges ■ Openness to the concept of an Exchange ■ Current experiences exploring comprehensive health insurance options and trusted resources ■ Must-have vs. nice-to-have information when comparing comprehensive health insurance options ■ Potential customer expectations for a Health Insurance Exchange ■ Potential messaging opportunities.	Conducted online between August 1 and August 12, 2011; survey participants included: ■ Pennsylvania small business owners / health insurance decision makers ■ Pennsylvania consumers, age 18 - 29 ■ Pennsylvania consumers, age 30 - 65

The Neiman Survey identified that for a Pennsylvania Exchange to be successful, in the eyes of those surveyed, it should:

- Provide a way for business and consumers to ask questions and get the right information, and
- Ensure that all language and information on the site can be easily understood and is actionable.

Successful implementation of these recommendations would require the Commonwealth to engage in stakeholder outreach to verify that the information being offered at their websites or offices is readily understandable, and easy for businesses and consumers to use, and that it meets their needs and answers the questions they need answered. For example, the Commonwealth may want to ensure that if it designs a website that it provides options that are easy for consumers to compare, and allows them to input their personal information (like the amount they can pay), to see what options they can afford.

Stakeholder Considerations

Stakeholder involvement is critical for successful implementation of any Health Benefit Exchange, and as noted earlier, it is requried by the ACA. Specific stakeholder involvement and activities will evolve and be developed as decisions are made regarding implementation of an Exchange, with each decision likely to trigger the need for specific actions or next steps. Consequently, while we have identified potential areas where stakeholder involvement may be useful or advised, because certain decisions have not yet been made that might trigger their need, it is not possible at this point to lay out a concrete stakeholder action plan. The following considerations were developed for the Commonwealth of Pennsylvania by KPMG LLP (KPMG), and is organized by focus area.

Regulatory / Legislative

In the establishment of any Exchange, there will be legislative and regulatory actions that need to take place, both at the federal and state levels – regardless of which is implementing the Exchange. The specific legislation and regulations will differ at the state level, but the necessity of new laws and regulations will exist regardless. Specific stakeholder actions have been identified as valuable or necessary to comply with federal law and proposed regulations. A review of these actions is provided below.

In the absence of a decision regarding whether a federal or state Exchange will be pursued, the Commonwealth needs to determine how it will refine and execute its existing outreach process to affected stakeholders, specifically in the carrier community and with Consumer Groups (including brokers, navigators, community partners, medical advocates, not-for-profits, and state and federal agencies, as well as individuals, families, employees and employers). The Commonwealth may want to consider a blanket outreach effort designed to reach as many of this universe as possible, with subsequent, more targeted efforts tailored to specific stakeholder/consumer groups.

One of the first instances where stakeholder outreach may be undertaken is prior to the introduction of legislation in the State legislature. There has already been a series of stakeholder meetings that have taken place, which were well attended and designed to solicit the views of the stakeholder community at large. When, and if, Pennsylvania Health Benefit Exchange legislation, supported by the Administration, is to be introduced, there may be additional public outreach, possibly through printed materials, through the Internet, or via the media (or a combination of efforts), to help educate and include the affected community at large.

If the Commonwealth decides to move forward and implement an Exchange, Pennsylvania needs to move quickly to draft establishment authority and implement both organizational and governance structures. In conjunction with this effort, Pennsylvania may initiate and maintain an outreach and communication process with both its key internal and external stakeholders. The outreach process to affected stakeholders is equally important, specifically in the carrier community, and with the Consumer Groups (including all of those mentioned above). The content of the outreach will be different depending upon the type of Exchange being pursued, but the stakeholders / consumer groups that will be impacted by the resulting programs are likely to be the same.

Governance and Organizational Structure

Determining the governance and organizational structure of the Exchange are among the first decisions that will have to be made by the Commonwealth. Significant interest was expressed during the Stakeholder sessions in the governance of the Exchange. Many who spoke or submitted written comments at the forums noted the need for a Governing Board/Steering Committee as part of the Exchange. Different stakeholders offered various opinions on the proper composition of such board. Options suggested include, but are not limited to, "a fair representation of stakeholders, non-industry experts, insurers, brokers, people with public insurance background, a nurse practitioner, a chiropractor, a member of the mental health community, etc." Stakeholders noted that "a board of directors should be appointed based

on relevant expertise, representing a broad spectrum of interests." Stakeholder feedback also stressed the importance of continuous and broad-based consumer input.

Future stakeholder actions will depend upon what decision the Commonwealth makes regarding governance structure, and on the organizational structure implemented. IT integration and architecture, business requirements, and integration will all vary and have different stakeholder needs, but all will likely require input from the Department of Public Welfare (DPW), business and other stakeholders. In the near term, these efforts could feed into a Level 1 Grant application; further down the road, they may support a Level 2 funding application.

Stakeholder Feedback regarding State vs Federal Exchange

The Pennsylvania Insurance Department (PID) has led the Commonwealth's initiative to seek and obtain input from all interested stakeholders. This has been done through several methods including one-on-one stakeholder meetings with the Department, acceptance of written statements from stakeholders and the coordination and execution of three stakeholder forums. These activities were undertaken by PID to gather feedback from the impacted community regarding ACA legislation and the establishment of a health insurance Exchange.

The feedback obtained through these various activities indicates that a large majority of providers, producers, insurers and community representatives alike expressed their desire for Pennsylvania to create its own Exchange, though one stakeholder expressed an interest in the state teaming with the federal government to create a federal Exchange as a means of promoting efficiencies and minimizing the duplication of efforts required. While most stakeholders are hopeful that the Exchange will assist individuals with the purchase of health insurance, at least two noted that the ACA may not be the answer.

Stakeholders expressed a preference for a state-based Exchange because of the flexibility of a state-run Exchange as opposed to a federal Exchange; one stakeholder noted that a Commonwealth Exchange could better support regionally operated plans or subsidiary Exchanges because of the regional differences in health insurance needs of Pennsylvania, while another commented that "an Exchange in PA allows for greater flexibility and reduced federal regulation" and because they believe they would have more input in the creation of such an Exchange. This can be accomplished through continued efforts planned by PID to seek input from stakeholders. When a preference was noted regarding where in the state an Exchange should be located, PID was often mentioned. One broker commented that the Exchange should be state-run, "as close to the consumer as possible and with the smallest bureaucratic footprint possible." Another insurer noted that "governance for the Exchange should sit within PID since the Department currently regulates insurers and has the expertise and relationship with the carriers." If the Commonwealth decides to house an Exchange in PID, these relationships may help to mitigate implementation challenges of the Exchange within the insurance market because insurers already have a direct line of access with the Pennsylvania Insurance Department.

Several stakeholders felt that the Exchange should include regionally operated plans or subsidiary Exchanges because of the regional differences in health insurance needs of Pennsylvania. Others felt that the Exchange should be an independent public authority, perhaps with involvement of key public officers, with a stakeholder advisory committee and staffed by consumer representatives and positioning the Exchange to hire and procure necessary materials more easily. One insurer agreed that a state Exchange is preferred over a federally run Exchange; however, it expressed that "a regional Exchange would be preferred over a state-run Exchange, because the market is regionally unique based on the four blues plans and commercial insureds."

The flexibility of a state-based Exchange was noted by several stakeholders as impacting their preference for a state program. "An Exchange in PA allows for greater flexibility and reduced federal regulation." It was felt that a state-based Exchange would allow for more stakeholder input and provide "flexibility in the benefit design." It was also noted that "when flexibility of plan design was limited in other states, healthcare costs increased." Another benefit of a state-run Exchange noted by stakeholders would be that the Commonwealth would have control over services provided and could exclude or require provisions of certain services under a state-created Exchange, whereas "Under a federal Exchange, each enrollee (man, woman, and child) will be assessed a charge to fund such covered services."

Other aspects of a state-based Exchange noted by stakeholders include: the Exchange having control of interoperability and having more flexibility with agency data sources; strengthening the ability of the Commonwealth to establish consistent data standards to most effectively meet its needs; and supporting the creation of Pennsylvania-specific tracking metrics to support the tax credit program and reduced cost-sharing subsidies. One provider suggested that "the Exchange should provide a streamlined accessible system between Federal Qualified Health Plans (FQHC) and essential providers." Another expressed the need for a state-based Exchange to have systems that talk to each other. Such concerns will have to be addressed if the Commonwealth decides to pursue a state Exchange.

Many stakeholders were concerned with a potential lack of control if the Commonwealth decides to pursue a federal Exchange. Issues that stakeholders want the Commonwealth to retain control over include: housing an Exchange in PID; the ability to form regional/subsidiary Exchanges that might better meet the needs of different parts of the state; the ability to require ongoing public communication, outreach and transparency; prohibition of gender-based premiums for all plans and products covered in Pennsylvania; and the inclusion of nurse practitioners as certified providers. Other issues relating to state-based control include: insurance companies/underwriters identified the need to keep Small Business Health Option Programs (SHOPs) to groups of 50 enrollees or less, which might not be a decision under state control if a federal Exchange is pursued; the future role of producers and brokers and their importance.

If the Commonwealth decides to move forward and implement an Exchange, Pennsylvania needs to move quickly to draft establishment authority and establish both organizational and governance structures. In conjunction with this effort, Pennsylvania must initiate and maintain an outreach and communication process with both its key internal and external stakeholders. The outreach process to affected stakeholders is equally important specifically in the carrier community and with the Consumer Groups. As noted above, the broader consumer groups in this instance include brokers, navigators, community partners, Medical advocates, not-for-profits, and state and federal agencies, as well as individuals, families, employees and employers). Ensuring public accountability, transparency and prevention of conflict of interest is also a major concern of many stakeholders. To incorporate such into an Exchange will take ongoing marketing, outreach and education efforts.

Program Integration

The stakeholder sessions did not provide any specific comments on program integration, but if the Commonwealth decides to implement a state-based Exchange, there are strategic decisions that will need to be made to ensure that program requirements are established with ease of integration in mind.

There are a variety of areas where working groups were identified as potential resources to help achieve critical tasks. Working groups are considered in this respect to be stakeholder actions as they may involve the efforts of those outside the direct control of the Administration. Focus areas identified that could potentially benefit from working groups include applications, notices, eligibility determination rules, and churn management (movement between public programs and QHPs).

Technology

Information technology will be a component of many business functions of the Exchange, including those set forth in the Act. Much of the process for developing and implementing required technology will not require stakeholder input, but each Exchange will maintain a website through which applicants and enrollees may obtain standardized comparative information on qualified health plans, apply for coverage, and enroll online. For more information on website requirements, refer to that section within this report, or in the *Options Analysis and Exchange Planning Considerations*.

KPMG assessed existing technology systems that the Commonwealth already possesses. Our findings indicate that there are areas in which Pennsylvania does not currently have the necessary technology in place to implement an Exchange. If the decision is made to pursue a state-based exchange, stakeholder feedback may be desired in determining whether the Exchange will outsource specific functions of the exchange or develop the necessary infrastructure in-house.

Financial Management

In addition to the implementation of administrative fees, feedback from stakeholders indicates some support for broad-based contribution to fund the Exchange, such as assessment of fees on plans both inside and outside of the Exchange, for example — sin taxes. Stakeholders also suggested the implementation of defined contribution plans.

The State of Maryland incorporates a requirement into their Health Benefit Exchange Act that its Exchange must publicize on its website the average amounts of fees or assessments, the administrative costs of the Exchange, and the amount of funds known to be lost through fraud, waste and abuse. If the Commonwealth considers similar action, additional efforts will likely have to be extended to collect such information if this is not already done, and to prepare educational materials appropriate for Web-posting, then engage in stakeholder outreach to ensure that the materials are adequately understood.

The Commonwealth may desire to continue to seek input from stakeholders on all topics related to the financial management and integrity programs of an Exchange and may wish to identify specific milestones within future financial management and oversight and integrity program planning.

Providing Assistance to Individuals and Small Businesses, Coverage Appeals and Complaints

The United States Department of Health and Human Services (HHS) *Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges*, Funding Opportunity Announcement (FOA), dated January 20, 2011, notes that although it emphasizes program integrity and financial management, one of the key principles that will inform federal funding and technical support for state establishment of Exchanges is public accountability and transparency. Providing Assistance to Individuals and Small Businesses, Coverage Appeals, and Complaints is one of eleven Exchange Establishment Core Areas. It is noted that successful Exchanges must ensure public accountability.

Exchanges are required to provide certain services for state residents, including responding to requests for information, providing a toll-free hotline, and helping individuals learn whether they are eligible for additional public assistance programs. Exchanges must also provide assistance for coverage appeals. Such assistance must also be available through navigators. Building sufficient capacity for providing assistance to state residents is a core activity of Exchange planning and establishment. HHS notes that an Exchange must collaborate closely with other entities in the state that might be carrying out similar activities and develop a plan to facilitate ongoing collaboration.

These requirements will necessitate that the Commonwealth engage in marketing and outreach activities at a variety of points; including in the design of its consumer assistance program, and when transforming existing consumer assistance efforts into one that will meet all the needs of an Exchange.

The Commonwealth's existing Consumer Assistance Program, and its other existing programs that provide assistance to Health Insurance Consumers, will help to meet the future needs of individual and small business assistance in relation to setting up and operating an Exchange, but additional actions may also be required. The Exchange may continue to consult with individuals and small businesses to gather feedback in response to upcoming legislation or regulatory action from HHS. Stakeholder forums, similar to those held by the PID, may be an effective way to document concerns of the stakeholders. Since future rulemaking will define the standards for an appeals process, exact needs are not known at this point. Additional issues related to appeals are noted later in this report (and in the *Options Analysis and Exchange Planning Considerations*), in the *Adjudication, Notification and Appeals section*.

Certification, Recertification and Decertification of Qualified Health Plans

One of the minimum functions of an Exchange is certification, recertification and decertification of qualified health plans. While the stakeholder sessions held by PID received no specific input on these issues, stakeholder involvement is specifically required by HHS (re: the FOA). States establishing an Exchange should begin defining their processes and

approaches to these activities with health plans early in the process. The activities below (related to stakeholder involvement) are currently required:

As certification, recertification and decertification activities relate directly to health plans, the regulated community will be interested in having an opportunity to provide input into the decision making process. Continued, targeted outreach to the regulated community should be considered. Potential tools that may be utilized to engage these stakeholders include focus groups, targeted meetings, and targeted interviews.

Once a process for the certification of qualified health plans and quality rating system has been established, the process may be shared with insurance companies that have currently approved health insurance filings with the Department. Identifying issues early in the process will give the Exchange time to develop strategies to mitigate those issues. Involvement of these stakeholders may also help define and communicate the role these stakeholders will fill related to the Exchange.

The quality rating system, a required component of any Exchange, will require additional guidance from HHS. In the meantime, the Commonwealth may wish to consider utilizing stakeholder engagement and ad hoc meetings to ensure that appropriate stakeholder consultation occurs in the development of the quality rating system.

Call Center

Operating a Call Center is another minimum function required of HHS by an Exchange, although this function could potentially be outsourced. Stakeholders have high expectations of a Call Center, believing Call Centers should: provide multiple avenues to access information supporting enrollment; provide exceptional customer service; assist consumers with questions, complaints and resolution; provide hard-copy applications for those without computer access; and have information available in various languages. Operation of a Call Center is integrally related to a successful consumer assistance plan, and the Commonwealth appears to be working towards ensuring this function meets future needs.

The ACA guidance suggests operation of Call Centers outside of normal business hours. The Commonwealth's current call center operates from 7:00 a.m. to 7:00 p.m. M – F, and from 9:00 a.m. to 3:00 p.m. Saturday, with voice mail and call back in place after hours. Online chat assistance is also available during that time. The Commonwealth may wish to consider involving individual consumer and small business stakeholders to solicit feedback on the need for after-hours operation

Exchange Website

Each Exchange will maintain a website through which applicants and enrollees may obtain standardized comparative information on qualified health plans, apply for coverage, and enroll online. Exchange websites will also need to post required transparency information. Exchanges may choose to provide many more services on their websites. In addition, each Exchange website must provide access to an electronic calculator that allows individuals to view an estimated cost of their coverage once premium tax credits have been applied to their premiums and the impact of cost-sharing reductions if they are eligible.

After collecting and verifying plan data, the Commonwealth may wish to test its website for clarity, ease of operation, and functionality with consumers and stakeholders. For more information on requirements of the Exchange Website, see the *Options Analysis and Exchange Planning Considerations.*

Navigator Program

Establishing a Navigator Program is another minimum function required of an Exchange. A Navigator Program is intended to assist consumers with the purchase of health insurance. In the creation of such a program, stakeholder input may be requested during the implementation phase and during development; vehicles for such input may include, but are not limited to, targeted meetings, focus groups, and a survey. A survey might ask what role Navigators will play in the Exchange, and what role producers and brokers will have in the Exchange. Many stakeholders that attended the PID

stakeholders' forums indicated that Navigators should be licensed professionals. For the purposes of this issue area, stakeholders include brokers, navigators, community partners, exchange administrators and medical leadership. The National Association of Insurance Commissioners (NAIC) has authored a document titled *The Comparative Roles of Navigators and Producers in an Exchange – What are the Issues*. The paper identifies potential issues with the Navigator Program and contains recommendations. Many of the points raised in this paper were also raised in testimony provided for the Stakeholder Listening Sessions PID conducted in August 2011.

Feedback in verbal and written comments provided by representatives of the insurance industry as part of the Stakeholder Listening Sessions clearly indicated a concern over what the future role of producers and brokers will be if an Exchange is implemented. A repeated message was that brokers provide a valuable service before, during, and after enrollment, including help to resolve issues with claims. These speakers stated that the brokers often act as extensions of the human resources departments of small employers. These industry representatives repeatedly argued that if Navigators cross the line and solicit, sell, and negotiate, that they should be licensed as producers. These stakeholders also suggested the Navigators should be required to carry errors and omissions insurance.

Stakeholders also suggested that the Commonwealth have a separate forum for streamlining the application, enrollment, and appeals processes and a separate statewide conference on the role of Navigators and Producers. Stakeholder input may be sought as the Commonwealth continues to plan for an Exchange, particularly to seek input and feedback on customer services beyond the application/enrollment stage, as one stakeholder in the Harrisburg Forum pointed out that customer service does not stop with plan selection.

As the Navigator Program is more fully developed, including representation of COMPASS Community Partners, brokers, producers, and other consumer assistance organizations in discussions may help identify issues that may occur during implementation. This early identification will give the Exchange time to develop strategies to mitigate those issues. Involvement of these stakeholders may also help define and communicate the role these stakeholders will fill related to the Exchange.

Eligibility

If the Commonwealth decides to implement an Exchange, the Exchange will need to facilitate plan selection for any individual who is eligible to enroll in a QHP. Requirements regarding eligibility are set out in the Act, and definitions are provided in the proposed regulations. Clear information regarding eligibility will have to be prepared and made available to Commonwealth residents and small employers. Media outlets may prove useful in this respect, as may brokers, established DoH, CHIP, DPW, and PID offices and websites, health plans, etc. Providing notice of eligibility must be built into the process – which the Commonwealth already has well underway in its existing public health programs.

Working groups could be formed under the auspices of an Exchange Steering Committee (should the Commonwealth decide to utilize one), as described in the Governance and Program Integration Options Analyses in the *Options Analysis Exchange Planning Considerations*. Working groups could prove useful for eligibility determination processes as well as the following work streams:

- **Applications** – This work group could be established to focus on the single streamlined application required. This work group will need to include representation of personnel with Medicaid, CHIP, and other health insurance backgrounds to make sure the application and notices address needs for QHPs, Medicaid and CHIP. As noted in the stakeholder feedback below, some participants in the stakeholder forums indicated a desire to have input into the future application process.

- **Notices** – This work group could be established to focus on the notices required. This work group would benefit from including representation of personnel with Medicaid, CHIP, and other health insurance backgrounds to make sure the application and notices address needs for QHPs, Medicaid and CHIP.

- **Eligibility Determination Rules** – This work group could be established for developing the requirements and rules that will be required for determining eligibility. The goal would be to ensure the rules required by ACA are established and that Pennsylvania-specific rules have been developed, reviewed, approved, and included as well. State-specific rules include the effective percentage of FPL needed for the second MAGI calculation required to protect existing Medicaid and CHIP populations.

- **Churn Management** – This working group could be established to identify the type of data that could be used to monitor churn between public programs and the QHPS, by tracking individual enrollees across the programs and using data analytic tools to detect, measure, and manage churn. These tools could also be used to detect fraud and abuse. This group could also help develop methods to understand external impacts that would affect churn and mitigate those impacts.

For the purposes of this report, such working groups are considered stakeholder activities. Each of these working groups would need to consider the policy implications of the changes and actions suggested and work closely with a policy work group that coordinates consideration of policy decisions.

Stakeholder interest was expressed in helping streamline the application process. The working groups tasked with working on the application and eligibility determination processes could benefit from additional stakeholder input concerning details of these processes. This input may be especially helpful in confirming that the application and notices can be successfully understood by potential applicants. As the rules for eligibility determination are finalized, mechanisms to communicate the rules out to the stakeholders may help facilitate implementation of the Exchange.

Enrollment Process

Pennsylvania stakeholders have high expectations. They want an Exchange to provide a shopping experience that is easy to use and provides a clear comparison of options to help make the decision process quick and easy. This input, combined with future stakeholder input, could help frame the design for the enrollment function, and requirements for the user experience. The Commonwealth may want to consider leveraging the design component outputs of the Enrollment User Experience (UX) 2014 project described in the Emerging Practices section**.** If the Commonwealth moves forward with establishing an Exchange, design of the enrollment process must begin soon.

If working groups are established, as discussed above, the work group tasked with working on the enrollment processes could benefit from additional stakeholder input concerning details of these processes. Stakeholder input may be especially helpful in confirming usability of the processes and systems related to enrollment. Also, as the processes and functionality for enrollment are finalized, mechanisms to communicate to the stakeholders how the enrollment function will work, including enrollment period deadlines, could help facilitate implementation of the Exchange.

Individual Responsibility Determinations

An Exchange must incorporate a process to receive and adjudicate requests from individuals for exemptions from the individual responsibility requirements of the Act. The Commonwealth already has well-established processes and technology in place to receive online applications for Medicaid and CHIP and process them. This existing capacity could be enhanced to meet the needs of a Pennsylvania Exchange; in doing so, however, it will be important to validate data and responses in regard to eligibility for exemptions.

Designing an appropriate process for receiving and adjudicating exemption requests and for the appeals process could benefit from targeted stakeholder input. Again, specific working groups could be utilized to assist in this process, with the applications work group working on defining application requirements; the notices work group working on requirements associated with providing notice of the results; and the eligibility determination rules work group defining the rules required for actually determining eligibility exemptions. All of the working groups may need to consider the policy implications of the changes and actions they suggest. Coordinating with a policy work group may also be considered.

Premium Tax Credits and Cost Sharing Reductions

Another minimum function required of an Exchange is to perform administrative activities related to premium tax credits and cost sharing reductions. Many of the key decisions to be made about premium tax credits and cost sharing reductions are dependent upon pending guidance from HHS. For many enrollees, the Exchange will serve as the first point of contact for reporting a change in income level, which could initiate redetermination of eligibility and transmission of information to HHS.

The stakeholder sessions generated no specific comments on the administration of premium tax credits and cost sharing reductions. This topic could be covered in any forums used to obtain input from stakeholders concerning eligibility determination processes.

Until the necessary federal guidance is received, recommendations cannot be made concerning appropriate next steps. While waiting, however, the Commonwealth could focus attention on the issue of eligibility and designing the necessary IT system to support the exchange and provide stakeholder education and notification. Communication with stakeholders on the topic of premium tax credits and cost sharing reduction may be best served after Exchange governance and IT systems are decided by the Commonwealth. By that point, further governance from HHS should be available and more detailed discussions may arise.

Adjudication, Notification and Appeals

In an Exchange, individuals may seek to contest the eligibility determinations made by the Exchange for premium subsidies and Exchange participation. Consequently, an Exchange must implement a system for processing appeals, which must be coordinated with Medicaid and CHIP. Future rulemaking will define the standards for the appeals process.

If the current CHIP and Medicaid appeals processes are basically kept intact, involvement of stakeholders may not be required to finalize how these processes will work with the Exchange. If major changes are made, stakeholder input may help detect potential issues with the new process before it is implemented. In this case, a session to review the suggested new process with representatives from the agencies involved, as well as CAOs and Community Partners that have assisted applicants with appeals, may be prudent. New processes will need to be defined for the other eligibility determinations related to QHPs, advance payment of the premium tax credit and cost sharing reductions, and employer liability. Use of working sessions with stakeholders as described above may be valuable in providing input to this process.

Information Reporting to IRS and Enrollees

An Exchange must report certain information each year to the IRS and enrollees, regarding the enrollee's coverage provided through the Exchange. Other states working toward Exchange implementation have begun drafting requirements for systems that adhere to the mandatory reporting requirements. If the Commonwealth decides to follow this path, it may consider making its actions public and transparent, so that stakeholders are aware of and comfortable with the actions that are being taken with potentially sensitive information.

The Exchange may find it useful to initiate conversations with insurers planning to participate within the Exchange. Insurance companies have maintained enrollee information databases for internal documentation of membership and are familiar with consumer privacy protection laws. Insurers' experience and resources may help to minimize duplication of efforts / information in order to satisfy mandatory requirements.

Health Insurance Market Reforms

Healthcare reforms are dynamically changing as new regulation and guidance are provided by HHS. While states will have flexibility regarding the scope and operation of an Exchange, funding grants provided by the federal government to establish Exchanges are contingent upon progress in implementing market-focused reforms. At this time, it is unclear exactly what progress must be made to satisfy the ACA, and how it will be measured. As this information becomes available, providing it to Exchange stakeholders in a timely manner will be important. Information collected at future stakeholder events could help the Commonwealth to measure voter understanding and appreciation for the various market reforms that have been promulgated per ACA guidance. It may also be important to illustrate how these concerns are driving or influencing Exchange design and consideration of the essential benefits package.

Stakeholder Considerations/Potential Outcomes by Focus Area

The table below incorporates actions indentified above, which may be required, or are provided for consideration by the Commonwealth in its planning efforts for a Health Benefit Exchange. Please note that not every focus area had specific action items suitable for inclusion; however, decisions made by the Commonwealth may ultimately result in stakeholder action in those areas.

Task Level	Activity/Milestone	Recommended Timing	Outcome
1	Draft Enabling Legislation ▪ Hold public hearings on Exchange legislation	November 2011	Solicit stakeholder feedback and enhance understanding ▪ Establish standards for the governing body ▪ Ensure public accountability and transparency ▪ Prevent conflicts of Interests
1	*****Develop a governance model by working with stakeholders to answer key questions about the governance structure of the Exchange:*** ▪ ***Will the State pursue a Regional Exchange?*** ▪ ***Will the Exchange be housed in a State agency, quasi-governmental agency, or non-profit?*** ▪ ***How will the governing body be structured?***	October 2011 – November 2011	The Commonwealth is actively focused on determining the best governance model to employ. One purpose of the KPMG report is to identify various governance options, highlight pros and cons and assess the Commonwealth's ability to implement ▪ Direction on where the Exchange will be housed (Quasi-Governmental entity, Not for Profit, Existing Agency or Multi-State approach) will enhance Input for the Level 1 Establishment Grant application to CCIIO
1	***(Q3) ** Complete Preliminary detailed design and system requirements documentation (e.g. technical, design, etc.)***	January 2012 – May 2012	Dependent on definition of Exchange model and deployment approach ▪ Significant undertaking that will require input from DPW and other stakeholders ▪ Formalized Business Requirements Document
1	***(Q4) **Finalize IT and integration architecture. Complete final business requirements and interim detailed design and system requirements documentations (e.g. technical, design, etc.)***	April 2012 – June 2012	Dependent on definition of Exchange model and deployment approach ▪ Will require input from DPW and other Exchange IT and business stakeholders ▪ Develop Detailed Technical Design Document to satisfy identified Exchange business requirements ▪ This is typically an input into the Level 2 Exchange Establishment Grant Application (final submittal due by June 29, 2012)

Task Level	Activity/Milestone	Recommended Timing	Outcome
1	*(Q4) Actively engage stakeholders in the development of the solicitation for proposals, through meetings, conferences, webinars, and other forums designed to gather stakeholder input*	April 2012	Incorporate insurers' feedback and inform development of feedback on developing standards.
1	Exchanges are required to respond to information requests, provide toll free hotline, educate individuals on available assistance, and ensure that assistance is available through Navigators ▪ These requirements will necessitate marketing and outreach at a variety of points including but not limited to design of the consumer assistance program, transforming existing functions to Exchange-based functions, providing notice, etc.	2011– 2012	Designing an Exchange that meets federal standards and promotes eligibility for Level 1 and 2 Grant funding Improved stakeholder education and interaction, call center, website, etc.
1	*ACA suggests operation outside of normal business hours* ▪ HHSCC currently operates M-F 7:00 a.m. to 7:00 p.m. and Saturday 9:00 a.m. to 3:00 p.m.; voice mail and call back procedures, and online chat are in place after hours ▪ Consider expansion to after hours		Individual and small business stakeholder input in assessing need for after hours operation should inform and enhance acceptance of ultimate decision in this regard
1	***Q1: **Collect and verify plan data for comparison tool***	April 2013 – July 2013	▪ Dependent on definition of Exchange model and deployment approach ▪ Requires input from DPW and other Exchange IT and business stakeholders
1	***Q3: **Test comparison tool with consumers and stakeholders. Before open enrollment: **Launch comparison tool with pricing information but without online enrollment function***	June 2013 – September 2013	Test scenarios Use cases System Test Plan
1	*Determine targeted organizations in the State that would qualify to function as Navigators*	2012	There are existing COMPASS Community Partners and other organizations identified during stakeholder forums that may want to act as Navigators
1	*2013 Q3 or before open enrollment: Finalize all application and notices, including stakeholder review, testing, translation of content, etc.*	2012 – 2013	Involve stakeholder in development, review and testing of materials to ensure seamless implementation

Task Level	Activity/Milestone	Recommended Timing	Outcome
2011	**Q1: **Begin developing requirements for systems and program operations, including:** ▪ **Providing customized plan information to individuals based on eligibility and QHP data** ▪ **Submitting enrollment transactions to QHP issuers** ▪ **Receiving acknowledgements of enrollment transactions from QHP issuers** ▪ **Submitting relevant data to HHS**	2011– 2012	Exchange Planning activities, led by PID have involved stakeholder meetings and targeted discussions, PID's Stakeholder Listening Sessions Incorporating stakeholder feedback into development of enrollment criteria and standards/implementation should enhance understanding and acceptance
1	*Review federal requirements for applications and notices, begin customizing federal applications and notices as allowable and begin developing requirements for Exchange-created applications and notices.*	December 2011 – January 2012	Initiate work on requirements Plan is completed for how stakeholders will be involved to provide input to and validate requirements
1	*2013 Q3 or before open enrollment: Finalize all applications and notices including stakeholder review, testing, translation of content, etc.*	May 2013 – August 2013	Applications and notices finalized
1	An Exchange must report certain information to the IRS and enrollees annually. Development of the process utilized to accomplish this could benefit from stakeholder input	2011-2012	Resulting reporting requirements developed transparently, and with enhanced understanding of requirements and need

Stakeholder Involvement Around the Country

As the Commonwealth makes decisions related to Insurance Exchange Planning, specifically related to stakeholder involvement, PID may wish to consider stakeholder initiatives in other States. Provided below are some examples of the various activities and/or programs currently underway.

- Minnesota – A Program Integration and IT Infrastructure Sub-Group under the Interagency Exchange Work Group was created to address program integration needs. Also a facilitator worked with policy, program, and IT staff from multiple agencies, along with various stakeholders, to develop object framing, concept and process models related to support operational and technical objectives and specification development. This work involved evaluating existing systems, Exchange requirements, and consumer needs so that Exchange IT specifications would meet coordination needs.

- Washington – State has met with consumer advocates and other stakeholders knowledgeable about the valuable roles producers and navigators can play in an Exchange. The state has also begun to evaluate the valuable lessons that can be learned from the Health Insurance Partnership (HIP) program, which acts as a small business exchange. Those discussions have helped it determine the necessity and scope of its initial review.

- Maryland – The Maryland Health Benefit Exchange Act (MD-HBA) provides the authority for establishing fees for Exchange revenue generation. As a part of this, the Exchange must publish on its website the average amounts of any fees or assessments, the administrative costs of the Exchange, and the amounts of funds known to be lost

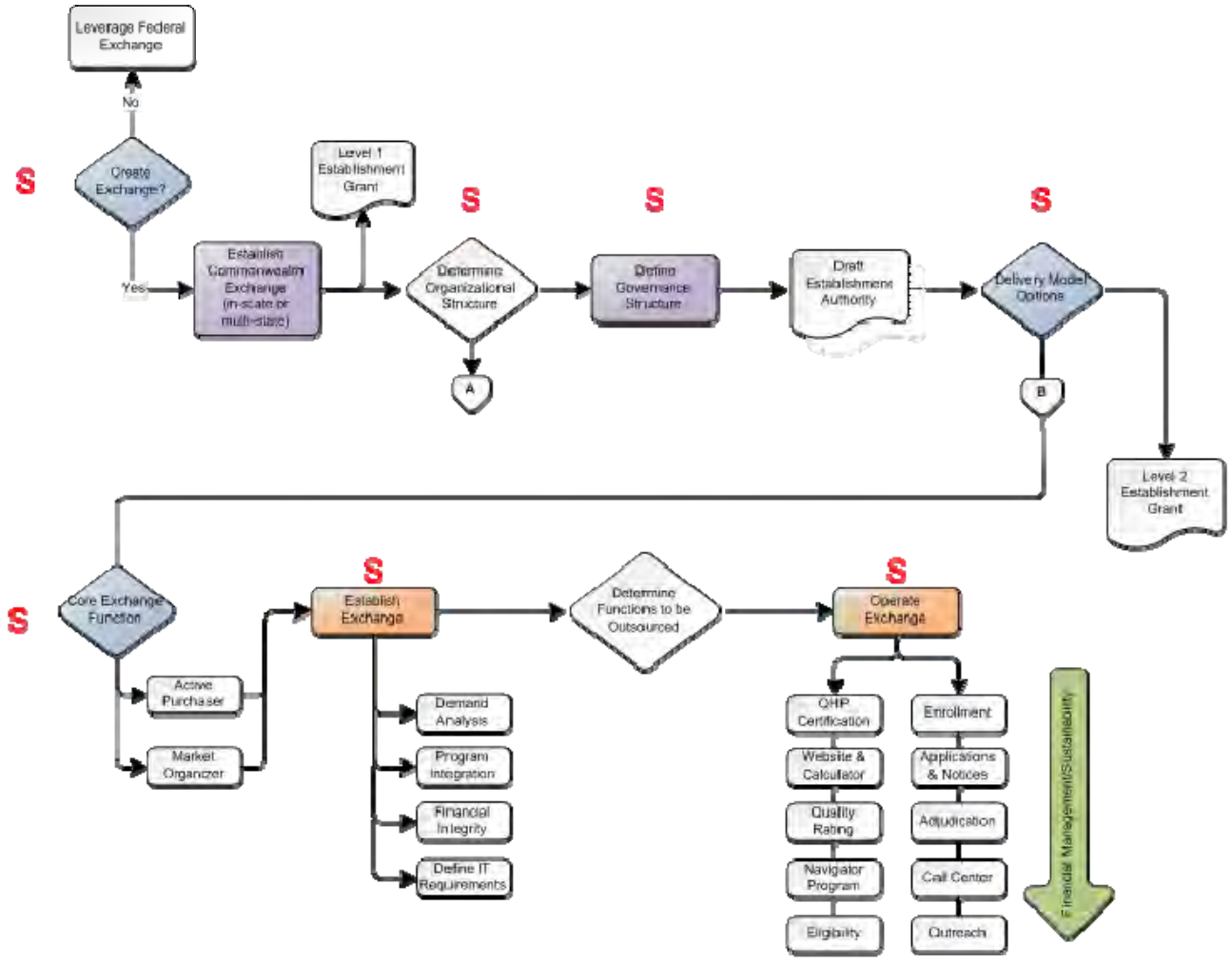
through waste, fraud and abuse. Clearly, this requirement will require (and generate) additional stakeholder interaction. If a similar initiative were undertaken by the Commonwealth, it would require preparation of specific educational and marketing materials, formatting for web posting, and creating the ability to track waste, fraud and abuse within the system.

- Wisconsin – As part of its application, Wisconsin recognized that while the health insurance exchange "provides an opportunity to transform the purchase and delivery of healthcare in America, it fundamentally changes how stakeholders will interact in the future. To be successful, Wisconsin will need to engage these stakeholders early and often." Stakeholder input referenced included sharing an Insurance Exchange White Paper in 2010, sharing the Exchange Prototype with an individual Exchange and a launch of an interactive website in December 2010 to allow consumers to test drive the Exchange, while soliciting feedback.

Moving Forward

Assuming the Commonwealth moves towards implementing a state Exchange, the Commonwealth may anticipate building on its efforts in the months ahead to help ensure stakeholder input is considered throughout the process of planning, establishing and operating an Exchange. Just as the stakeholder population may need to be revisited often, the steps for moving forward towards engaging stakeholders may also be updated to reflect changes and decisions made. This section of the plan outlines the various points during which stakeholder input may be considered. Certainly, as the Commonwealth moves forward in its decision-making process regarding establishment of an Exchange, it can fine-tune and adapt/expand upon this initial Stakeholder Communication and Outreach Plan to ensure that the resulting action plan meets its evolving needs.

The flowchart below has been taken from the Insurance Exchange Planning Report and updated to reflect when stakeholder input might be considered (as noted with a red 'S'). The graphic demonstrates the importance of stakeholder input as there is an opportunity to solicit feedback at almost every phase of the Exchange development process. When making management decisions to execute any of the activities or tasks described in the pages that follow, the Commonwealth must always weigh the cost, level of effort required and other challenges with the benefits of obtaining feedback and other strategic or policy initiatives.



Based on the circumstances of a particular stakeholder, the stakeholder may have certain preconceived notions or biases that may be reflected in its responses. As such, two levels of stakeholder input may be considered throughout the process including 1) general thoughts and concepts and 2) stakeholder-specific feedback. General thoughts or concepts might involve questions such as:

- Should Pennsylvania develop its own Insurance Exchange or rely on the federal government?
- What form of organizational structure should be implemented to manage an Exchange? Quasi-Governmental? Not-for-Profit? Existing State Agency? Other?
- What type of oversight body exists or should be developed to help govern the Exchange?

This type of information has already been solicited during the Stakeholder Sessions held by PID in August. Successful stakeholder interaction may also consider how the information collected/shared will be utilized. The Commonwealth may wish to consider providing a forum for stakeholders to understand how their input was considered in the decision-making process. A published or online responsiveness summary could meet this need.

Dependent upon the stakeholder group, there may be different interests or opinions. It is important to understand the dynamic and the background as to why someone has responded in a particular way as well as solicit feedback on topics that may only impact a particular stakeholder group. The concepts listed below collected in part from the Neiman Survey serve merely as examples of the stakeholder-specific topics with which particular groups of stakeholders may be primarily concerned.

Individuals/Employees and Families

- The health plan comparison, selection, and payment experience is easy to follow and intuitive.
- There is a single point of entry for qualification and enrollment into any program.
- Access to support and tools to manage benefits is available in more ways than only on-line.

Possible stakeholder engagement tools that may be used to approach Individuals / Employees and Families include focus groups, surveys, and targeted interviews.

Employers

- A simple, automated process to select healthcare options for employees exists with clear instructions.
- There is an intuitive process to qualify and enroll employees and get help when necessary.
- The Exchange incorporates flexibility in payment plans and allows employers to pay monthly premiums net of tax credits and premium rebates.
- Clear reports are available to assist with managing employee enrollment status and communication is timely with regard to changes made.
- Employers are represented on the advisory committee or other governing body established to oversee the Exchange.

Possible stakeholder engagement tools that may be used to approach Employers include focus groups and targeted interviews and inclusion on an advisory board if such is established.

Brokers, Navigators and Community Partners

- Tools and information are available to help third parties guide employers and individuals/families to compare, select, and enroll in a health plan.
- Reports are available to manage enrollments and support commission payments as appropriate.
- Third parties are consulted in policy decisions and appropriately represented on the advisory committee or other governing body.

Possible stakeholder engagement tools that may be used to approach Brokers, Navigators and Community Partners include focus groups and targeted interviews and inclusion on an advisory board if such is established.

Health Plans

- There is a fair process through which health plans can offer medical and other ancillary products to attract additional members through an open marketplace.
- The process to become a qualified health plan is transparent and efficient.
- Reporting mechanisms and processes to communicate eligibility, enrollment, and payment information are not overly cumbersome or time-consuming.

Possible stakeholder engagement tools that may be used for health plans include ensuring their representation on an advisory board if such is created, and / or targeted interviews.

Exchange Administrators and Medicaid Leadership

- Efficient processes are established that support health plan and other program enrollment and premium payment processing (both standard and exceptions).
- Tools and reports are developed and available that help to manage work load and track key processes of the exchange (e.g., performance, eligibility, enrollments, and quality).

Possible stakeholder engagement tools that may be used to ensure inclusion of Exchange administrators and Medicaid leadership include targeted interviews and inclusion on an Advisory board if such is established.

State and Federal Agencies

- Requirements, frequency and format for data exchanges are aligned with other state agencies as appropriate and comply with the federal guidelines.
- Consistent data standards and other factors have been considered to allow for smooth transfer of data from various sources (e.g., income data).
- Reports tracking use, tax credits, reduced cost-sharing, etc. are made available and easy to use.

Possible stakeholder engagement tools that may be used to ensure inclusion of Exchange state and federal agencies include targeted interviews and participation on an advisory board if such is established.

Stakeholder outreach is required under the Act, and is critical to the successful implementation of any Exchange, but prior to outreach, the Commonwealth might consider and undertake the development of materials that may be used to educate and engage targeted audiences. Any such materials will be unique to the needs of the Commonwealth, and will depend on initial decisions that have not yet been made, but include such things as: Background materials describing the type of Exchange envisioned by the Commonwealth (or that it has decided upon); this will depend, of course, on when the materials are presented to the targeted groups (or the public at large). Furthermore, targeted materials may be needed for different stakeholders, to help answer specific concerns of those groups, and to fulfill specific needs. For example: Individuals with limited resources may likely need simply written materials provided to them via mail, or through other state assistance programs, which educate them on their opportunities and responsibilities regarding enrollment and maintaining health coverage; agents and brokers may have completely different needs and are more likely to be interested in opportunities to engage in policy decisions, and to have opportunities to assist consumers in comparing, selecting, and enrolling in a qualified health plan.

Section 1311(d) of the ACA requires that each Exchange consult with a variety of key stakeholders in the planning, establishment and ongoing operation of Exchanges. Additionally, outreach and education are required as part of operating an Exchange. The tables on the following pages present a potential work plan to address these areas and include the original FOA milestones (in italics), the proposed timing, and potential outcome(s).

Stakeholder Consultation

Task Level	Activity/Milestone	Recommended Timing	Next Steps
1	*Establish a stakeholder advisory committee with the support of the governor and state legislature to solicit input on Exchange design and function by stakeholder groups.*	November 2011 – December 2011	■ Work group established under Steering Committee described in the Program Integration Options Analysis / Timeline – Consolidate input collected from all stakeholders – Share stakeholder input with governor and state legislature – Solicit input from the governor and state legislature and discuss next steps ■ Staff other work groups such as the outreach work group
1	*Complete stakeholder meetings that cover all regions of the state.*	August 2011	■ Stakeholder input received – Designate the Steering Committee or other governing body to review input received by the Department – Post stakeholder input to a public location (i.e. newsletter, PID website, Exchange website, etc.) – Identify when stakeholder input leads to decisions – Share decisions with the stakeholders as information becomes publically available
1	*****In addition to general stakeholder consultation, establish, implement, and document a process for consultation with federally recognized Indian Tribal governments to solicit their input on the establishment and ongoing operation of the Exchange.***	N/A	■ Note: There are no federally recognized Indian Tribal governments in Pennsylvania
1	*Provide to HHS publicly-available minutes from completed open stakeholder meetings.*	January 2012 – December 2012	■ Evidence of public involvement

Task Level	Activity/Milestone	Recommended Timing	Next Steps
2	■ Work groups under the Steering Committee document minutes to public meetings and post to a Commonwealth Website.	January 2012 – December 2012	■ Document meeting minutes ■ Consolidate and review meeting minutes for accuracy and clarity ■ Review the document for public release and modify meeting minutes if necessary ■ Post meeting minutes to a Commonwealth Website or other public access location
2	■ Work groups collect documented minutes and submit to HHS in the manner HHS specified.	January 2012 – December 2012	■ Transmit meeting minutes in the manner specified by HHS
1	*Complete stakeholder meetings and provide publically-available minutes related to the open enrollment process and outreach materials.*	January 2013 – October 2013	■ Evidence of public involvement
2	■ Work groups under the Steering Committee document minutes to public meetings and post to a Commonwealth Website.	January 2013 – October 2013	■ Document meeting minutes ■ Consolidate and review meeting minutes for accuracy and clarity ■ Review the document for public release and modify meeting minutes if necessary ■ Post meeting minutes to a Commonwealth Website or other public access location
2	■ Work groups collect documented minutes and submit to HHS in the manner HHS specified.	January 2013 – October 2013	■ Transmit meeting minutes in the manner specified by HHS
2	■ Public Outreach work group provides HHS with outreach materials, once developed, in the manner specified by HHS.	April 2013 – October 2013	■ Develop outreach materials ■ Consolidate and review materials for accuracy and clarity ■ Review the outreach materials for public release and modify if necessary ■ Transmit outreach materials in the manner specified by HHS
1	*Post evidence of regular consultation with required stakeholders and other groups and holds regular public meetings to solicit public input on the Exchange website.*	January 2014 – December 2014	■ Evidence of ongoing public involvement

Task Level	Activity/Milestone	Recommended Timing	Next Steps
2	■ Summarize feedback received through feedback feature of the Exchange website and surveys implemented.	January 2014 – December 2014	■ Consolidate input collected through the feedback feature of the Exchange website and surveys ■ Share feedback with the appropriate internal audiences ■ Review feedback for public release and modify if necessary ■ Post feedback to a Commonwealth Website or other public access location
2	■ Conduct quarterly open forums to obtain feedback on the Exchange.	January 2014 – December 2014	■ Schedule quarterly open forums to obtain feedback ■ Document meeting minutes ■ Consolidate and review meeting minutes for accuracy and clarity ■ Review the document for public release and modify meeting minutes if necessary ■ Post meeting minutes to a Commonwealth Website or other public access location
2	■ Provide feedback to HHS in a manner specified by HHS.	January 2014 – December 2014	■ Transmit meeting minutes in the manner specified by HHS

Outreach and Education

Task Level	Activity/Milestone	Recommended Timing	Next Steps
1	*Perform market analysis / environmental scan to assess outreach/education needs to determine geographic and demographic-based target areas and vulnerable populations for outreach efforts.* ■ Develop outreach and education plan to include key milestones and contracting strategy. ■ Distribute outreach and education plan to stakeholders and HHS for input and refinement.	December 2011 – July 2012	■ Identify target areas and populations for outreach ■ Create an outreach and education plan that includes input from stakeholders and HHS

Task Level	Activity/Milestone	Recommended Timing	Next Steps
2	Coordinate with Navigator study that is collecting demographic data on the underserved populations.	December 2011 – April 2012	■ Extract demographic data from the Navigator study to be used in the outreach and education plan ■ Analyze how the Exchange can assist underserved populations
2	Develop outreach and education plan	May 2012	■ Integrate demographic data and analysis from the Navigator study to be used in the outreach and education plan ■ Review the outreach and education plan for public release and modify if necessary ■ Post outreach and education plan to a Commonwealth Website or other public access location
2	Distribute outreach and education plan to stakeholder and HHS, receive and update based on input.	June 2012 – July 2012	■ Transmit outreach and education plan in the manner specified by HHS ■ Review HHS input and update outreach and education plan as necessary ■ Post HHS input to a Commonwealth Website or other public access location
1	*Develop a "toolkit" for outreach to include educational materials and information.*	May 2012 – November 2012	■ Develop toolkit for outreach – Gear outreach toolkit to underserved populations; determine construct and components of toolkit that meets the Commonwealth budget and outreach needs – Provide informational materials in multilingual formats – Provide a frequently asked questions document on Health Insurance and Exchanges

Task Level	Activity/Milestone	Recommended Timing	Next Steps
1	*Develop performance metrics and evaluation plan.*	September 2012 – November 2012	■ Develop outreach performance metrics and evaluation plan – Design consumer surveys to: determine the effectiveness of outreach materials, to measure pre / post consumer understanding of Exchange and health insurance, to measure consumers' perceived value of health insurance – Observe consumer interest in the Exchange by region – Metrics should be established for community navigators based on client outreach and goals for completed application
1	*Design a media strategy and other information dissemination tools.*	September 2012 – November 2012	■ Design outreach media strategy and other dissemination tools – Provide online consumer websites and consumer-friendly pamphlets – Provide informational materials in multilingual formats
1	*Submit final outreach and education plan (to include performance metrics and evaluation plan) to HHS.*	December 2012	■ Develop final outreach plan – Consolidate information collected into a final outreach plan – Review the final outreach and education plan for public release and modify if necessary – Post final outreach and education plan to a Commonwealth Website or other public access location
1	*Focus test materials with key stakeholders and consumers and make refinements based on input.*	December 2012 – February 2013	■ Materials updated based on input from stakeholders
1	*Launch outreach and education strategy and continue to refine messaging based on response and feedback from consumers.*	March 2013	■ Outreach program launched

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