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Consulting Group

Blueprint for Exchange Business Operations

Maryland Health Benefit Exchange

January 31, 2012

Support for this resource was provided by a grant from the Robert Wood Johnson Foundation's State Health Reform Assistance Network program

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Introduction

This document is intended to provide a high level overview of the business functions that must be established, the type of work that must be undertaken, and a relative timeline and chronological order for establishing the Maryland Health Benefit Exchange. This document is organized around 17 core work processes necessary for exchange implementation. While there is a considerable amount of overlap and interdependency between these processes, for ease of discussion and sequencing, they can be grouped into six primary business areas which occur in rough chronological order: Exchange Set Up, Core Systems, Communication & Outreach, QHP Plan Management, Risk Adjustment and Reinsurance, and Regulatory Compliance & Reporting. These major business areas do not represent the entire list of tasks and responsibilities that the Exchange will need to complete prior to 2014, but this structure provides sufficient detail to allow key stakeholders and Exchange staff with a blueprint of the major business operation functions critical to successful implementation.

PRIMARY BUSINESS AREAS	CORE WORK PROCESS
I. Exchange Set Up	1. Governance and Oversight 2. Internal Administration 3. Financial Management
II. Core Systems	4. Eligibility Verification 5. Premium Tax Credit and Cost Sharing Subsidy Calculator 6. Website (and Decision Support Tools) 7. Enrollment & Billing 8. Customer Service Operations (Call Center) 9. SHOP-specific Processes
III. Communication & Outreach	10. Outreach & Marketing Plan 11. Navigator Program 12. Broker Program
IV. QHP Plan Management	13. QHP Certification 14. Plan Rating System
V. Risk Adjustment and Reinsurance	15. Risk Adjustment and Reinsurance
VI. Regulatory Compliance & Reporting	16. External Reporting 17. Mandate Determinations & Appeals

For each of the 17 core work processes, we have provided a detailed summary of five types of information:

1. Federal Exchange Requirements as outlined in the Affordable Care Act (ACA) and the most recently available proposed federal rules for Exchange Eligibility, Exchange Establishment, and Risk Adjustment and Reinsurance. *An important caveat to note is that, throughout the document,*

we have relied upon most recently proposed federal rules. To the extent that these rules change with the provision of final regulations, the information in this document will become out of date.

2. Key Federal Milestones based on the ACA, most recently available federal guidance, and timelines and gate reviews based upon federal exchange establishment grant funding opportunities

3. Key Project Activities, a detailed list of the major business tasks and activities required to implement each core work process

4. Key Considerations and Decision Points, contextual information the Exchange will need to weigh as it moves down the implementation timeline

5. Key Dependencies, the elements and decisions that need to be in place to bring each core work process to completion

A separate analysis and summary of state responsibilities and options related to ACA-required risk mitigation programs, previously developed by Wakely, has been appended as Attachment 1.

Overview of Primary Business Areas

Primary Business Area I: Exchange Set Up

During Exchange set up, the state will establish the legal and administrative infrastructure necessary to obtain funding, hire staff, and begin implementing the many systems, business processes, and activities for which the Exchange is responsible. Maryland has already achieved many key milestones in this business area, including enacting legislation to establish its Exchange as a public corporation and independent unit of state government, appointing a Board of Directors, and hiring an Executive Director.

Primary Business Area II: Core Systems and SHOP-specific Processes

The procurement, development, and management of the core systems needed to support basic operations will be the largest, most complex, and most costly element of Exchange implementation. These core systems include Eligibility Verification, Premium Tax Credit Administration, Website, Enrollment, Billing and Collections, Customer Service (Call Center) and SHOP-specific functions. Maryland is well on its way in the procurement of these systems and the development of project management capacity to complete implementation, but a number of key tasks and policy decisions remain ahead. One critical element with long-term relevance will be the assessment of ongoing system maintenance costs once the components have been developed. While federal funding is available for start-up expenses, the Exchange must be fully self-sustaining by January 1, 2015. The Exchange should anticipate both the technology lifespan and expansion capability of any system purchase given the absence of any federal support after 2014. While it is difficult to predict enrollment gains in the out years, the Exchange should nonetheless factor in growth expectations,

either from enhanced take-up, eligibility expansion, or the potential for additional populations to utilize the Exchange.

Primary Business Area III: Communication & Outreach

The communications strategy employed by the Exchange must reflect its multi-faceted nature and incorporate multiple discrete functions each demanding their own core competencies:

- Marketing – developing the formal marketing plan
- Public relations – managing communications with the press and the public
- Outreach – grassroots communications to individuals, advocates, and other stakeholders, often in partnership with other organizations
- Advertising – communicating via internet, mobile texting, signage, print, radio, and television messages to individuals and employers
- Sales – working with health plans, brokers, or directly with individuals and small business to encourage and facilitate enrollment through the Exchange

Primary Business Area IV: QHP Plan Management

Certifying, offering, managing, and reporting on the performance of QHPs is the core business purpose of the Exchange, and the ability to do so will involve several steps and will depend on much of the other work outlined in this document. Maryland has already made significant progress on the policy decisions relevant to this business area. For example, Maryland's exchange has defined and is recommending an approach to "active purchasing" which is balanced and incremental: having the ability to add requirements above the ACA minimum standards but allowing all health plans that meet these requirements to participate.

To operationalize this vision, the Exchange must first establish standards for QHPs, which will be informed by federal guidelines, and then determine which requirements, if any, the Maryland Exchange will develop for benefit designs to be offered through the Exchange. It will then need to develop the certification process itself and ensure that the operational capacity to support ongoing carrier relationships is in place (e.g., the ability to efficiently acquire carrier rates, enroll members, work with the carriers customer service platform, transfer funds, and receive claims data). Once QHPs have been selected, the Exchange must obtain plan performance and quality information to support the plan comparison functions required by ACA, report on QHP quality, and develop procedures to monitor compliance with federal and Exchange requirements.

Primary Business Area V: Risk Adjustment and Reinsurance

The ACA creates three kinds of risk adjustment programs: a temporary reinsurance program for non-group health plans, a risk adjustment program for issuers offering plans in the individual and small group markets, and a temporary risk corridor program for qualified health plans participating in the Exchange (individual and small group markets). The state can choose to administer the risk adjustment program themselves or defer administration to HHS; reinsurance must be administered by states that build their own Exchanges. HHS will administer the risk corridor program for all

states. Wakely has developed a detailed issue brief summarizing state requirements under most recently released proposed federal rules, which is appended to this document as Attachment 1.

Primary Business Area VI: Regulatory Compliance & Reporting

The Exchange's public-facing regulatory responsibilities include providing a large amount of information related to QHP performance, Exchange finances, and customer satisfaction, as well as the management of individual and employer eligibility appeals processes and the issuance of certificates of exemption from ACA individual responsibility provisions. These compliance and reporting activities will affect virtually every core system and work process and need to be at the front-end of the operational development of the Exchange. In addition to performing flawlessly on the customer transactional side of the business, ensuring compliance with federal and state oversight agencies, as well as producing thorough, accurate, and timely financial and management reports, will do as much for the credibility of the Exchange, in the eyes of the legislature, the public, and market participants, as any other function it will perform.

I. Exchange Set Up

1. GOVERNANCE & OVERSIGHT

Exchange Governance	**Organization Types** The Exchange must be a governmental agency (including either a state agency or a quasi-public agency) or nonprofit entity established by a State, and may contract with outside parties, including the Department of Human Services, for purposes of administering aspects of Exchange operations, provided such entities are not health insurance carriers or treated as such under federal law. **Governance Structure** If the Exchange is an independent state agency or a nonprofit entity established by the state, the state must ensure that the Exchange has a publicly accountable governing board that is administered under a formal operating charter or by-laws and holds regular public meetings that are announced in advance. **Board Composition** A majority of the voting members on the board must have relevant experience in health insurance or health care related fields. The board cannot include a majority of representatives with a conflict of interest, including representatives of health insurance carriers, agents, or brokers. **Governance principles** The Exchange must adopt and publish its governance principles, which must include standards for ethics, conflict of interest, accountability, transparency, and disclosure of financial interest. HHS may periodically review the accountability structure and governance principles of a State Exchange. **SHOP Governance** States may elect to create an independent governance and administrative structure for the SHOP if the they ensure that the SHOP coordinates and shares relevant information with the Exchange operating in the same service area.
Key Federal Milestones	**2012** • Spring 2012: Exchange Approval Application released by HHS • Spring 2012: Readiness Assessments begin • Fall 2012: HHS Start Accepting Exchange Approval Applications **2013** • January 1, 2013: Final Exchange approval and conditional approval decisions made

Key Project Activities	**Initial governance tasks** • Develop/maintain board calendar & location of meetings • Develop/maintain Board Subcommittees • Develop/maintain Board Policies and Procedures • Approve Level II grant application • Develop and approve interagency agreements • Develop schedule for processing reports and recommendations as required by statute • Develop/maintain process for stakeholder consultation
Key Decisions & Considerations	Maryland has already passed legislation establishing the Exchange as an independent public entity, and has appointed an exchange Board. Additional considerations include how and whether to contract with other entities for purposes of administering aspects of Exchange operations (provided such entities are not health insurance carriers), finalizing Exchange authority and responsibilities in anticipated legislation, and development of governance principles and standards. The Exchange will need to establish policies and procedures that define the role of the board, if applicable; the relationship between the board and management; and the role of the board in the larger state policy and market environment. For example, electing a protocol for dealing with press inquiries and public statements will be a critical element for establishing board operations. In addition to establishing a governing authority, the exchange will need to obtain a legal entity that can obtain an employer ID for payroll and tax purposes, as well as to hold bank accounts and obtain credit.
Key Dependencies	• Adequate Board authority and support from stakeholders and government to achieve mission

2. INTERNAL ADMINISTRATION

Exchange Administration	**Operational Capacity** The Exchange must develop or make provision for the requisite administrative infrastructure to carry out the requirements outlined in the ACA and subsequent and forthcoming federal guidance.
Key Federal Milestones	**2012** • Each state must ensure it provides the Exchange with the authority to meet all the Exchange requirements of the ACA • The Exchange must demonstrate its ability to perform required activities to HHS by Fall of 2012 for HHS approval

Key Project Activities	**<u>Staffing</u>** • CEO hires key Senior Management, including CFO/COO/CIO • Develop staffing plan • Identify salary structure and benefits for exchange personnel • Develop exchange organizational chart • CEO/Sr. Management begin to hire exchange staff, especially in key areas of IT, Finance, and Ops • Develop organizational policies & procedures • Begin to hire consultants for subject matter expertise in key areas • Develop contracting mechanism to easily bring on consultants & suppliers • Hire IT project manager for implementation oversight • Identify vendors/suppliers for administrative needs **<u>Key administrative tasks</u>** • Locate physical space for exchange (temporary or permanent) • Acquire computers, software, email capability, data storage, communications equipment • Ensure physical facility is properly wired and configured for IT needs of staff • Develop a procurement strategy for IT purchase in coordination with Medicaid, including order of priority for systems • Develop technical specifications in accordance with key policy decisions • Assess IT requirements for Exchange data needs • Working with IT consultants, develop IT budget • Assign staff ownership for completion of reports & recommendations required by statute • Set up recurring interagency meetings and/or ensure exchange representation in existing meetings • Acquire Tax ID for exchange • Register exchange as public authority with Secretary of State, IRS, etc. • Develop Level 2 grant application
Key Decisions & Considerations	The expected rapid growth in staff will require early decisions with long-term impact in areas such as office space, benefits, policies, financial management, and reporting. 1. *Office Space.* In looking for physical space the key considerations include: • Proximity to key partners, state agencies, and board meeting venues • Ability to house anticipated personnel or expand to support staff growth • Adequate meeting space for key partners, carriers, and vendors • Facilities reflective of public status, with an emphasis on accessibility • Adequate security for staff and visitors 2. *Establishment of New Entity.* The Exchange will need to establish the appropriate credentials, including: • Establish a Tax ID number and obtain a mailing address • Establish the corporation with the IRS, and depending on state laws, the State Department of Revenue, the State Department of Unemployment Assistance, and the Secretary of State 3. *Banking Relationships.* A banking relationship is needed to meet cash

	management and expense obligations, including check-writing and electronic fund transfer (EFT). A referral from the State Comptroller, who often deals with several institutions, can result in a more cost-effective banking relationship. Due to the potential intake of a significant amount of cash, the Exchange should be able to manage its daily cash needs; invest in a safe, liquid, higher yield account; and at the appropriate time and if allowable under enabling legislation, implement a line-of-credit. A strong cash management process may also need to be instituted between the Exchange and the State Comptroller. 4. *Office Equipment, Furniture, and Supplies.* To support new hires, a dedicated resource is needed to manage the lead time necessary to order equipment for new staff, a supply vendor, and build out offices and workstations. A process to receive and safely store supplies will also be needed. Developing a standard computer and software configuration will ease in ordering and provide consistency in updating software. Leasing equipment is generally more cost effective, but the Exchange should assess the pros and cons and begin to develop an inventory by tagging, labeling, and securing equipment. 5. *Employee Benefits, Policies, and Procedures.* Employee benefits and HR policies will be important factors in the recruitment effort and will have administrative cost implications that need to be understood before committing. The Exchange will likely want to attract personnel with both public and private experience, and these groups may have different expectations in this area (e.g., balance of vacation and personal time, pension, salary, etc.). 6. *Other Policies and Procedures.* For many start up organizations, this area is not fully developed until an external event precipitates the need. As a highly transparent entity, the Exchange should have much of this area completed prior to the heavy ramp up of staff in 2012. For example, the employee handbook should include rules in areas such as office hours, attendance expectations, training and hiring, annual reviews and employee leave. The Exchange will also need to develop Purchasing and Contracting Policies, Corporate Planning, Regulatory Compliance, Federal Regulation Review, Disaster Response, as well as a formal process for regular updates and revisions.
Key Dependencies	• Exchange start-up funding secured • Exchange Enabling legislation passed • Board of Directors appointed • Preliminary funding acquired (Level I Federal grant) • Exchange Senior Management hired

3. FINANCIAL MANAGEMENT

Exchange Financing	**Self-Sustainability** The Exchange must be financially self-sustainably beginning January 1, 2015, and federal funding for Exchange establishment and operations will not be available after that point. Maryland must establish a funding mechanism sufficient to support the operations of the Exchange. The Exchange Board has recommended a broad-based financing scheme supplemented by transaction-based fees related to QHP enrollment, with decisions to be made in 2013.
Financial Reporting	**Federal Financial Reporting** The Exchange must keep an accurate accounting for all activities, receipts, and expenditures and must submit an annual financial report to the Secretary of HHS. **Administrative Costs and Fees** The Exchange must publish the costs and fees associated with operating the organization, including the average cost of licensing, required regulatory fees and payments to operate the Exchange, Exchange administrative costs, and an accounting of money lost to fraud, waste, and abuse.
Oversight and Audit	**Federal Audit** The Exchange will be subject to annual audits by the Secretary of HHS, who may also conduct other periodic reviews and investigations or require additional financial reporting at his or her discretion. If HHS determines that the Exchange or the state has engaged in serious misconduct related to financial integrity, it may impose financial penalties on the state not to exceed 1% of annual federal payments under the authority of HHS (including Medicaid). **GAO Oversight** The Exchange will also be subject to oversight from the Government Accountability Office (GAO), who will conduct an operational and performance measurement review to commence not later than 2018. This review will include an assessment of: • Exchange operations, administration, and expenditures • Surveys and reports of qualified health plans • Claims statistics relating to qualified health plans • Member complaints • Utilization and adoption of Exchanges; • Adequacy of provider networks

Fraud, Waste, and Abuse	**Fraud, Waste and Abuse** The Exchange will be required to implement a plan to prevent fraud, waste, and abuse, the requirements of which will be specified by HHS. **False Claims Act** In addition, all money collected or paid in connection with Exchange activities and/or through the Exchange will be subject to and required to comply with tenets of the False Claims Act.
Key Federal Milestones	**2012** • Develop a plan to ensure sufficient resources to support ongoing operations and determine if legislation is necessary to assess user fees • Assess adequacy of accounting and financial reporting systems and finalize financial systems IT plan • Develop guidance for premium processing requirements • Conduct a third party objective review of all systems of internal control **2013** • Demonstrate capability to manage the finances of the Exchange soundly, including the ability to publish all expenses, receivables, and expenditures consistent with Federal requirements • Establish a funding source sufficient to support Exchange self-sustainability **2014** • Post information related to Exchange financial management on its website and has identified other means to make financial activities associated with the management of the Exchange transparent • Submit the required annual accounting report to HHS
Key Project Activities	**Staffing** • Hire accounting and budgeting staff • Hire payroll vendor • Hire audit firm (operational and financial) **Requirements Definition** • Begin to develop administrative budget model • Research short term accounting system to record basic exchange rec/pay transactions • Develop exchange chart of accounts • Identify accounting structure for recording of transactions -- GAAP/STAT, etc. • Identify and scope out basic financial reports for CMS/BOD during start up • Set up banking structure in coordination with State Comptroller • Working with Office of Medicaid, begin to develop IT operational financing strategy • Develop a contracting process for acquiring computers and office equipment • Begin to develop system of internal control for exchange finance operations **Other** • Refine five year budget and self-sustainability model • Prepare financial & budget components of level 2 grant application • Begin to assess longer term exchange finance systems – Premium Billing; Accounting; QHP Coordination • Develop necessary administrative and financial infrastructure to receive Exchange funding from source selected to support Exchange operations
Key Decisions &	The Exchange must both meet the administrative and financial needs of the entity

Considerations	itself (i.e., ensuring the Exchange has sufficient resources to pay staff, rent, and vendors) as well as the appropriate controls and reporting capabilities to manage state and federal funds. Ensuring that the Exchange has sufficient analytical and reporting capabilities to track and report on the funds under its control will be critical. 1. *Accounting System.* Accounting staff must select accounting software capable of supporting general ledger, accounts receivable, accounts payable, payroll and reporting. A simple off-the-shelf program will suffice in the short term; longer-term, the Exchange will likely outgrow a basic package and will need to select either a more expensive enterprise resource planning (ERP) system that has greater levels functionality and complexity, or a more modest software package commonly in use by small businesses. Accounting staff will also need to develop a chart of accounts, which will represent the backbone of financial reporting and must be at an appropriate level of detail to meet the financial management and reporting needs of the organization. 2. *Financial and Management Reporting.* The Exchange should be able to produce basic financial statements such as a statement of net assets; statement of revenues, expenses, and changes in net assets; and a statement of cash flows. Other financial reports will include a budget variance report, a monthly trial balance, significant payments to vendors, as well as periodic reports on current and projected cash flow needs. Significant variances from budget should be researched and documented, with a plan of remediation proposed. As the Exchange moves out of start-up, regular operational reports will be necessary such as call center metrics, website activity, projected revenue and enrollment, as well as reports identifying the level of revenue and expense by individual and small group and financial reporting to monitor and support ongoing cost allocation between the Exchange and other publicly subsidized programs, especially Medicaid. In addition to internal control and management reports, the Exchange will need to produce regulatory and compliance reporting for HHS and relevant state-based oversight bodies. These reports are discussed in more detail under regulatory and compliance functions later in this document. 3. *Payroll.* Features to look for in a payroll system include online capability to safely and securely add, delete, and change employee data; employee look-up of payroll status; automatic filing and payment of state and federal taxes; direct deposit; HSA/FSA; public transportation deductions; and ease of retroactive transactions. From an internal control perspective, the Exchange should have the ability to review and approve the payroll register prior to disbursement. As a public authority, the Exchange should consider leveraging the state payroll system if permissible under state law. This system may ease startup, but it may provide less functionality. 4. *Financial Controls to Prevent Fraud, Waste, and Abuse.* The Exchange is required to be audited by the Secretary of HHS, and will also likely be subject to state-level audits and operational reviews. Because of its wide-ranging activities and numerous partnerships, the Exchange will need to display a high degree of

	transparency, competency, and program integrity. The Exchange may look to existing government agencies as well as other examples of best practices for internal control models to evaluate. In beginning the assessment of the requirements of a system of internal control, the Exchange should look to the Committee of Sponsoring Organizations (COSO) internal control integrated framework which focuses on five components of internal control: (1) Control Environment; (2) Fraud Risk Assessment; (3) Anti-fraud Control Activities; (4) Information and Communication; and (5) Monitoring. Designing a system correctly from the outset should be an early goal, as retrofitting systems and processes to correct gaps generally leads to greater administrative costs, potential for liability, financial and political risk, and a greater likelihood of audit findings. 5. *Budgeting and Financial Planning.* In addition to the financial controls discussed above to manage against fraud, waste, and abuse, the Exchange will need to develop a strong budgeting and cost management program. The Exchange will need to draw up a detailed budget plan and develop a process for regular management reporting and an ongoing cost management and accountability structure. Establishing regular meetings between finance staff and functional leaders, paired with ongoing budget variance reporting, will create appropriate tension between operational and financial constraints. 6. *Technical and Analytical Infrastructure to Obtain Funding.* The Exchange board has recommended a broad-based financing source supplemented by transaction-based fees to support Exchange operations. Utilizing such a funding source will require the Exchange to work with state to establish a mechanism to collect monies from the source of funding, as well as develop the ability to capture and appropriately account for transaction-based fees. In addition, the Exchange will need to analyze and monitor trends in these financing sources to appropriately forecast revenue, manage expenses, and refine and/or seek changes in the funding rate or structure as appropriate.
Key Dependencies	• Enabling legislation passed • Board of Directors appointed • Senior Exchange Management hired (CFO) • Coordination with Exchange IT core system component development (premium billing, financial system, reporting, etc.) • Assessment of requirements of a system of internal control • Coordination and integration with federal agencies related to data submissions, financial transfers, etc. • Funding source established and funds-acquisition process established

II. Core Systems

4. ELIGIBILITY VERIFICATION

Eligibility Determination	**Eligibility Determination** The Exchange must assess eligibility for individuals seeking premium and cost-sharing subsidies as well as eligibility for those not seeking subsidies to enroll in QHPs. The eligibility system must capture and verify required information to determine eligibility, support the ability to track changes in individual income, circumstances, and employment status, and interface with the required tax credit, enrollment, billing, and account management functions operated by or on behalf of the Exchange.
Employer Information	**Employer Data Verification** The Exchange will need to be able to verify the insurance available to individual enrollees through their employer. Tax credits and cost sharing subsidies are available to individuals who do not have access to affordable, minimum essential coverage through their employer. The exchange will need to determine if the applicant's employer offers coverage that meets the minimum value (at least 60% of total allowed costs of required benefits) and if such coverage is affordable to the employee (i.e., the employee's share of the cost of individual-only coverage cannot exceed more than 9.5% of income). The comparison of cost to income is based on the individual employee only, (i.e., not on the cost of family coverage or on the employee's total household income).

Medicaid Integration	**Single Application** States must use a single streamlined application for both Exchange and Medicaid MAGI eligibility determinations and adhere to "no wrong door" requirements. The Exchange is required to determine eligibility for certain Medicaid applicants, and commentary to proposed rules anticipates that these activities will be conducted in cooperation and coordination with Medicaid and CHIP program agencies and eligibility systems. **Medicaid MCO Enrollment** In addition to eligibility, current proposed rules indicate that the Exchange may facilitate delivery system or health plan selection for Medicaid and CHIP, including transmitting enrollment transactions to health plans, if the agencies administering Medicaid or CHIP enter into an agreement with the Exchange to perform this function. **Non-MAGI Coordination** Non-MAGI evaluation must occur simultaneous to the eligibility determination for premium tax credits. States may use supplemental or alternative forms for evaluating non-MAGI populations or provide a single, integrated eligibility process for all populations. If using a separate form, the Exchange must develop the capacity to electronically transfer information to the Medicaid agency for non-MAGI applicants. **MMIS System Interface** The eligibility system developed by the Exchange, to the extent that it handles and stores Medicaid eligibility information, must interface with and supply member eligibility information to existing or newly developed MMIS claims adjudication and payment systems.

Notification	**Tax Credit Notification** Once the Exchange has determined individual eligibility for tax credits and/or cost-sharing subsidies, it must provide notification and information to the following entities: QHPs – eligibility for and the amount of advance payments of premium tax credits and cost-sharing reductions HHS – (1) eligibility for and the amount of advance payments of premium tax credits and cost-sharing reductions; and (2) enrollees' names in cases where the Exchange determines eligibility based in part on a lack of affordable coverage provided by an individual's employer. Treasury - To reconcile the amount of advance payments received by an individual with the amount allowed based on his or her tax returns. Employers – in cases when an employee is determined eligible for tax credits and subsidies based in part on a finding that the employer does not provide minimum coverage that is affordable. **Medicaid Notification Requirements** The eligibility system must also support Medicaid notification requirements, including initial and ongoing correspondence with applicants and enrollees related to eligibility determination, redetermination, and other status changes for which notification is required.
Timeframes	**Timeframes** The Exchange must provide real-time eligibility determination functionality. If an applicant is found eligible to enroll in a QHP but fails to do so within the open enrollment period and later seeks to enroll, the applicant does not need to re-submit eligibility information, as long their enrollment occurs prior to what their annual redetermination date would have been, and the eligibility information is up to date or updated.

Verification	**Federal Data Hub** The Exchange must verify individual income and eligibility information with various federal agencies, including the Social Security Administration, the Department of Treasury, and the Department of Homeland Security through an interface with the federal data hub. **State-based Information Collection** To the extent that state-based demographic information collected for purposes of verification is provided by existing state agencies or a state-based data hub, the eligibility system must interface with these data systems to acquire necessary information. **"Reasonable Compatibility"** Proposed eligibility rules include a "reasonably compatible" standard that prohibits the Exchange from requesting additional documentation if the information available through electronic data matching is "reasonably compatible" with information provided by the applicant. Proposed rules indicate that "reasonably compatible" does not mean an identical match but that information is generally consistent. States will be provided with flexibility in applying this standard because reasonable compatibility will vary depending on circumstances.
Redetermination	**Annual Redeterminations** The Exchange must re-determine the eligibility of a QHP enrollee annually using tax return data for individuals receiving advance tax credits. Enrollees must receive an annual redetermination notice with the updated household income information and the enrollee's projected eligibility for the following year, including the expected amount of any advance tax credits and cost-sharing reductions. The enrollee must sign and return the notice within 30 days, reporting any changes. If the enrollee fails to return the notice, the Exchange will re-determine the individual's eligibility based on the information provided in the notice. Because Medicaid is also required to perform annual redeterminations, the Exchange will need to align and/or coordinate renewals between programs to avoid creating a burden related to households with members in multiple programs. **Ongoing Redetermination Activity** Enrollees must report – within 30 days – changes to their eligibility for premium tax credits or enrollment in a QHP. The Exchange must also periodically examine electronic data sources to identify death and eligibility determinations with respect to Medicaid, CHIP or BHP.

Key Federal Milestones	**2012** • Q1 -Begin system development including any systems development needed by other applicable subsidized programs • Q4 - Complete system development and prepare for final user testing, including testing of any systems with other applicable subsidized programs **2013** • Q1 -Begin final user testing, including testing of all interfaces • Q3 or before open enrollment - complete user testing, including full end-to-end integration testing with all other components • As early as mid-2013 -begin conducting eligibility determinations for other applicable public programs, coordinating all relevant business functions, and receiving referrals from other publicly subsidized programs (Medicaid, CHIP, expansion programs) for eligibility determinations
Key Project Activities	**Analysis Phase** • Ensure close coordination with the Department of Human Services • Assign Exchange IT staff to work groups / committees to ensure Exchange representation • Develop cost allocation methodology as part of operational financing strategy • Conduct IT gap analysis and develop business/technical requirements **Procurement Process** • Develop RFPs • Publish RFP's • RFP Bidders conference • Receive RFP responses • Assess and score RFP's • Select vendor(s), negotiate terms, finalize contracts **System Development** • Design, build, test interfaces with federal hub, state and other verification sources • Integrate new eligibility rules into decision trees • Identify customer service requirements and technology to support applicants • Determine exception and referral processing (i.e., Non-MAGI populations) consistent with federal regulations • Document and develop reporting requirements • Document and develop noticing requirements • Develop process for determination of newly eligible and existing Medicaid • Integration of eligibility determination and process for administration of tax credits • Develop policies and procedures for redetermination **Other** • Final user testing (including interfaces and full end to end integration testing with all other components) • Begin conducting eligibility determinations for other publicly subsidized programs, coordinating all relevant business functions, and receiving referrals from Other publicly subsidized programs (Medicaid, CHIP, Expansion programs)
Key Decisions & Considerations	Eligibility determination and validation is a critical, highly complex process with

	multiple policy and technical challenges for states to overcome. Here, we present a few key considerations from a business and integrity perspective: 1. *Medicaid Alignment.* While eligibility rules are remarkably consistent between the Exchange and Medicaid, some differences remain. For example, Medicaid will use current income while projected annual income will be used for tax credit determinations; family definitions differ; certain types of income are treated differently; and the point in time in which the Federal Poverty Level (FPL) is applied differs. Where differences exist, the Medicaid requirement will take precedence as Medicaid eligibility must always be determined first. If the applicant does not qualify for Medicaid, the eligibility system will default to the exchange specific requirements. 2. *Data Verification.* Current proposed rules are designed to make eligibility verification more flexible, but present some challenges for states. For example, the "reasonably compatible" standard for information submitted electronically will require more sophisticated matching and verification processes. A similar issue arises in the SHOP eligibility process, in which the SHOP may assume the validity of employee-submitted data unless it determines there is "reason to doubt" the veracity of submitted information. If not further clarified through federal guidance, states will need to develop process rules for this function. 3. *Employer Data.* The identification and incorporation of employer data to validate whether or not individuals have access to affordable, qualified health insurance will present a challenge. Employer wage and payroll information may be available from existing tax or unemployment insurance databases, but insurance offer status, employee contribution requirements, and premium levels most likely will not. The Exchange will need to develop processes to obtain and match against this information to determine eligibility. One useful step may be to explore how DHS has obtained ESI information to fulfill Maryland Medicaid requirements.
Key Dependencies	• Coordination with Medicaid, CHIP and other applicable state health subsidy programs • Coordination with Insurance Administration • Completed eligibility system IT Gap Analysis • Review Federal requirements for notices • Integration with federal data services hub • Coordination and integration with Exchange IT core system component development (website, enrollment, premium billing, financial system, reporting, noticing, appeals etc.)

5. PREMIUM TAX CREDIT ADMINISTRATION

Tax Credit and Subsidy Determination	**Tax Credit and Subsidy Determination** The Secretary of HHS and the Secretary of Treasury will develop a system to calculate advance determinations of tax credits and cost sharing reductions based on individual eligibility criteria. Tax credit eligibility will be based upon household income in the most recent taxable year for which information is available. The Exchange must interface with this system to calculate the amount of advance tax credits and cost sharing reductions for individual enrollees. **Changes in Enrollee Circumstances** The Exchange must implement procedures developed by HHS to evaluate changes in enrollee circumstances, such as substantially reduced income, changes in family size or household circumstances, change in filing status, the filing of an application for unemployment benefits, or other significant changes affecting eligibility.
Tax Credit and Subsidy Payment and Reconciliation	**Payment and Reconciliation** Once determined, Treasury will make advance tax credit payments to QHP issuers to reduce the premium liability of eligible enrollees. The Exchange must track and verify the amount of tax credits paid to issuers to appropriately account for enrollee and carrier premium liabilities and collections. Carriers are required to report on the amount of premium reduction received from the Treasury and include an itemized reduction in each monthly billing statement.
Tax Credit and Subsidy Calculator	**Web Based Credit and Subsidy Calculator** The Exchange must develop a calculator to allow enrollees to incorporate their estimated tax credit and cost-sharing reductions when comparing available QHPs via the Exchange website.
Key Federal Milestones	**2012** • Q1 - Begin system development • Q4 - Complete systems development and prepare for final user testing **2013** • Q1 - Begin final user testing, including testing of all interfaces • Q3 or before open enrollment -complete user testing, including full end-to-end integration testing with all other components • As early as mid-2013 -begin submitting tax credit and cost-sharing reduction information to QHP issuers and HHS

Key Project Activities	**<u>Analysis Phase</u>** • Develop and finalize business and technical requirements **<u>Procurement Process</u>** • Develop RFPs • Publish RFP's • RFP Bidders conference • Receive RFP responses • Assess and score RFP's • Select vendor(s), negotiate terms, finalize contracts **<u>System Development</u>** • Build to utilize eligibility solution information obtained from federal data hub and other verification sources with QHP premium data • Build to provide relevant information to QHP issuers and HHS to start, stop or change level of tax credit and cost sharing **<u>Other</u>** • Final user testing (including interfaces and final end to end integration testing with other components) • Begin submitting tax credit and cost sharing reduction information to QHP issuers and HHS
Key Decisions & Considerations	The Exchange is the only place where individuals can access ACA premium tax credits and cost-sharing reductions. Allowing enrollees to quickly determine the subsidy amount while engaged in plan comparison shopping is both a core business function and an important customer service feature. 1. *Employer Information Verification.* The exchange will need to evaluate the best way to verify employer data for employed applicants applying for premium tax credits. Access to state-based data bases is one option and might include premium assistance programs or coordination of benefit programs designed to ensure that the state's Medicaid program is always the payer of last resort. An alternative option to a state data base might entail a form that employers are required to submit to the Exchange either upon request or annually. HHS may offer exchanges the ability to access federal data on employer-sponsored insurance, but this last option is only a possibility and the regulations do not suggest that it is likely. 2. *External Interfaces.* The premium tax credit calculator will require coordination with multiple processes and stakeholders. The calculation itself is dependent on the cost of the second lowest priced silver plan, so coordination with the QHP certification process is very important. Robust system controls, data security, quality integrity processes, and reconciliation processes will be necessary to manage the interfaces between the Treasury, HHS, and QHP's, since the Exchange will be the source of record for enrollment, but the actual funds flow for tax subsidies will be from the US Treasury to the QHP's.

Key Dependencies	• Completed requirements for systems and program operations • Integration with federal data services hub • Coordination and integration with QHPs • Completion of procurement process • Coordination and integration with Exchange IT core system component development (website, CRM, enrollment, premium billing, financial system, reporting, noticing, appeals etc.)

6. WEBSITE AND DECISION SUPPORT TOOLS

Reporting and Transparency

QHP Comparative Information

The Exchange website must provide standardized comparative information on each available QHP minimally including the following:

- Premium and cost-sharing information
- Summary of benefits and coverage
- Actuarial value tier (Catastrophic, Bronze, Silver, Gold)
- The results of enrollee satisfaction surveys
- QHP plan quality ratings
- Medical loss ratio information as reported to HHS
- Transparency of coverage measures reported to the Exchange during QHP certification
- The provider directory made available to the Exchange as part of QHP certification

Financial Disclosures

The Exchange must publish the following material to the website:

- The average costs of licensing required by the Exchange
- Any regulatory fees required by the Exchange
- Any other payments required by the Exchange
- Administrative costs of operating the Exchange
- Money lost to waste, fraud, and abuse

Consumer Assistance Information

The website must provide applicants with information about Navigators and other consumer assistance services, including the toll-free telephone number of the Exchange call center.

Website Functionality	**Eligibility and Enrollment** The website must support online, real-time eligibility determination, and support enrollment for small and non-group customers. **Consumer Support Tools** The Exchange website must include a calculator to facilitate the comparison of available QHPs after the application of any advance payments of the premium tax credit and any cost-sharing reductions. **Account Management** In the June 2011 proposed rules, HHS contemplates account management functionality that would permit consumers to store and access information on the website. This would allow both applicants and enrollees, as well as case workers, navigators, and brokers, to store, access and update personal account information.
Accessibility	**Accessibility** The website must be accessible to people with disabilities in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act. It must also provide meaningful access for people with limited English proficiency.
Other Web Functions	**Broker/Agent Information** The Exchange may choose to provide information regarding licensed agents and brokers on its website. The Exchange will also likely contemplate developing a portal for brokers to support their sales activities, monitor performance, facilitate compensation, and allow for account management. Similarly, the Exchange may wish to provide a portal with similar functionality for Navigators
Key Federal Milestones	**2012** • Q1 -Begin systems development • Q3 -Submit content for informational website to HHS for comment • Q4-Complete systems development and final user testing of informational website **2013** • Q1 -Launch information website • Q1-Collect and verify plan data for comparison tool • Q3 -Test comparison tool with consumers and stakeholders • Prior to Open Enrollment -launch comparison tool with pricing information but without online enrollment function • As early as mid-2013 -launch fully functioning comparison tool with pricing information and online enrollment functionality on the first day of open enrollment

Key Project Activities	**Analysis Phase** • Requirements definition for all exchange website functionality **Procurement Process** • Develop RFPs • Publish RFP's • RFP Bidders conference • Receive RFP responses • Assess and score RFP's • Select vendor(s), negotiate terms, finalize contracts **System Development** • Online comparison of qualified health plans • Online application and selection of qualified health plans • Premium tax credit and cost sharing subsidy calculator • Quality rating functionality system requirements • Requests for assistance • Links to other subsidized health programs • Integration with Eligibility system • Integration with SHOP • Integration with QHP • Integration with Medicaid **Other** • Final user testing of informational website • Launch information website • User testing of all component functionality • Collect and verify plan data for comparison tool • Test comparison tool with consumers and stakeholders. • Launch tool with comparison shopping and pricing but without online enrollment functionality • Launch fully functioning comparison tool with pricing information and online enrollment functionality on the first day of open enrollment

Key Decisions & Considerations	The website represents the only interaction many will have with the Exchange. The website intersects with and transmits information from every part of the Exchange, so having a solid and flexible website design in place will be necessary before other work processes can complete. Because virtually every design decision will be based on a policy decision, regulatory requirement, or functional need, managing the development of the site, while largely an IT exercise, will require collaboration from all areas of the Exchange. The build versus buy choice on website development must be made early, and the state has many options on both fronts. Vendors are already in the marketplace with customizable solutions and IT talent is readily available if a state prefers to build their own website functionality. Website design must successfully engage the prospective buyer within the first few clicks, especially for a "grudge buy" like health insurance. Design features the Exchange may wish to consider include: • Decision-trees or other decision-support tools that can streamline decision making and choices to reduce confusion without limiting product choice • User-generated reviews • Online feedback functionality • Imagery and videos • Mobile device capability and features • Accessibility for disabled and/or limited English viewers as a design element of the site • Differences and/or alignment between SHOP and non-group If included in the final regulations, account management and the ability to store personal information on the website that are contemplated in the June 2011 NPRM might have significant bearing on core system designs, particularly given security needs.
Key Dependencies	• Completed requirements for systems and program operations • Coordination and integration with QHPs, Navigators, Medicaid and Other publicly subsidized programs (Medicaid, CHIP, expansion programs) • Procurement for Services and Solution • Coordination and integration with Exchange IT core system component development (CRM, enrollment, premium billing, financial system, reporting, noticing, appeals etc.)

7. ENROLLMENT AND BILLING

QHP Enrollment	**Plan Enrollment** Once an individual has selected a plan, the Exchange must notify the issuer of the enrollee's selection and transmit information necessary for the carrier to enroll the applicant. **Data Transmission and Reconciliation** The Exchange must send eligibility and enrollment information to carriers on a timely basis and develop a process by which carriers can verify and acknowledge the receipt of this information. Enrollment information must be reconciled with QHP issuers no less than monthly. The Exchange must maintain records of all enrollments in QHPs through the Exchange and submit enrollment information to HHS on a monthly basis.
Open Enrollment	**Open Enrollment** The Exchange must establish initial and annual open enrollment periods. Individuals may only enroll in or change QHPs during open enrollment or a special enrollment period (described below). The initial open enrollment period will be from October 1, 2013 through February 28, 2014. Thereafter, annual open enrollment for coverage effective January 1st must begin October 15 and extend through December 7 of the preceding year. The Exchange must provide advance notice about open enrollment to all enrollees.

Special Enrollment Periods	**Reasons for Special Enrollment** The Exchange must allow for special open enrollment periods for qualified individuals that experience one of the following triggering events: • Loss of minimum essential coverage • Marriage, birth, adoption or placement for adoption • Citizenship or legal residency changes • Errors, misrepresentation, or inaction by the Exchange, HHS, or their agents • QHP contract violation in relation to an individual • Change in eligibility for advance payments • Permanent move resulting in access to new QHPs • Loss of coverage, other than for non-payment of premium or situations allowing rescission. • An Indian, as defined by the Indian Health Care Improvement Act, may enroll in a QHP or change from one QHP to another one time per month • Other exceptional circumstances **Duration** Special open enrollment period will last for 60 days from the date of a triggering event. **Risk Management Safeguard** During special enrollment periods, enrollees may only change plans at the same actuarial value tier.
Coverage Timing	**Coverage Timing** For plan selections received between the first and 22nd of the month, the Exchange must ensure enrollment effective dates as of the first day of the following month. For selections made between the twenty-third and last day of the month, the Exchange must ensure a coverage effective date of either the first day of the following month or the first day of the second following month.

Coverage Termination	**Termination Circumstances** The Exchange and/or issuers may terminate coverage in the following circumstances: • Loss of eligibility • Access to minimum essential coverage • Lack of payment beyond three month grace period • Coverage is rescinded • The QHP is terminated or decertified • The enrollee changes from one QHP to another **Record Keeping and Reporting** The Exchange must establish record keeping requirements for issuers related to coverage termination and retain records in order to facilitate audit functions. The Exchange must also track the number of coverage terminations and provide a monthly report of such activity to HHS. **Reasonable Accommodations** The Exchange must establish standards for termination of coverage that require issuers of QHPs to provide reasonable accommodations to individuals with mental or cognitive conditions.
Premium Aggregation - SHOP	**Billing** The SHOP must provide employers with a monthly bill that identifies the total amount due to each QHP issuer for employees covered through the Exchange. **Collections** The SHOP must collect the total amount due from employers for QHP coverage on a monthly basis, and remit the total due to each QHP issuers.
Premium Aggregation – Non-Group	**Premium Billing and Collections** Draft regulations do not specify Exchange responsibilities with respect to premium billing and collections. The Exchange can bill members and collect payments on behalf of QHP issuers, or enrollees may choose to pay carriers directly. For enrollees who elect to make payments through the Exchange, the Exchange will need to develop the capacity to generate bills, process electronic funds transfer and/or credit card payments, and generate receipts. Uniform policies should be established across carriers for enrollment, billing cycles, collections, late payments, and termination for non-payment.
Key Federal Milestones	**2012** • Q1 -Begin system development • Q4 -Complete systems development and prepare for final user testing **2013** • Q1 -Begin final user testing, including testing of all interfaces • Q3 or before open enrollment -complete user testing, including full end-to-end integration testing with all other components • As early as mid-2013 -begin enrollment into qualified health plans

Key Project Activities	**Analysis Phase** • Develop and finalize business and technical requirements **Procurement Process** • Develop RFPs • Publish RFP's • RFP Bidders conference • Receive RFP responses • Assess and score RFP's • Select vendor(s), negotiate terms, finalize contracts **System Development** • 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 • Integration with Call Center Services solution • Premium Billing Functionality Account set up; Invoice generation; Interface with lockbox; Payment receipt process; Financial Management; Refunds; Member Support (e-pay functionality, online account view, etc.); Noticing; Reporting. **Other** • Final user testing including testing all interfaces with partners • Begin enrollment into qualified health plans
Key Decisions & Considerations	For the non-group market, the Exchange will need to determine whether and to what extent it wishes to facilitate enrollment and administer premium payments. For enrollments in the individual exchange, the exchange must decide if the enrollment application will be passed through to the carrier or Medicaid/CHIP agency, or if additional enrollment responsibilities will be carried out by the Exchange. Minimally, the Exchange will expect to capture plan selection, premium subsidy level, monthly enrollee premium (subsidized or unsubsidized), effective date of coverage (or termination), and member data. FFS Medicaid/CHIP applications will most likely be passed through to the appropriate agency, but for managed care products, the Exchange has the ability to make Medicaid enrollments. ID card issuance and distribution of member enrollment materials will most likely be done by the carrier. With respect to premium collections, proposed federal rules released in July 2011 provide three options. The Exchange can: • Choose to have individuals pay the QHP issuer directly • Facilitate an electronic "pass-through" without retaining any of the payment. • Collect premiums from enrollees and pay an aggregated sum to QHP issuers Regardless of the preferred approach, individuals may choose to pay the QHP issuer directly. This means that the Exchange, if involved in premium collection, must also build an exception process for those individuals who choose to pay the carrier directly. Because the Exchange is the source of record for premium flows and tax credits, this may create an administrative challenge. For the SHOP exchange, the enrollment process has two layers: employer and employee. Employer considerations include an employer account set-up process

	with enrollment, billing and collection elements including: tier and/or plan(s) selected; contribution level(s); tax credit eligibility; employee census data; employee change and termination notices; generation of group premium quotations; document imaging capabilities and repository; notification process; billing and invoicing; protocols for accepting checks or EFT payments; and COBRA administration. The enrollment system for small business employees must first account for the match-up between employer and employee, and then provide or capture such information as: access to appropriate plan selections, contribution levels, employee enrollment application process, effective date of coverage, and exchange generated confirmation of selection with letter providing access to services prior to QHP ID card receipt. To alleviate administrative burden on small employers, unlike the individual exchange, the SHOP exchange is required to perform premium payment administration and aggregation duties, which will necessitate a very complex funds flow and accounting structure. Because of the close coordination required to ensure interaction and consistency between the Exchange and issuers related to eligibility, enrollment, and billing, the exchange should begin talking with potential QHP issuers as soon as the second quarter of 2012. Both groups need to understand operational interfaces, key system constraints, and allow time for all parties to build out necessary systems. While exchanges may enjoy federal funding for exchange development, private carriers will not. New MLR requirements will encourage carriers to cut administrative costs, not add to them, although they will do so to effectuate enrollment gains. The key for successful exchange-carrier partnerships will be "early and often" communication strategies to avoid surprises to either party.
Key Dependencies	• Coordination with Medicaid, CHIP and other applicable state health subsidy programs • Coordination and integration with QHPs • Completed IT Gap Analysis and requirements definition • Procurement for Services and Solution • Integration with federal data services hub • Review Federal requirements for applications • Coordination and integration with Exchange IT core system component and services development

8. CUSTOMER SERVICE (CALL CENTER)

Customer Service

Toll-Free Number Functionality

The ACA requires that the Exchange operate a toll-free telephone number to assist individuals and employers seeking assistance with:

- The types of assistance available (including advance payments of the premium tax credit, cost-sharing reductions, and Medicaid);
- Other consumer assistance available (including Navigator programs and CAPs);
- The application process for coverage through the Exchange and Medicaid;
- The types of QHPs offered;
- The premiums, benefits, cost-sharing, and quality ratings associated with the QHPs offered; and
- Enrollment in QHPS

This toll-free number must be accessible to individuals with disabilities and those with limited proficiency in English.

Call Center Operations

Customer Service Infrastructure

The Exchange will need to ensure that call center staff are appropriately trained and have the system resources available to interact with the customer service resources at the health insurance issuers offering coverage through the Exchange.

Consumer Assistance

The call center will also need to provide information on and support to the other consumer assistance programs available to consumers to assist with their health insurance.

Other Customer Service Requirements

The Exchange should consider operating the call center outside of normal business hours and adjust staffing levels to account for times of higher call volumes. The Exchange call center must maintain confidentiality and notify consumers of the safeguards for privacy of personally-identifiable information.

Key Federal Milestones	**2012** • Initiate effort to develop and assess options for Customer Service call center **2013** • Q2 -Complete call center procurement process and select a vendor to operate the call center • Q2-Develop call center customer service representative protocols and scripts to respond to likely requests from health care consumers in the State • Q2-Develop protocols for accommodating the hearing impaired and those with other disabilities and foreign language translation services • 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 • 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
Key Project Activities	**Analysis Phase** • Determine to enhance existing Call Center Operations or Procure/build call center services and define requirements **Procurement Process** • Develop RFPs • Publish RFP's • RFP Bidders conference • Receive RFP responses • Assess and score RFP's • Select vendor(s), negotiate terms, finalize contracts **Administrative/Start up Activities** • Establish/modify facility for Customer Services Center • Set up organizational structure for Customer Services Center • Create Job Descriptions • Staff Customer Services Center • Develop/confirm workplace principles • Identify/Develop training program for staff • Identify/develop standard reports. • Identify/Develop proposal for Customer Service related communications. • Identify/Develop production schedule for Premium Billing. • Policy and Procedures for all Customer Services functions: *Member encounter support; member complaints and grievances; Member Self Service; Member Outreach; Member Enrollment; Member Appeals; Member Premium Billing; Member Hardship Requests; Permission to Share Information; Document Management and Mailings; Certificate of Exemption.* • Negotiate sub-contracts (as needed) • Develop continuity of operations plan.

Key Decisions & Considerations	The Exchange should assess the capabilities and capacities of current call centers to determine how to best establish the call center at the Exchange and organize other call centers in the state. The Exchange will want to work with other state leaders to understand how the call center can best serve residents of the state. Specific decisions the Exchange will want to consider include: • Will the call center be housed within the Exchange or will call center functions be outsourced to a third party? • What staffing level will be needed to operate the Exchange or manage the vendor contract? • How will the call center support Navigators and/or brokers? • In what ways will the call center interact with other consumer assistance programs currently available in the state and/or created by the ACA?
Key Dependencies	• Collaboration with state to determine if call center functions can be shared • Completed requirements for systems and program operations • Coordination and integration with QHPs, Navigators, Medicaid and Other publicly subsidized programs • Completion of procurement process (if applicable) • Coordination and integration with Exchange IT core system component development (website, CRM, enrollment, premium billing, financial system, reporting, noticing, appeals etc.)

9. SHOP SPECIFIC FUNCTIONS

General SHOP Requirements

Employer and Employee Choice

The SHOP must allow employers to select a level of coverage and make all QHPs within that level available to qualified employees. In addition, the SHOP may choose to allow employers to limit employee choice or make one or more QHPs available to employees by a different method. Maryland's Exchange recommends offering the federally-required level of employee choice as well as continuing to allow small employers to offer one issuer with one or more qualified health plans in the Exchange.

Rates and Rate Changes

The SHOP must require all QHP issuers to make any change to rates at a uniform time that is either quarterly, monthly, or annually. Rates for qualified employers may not vary during the plan year.

Merged Market Availability

In unmerged markets, the SHOP may only offer health plans available in the small group market. If a State merges the individual market and the small group markets, the SHOP may permit a qualified employee to enroll in any QHP that meets ACA-required deductible maximums and levels of coverage for the small group market. At the same time, the SHOP advisory committee report stated that a market merger in Maryland would be associated with significant uncertainty as well as a negative impact on premium rates. Maryland's Exchange recommends not merging the individual and small group markets at this time.

Large Group Market Expansion

Prior to 2016, states may choose to limit SHOP to small employers with 50 or fewer employees, which Maryland's Exchange recommends. Beginning in 2017, states may expand the SHOP to the large group market beginning in 2017. Large employers who wish to purchase through the SHOP must make all full-time employees eligible to purchase one or more QHPs offered through the SHOP.

SHOP Eligibility Standards	**Eligibility Standards** To purchase coverage for employees through the SHOP, employers must meet the following criteria: • Be a small employer • At a minimum, offer all full-time employees coverage in a QHP through the SHOP • Either have its principal business address in the Exchange service area and offers coverage to all its employees through that SHOP or offers coverage to each eligible employee through the SHOP serving that employee's primary worksite **Employee Participation in Multiple Exchanges** The SHOP shall allow employers to offer coverage to those employees whose primary worksite is in the SHOP's service area. **Eligibility Continuity and Employer Growth** If an employer purchasing through the SHOP increases the number of employees beyond the definition of a small group, they must be allowed to continue SHOP participation, unless they elect to discontinue or become ineligible for another reason.

SHOP Eligibility Processes	**Eligibility Process** The Exchange must develop a process to determine the eligibility of employers and employees to purchase coverage through the SHOP, including the acceptance and review of employer and employee application forms. The SHOP must provide notice of approval or denial of eligibility to employers and employees and must inform employers and employees of their right to appeal such determination. **Verification Process** The SHOP must verify that individual applicants are identified by the employer as employees that have been offered coverage. The SHOP must otherwise accept application information attested to within the application unless the SHOP has "reason to doubt" the veracity of application information, which, according to the NPRM, could result from a review of quarterly wage filings or an attempt by a small employer to enroll more individuals than allowed under the definition of small employer. The SHOP may choose to establish additional methods to verify the information provided by individual applicants. If the SHOP doubts the veracity of information on either the employer or employee application, it must inform the applicant employer or individual and allow 30 days for the provision of additional information. If satisfactory documentation is not received, the SHOP may deny eligibility and provide notice to either the employer or employee. If enrollment pending verification took place, the SHOP may discontinue coverage at the end of the month following the month in which notice was provided. **Employer Withdrawal** If a qualified employer discontinues coverage through the SHOP, the SHOP must ensure that each QHP terminates the coverage of the employer's qualified employees and ensure that employees enrolled in QHPs receive notification prior to termination.

SHOP Enrollment

Enrollment Process

The SHOP must process the SHOP single employee applications of qualified employees to the applicable QHP issuers and facilitate the enrollment of qualified employees in QHPs.

The SHOP must establish a uniform enrollment timeline and ensure that the following activities occur before the effective date of coverage for qualified employees:

- Determination of employer eligibility
- Qualified employer selection of QHPs
- Provision of a specific timeframe during which the employer can select the level of coverage or QHP offering, as appropriate
- Provision of a specific timeframe for qualified employees to provide relevant information to complete the application process
- Determination and verification of employee eligibility for enrollment through the SHOP
- Processing enrollment of qualified employees into selected QHPs
- Establishment of effective dates of employee coverage

Data Transmittal

To enroll qualified employees, the SHOP must ensure employees are notified of the effective date of coverage and transmit enrollment information on behalf of qualified employees to QHP issuers within the established timeline for Employee selection.

Record Retention

The SHOP must receive and maintain records of enrollment in QHPs, including identification of qualified employers and employees participating in the SHOP.

Monthly Data Reconciliation

The SHOP must reconcile enrollment information and employer participation information with QHPs at least monthly.

Employee Termination

If any employee terminates coverage from a QHP, the SHOP must notify the individual's employer.

Employer Enrollment	**Initial Open Enrollment** The SHOP must adhere to the initial open enrollment period (October 1, 2013), ensure that enrollment transactions are sent to QHP issuers timely, and ensure that issuers adhere to required coverage effective dates. **Rolling Enrollment** Qualified employers may purchase coverage at any point during the year. The employer's plan year must consist of the 12-month period beginning with the qualified employer's effective date of coverage. **Employer Annual Election Period** Prior to the completion of the employer's plan year and before the annual employee open enrollment period, the SHOP must provide employers the opportunity to change their participation in the SHOP for the next plan year and must provide employers with notification in advance of this period. Possible changes made during this period include: • The employee choice model • The employer premium contribution • The level of coverage offered • The plans offered
Employee Enrollment	**Annual Open Enrollment** The SHOP must establish an annual open enrollment period for employees prior to the completion of the plan year. Employees hired outside of the initial or annual open enrollment periods must be allowed a specified period to seek coverage beginning on the first day of employment. **Employee Renewal** At open enrollment, employees will remain enrolled in their plan as long as they remain eligible, unless they disenroll, enroll in another QHP if this option exists, or the QHP is no longer available.

Application Requirements	**Application Submission** The SHOP must allow employer and employee applications to be submitted via the internet, by phone, by mail, or in person. HHS will develop model employer and employee application forms that the SHOP may use. The SHOP may use an alternative application form if it collects the required information and has been approved by HHS. **Employer Applications** The SHOP must use a single application to determine employer eligibility. The application must collect the following information: • Employer name and address of employer's locations • Number of employees • Employer Identification Number (EIN) • A list of qualified employees and their social security numbers **Employee Applications** The SHOP must use a single employee application form for eligibility determination, QHP selection, and plan enrollment. Information collected must be sufficient to establish eligibility and complete enrollment (e.g., plan selection information and identification of dependents).
Key Federal Milestones	**2012** • Q1 -Begin system development • Q4 -Complete systems development and prepare for final user testing **2013** • Q1 -Begin final user testing, including testing of all interfaces • Q3 or before open enrollment -Complete user testing, including full end-to-end integration testing with all other components • As early as mid-2013 -Begin enrolling employees of small employers into qualified health plans

Key Project Activities	**Staffing** • Hire SHOP specific staff **Administrative and Operational Considerations** • Coordination with individual and Medicaid call centers • Determine website functionality and integration with individual exchange • Determine operational implications of federal regulations/guidance • Develop policy and procedures: Customer Service; Employer set up: self-service, through call center or broker; Broker setup and maintenance; QHP setup and maintenance; Employee shopping experience; Triage between individual and SHOP exchange scenarios; Enrollment, Renewal and disenrollment of employees, employers, brokers, QHPs; Outreach and open enrollment (continuous); Financial Management; Reporting; Billing and Collections: List Bill versus Composite Rating, Online Payment options, Reconcile payments (lockbox, nonpayment, reporting), Payment to QHP, Payment to Brokers, Premium rate updates from QHPs; Develop technical specifications in accordance with key policy decisions. **Procurement (website, call center, print/fulfillment, marketing, other)** • Develop RFP's • Publish RFP's • RFP Bidders conference • Receive bids • Assess and score RFP's • Select vendor(s), negotiate terms, finalize contracts **Other** • Implement, test, validate, go live
Key Decisions & Considerations	To attract employers, the SHOP Exchange must create an efficient process similar to or superior than those found in the commercial market. In addition to verifying eligibility and facilitating enrollment, SHOP functionality will need to address online premium quote generation, employer account set up, plan selection options, contribution levels, employee cost calculator, employer invoicing and payment, aggregated payments, customer service protocols, broker training and sales tools, broker compensation, and broker reporting. Key decisions include: 1. *Employee Choice Models.* The Exchange will need to determine which options to provide to employers. Maryland's Exchange recommends offering the federally-required level of employee choice as well as continuing to allow small employers to offer one issuer with one or more qualified health plans in the Exchange. 2. *Issuer Standardization.* The Exchange will need to decide whether and to what extent to require standardization in carrier underwriting and administrative processes for serving employers in the employee choice model. Factors suggesting a level of standardization include: • The employer is required to perform certain functions in group insurance, such as non-discrimination in contributions that cannot be undermined by varying practices of the health plans s/he offers.

	• The employer must be able to understand and handle administrative tasks with. Differences in the way that carriers perform certain functions, while tolerable if the employer offers only one carrier, become intolerable with multiple carriers in the group. • The Exchange is performing functions normally handled by a single carrier, such as billing and collection, and therefore needs some degree of uniformity to manage those functions across carriers. • Standardization across plans may be required to minimize the potential for adverse selection. Areas of potential uniformity or carrier standardization include the following: 1. Application of Adjusted Community Rating 2. Rating-basis type (e.g., 1-person, 2-adults, 1 adult + 1 child, etc.) 3. Participation Requirements 4. Effective dates 5. Premium billing, collections & termination for non-collection 6. Broker commissions 7. Employer audits 8. Late Adds & Terms, Qualifying Events, COBRA 9. Out-of-State Coverage
Key Dependencies	• Completed requirements for systems and program operations • Finalized federal guidance on employee choice, minimum participation regulations, and other SHOP specific issues • Coordination and integration with QHPs, Brokers, and Navigators • Procurement for Services and Solution for shopping, billing, collections, and distribution of premiums to issuers • Coordination and integration with Exchange IT core system component development (website, CRM, enrollment, premium billing, financial system, reporting, noticing, etc.)

III. Marketing & Outreach

10. OUTREACH & MARKETING PLAN

Communications	**Communications Strategy** The Exchange must conduct communications on the health coverage options available, as well as on the ACA requirements more broadly. This communications strategy will also have to include a marketing component for the QHPs offered through the Exchange. **Consumer Protections** The Exchange may not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation when establishing its communications campaign. The Exchange is also prohibited from collecting, using, or disclosing personally identifiable information as part of its communications strategy.
Outreach	The Exchange must conduct outreach and education activities to inform consumers about the Exchange and to encourage participation. Principles of this outreach campaign include: • Maximizing enrollment of eligible individuals in QHPs • Supporting the needs of consumers during the Open Enrollment period • Guaranteeing broad outreach while still considering the needs of people with disabilities, individuals with low literacy, and those with limited English proficiency • Creating targeted outreach strategies for specific groups including hard to reach populations and populations that experience health disparities due to low literacy, race, color, national origin, or disability, including mental illnesses and substance use disorders • Ensuring the Exchange does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation when establishing its outreach campaign

Consumer Assistance	**Consumer Assistance** The Exchange must have a consumer assistance function and must refer consumers to other consumer assistance programs in the state when available and appropriate. Consumer Assistance Program (CAP) grants were designed to provide assistance with a broader scope of health coverage options not limited to Exchanges. Specifically, recipients of CAP grants are instructed to • Assist with the determination of eligibility for and enrollment in health insurance • Help file grievances and appeals • Provide information about consumer protections • Collect data on inquiries and problems and how they are resolved The Exchange will need evaluate CAPs within its state to ensure that there are appropriate resources to meet consumer needs. The Exchange will also have to ensure that efforts among all entities conducting outreach and education, including navigators, are coordinated and convey accessible, accurate, appropriate, fair and impartial information.
Key Federal Milestones	**2012** • "Develop a ""toolkit"" for outreach to include educational materials and information" • Develop performance metrics and evaluation plan • Design a media strategy and other information dissemination tools • Submit final outreach and education plan (to include performance metrics and evaluation plan) to HHS • Focus test materials with key stakeholders and consumers and make refinements based on input **2013** • Q1 - Launch outreach and education strategy and continue to refine messaging based on response and feedback from consumers
Key Project Activities	**Staffing** • Hire Chief Communications Officer • Hire Chief Sales & Marketing Officer • Develop a high level communication & outreach strategy for exchange • Solicit input from key stakeholders in state • Develop an outreach and marketing budget • Develop return on investment (ROI) metrics **Procure Marketing Services** • Solicit federal grant funds through Level 2 grant to develop and implement a broad marketing and outreach campaign • Develop & Publish RFP for Marketing & Advertising Vendor • Finalize RFP process and select vendor • Working with vendor, begin market research and planning activities **Select outreach and marketing partners** • Identify outreach partners (other state agencies and existing health care advocacy groups) • Identify potential marketing partners and alliances for exchange • Select outreach and marketing partners **Other** • Execute outreach and communication plan • Collect data and calculate ROI

Key Decisions & Considerations	The traditional components that make up a successful communications strategy include: • Public and Media relations - managing communications with the press and inquiries from the public • Marketing - developing the formal marketing plan and establishing any public or private partnerships • Advertising - communicating via internet, mobile texting, signage, print, radio, and television messages to individuals and employers • Sales - working with health plans, brokers, or directly with individuals and small business to encourage and facilitate enrollment through the exchange. • Market research – support data-based decision making through compiling information on Exchange customers The Exchange will want to consider all these components when creating content for its website, notices, and general communications materials. The Exchange should assess existing consumer assistance needs within the state and the range of consumer assistance programs working to meet those needs. The Exchange should also conduct a detailed customer and competitor analysis to shape its ultimate communications strategy. Other important considerations include: • How can the Exchange apply the lessons learned through its communications and outreach function to assist with the QHP certification process and/or standardizing benefits? • How can the Exchange utilize its marketing strategy to push purchasing towards the Exchange? • How will the Exchange determine the effectiveness of the communications plan across the many constituencies that will be served by the Exchange, including individuals eligible for tax credits, non-subsidized individuals, and small group employers and their employees? • Will the Exchange partner with existing consumer assistance programs in the state?
Key Dependencies	• Hire key marketing and outreach staff • Funding and procurement process for outreach and marketing services

11. NAVIGATOR PROGRAM

Exchange Responsibilities	**Selecting Navigators** The Exchange is required to choose Navigators from at least two types of entities: consumer focused non-profit groups, professional associations, commercial fishing organizations, chambers of commerce, unions, licensed brokers, Indian tribes, tribal organizations, and state or local human service agencies. When evaluating candidates, the Exchange must assess whether the Navigator has demonstrated existing relationships (or the ability to establish relationships) with employers, employees, consumers, and the self-employed and whether any conflict of interests exist. The Exchange must also have the resources available to ensure that all Navigators meet any licensing, certification, or other standards prescribed by the Exchange, the state, or HHS as applicable. The report of Maryland's advisory committee recommends separate Navigator programs to support individuals and small businesses. **Navigator Funding** Federal funds provided to states to establish exchanges may not be used to fund Navigator grants. HHS recommends that the Exchange evaluate whether the state would want to draw down federal Medicaid and CHIP matching funds for Navigator activities that target these populations.

Navigator Responsibilities	**Navigator Functions** Navigators will perform public education on behalf of the Exchange, especially to hard-to-reach populations, and help individuals through the plan selection and eligibility determination process. Though this program, Navigators must be available to provide assistance in person or through interactive technology to individuals in all regions of the state. Specific required functions include: • Distribute fair and impartial information about enrollment in QHPs and the availability of premium tax credits. Such information should also acknowledge other health programs that may be available to the applicant • Facilitate enrollment in QHPs • Provide referrals to appropriate state agencies for enrollees with grievances, complaints, or questions about their health coverage • Provide information that is linguistically and culturally appropriate to the populations served by the Exchange, including individuals with limited English proficiency • Ensure accessibility and usability of Navigator tools and functions for individuals with disabilities • Maintain expertise in eligibility and enrollment **Navigator Eligibility** Health insurers cannot be Navigators and Navigators may not receive any direct or indirect incentives from any health insurance issuers in connection with enrollment in QHPs.
Key Federal Milestones	**2012** • Determine targeted organizations in the State who would qualify to function as Navigators **2013** • Q2 - Determine Navigator grantee organizations and award contracts or grants (funded from the organizational funds for the Exchange)

Key Project Activities	**<u>Staffing</u>** • Hire exchange staff to oversee Navigator program • Determine level of consulting services required, if any **<u>Analysis and Policy Development</u>** • Schedule Navigator stakeholder meetings to solicit input from key stakeholders • Determine level of training and certification required of Navigators by Exchange • Develop Navigator training program • Determine level of compensation to be paid to Navigators -- per enrollee/fixed grants, etc. • Develop funding stream for Navigators -- pre 2014 / post 2013 **<u>Navigator Management Tool Procurement</u>** • Develop RFP for Navigators • Select Navigators **<u>Other</u>** • Train Navigators • Begin operations of Navigators

Key Decisions & Considerations	As both revenue and expense generators, Navigators are crucial to the Exchange's financial self-sufficiency. However, the ACA has allowed the Exchange wide discretion in terms of the size and scope of their Navigator program. Key activities considerations include the following: *Role Definition.* The Exchange must define the role of Navigators, and how it does or does not overlap with insurance brokers or other existing market actors. Models considered by Maryland's Exchange include a SHOP Exchange interface model in which producers would be permitted to sell QHPs in the Exchange, and would be compensated by insurance carriers as producers, not Navigators. Navigators would be paid by grants and would assist with eligibility and enrollment for individuals in both the Exchange and Medicaid. *Program Financing.* Financing Navigator start-up costs through non-federal sources prior to Exchange operations in 2014 will present a challenge. Potential sources of funding include state general funds, infrastructure components of existing Medicaid outreach contracts, or foundation or other private funding. Depending upon the financing mechanism selected for Exchange operations, beginning collections prior to January 1, 2014 may be an additional option. *Compensation.* The ACA does not prescribe a specific model for compensating Navigators. The Exchange may choose a grant funding mechanism, a "sales" oriented performance based payment system, or a hybrid method that both supports Navigator infrastructure and ties payment to performance. A model being considered by Maryland's Exchange would compensate Navigators with grants, while maintaining the role of producers with compensation by health insurance carriers. *Certification, Training, and Oversight.* The Exchange will need to develop an application and/or RFP process to identify and select participating organizations, and develop a training and oversight program that will both monitor navigator performance as well as provide the support, guidance, and assistance required by participating organizations. Key Decision points include: • How will the success of Navigators be measured? • Should the state conduct a competitive procurement to award navigator grants or accept any organization/person that meets the established criteria? • What is the staffing need to provide oversight of the Navigator program? • What training and expertise should be required of a Navigator? • Does the Exchange want to create a separate web module for Navigators? • What special training and support services should be provided to producers who are selling Exchange products? (see section on "Brokers," below)
Key Dependencies	• Navigator financing source identified • Coordination with Marketing and Outreach strategy • Navigator identification and certification • Coordination and integration with Exchange IT core system component development as applicable

12. BROKER PROGRAM

Role of Brokers	**Broker Functions** Broker can perform the following the functions outlined in proposed rules: • Enroll qualified individuals, employers, and employees in QHPs • Assist individuals and employers with their applications for insurance coverage, including providing the documentation on group size • Assist with applications for advance payments of the premium tax credit and cost-sharing reductions **Other Potential Functions** While not explicitly set forth in regulation, Brokers may also offer further assistance to Exchange customers by providing: • Personalized decision support • Assistance with employer reporting requirements • Promotion of and assistance with the small business tax credit • Insurance renewal support • Implementation and management of employer wellness programs • Assistance with client claims disputes and possible eligibility changes
Role of Exchange	**Broker Information** The only federal guidance to date specifies that the Exchange should display information about brokers on its website or in other public materials. **Other Broker Functions** The Exchange may want to establish a self-service Broker Portal for easy quote generation and plan comparison. Other functions the Exchange may want to build into this portal include: • Account management functions including statement generation, data interchanges with carriers, and billing • Online training and licensure materials • Interactive functionality to handle broker inquires and reporting
Key Federal Milestones	• Broker functionality, training, and oversight must be in place prior to start of open enrollment, if brokers will be a sales channel utilized by the Exchange.

Key Project Activities	**<u>Analysis</u>** • Perform market study to determine broker compensation, services provided, markets serviced • Schedule broker stakeholder meetings to solicit input from broker community • Using data from market study and stakeholder meetings, develop exchange broker strategy • Determine level of broker compensation for writing exchange business • Determine funds flow of broker payments **<u>Implementation</u>** • Reflect broker-specific policies in QHP procurement • Develop a broker training program for exchange products • Develop broker management tool to track key broker metrics • Develop a broker-advisory council for ongoing feedback from brokers once operational
Key Decisions & Considerations	The Exchange will have to determine the ultimate role of, compensation, and services provided for brokers. To establish an operational working relationship with brokers, the Exchange will need to determine the following: • To what extent the Exchange will rely upon brokers in the small and non-grou markets • The level and model of compensation (per-subscriber per-month, flat fee, percent of premium, etc.) • Tools and technical infrastructure needed to execute compensation arrangements, monitor performance, and facilitate account management • Certification, training, and service requirements to support brokers • Intersection between Exchange requirements and current licensure requirements established by the MIA • Whether the Exchange will want to develop a preferred list of brokers • Online tools and services • Interaction between brokers and Medicaid/expansion populations
Key Dependencies	• Coordination with Marketing and Outreach strategy • Role definition for brokers and Navigators • Assessment of current landscape to determine current broker and navigator roles, typical services provided, and basis of compensation • Coordination and integration with Exchange IT core system component development as applicable

IV. QHP Plan Management

13. QHP CERTIFICATION

QHP Certification

QHP Certification and Recertification Process

The Exchange must establish a process to award certification to QHPs. This process must be completed prior to open enrollment in October 2013. In addition, the Exchange must establish a process to recertify QHPs on an annual basis by September 15 of each year.

QHP Compliance Monitoring and Decertification

The Exchange must develop and maintain a process to monitor ongoing QHP compliance with certification criteria and establish a decertification process for plans found not in compliance. The decertification process must include a QHP appeal process and appropriate notification to the issuer, the state insurance bureau, HHS, and enrollees, who must be granted a special open enrollment period to change plans.

QHP Compliance and Rate Review

Rate Review

On an annual basis, issuers must provide justification for requested rate increases to the Exchange. The Exchange is responsible for reviewing this information prior to the effective date of the increase, and must incorporate both state guidance as well as information related to the rate of increase for products sold outside the Exchange.

Accreditation

All QHPs must be accredited by an organization recognized by HHS. For plans not yet accredited at the time of certification, the Exchange must establish a uniform period after certification by which plans must become accredited and monitor QHP progress towards this deadline.

Service Area and Network Adequacy

The Exchange must establish standards and a monitoring process to ensure that QHP provider networks are adequate and offer sufficient choice and that QHP service areas comply with federal (or Exchange, if applicable) requirements. Under federal standards, service areas must be at least one county and cannot be discriminatory on the basis of race, ethnicity, language, health status, medical cost, service utilization, or medical service availability.

Data Collection and Reporting	**Annual Information Submission** The Exchange must collect information from QHPs at least annually in a form to be determined by HHS related to QHP rates, covered benefits and cost sharing requirements. **QHP Transparency Reporting** In a manner to be defined by HHS, the Exchange must collect information from QHPs related to claims payment policies and practices, financial disclosures, enrollment and disenrollment, denied claims, rating practices, out-of-network cost sharing and payment policies, and enrollee rights under ACA. The Exchange must also ensure that this information is posted by the QHP and monitor the QHP's performance in providing timely cost sharing information to enrollees.
Multi-State Plans	**Multi-State Health Plans** The Office of Personnel Management (OPM) will designate at least two Multi-State health plans that will participate by 2017 in all state based exchanges as well as the federal fallback exchange. Multi-state plans must have a uniform benefit package in all states, meet benefit design requirements spelled out in the ACA, meet all requirements of QHPs, and meets federal and state (if more restrictive) rating requirements. Under currently proposed federal rules, Multi-State Plans are exempt from the state's certification process and deemed eligible for participation in the Exchange.
Dental Plans	**Stand-Alone Dental Plans** The Exchange must allow for the offering of a limited scope dental benefit plan through the Exchange. Selected plans must cover the pediatric dental essential benefit laid out in ACA. Dental plans can be stand-alone or offered with a QHP, and the Maryland Exchange has recommended pursuing both stand-alone and bundled options.
Key Federal Milestones	**2012** • 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 • Q3 – Release RFP • Q4 - Begin training health plan issuers to become qualified health plans **2013** • Q3 – Conduct readiness reviews • Complete QHP Certification Process: September 30, 2013 **2014** • Q1- Begin collecting user fees if the exchange is using this funding mechanism • Q1- Demonstrate capability to monitor the practices and conduct as well as pricing and benefits of QHPs

Key Project Activities	**Staffing** • Determine exchange staff to oversee QHP procurement **Analysis** • Develop with IT, operational specifications for QHP's -- enrollment/premium rates/billings • Compile data necessary to analyze and develop procurement goals • Analyze data and develop state procurement goals • Communicate goals of procurement with BOD • Develop communication plan to meet with carriers prior to release of RFP • Incorporate into QHP procurement strategy OPM offerings • Organize cross-functional QHP procurement team • Incorporate Plan Rating System in procurement • Incorporate Risk Adjustment methodology in procurement **Procurement** • Develop and publish RFP • Select & Contract with QHP's **Other** • Begin implementation of QHP's • Implement, test systems, interfaces, website design • Begin open enrollment
Key Decisions & Considerations	The Exchange must establish standards for QHPs, which will be informed by federal guidelines, and then develop its requirements, if any, for benefit designs to be offered through the Exchange. It will then need to develop the certification process itself and ensure that the operational capacity to support the ongoing carrier relationship is in place (e.g., the ability to efficiently acquire carrier rates, enroll members, work with the carriers customer service platform, transfer funds, and receive claims data). 1. *QHP Certification Approach.* The Exchange has flexibility in its approach to QHP certification as well as the certification criteria it employs. For example, the Exchange has recommended that transition of care language should be included in contracts as part of QHP certification. The Exchange has also made important recommendations regarding required carrier participation inside and outside the Exchange. Additional considerations include: • Will the Exchange take an active purchasing role, a passive contracting strategy, or something in between? The Exchange board has developed recommendations for a flexible and incremental strategy that provides the ability to add requirements above ACA standards but allows all plans that meet these requirements to participate. • Will the Exchange leverage the certification to achieve value and quality objectives or to help reform the larger health care market? • What impact will certification criteria have on carrier participation and the attractiveness of the Exchange to individuals and small groups? • Will the certification process be the same for small and non-group markets? • How will the state define its essential benefit package? • Will plan designs and product features be standardized or will innovation

	among QHPs be encouraged? • How much plan choice will be offered? 2. *Certification Process.* This process can take the form of a more formal RFP selection process, or a less formal application and approval process. Throughout this process, the Exchange will need to communicate with stakeholders on the expected timeline, process and goals of the solicitation process. Once the certification process is complete, the Exchange will need to finalize negotiations and execute contracts with all successful QHP issuers. Simultaneously, the Exchange will need to begin work with each carrier to ensure that necessary interfaces between carriers and the Exchange are all in place and fully tested before open enrollment season. 3. *Plan Management and Oversight.* Additional plan management capabilities must be in place, including the ability to monitor ongoing QHP compliance and a process to ensure price increases are reviewed and justified in a timely manner, and that the review process is not duplicative or disruptive of existing insurance bureau rate review processes. 4. *Integration with Plan Rating System.* The plan rating system (discussed below) developed by the Exchange will allow the Exchange and consumers to evaluate QHPs on the dimensions of quality and value. This system will share several key components with the QHP certification process, including the acceptance, evaluation, and storage of plan information, as well as an identification of the key elements of plan performance and value that the Exchange will evaluate. Creating linkages – both from a technical and policy perspective – between the QHP process and the plan rating system will allow the Exchange to extract greater value from both processes, streamline operations, and provide greater overall consistency in its interactions with the public and the market.
Key Dependencies	• Risk adjustment and reinsurance parameters established • Insurance market reforms in place • Eligibility, enrollment, and tax credit administration system readiness and policy decision making final or near final • Website and plan comparison tools operational • Exchange data and reporting interfaces completed

14. PLAN RATING SYSTEM

QHP Rating	**QHP Plan Comparison Information** In addition to QHP plan features (premium, cost-sharing, benefits summary, rating tier, etc.) the Exchange must publish information about QHPs that would be helpful to consumers when comparing available health plans. Specifically, the ACA requires the Exchange to rate QHPs on the basis of quality and price. **Plan Rating Metrics** Quality ratings will be determined based upon data collected from health issuers during the certification process (and thereafter). However, the specific quality standards HHS will require as part of the rating process have been deferred to future regulation.
Exchange Rating System	The ACA requires that the plan rating system built by the Exchange would need to rate QHPs in each benefit level on quality and price. This rating system must be available on the Exchange website for consumers to easily compare available plans. Further federal guidance has also included the requirement that customer service staff at the Exchange call center must be able to provide guidance on the specific quality ratings for each QHP. The Exchange may also want to build its rating system to allow QHPs to be compared on provider quality, network adequacy, and customer support services among other criteria.
Key Federal Milestones	**2012** • Complete procurement tasks related to health plan quality rating method development • Include quality rating functionality in system business requirements for the Exchange website • Complete system development of quality rating functionality • Complete testing and validation of quality rating functionality **2013** • Before Open Enrollment - Post quality rating system information on the Exchange website **2014** • Continually update quality rating information on the Exchange website and for call center representatives so they have the most up to date information on QHPs

Key Project Activities	**Plan Rating System** • Review federal guidance for Plan Rating System • Determine goals of state in rating QHP's • Select type of quality/cost metrics to rank QHP's • Determine availability of plan rating data • Integrate with exchange website • Develop implementation plan for ongoing data maintenance and updating of ratings • Integrate with QHP procurement strategy • Include plan rating specifications into QHP procurement document
Key Decisions & Considerations	The rating system should be established before the QHP certification process is initiated as it will be important for prospective carriers to understand what metrics are important to the selection process. From a strategic perspective, the Exchange should regard the plan rating system as a competitive differentiator as it will allow consumers to compare plans and make meaningful, informed choices. Under an active purchaser model, the plan rating system can also be utilized during the certification process by providing differential value to QHPs that rank high on the plan rating system. In a more facilitative process, a robust plan rating system can lend an alternate method to spur plan competition by directing consumers to those plans offering the highest quality and value. Although federal guidance on quality rating has not been released, the Exchange can begin to plan for this process by: • Understanding current quality data available on plans sold within the state and whether this data is being shared publicly • Determining the quality components the Exchange would want measured • Evaluating existing sources of quality data including the Consumer Assessment of Healthcare Providers and Systems (CAHPS), the Healthcare Effectiveness Data and Information Set (HEDIS), and the Health Outcomes Survey (HOS), as well as existing rating systems including the CMS's Stars system for Medicare Advantage, National Committee for Quality Assurance (NCQA), and URAC. Additional important decision points include: • How will the Exchange communicate quality ratings on the website (i.e. letter grades, stars, written statements)? • Will the Exchange want to allow consumers to compare plans based on the rating of individual quality components such as preventive care and behavioral health, or a more aggregate score or rating? • Does the Exchange want to push customers towards the QHPs that offer the best overall value in terms of cost and quality? If so, how? • How can the rating system be used to assist the Exchange during the QHP certification process?
Key Dependencies	• QHP certification process • Identification of key metrics • Exchange data storage and analysis capabilities developed • Coordination and integration with Exchange IT core system component development

V. Risk Adjustment and Reinsurance

15. RISK ADJUSTMENT AND REINSURANCE

Federal Requirements	*For a detailed overview of Exchange responsibilities related to ACA risk mitigation programs, please refer to Attachment 1, " Analysis of HHS Proposed Rules On Reinsurance, Risk Corridors And Risk Adjustment", prepared by Wakely Consulting Group.*
Key Federal Milestones	**2012** • Release of Federal risk adjustment model and reinsurance parameters – Oct. 2012 • State deadline to propose alternate model and parameters for HHS approval – Nov. 2012 • State deadline to file exception to minimum standards for data collection (if APCD in place) – Dec. 2012 **2013** • HHS informs states if alternate model and parameters are approved – Jan. 2013 • State deadline to provide notice to local stakeholders that alternate model and parameters will be used – Mar. 2013
Key Project Activities	• Determine level of interaction necessary with HHS regarding federal implementation of risk corridors • Determine availability of enrollment and claims data for analysis • Assess characteristics of state APCD and identify changes needed to support risk adjustment • Compile necessary data to begin analytical assessment • Determine where program will be managed within the state • Convene risk adjustment workgroup • Decide where data will be held and managed for startup and operations • Contract with subject matter experts • Develop risk adjustment methodology for program implementation • • Discuss proposed risk adjustment methodology with carriers and solicit input • Communicate with BOD program specifics after meeting with carriers • Develop " dry runs " of agreed upon methodology to determine impact on market • Share results of " dry runs " with carriers; modify methodology if necessary • Develop implementation plan -- data management; communications; funds flow; reconciliation • Implement program
Key Decisions & Considerations	1. *Governance and Administration.* These functions can be governed by the Exchange, another state agency, or a separate, qualified reinsurance organization. Administrative functions for reinsurance programs can be contracted to a third-party administrator, but the Exchange (or alternate governing authority) will need to set policies and program parameters.

	2. *Administrative Infrastructure.* The Exchange (if operating risk adjustment) must have the capacity to accept, store, and analyze large volumes of claims data from health carriers. Access to the state's APCD, if feasible, will reduce the administrative efforts and cost impact of operating this program. Other important administrative considerations include: a. Development of a data audit function, integrity controls, and public reporting to provide sufficient levels of transparency to sustain trust and support. b. Establishing key vendor relationships to plan for and implement the analytical, actuarial, and data management components of the program c. Establishing a cash management and payment system to collect and disburse money 3. *Program Financing.* Reinsurance can be funded as an add-on to carrier assessments; risk adjustment must be funded via the Exchange funding source or an alternative mechanism. 4. *Model and Parameter Development.* HHS will establish a risk adjustment model as well as program parameters for risk adjustment and reinsurance (e.g., assessment level, attachment point, coinsurance, etc.). States must determine if they wish to use the federal model and parameters, or employ state-specific elements for either program. 5. *Simulation Modeling.* To ensure that program parameters are appropriate and will not result in shortfalls, the state will want to model various assessment rates and attachment point, coinsurance and cap options given those various assessment rates. 6. *Carrier Communication.* Communicating with carriers will be a critical component of program success, as they will require detailed understanding of the program in sufficient time to incorporate program parameters and anticipated affects into their pricing for 2014. The more transparent the process, the more like carriers are to accept and support it, and the less likely to price defensively in an uncertain new market.
Key Dependencies	• Decision-making related to risk mitigation administration and governance • Data storage and analytical infrastructure • Release of HHS risk adjustment model • Health insurance market reform implementation

VI. Regulatory Compliance and Reporting

16. EXTERNAL REPORTING AND CONSUMER PROTECTION

Health Plan Information	**Plan Features** At a minimum, the Exchange website must include information for each available QHP, including premium and cost-sharing information, a summary of benefits and coverage, and the plan's rating tier (bronze, silver, gold, or catastrophic). The Exchange must also make accessible QHP provider directories received during QHP certification. **Plan Quality Rating and Transparency** In addition to plan features, the Exchange must publish the results of enrollee satisfaction surveys conducted by the Secretary, plan quality ratings, plan medical loss ratio information, and measures of QHP coverage transparency.
Accessibility	**Accessibility** The Exchange website must be accessible to individuals with disabilities in accordance with the ADA and Section 504 of the Rehabilitation Act, as well as reasonable access to individuals with limited English proficiency.
Consumer Assistance	**Consumer Assistance** The Exchange must provide a consumer assistance program, including a toll-free telephone number and accessible web portal. When available and appropriate, the Exchange must also refer individuals to consumer assistance program in the State. **Navigator Information** The Exchange must provide information about Navigators and the Navigator program (as discussed in the section on Navigators, above).
Financial Reporting	**Administrative Costs and Fees** The Exchange must publish the costs and fees associated with operating the organization, including the average cost of licensing, required regulatory fees and payments to operate the Exchange, Exchange administrative costs, and an accounting of money lost to fraud, waste, and abuse. **Federal Financial Reporting** The Exchange must keep accurate accounts and provide an annual financial report to HHS. In addition to receiving such reports, the Secretary will conduct annual audits and may also require additional financial reports and/or conduct investigations of Exchange financial activities at any time.

Key Federal Milestones	**2011-2012** • Develop requirements for systems and program operations including capturing data used in enrollment process; submitting relevant data to HHS for later use in information reporting: capacity to generate information reports to enrollees • Q1-Q3 Systems development **2013** • Q1-Q3 Final user testing including testing all interfaces including full end-to-end integration testing with all other components
Key Project Activities	**Analysis Phase** • Identify reporting requirements per ACA and CMS/HHS guidelines • Solicit BOD and key stakeholder input as to type of information exchange should report • Develop list of reports mandatory and optional • Depending on level of reporting, hire exchange staff to support initiative **Development** • Create report template for content of each report • Develop or acquire necessary databases to support mandatory and optional reporting • Create schedule of report publication dates: monthly; quarterly; annual **Other** • Develop IT requirements: reporting tools; interfaces; CMS/HHS requirements
Key Decisions & Considerations	To meet its consumer protection and public reporting requirements, which primarily relate to collecting, managing, and then distributing information, the Exchange must develop adequate data collection, storage, and reporting capabilities; document management policies and procedures; and the dedicated attention of a compliance officer or reporting manager. 1. *Data System Integration, Flexibility, and Integrity.* The basis for any reporting system is the accessibility of information from the Exchange's core operating systems, the integration of these systems with each other, and centralized data storage facility to provide accurate, timely, and consistent information related to Exchange operations, health plan performance, and financing. Mapping Exchange data and business reporting requirements as an integral component of Exchange system development will help ensure adequate flexibility and timely reporting activities downstream. Key considerations when developing a data storage and reporting system include: • Dedicated data base management staff (internal or contracted) • Uniformity and consistency in data elements across systems • Security and quality testing to ensure data integrity and accuracy • Data back-up and snap-shot abilities for consistent past information • Secure access to source data views and tables, sufficient analytical resources, and adequate data flexibility to adapt to new reporting needs 2. *Health Plan Data.* Information from carriers constitutes the majority of Exchange reporting requirements. Reporting these elements will require the

	Exchange to obtain information on enrollment, claim denials, financial disclosures, enrollee satisfaction, and quality metrics. In particular, developing the methodology and implementing the reporting of quality rating metrics will require significant data storage and analysis capabilities, and, depending on the level of sophistication desired for online consumer assistance tools, will also require significant technical resources to place these tools onto the Exchange website. The Exchange may consider making adherence to Exchange data and reporting protocols, as well as a commitment to transparency and consumer information, important elements of QHP certification. 3. *Financial Management.* As indicated in Financial Management, above, the Exchange will need to establish a system of internal control early in the process to be able to meet its many state, federal, and public financial reporting requirements and manage multiple external audits. Similarly, the Exchange should establish a process to periodically review, re-assess, and update its internal control and management reporting processes.
Key Dependencies	• Completed requirements for Exchange, QHP, and Federal reporting • Coordination and integration with necessary partners/data sources to address all functional areas of the Exchange including Eligibility & Enrollment, Plan Management, Risk Management (including Risk Adjustment & Reinsurance), Appeals Management, Marketing & Outreach, Financial Management, and Customer Service/Call Center • Completed Procurement for Services and Solution (as applicable) • Coordination and integration with Exchange IT core system component development (website, CRM, enrollment, premium billing, financial system, reporting, noticing, appeals etc.)

17. EXEMPTION CERTIFICATION AND APPEALS PROCESSES

Individual Mandate Exemptions

HHS Process Implementation

The Secretary will establish procedures for the acceptance of applications for exemption from the individual mandate. The Exchange is expected to develop the ability to implement these processes and procedures.

Individual Status Determination

The Exchange must be able to determine, for each individual, whether the individual is exempt from individual mandate obligations due to: (a) membership in an exempted group (e.g., religious, tribal affiliation); (b) income less than 100% FPL; (c) lack of affordable coverage access; or (d) hardship.

Data Collection

Data required to verify appeals based on membership in an exempt group or hardship appeals will be determined by HHS.

For appeals based on lack of affordable coverage or income based appeals, the information required for verification is the same as that which must be used to determine eligibility for premium tax credits based on income and access to employer-sponsored coverage, namely: Income and family size, family status and income changes, employer information (name, address, EIN), full/part-time status, whether employer offers minimum coverage, lowest cost employer plan (if offered), and the employee's required contribution. While not specified, this information may come from the individual or be obtained from the Exchange eligibility system.

Data Transmittals

For individuals granted a certificate of exemption, the Exchange must transmit a list of individuals and their identification numbers to HHS.

Employer Liability Determination	**Access to Employer-Sponsored Coverage** The Exchange must have the capacity to determine whether individuals have access to employer sponsored insurance, and whether such coverage is affordable to the employee. In addition to the employee's income, this will require the Exchange to collect information identifying the employer, whether qualified health insurance is offered, and the employer and employee-required contributions for such insurance. **Employer Notification** The Exchange must notify 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 offer minimum essential coverage or the coverage is not affordable or does not meet the minimum value requirement. Further, the Exchange must offer the employer an opportunity to appeal. The Exchange must also notify employers if their employees inform the Exchange that they are changing employers or discontinuing coverage with a QHP. **Data Transmittal** The Exchange must provide the Secretary of the Treasury with a list of employees who were determined eligible for the premium tax credit either because the employer did not offer qualified coverage, or because such coverage was deemed unaffordable. In addition, the Exchange must provide the Secretary with a list of individuals who changed employers or cease enrollment in a QHP.
Appeals	**Appeals Processes** The Exchange must establish and maintain an appeals process for findings and determinations related to: 1. Individual eligibility for premium tax credits and cost-sharing subsidies 2. Determination of Employer eligibility to purchase coverage through the SHOP Exchange 3. Determination of eligibility for exemption from individual responsibility requirements 4. Employer responsibility determination for employees determined eligible for premium tax credits 5. QHP decertification
Key Federal Milestones	**2012** • Q2 Begin developing business processes and operational plan for appeals functions • Q4 Establish resources to handle appeals of eligibility determinations including training on eligibility requirements **2013** • Q3 or before open enrollment - Initiate communication with HHS on process for referring appeals to the Federal appeals process

Key Project Activities	**Staffing** • Determine amount of existing resources which could be leveraged • Hire necessary staff **Analysis Phase** • Identify obligations and requirements per ACA and CMS/HHS guidelines • Document appeals processes currently in operation in other state agencies • Document a process flow of how certificates of exemption and appeals would be administered • Identify as part of process flow: data needs; type of support staff required; est. # of appeals • Develop specifications for IT needs • Develop implementation plan for appeals department in exchange: budget; physical space; staff **System Development** • Build or modify solution to manage exemption requests and appeals • Final user testing (including all interfaces and integration with other components) **Other** • Begin processing exemptions from individual responsibility
Key Decisions & Considerations	Carrying out the politically sensitive tasks of managing appeals of eligibility, informing employers of potential liabilities, and issuing certificates of exemption efficiently, effectively and with considerable flexibility will be necessary to maintain public support for health reform, and will be vital to supporting an accessible, transparent, and consumer-oriented organization. There are three major components to establishing the appeals program: a policy component, a process management component, and a technological/data interface component. From a policy perspective, the Exchange will need to develop rules and processes that guide the appeal process that meet the needs of both the requirements and the state's policy environment. To implement the process, the Exchange needs to be sufficiently staffed and managed in a way that ensure that the appeals process is efficient and can support the growth in membership coming through the Exchange. Finally, the appeals program must be supported by a data system that integrates with the eligibility, enrollment, and employer information systems needed to make appropriate determinations.
Key Dependencies	• Completed requirements for systems and program operations • Coordination and integration with Medicaid and other applicable public programs • Procurement for Services and Solution (as applicable) • Coordination and integration with Exchange IT core system component development (CRM, reporting, noticing, etc.)

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Attachment 1: Analysis of HHS Proposed Rules on Reinsurance, Risk Corridors and Risk Adjustment

Maryland Health Benefit Exchange

January 31, 2012

Support for this resource was provided by a grant from the Robert Wood Johnson Foundation's State Health Reform Assistance Network program

State Health Reform Assistance Network
Charting the Road to Coverage

RESEARCH BRIEF
August 2011 (Revised September 1, 2011)

Analysis of HHS Proposed Rules On Reinsurance, Risk Corridors And Risk Adjustment

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INTRODUCTION & OVERVIEW

On July 11, 2011, the U.S. Department of Health and Human Services (HHS) issued proposed rules, titled "Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment." The proposed rules implement standards for these programs for states and health insurance issuers ('issuers'). By compensating issuers for the risks related to the individuals they enroll, these provisions are designed to lessen the financial risk issuers and state health benefit exchanges (exchanges) will face under the Patient Protection and Affordable Care Act (ACA). This will mitigate the impact of adverse selection and encourage issuers to compete based on cost and quality, rather than attracting only the healthiest, lowest-cost enrollees. Thus, these provisions are critical to the successful implementation of the ACA's coverage expansion provisions.

This paper summarizes the proposed rules and provides our perspective on the implications. It is intended for policymakers and state officials familiar with the complexities underlying these issues. As with any papers produced shortly after proposed regulations are released, the comments in this paper may quickly become out-of-date as regulations are revised, clarifications are issued, and as the authors continue to discuss the issues and implications of these complex new rules. We encourage you to contact the authors directly for updates and further discussion on any of these topics. The opinions expressed in this paper are those of the authors, not of the Robert Wood Johnson Foundation or others at Wakely Consulting Group.

While a number of important details are outstanding and some critical questions and issues are raised by these proposed rules, our opinion is that these rules are a large step in the right direction. They allow states flexibility while still providing federal support. The programs provide significant financial protections which are necessary given the market and financial uncertainties created under the ACA. A critical issue for policymakers is the aggressive timeline required for implementation of these programs; a substantial amount of analysis and interaction with key stakeholders needs to be performed in a short period of time. In addition, even with good data, states, health insurance carriers, providers and members will face uncertainty.

For purposes of this paper, we do not refer to the rules as 'proposed' in each instance even though it is clear these are all proposed rules at this point. HHS is seeking comment and any of the rules may change based on the comments they receive. HHS has provided discussion and narrative preceding the proposed rules which we refer to as the preamble throughout this paper.

The following table shows which market segments each program affects and the administrative responsibility for each program:

Table 1
Program Applicability by Market and Administration

	Sold within Exchange		Sold Outside Exchange			Who Administers	
ACA Provision	**Individual**	**Small Group**	**Individual**	**Small Group**	**Grandfathered**	**State Run Exchange**	**Federal Run Exchange**
Risk Adjustment	Yes	Yes	Yes	Yes	No	State or HHS[1]	HHS
Reinsurance	Yes	No	Yes	No	No	State	State or HHS[1]
Risk Corridor	Yes	Yes	No	No	No	HHS	HHS

[1]State can decide to administer or allow HHS to administer. If HHS administers, all parameters will be federal.

Each of these programs is funded differently. Since Risk Adjustment is expected to be budget neutral, no funding is needed although administrative funding will be required for states that decide to administer the program. While Reinsurance only benefits the individual market, the entire insurance market, including self-funded plans, contributes to the funding on a percent of premium basis (or percent of medical costs for self-insured plans). To date, there is no mention of how the Risk Corridor program will be funded if the amount that HHS must pay to insurers exceeds the amount HHS receives from insurers.

The proposed regulations address a number of questions that states, health insurance carriers, providers and other stakeholders had when contemplating how to implement the ACA. The most important questions and the answers provided in the proposed regulations and accompanying narrative are addressed below (please remember—these are proposed rules, not final):

RISK ADJUSTMENT – KEY QUESTIONS & ANSWERS

1. Will each state have to administer their risk adjustment program or will risk adjustment be a federal program? Answer: Under the proposed rules, each state can decide whether to do it themselves or let HHS administer the program. States can develop state-specific risk adjustment models and/or weights, but these need to be filed in advance for approval by HHS.
2. Will the federal model be a distributed model where carriers just send in results or a centralized model where carriers send in detailed encounter data and states or HHS calculates results (the distributed model seems to be favored by some insurance companies and insurance company associations)? Answer: Under the proposed rules, HHS would require a centralized model, where issuers would submit raw claims to the state or HHS acting on behalf of the state. States will not have discretion as part of the choice of the model and methodology to change this basic approach. Therefore, if states decide to develop their own model, it will be necessary to begin the planning and assessment of the program soon since as noted in the Timing of Reinsurance and Risk Adjustment section. It is recommended that these states file their model by November 2012.
3. What data will be used (likely possibilities include demographic information, medical diagnoses codes [ICD-9's], pharmacy codes [NDCs] and income level)? Answer: While not in proposed regulations, the preamble accompanying the release states that HHS intends to use demographic, medical diagnoses and pharmacy codes.
4. Will states and HHS implement auditing procedures like that in the Medicare Advantage program (called risk adjustment data validation [RADV] audits)? Answer: Yes, although the intent of the regulations is that these audits would be budget

neutral across carriers, which is not the case with RADV audits. In the ACA's risk adjustment audit program, error rates (or rates of unsubstantiated codes) will be judged relative to the rates of other carriers, not on an absolute basis.

REINSURANCE – KEY QUESTIONS & ANSWERS

1. Assessments of the entire insurance market will pay for the reinsurance program. How will these assessments be calculated? Exactly who will be assessed? Answer: Under the proposed rules, a uniform percentage of premiums will be applied to all fully insured plans and all states (percentage of claims for self-funded employers). States have the option of increasing the assessment but may not decrease it.
2. Will the reinsurance provision be based on specific medical conditions with a general (not member specific) reimbursement amount assigned to each condition, or will it follow typical stop loss reinsurance provisions with the reimbursement to the insurance carrier depending on actual expenditures for that specific person? Answer: Under the proposed rules, the reinsurance provision will follow typical stop loss reinsurance provisions based on actual expenditures. However, unlike typical stop loss reinsurance, the attachment point will be relatively low compared to commercial reinsurance and allowable amounts will be capped at a commercial stop loss reinsurance amount. Therefore, this protection will not be for the highest cost individuals, but for a disproportionate share of 'higher' cost individuals. States have the option to change the attachment point, coinsurance rate and cap amount (including eliminating the cap) compared to the federal parameters.

RISK CORRIDOR – KEY QUESTIONS & ANSWERS

Any surprises in the risk corridor proposed rules? Answer: No—the risk corridor proposed rules are pretty straightforward and do not contain any surprises. HHS will provide pro-rata, aggregate reinsurance if health plan results are more than 3 percent different than target. From 3 percent to 8 percent, HHS will assume 50 percent of favorable or unfavorable results and above 8 percent, HHS will assume 80 percent of favorable or unfavorable results.

RISK ADJUSTMENT DETAILS

The risk adjustment program under the ACA is a permanent program that will begin in 2014. The risk adjustment program is intended to protect health plans operating in the individual and small group markets both inside the exchange and outside of the exchange from attracting a higher than average health risk after consideration of the allowable rating variables (age limited to 3:1, family size / composition, tobacco use and geographic area). Unlike reinsurance, states that establish a state-based exchange do not have to administer the risk adjustment program. They can either administer the program or outsource this function to HHS. Also different than reinsurance, HHS will administer the risk adjustment program if the state does not establish a state-based exchange.

The state can have the risk adjustment functions performed by the exchange or another eligible entity. Per the regulations, in addition to the state Medicaid agency, an eligible entity is one that:

1. Is incorporated in at least one state;
2. Has experience in the individual and small group markets; and
3. Is not or does not act as a health insurance issuer.

HHS will develop a federal model that states can use or HHS will use to administer the state's risk adjustment program if they choose. Alternatively, states can file their own model or use a model for which any other state has filed and received approval. The proposed rules provide some minimum criteria for the model including performance similar to or better than the federal model.

If a state decides to develop its own model or adjust the federal weights, it needs to do so at least as often as the federal model is updated.

State models must meet criteria based on principles that guided the creation of the hierarchal condition categories (HCC) model used in Medicare Advantage risk adjustment, including:

1. Accurately explaining cost variation;
2. Choosing risk factors that are clinically meaningful to providers;
3. Encouraging favorable behavior and discouraging unfavorable behavior;
4. Using data that is complete, high quality and available in a timely fashion;
5. Providing stable risk scores over time and across plans; and
6. Minimizing administrative burden.

HHS is requiring risk adjustment activity reports in the year after the benefit year showing average actuarial risk for each plan, the charges and payments, and likely additional information. While not stated in the proposed rules, likely information might include prevalence reports showing the drivers behind differences in the results and normalization factors. We would expect HHS to develop a standardized report, allowing states the ability to include additional information. The report structure would need to be able to accommodate state-specific risk adjustment methods and models.

Applying Risk Adjustment Results

The proposed rules include a discussion of important actuarial pricing issues regarding integrating risk adjustment results with allowable rating variables under the ACA. Carrier strategies with respect to setting their rating variables (or the state requiring carriers to use standardized rating variables) make this a complex topic.

The preamble to the proposed rules identifies two possibilities for the calculation of premium rates to be used in the application of risk adjustment results:

1. Calculating a statewide normalized premium by taking actual premiums and adjusting them to a 100 percent actuarial value, and then applying the actuarial value of each specific plan to that statewide normalized premium; or
2. Using actual premiums.

Approach one is intended to protect efficient health plans since it uses statewide premiums adjusted for differences in benefits only. This approach actually protects efficient health plans as compared to Approach two if they attract members with higher than average morbidity (i.e., sicker). It disadvantages them if they attract members with lower than average morbidity (i.e., healthier) since their payouts will be based on a higher average premium than their actual premium.

The discussion of these issues assumes the risk pool will be the entire state, which would prohibit states from calculating the standard risk by geographic area. This approach will cause area factors to reflect differences outside of risk, and cause a larger impact to premiums by area than would otherwise occur. For example, assume pre-ACA and risk adjustment, that premium rates in Chicago were higher than in Southern Illinois because individuals in Chicago were less healthy (and only because Chicagoans are less healthy). Under a statewide risk pool where premiums are based on the average statewide risk, ultimate risk adjusted revenue would not change but premium rates in Chicago will decrease and premium rates in Southern Illinois will increase.

The proposed rules assume that payments and charges will not be equal due to uncertainties in the parameters and ‘standard risk’. This appears to be based on an assumption that transfers would occur according to fixed risk adjustment parameters rather than assuming the parameters themselves would be subjected to a normalization process. If the parameters themselves were subjected to this normalization process prior to payments and charges being calculated then, by definition, the results would be budget neutral.

Presumably, a state could perform this normalization before calculating payments and charges. However, if they do not and the federal approach does not, then a final reconciliation would need to take place. In those instances, if payments are greater

than charges, HHS has identified three possible methods without an indication as to which approach the federal methodology would use:

1. Decrease plan payments on prorated basis to equal plan charges;
2. Increase plan charges on prorated basis to equal plan payments; or
3. Split the shortfall and prorating in both directions.

If charges are greater than payments, HHS has identified two possible methods without an indication as to which approach the federal methodology would use:

1. Reduce gross plan charges on a prorated basis; or
2. Put excess plan charges in a reserve account for future use (risk adjustment only presumably).

Data Collection

If a state decides to allow HHS to administer the risk adjustment program, the state can either collect the data and pass it on to HHS (i.e., through an APCD) or allow HHS to collect the data. If the state chooses to administer the risk adjustment methodology, they must collect the data.

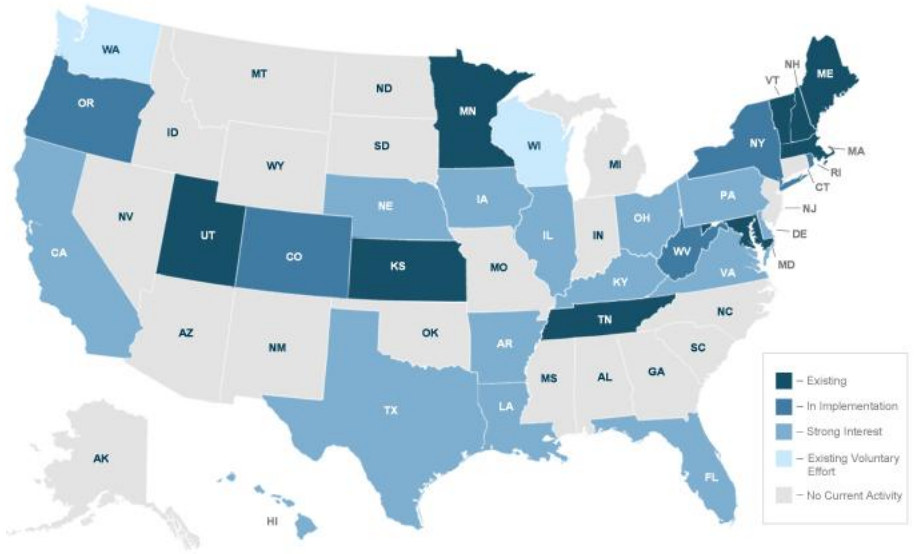
There are minimum standards governing collection of data. These include a standardized format for electronic transmission of all health care claims including enrollment and benefit information. Additionally, the state must ensure privacy of information by utilizing administrative, physical, and technical safeguards against unintended disclosure or use of individually identifiable information. Addressing these requirements will require significant resources.

States that have APCDs that are operational on or before January 1, 2013 are exempted from the minimum data collection standards described above. Eleven states have an APCD currently (two being voluntary systems not run by the state), with up to five states in the process of implementing one. The advantage of developing an APCD includes relatively lower administrative overhead as the state would not have to collect and conform to standards such as the National Council for Prescription Drug Programs (NCPDP) claim transaction or the HIPAA ASC X12N 837. These standards were developed for use within the context of an electronic data interchange (EDI) environment, and not all elements required by the standards are necessary for purposes of risk adjustment, reinsurance and risk corridor calculations.

RETROSPECTIVE OR PROSPECTIVE?

Will the federal model use 2014 data to develop risk adjustment results for 2014, or will data prior to 2014 be used? This is one of the key questions and the proposed rules do not explicitly answer it. The rules point strongly to a retrospective model with the example listed regarding claims run-out in the preamble ("For example, HHS may require that states complete risk adjustment activities by June 30 of the year following the benefit year"). However, this timing could also work under a prospective approach. A prospective approach could be developed in the few states that already have an all payer claims database (APCD), know quite a bit about their uninsured (or have a very low uninsured rate), and already mandate coverage of fairly comprehensive benefits. However, a prospective approach would require a leap of faith concerning the previously uninsured and inherently would not be able to capture potentially meaningful differences in the health status of previously uninsured across health plans. Further, a prospective approach would require the use of data prior to 2014 which would mean that health plans submitting data would need to be well aware of the payment implications of data submitted in 2012 and 2013. These hurdles are significant and we expect the federal model to be retrospective for 2014 and probably 2015. Further, we would expect states that wanted to use a prospective approach to be required to provide significant proof to HHS that such an approach accomplishes HHS' stated objectives for risk adjustment.

Chart – Status of APCD Efforts as of July 11, 2011[1]



Risk Adjustment Auditing

The proposed rules require that the state or HHS on behalf of the state must audit data used in the risk adjustment process. The state or HHS on behalf of the state may (but appears are not required to) extrapolate the results of the audit on a statistically valid sample to all risk adjustment covered plans offered by that issuer. An appeals process must be provided.

A similar program in Medicare Advantage has created considerable controversy because the error rates are used on an absolute basis, rather than being compared to the error rate in the fee for service Medicare program on which the risk adjustment model is calibrated. Unlike in the Medicare Advantage program, the proposed rules indicate that the standard risk in the state would be adjusted for the results of the RADV audits. Therefore, if each and every plan in the state had a two percent error rate, the standard risk in the state would be adjusted downward by two percent and risk adjustment results across plans would not change because the error rates were uniform.

This approach appears fair, but creates some logistical issues. All plans would need to be audited over the same time period for this process to result in an equitable adjustment. State resources to perform these audits will therefore be strained.

Related to auditing, the proposed rules allow health plans to contract with providers to ensure that necessary risk adjustment data are received. This allowance is important since it permits health plans and providers to work together, and have formal financial arrangements to ensure all relevant data are being submitted.

REINSURANCE DETAILS

The reinsurance program under the ACA is a temporary program that will operate from 2014 through 2016. The reinsurance program is intended to protect health plans operating in the individual market from specific high-cost individuals. Unlike risk adjustment, states that establish a state-based exchange must administer the reinsurance program. They cannot outsource this

[1] Source: www.apcdcouncil.org/

function to HHS. States that do not operate an exchange may still operate the reinsurance program or allow HHS to operate the program.

States can contract with or establish a reinsurance administrator subject to certain standards. The proposed rules include guidance that allows states to establish contracts with multiple reinsurance administrators, but requires their geographic coverage areas to be distinct and, in aggregate, cover the entire individual market. Subcontracting some administrative functions by the reinsurance entity is allowed, subject to review to ensure the contracts are appropriate.

Table 2 below shows the nationwide contribution requirements published in the law. These amounts represent minimum funding for the reinsurance program and general U.S. Treasury funding.

Table 2
Nationwide Contribution Requirements (in billions)

Program	2014	2015	2016
Reinsurance	$10	$6	$4
U.S. Treasury	$2	$2	$1

We have developed preliminary estimates of the assessment for reinsurance and the net impact to individual market premiums in Table 3 below. We have assumed 8.5 percent annual trend from 2014 to 2016.[2] The range of amounts listed are national estimates, are inherently uncertain[3], and may vary significantly by state based on the market composition.

Table 3
Reinsurance and Premium Impact Estimates
Higher and Lower Estimate Scenarios of Individual Market Enrollment (National)

Description	Higher Estimate of Individual Market Enrollment			Lower Estimate of Individual Market Enrollment		
	2014	2015	2016	2014	2015	2016
Net Assessment (Reinsurance Only—Not Treasury Contribution)	1.2%	0.7%	0.4%	1.3%	0.7%	0.4%
Net Impact to Individual Market Premiums (US)	-7.2%	-3.4%	-2.0%	-11.2%	-5.0%	-2.6%

HHS will publish the actual minimum contribution rate in the advance notice in October 2012 (see Table 4 for complete schedule). States can increase this rate depending on a number of factors:

1. In that state, the size of the individual market (including previously uninsured joining the market) relative to the entire market will drive the level of coverage afforded by the national minimum assessment rate. The larger the individual market as a proportion of the total market, the lower the assessments available for reinsurance as compared to potential coverage.
2. The relative health of enrollees in the individual market post reform may suggest that some states with a relatively sick population will increase the HHS rate to provide the same level of coverage all else being equal.

[2] This is important since premiums will likely increase between 2014 and 2016, which decreases the calculated contribution rate.

[3] Issues including the size of the individual and group markets, premium trend, enrollment, and other issues make the estimate of the reinsurance assessment and effect on individual premiums uncertain.

3. Finally, states may increase assessments to cover administrative costs for operation of the reinsurance entity. It is important to note that states may not use the federal assessment rate and then allocate some of those collections to administrative expenses. If the state wants to fund reinsurance administrative expenses, they must increase the assessment.

Sample Reinsurance Calculation

Reinsurance Parameters	State or Federal Reinsurance	Traditional Reinsurance
Attachment Point (paid claims threshold where reinsurance begins)	$50,000	$200,000
Coinsurance Rate (percent between attachment point and cap for which reinsurer is liable)	80%	85%
Reinsurance Cap (claims in excess of the cap are not eligible for reinsurance)	$150,000	$2,000,000

Example

Insurer Initial Paid Claim Amount = $500,000

Net Insurer Liability* = $50,000 + 20% x (150,000 - 50,000) + (200,000 - 150,000) + 15% x (500,000 - 200,000) = $165,000
State or Federal Reinsurance Payment* = 80% x (150,000 - 50,000) = $80,000
Traditional Reinsurance Payment = 85% x (500,000 - 200,000) = $255,000

* Note that the State/Federal Payments may be prorated down for all insurers if the total payments exceed the available funds

HHS will publish the attachment point, coinsurance rate and reinsurance cap each year. Only costs related to essential benefits are eligible to be reimbursed (detailed definitions are pending on what constitutes essential benefits). States may modify these values, but must publish the modifications in a state notice by early March in the year before the effective date as outlined in the Timing of Reinsurance and Risk Adjustment section. It appears that the proposed rules would not allow states to modify the structure of the formula.[4]

States are responsible for collecting data to administer the program and for making sure that payments do not exceed contributions.[5] Payments may be reduced on a pro-rata basis if, in the absence of such reduction, payments would exceed contributions.

States may coordinate the state high risk pool with the reinsurance program as long as it conforms to the other provisions of the proposed rules.

In the preamble, additional points are made:

1. If contributions exceed payments, states may retain those funds as surplus/stabilization funds or pay out the amounts on pro-rata basis (effectively increasing the coinsurance rate).
2. States can adjust the attachment point, coinsurance rate and reinsurance cap to manage the amount of payments from year-to-year (e.g., if collections in one year exceed payments, the state can increase coverage offered through the pool to increase payments in the next year).
3. States can alter reinsurance parameters to adjust the way payments are distributed across the three year period (e.g., to more heavily weight payments in the first year relative to the federal payment schedule).

[4] States cannot modify the structure of the reinsurance formula: For example, to re-adjudicate claims at a percentage of Medicare prior to applying the formula, or to make fixed payments for certain medical conditions.

[5] Proposed rules do not say that reinsurance contributions cannot exceed payments.

TIMING OF REINSURANCE AND RISK ADJUSTMENT

The proposed rules discuss the timing of the process for releasing benefit and payment parameters and for states to file proposed changes to those parameters. The following table shows the timing of the notice for 2014 through 2016. Future years will follow this pattern.

Table 4
Annual Federal Notice of Benefit and Payment Parameters (2014 through 2016)

Annual Federal Notice	2014	2015	2016
HHS Publishes Advance Notice	Mid Oct 2012	Mid Oct 2013	Mid Oct 2014
Comment Period Ends	Mid Nov 2012	Mid Nov 2013	Mid Nov 2014
HHS Publishes Final Notice	Mid Jan 2013	Mid Jan 2014	Mid Jan 2015

If states plan to modify federal parameters, HHS proposes that they would need to issue a notice no later than early March in the year before the effective date (for example, in early March 2013 for 2014).

If the state does not issue a notice by the deadline, then the federal parameters would automatically go into effect.

If states plan to file an alternate risk adjustment model, the rules propose that they do so by November two years prior to the benefit year (i.e., November 2012 for 2014). HHS would commit to reviewing and notifying states within 60 days, at the time of publication of the Final Notice (see Table 4 above), whether such model was approved. After approval, any state could use the model. Updates to models would follow same process and timing.

The state and federal notices will include a full description of the risk adjustment model, including demographic factors, diagnostic factors, utilization factors (if any), the mapping logic to the risk group (i.e., which ICD-9's map to which condition categories), the weights for each category, required data, and timelines for data submission and factor determination.

Timing for risk adjustment transfers is not included in the proposed rules (when plans that owe to the pool would pay, and when plans that are owed from the pool would receive payment).

The risk adjustment program will affect premium rates, potentially significantly for any given issuer. Because of the relative nature of risk adjustment, issuers cannot analyze only their own data to estimate the impact of risk adjustment. Risk adjustment simulations in 2012 and early 2013 and/or access to supplemental market-wide datasets will be critical to inform health plan pricing. Because simulations will need to take place prior to 2014, states and health plan associations will need to drive any simulations even in states where HHS will be administering the risk adjustment program in 2014 and beyond. HHS may be able to assist in the organization and distribution of supplemental datasets on the currently uninsured population, standard insured population, and provide other relevant data to simulations. Many states do not have an existing or a soon to be available APCD and therefore cannot leverage that data in running simulations. In states without an existing APCD, a simulation using a distributed model may be the only feasible approach. And while a distributed model presents significant concerns when actual funds are affected starting in 2014, it is a reasonable alternative and maybe the only possibility for simulation purposes in many states. A distributed model approach will require cooperation by health insurance issuers, which would seem prudent given the stakes.

RISK CORRIDOR DETAILS

A federally-administered risk corridor program will limit the gains and losses of a Qualified Health Plan (QHP) operating in the exchange. This program will be in place for three years (2014-2016) and is intended to stabilize the market by sharing risk at a time when implementation of reform will make accurate rate setting challenging at best.

The risk corridor mechanism compares the total allowable medical costs for a QHP (excluding non-medical or administrative costs) to those projected or targeted by the QHP. If the actual allowable costs are less than 97 percent of the QHP's target amount, a percentage of these savings will be remitted to HHS (limiting gain). Similarly if the actual allowable cost is more than 103 percent of the QHP's target amount, a percentage of the difference will be paid back to the QHP (limiting loss). The QHP's target amount is defined as the plan's total premiums incurred less allowable administrative costs. Allowable costs are defined as the QHP's actual total paid medical costs, excluding allowable administrative costs, in providing the QHP's covered benefits.

The following table shows the percentages that are applied based on the comparison of a QHP's target amount and allowable costs.

Table 5
Risk Corridor Parameters

Allowable/Target	Action	Amount Paid
Greater than 108%	HHS pays QHP	2.5% of Target + 80% of amount in excess of 108%
103% to 108%	HHS pays QHP	50% of amount in excess of 103%
97% to 103%	No action	No payment transfer
92% to 97%	QHP pays HHS	50% of difference between 97% of target and allowable cost
Less than 92%	QHP pays HHS	2.5% of Target + 80% of difference between 92% of target and allowable

The allowable costs are reduced for any direct or indirect remuneration (e.g., drug price concessions, discounts, grants) or cost sharing reductions received from HHS. For the target amount, QHP issuers would be required to submit *adjusted* premium data to HHS. Reported premiums are adjusted for any risk adjustment or reinsurance payments including user fees paid.

The following table shows an example of a risk corridor payment calculation.

Table 6
Risk Corridor Example

Example: Allowable / Target less than 92%	
QHP Target	$10 million
QHP Allowable Cost	$8.8 million
Allowable/Target	88%
92% of Target	92% x $10m = $9.2 million
92% of Target - Allowable Cost	$9.2m - $8.8m = $400,000
QHP pays 2.5% of Target	2.5% x $10m = $250k
+ QHP pays 80% of difference	80% x $400k = $320k
QHP total payment to HHS	$570k
Revised Allowable / Target	($8.80m + $0.57m) / $10m = 93.7%

On the question of timing, while HHS has not set forth any deadlines at this time, timeframes being considered include making payments within 30 days of receiving a notice from HHS (and HHS would make payments in a similar timeframe after HHS determines that a payment is owed to the QHP). Since the timing of the program adjustments may run concurrently, QHPs may need to estimate the reinsurance they expect to receive when reporting risk corridor premium information.

If HHS sets the allowable target equal to the minimum loss ratio as may be reasonably expected, the risk corridor program essentially prevents health plans from excess losses (50percent or 80 percent protection depending on level of losses) while the minimum loss ratio program protects against excess profits (100 percent protection). This approach creates potentially unintended consequences, especially for health plans that have administrative loads below that required under the minimum loss ratio.

WHAT DO STATES NEED TO DO?

1. For both risk adjustment and reinsurance, develop a plan for which agency or organization will administer necessary functions.
2. Reinsurance—Model the funds available under various assessment rates and attachment point, coinsurance and cap options given those various assessment rates.
   States do not want to be in a position where funds from the assessments are insufficient to cover the stated coverage levels. The previously uninsured population and uncertainties surrounding this population will create significant uncertainty with these estimates.
3. Risk Adjustment—Key issues that states need to decide upon include:
   a. Use the federal model or file a state model.
   b. If the federal model is used, should the state or HHS administer it?
   c. Develop an APCD in advance of federal requirements or wait for federal 'push'?
   d. How should the risk adjustment audit process function, including who will perform the audits and what the schedule and level of adjustments for payment transfers should be?
4. All Programs—States should create a stakeholder workgroup. The work plan should identify necessary steps, stakeholder feedback checkpoints and timelines. States should first meet internally to structure the stakeholder workgroup role and decide which decisions should be retained by the state versus delegated to the workgroup for recommendations. Potential workgroup members include individuals from the state exchange, department of insurance, health plans and providers.

WHAT DO HEALTH PLANS NEED TO DO?

1. Discuss forming a workgroup in your state to develop an APCD, and to identify the best approach for risk adjustment and reinsurance methods and processes, including simulations in advance of 2014. Timing will be critical and risk adjustment simulations will need to be run well in advance of the summer of 2013, when premium rates will need to be developed and filed.
2. Review coding practices and provider agreements to make sure you will not be disadvantaged when risk adjustment is implemented.
3. Work with valuation actuaries and financial reporting teams to identify issues and timing with respect to reinsurance, risk adjustment and risk corridors. Work with the department of insurance to ensure compliance.

OUTSTANDING ISSUES

1. The proposed rules seem to indicate that the same federal assessment percentage, attachment point, coinsurance amount and cap amount will apply to all federally run exchanges (across states). Because each state will have a different proportion of business in their individual market and a different risk profile of members in the individual market, it seems necessary to have state-specific parameters that would be developed by HHS. As part of the federal notice,

will HHS publish state-specific parameters?
2. Will the federal risk adjustment model be retrospective, prospective or will it offer both options?
3. Does HHS intend for risk adjustment calculations to be statewide, thereby adjusting current geographic differences in premium? Is there state flexibility in performing risk adjustment calculations by area?
4. Will HHS meet with carriers in states where they are administering the risk adjustment system? How will carrier questions be answered?
5. Is income being considered as part of the federal risk adjustment model? Including it as an optional variable as part of the core federal model, with state specific calibration, would offer states flexibility to address a particular concern with adverse selection in the exchange.
6. Will states be allowed to assess carriers to pay for the risk adjustment code audits and, more broadly, for the risk adjustment approach? This would align incentives for efficiencies since the risk adjustment program transfers funds across health insurance companies.
7. The target amount definition in the proposed rules indicates the 'target amount' is equal to premiums less allowable administrative expenses. Allowable administrative expenses would seem to be defined by health plans. Health plans will likely try to maximize these administrative expenses, subject to the Minimum Loss Ratio requirement. This would appear incentivize health plans to file premium rates using a target loss ratio equal to the minimum. Is HHS considering requirements that would prevent this approach or will the states need to address this issue?

FINANCIAL STATEMENT ISSUES FOR HEALTH PLANS

Valuation actuaries are also going to be affected by the ACA. The reinsurance, risk adjustment and risk corridor programs will create new actuarial assets and liabilities for health plans. These amounts may not be known until well after the year ends. The reinsurance and risk adjustment program results will depend not only on the health plan results, about which each health plan will know something, but also on the results for other health plans in the market. Since risk corridor results will depend on reinsurance and risk adjustment results, they will also be uncertain. Health plans, states (exchanges), departments of insurance and HHS will need to work closely together to develop appropriate timelines, methods, standards and flexibility in dealing with these important issues. Current Medicare Advantage Part D reinsurance and risk corridor financial statement rules will provide a useful frame of reference. For these programs, developing interim reporting will be critical in informing year end estimates.

OPERATIONAL IMPACT ON STATES

The regulations contemplate a significant role for states in the administration of both the reinsurance and risk adjustment programs. These functions can be run from the exchange or by another entity within the state. While funding for the reinsurance program can be included in the assessment from carriers, meaning no additional state or federal funding will be required to manage the program, the risk adjustment program, similar to other ACA responsibilities such as granting exemptions to the individual responsibility requirement, will create a state expenditure requiring a funding source. Some of the operational and cost considerations of this program are outlined below.

Of the two programs, the reinsurance program is less operationally complex. The role of the state in administering the pool will primarily be a fiduciary one of funds collection, management and disbursement, which will require an initial and ongoing emphasis on the development of policies and processes to ensure sound financial stewardship. Critical functions to manage this program include the establishment and periodic modification of reinsurance parameters; assessment collections and cash management; claim intake (summary level) and payment; analysis and reporting; and claims audit. These functions can be performed by the state or by an entity or entities contracted by the state, and can also be subcontracted. Funding for the administration of the reinsurance program can be included in the assessment on carriers, so no additional state or federal funding is required for the operation of the reinsurance pool.

Risk adjustment represents a more comprehensive commitment from the state. States choosing to develop and administer this program will need to develop the data collection and storage capabilities required to intake, securely store and analyze carrier claims and enrollment data, including the acquisition of data warehousing hardware and software, along with a dedicated staff to manage, analyze and report on this information. Other key cost components will be software licensing

fees for the risk adjustment tool selected by the state and developing the IT infrastructure and connectivity required to interface with carriers for the acquisition of data as well as product rating and premium information. The calculation process itself will require the development of normalized risk scores at the individual product and carrier level, and then translating these scores into payment and recoupment amounts. A portion of these activities (namely, the acquisition and analysis of carrier claims data and software licensing) will need to be performed prior to the state's decision regarding whether or not to rely on the federal model or to self-administer the risk adjustment program.

The total cost of managing this program will vary considerably depending on several factors:

1. Existing resources the state can rely upon, such as an existing APCD. The ability to leverage an existing data infrastructure will significantly reduce the cost to the state.
2. Existing familiarity with risk adjustment models in other state programs such as Medicaid Managed Care.
3. The level of state-specificity that states choose to pursue, including whether they wish to develop both their own model and administrative methodology, rely on the federal methodology but reweight based on a state-specific population, or rely on the federal model and only implement a state-specific payment adjustment methodology.
4. The size of the insurance market and the number and variety of carriers and products sold in the state. Risk adjustment will be far more complex and time-consuming for states with more than 10 licensed carriers than for states with fewer carriers.

Funding for this program is not contemplated in the proposed regulations, and states have options with respect to a source of funding. One approach is to place the administration of the risk and reinsurance programs in the state exchange, and use establishment grant funding to design, develop and build the required infrastructure. Ongoing cost, which should be modest relative to the start-up of the program, can be included in the exchange assessment. For states that use risk adjustment in their Medicaid Managed Care program, further efficiencies and cost offsets can be achieved by leveraging the newly developed exchange function to calculate and administer the Medicaid Managed Care risk program.

CONCLUSION

The proposed rules thoughtfully address many of the key issues associated with the risk adjustment, reinsurance and risk corridor programs although important details and decisions are still pending. As discussed in this paper, these programs will have a significant impact on premiums and the health insurance marketplace. HHS, states and health plans have a lot of work to do over the next two years. Careful planning, in-depth analysis and clear communication are critical to the success of these programs and the new health insurance marketplace.

ABOUT THE PROGRAM
State Health Reform Assistance Network, a program of the Robert Wood Johnson Foundation, provides in-depth technical support to states to maximize coverage gains as they implement key provisions of the Affordable Care Act. The program is managed by the Woodrow Wilson School of Public and International Affairs at Princeton University.

ABOUT WAKELY CONSULTING GROUP
Wakely Consulting Group is an actuarial and healthcare consulting firm specializing in government healthcare programs including state and federal reform, Medicaid and Medicare Advantage.

ABOUT THE ROBERT WOOD JOHNSON FOUNDATION
The Robert Wood Johnson Foundation focuses on the pressing health and health care issues facing our country. As the nation's largest philanthropy devoted exclusively to health and health care, the Foundation works with a diverse group of organizations and individuals to identify solutions and achieve comprehensive, measureable and timely change. For nearly 40 years the Foundation has brought experience, commitment, and a rigorous, balanced approach to the problems that affect the health and health care of those it serves. When it comes to helping Americans lead healthier lives and get the care they need, the Foundation expects to make a difference in your lifetime. For more information, visit *www.rwjf.org*.

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Wakely
Consulting Group

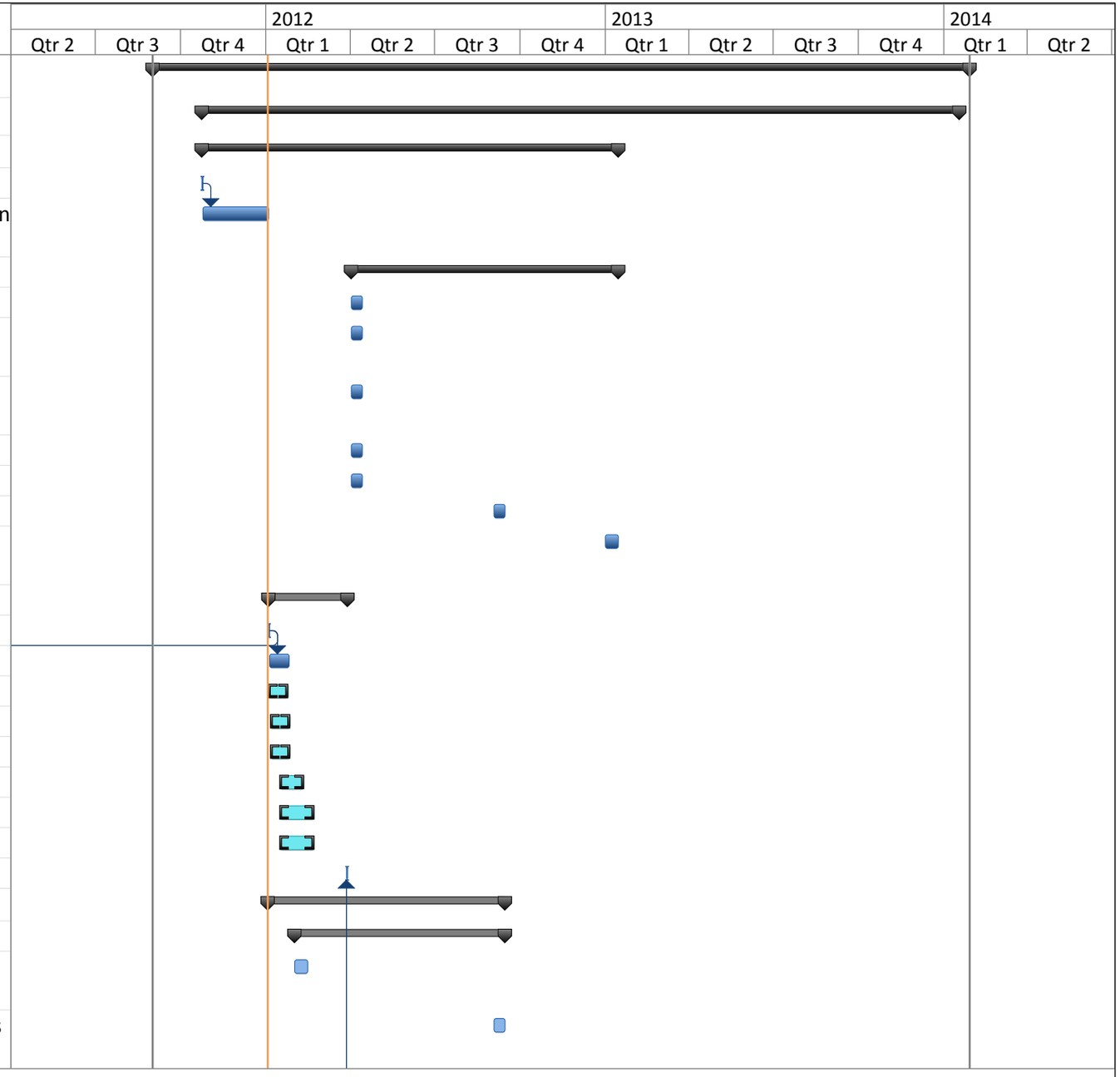
Attachment 2: Exchange Business Operations Timeline (Illustrative)

Maryland Health Benefit Exchange

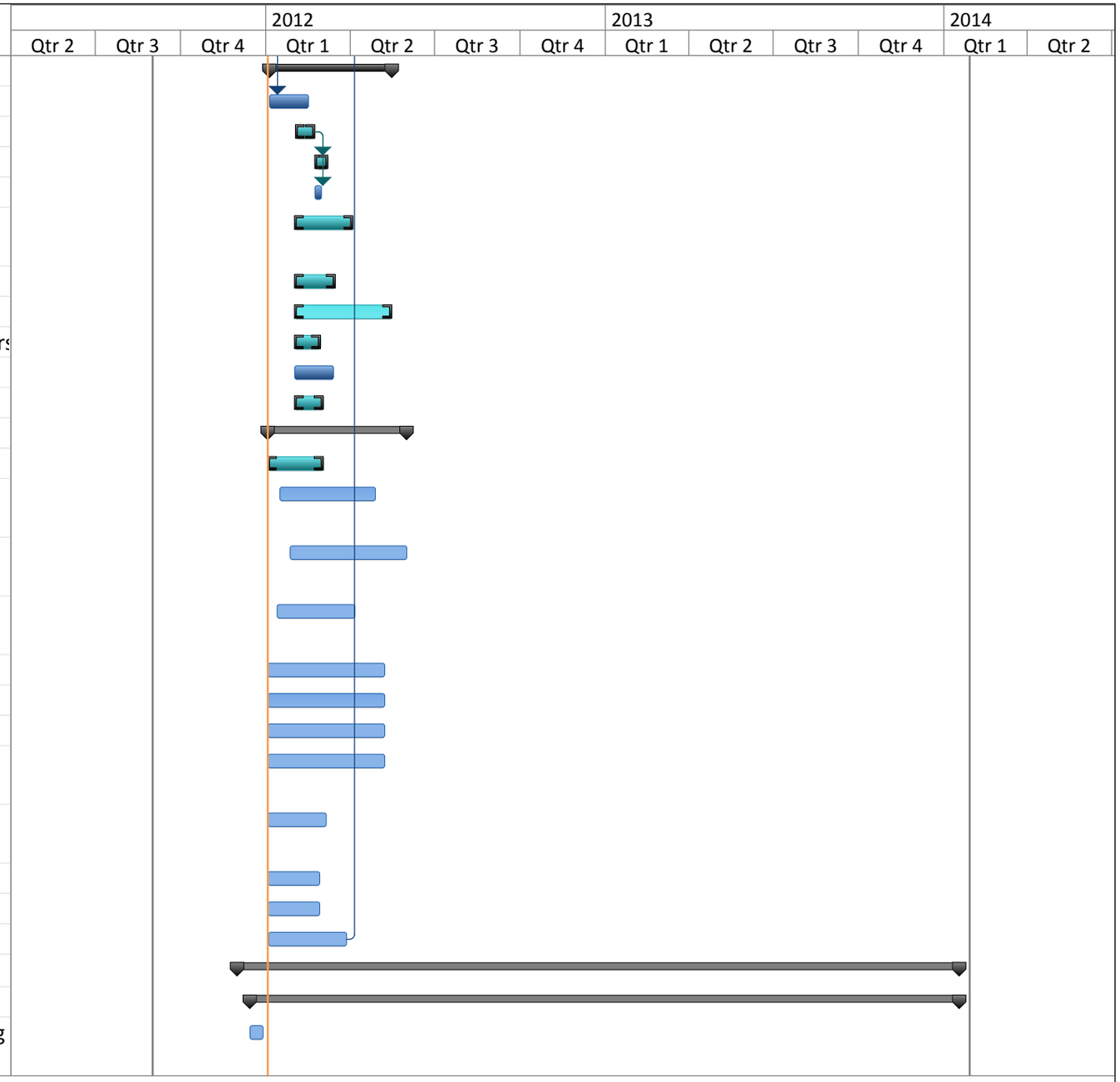
January 31, 2012

Support for this resource was provided by a grant from the Robert Wood Johnson Foundation's State Health Reform Assistance Network program

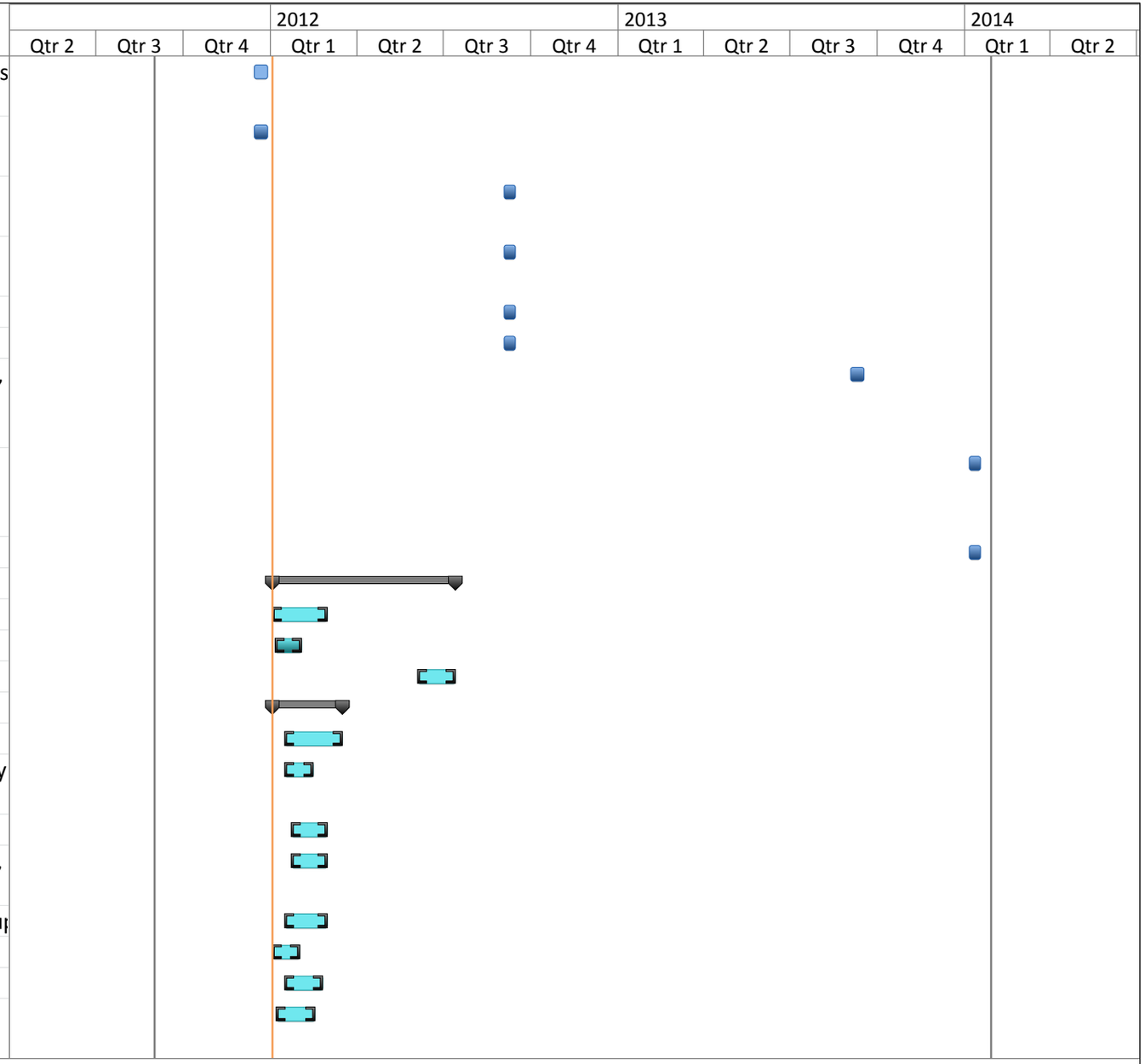
ID	Task Name
1	**Business Operations Timeline**
2	**Exchange Set-up**
3	**Governance & Oversight**
4	BOD appointed and convenes first meeting
5	Temporary staff appointed to support Board until Exchange CEO and staff in place
6	**Key Federal Milestones**
7	2012 Q2-Establish governance structure
8	Appoint a governing board(if applicable) and a management team sufficient to oversee the operations of the Exchange
9	Develop a formal operating charter or by-laws that are consistent with Federal and State requirements
10	Spring 2012: Exchange Approval Application released by HHS
11	Spring 2012: Readiness Assessments begin
12	Fall 2012: HHS Start Accepting Exchange Approval Applications
13	January 1, 2013: Final Exchange approval and conditional approval decisions made
14	**Initial BOD tasks**
15	BOD selects CEO
16	Exchange CEO identifies issues requiring Board vote
17	BOD begin process to hire legal counsel
18	BOD develops board calendar & location of meetings
19	BOD develops Board Subcommittees
20	BOD develops Board Polices and Procedures
21	BOD begins process to adopt Organizational Bylaws
22	BOD adopts conflict-of-interest rules for Directors & Exchange Staff
23	Approve and/or Level 2 grant application
24	**Internal Administration**
25	**Key Federal Milestones**
26	Each state must ensure it provides the Exchange with the authority to meet all the Exchange requirements of the ACA
27	The Exchange must demonstrate its ability to perform required activities to HHS by Fall of 2012 for HHS approval



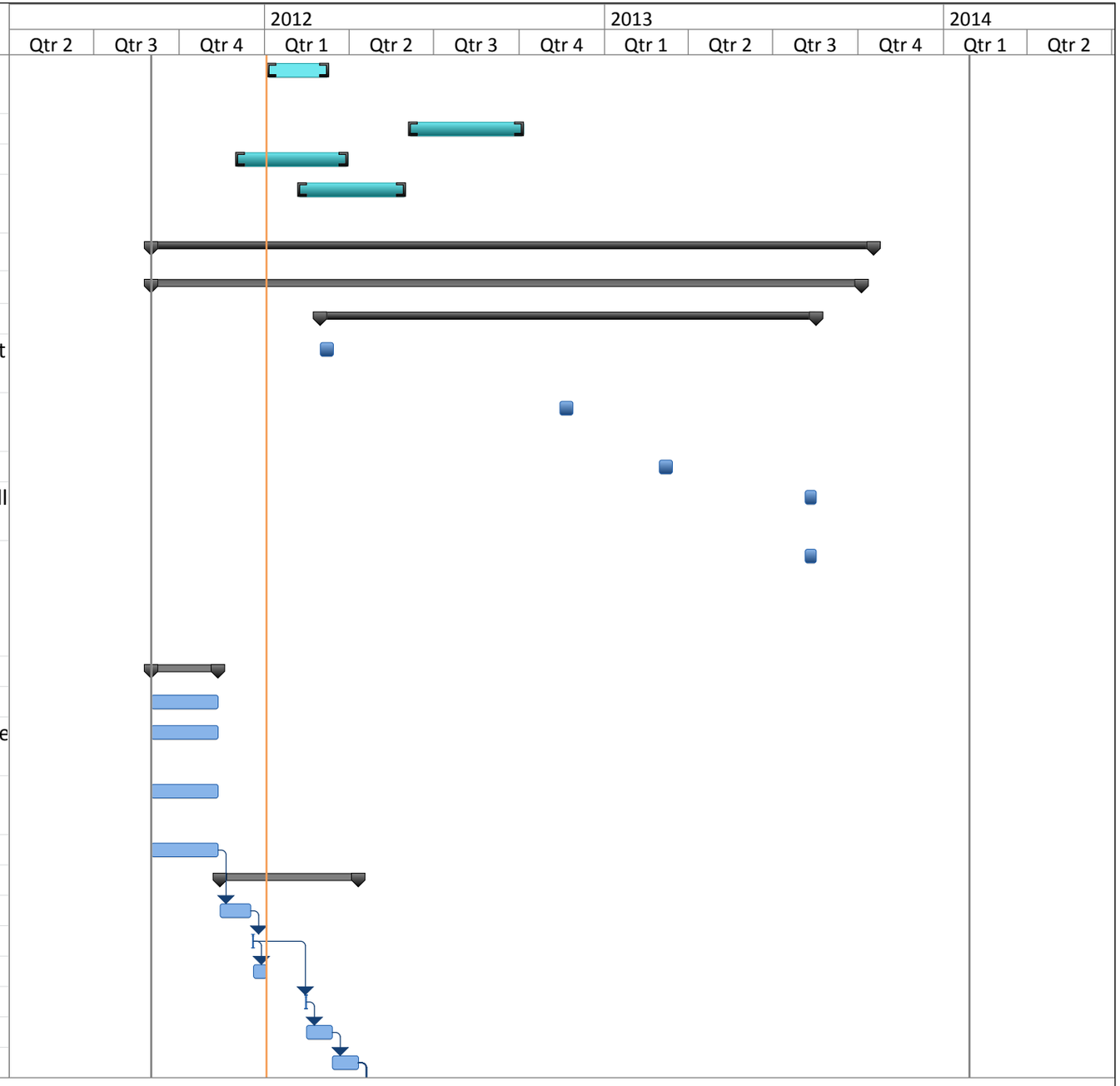
ID	Task Name
28	**Staffing**
29	CEO hires key Senior Mgmt, including CFO/COO/CIO
30	Develop staffing plan
31	Identify salary structure and benefits for exchange personnel
32	Develop exchange organizational chart
33	CEO/Sr. Mgmt begin to hire exchange staff, especially in key areas of IT, Finance, and Ops
34	Develop organizational policies & procedures
35	Begin to hire consultants for subject matter expertise in key areas
36	Develop contracting mechanism to easily bring on consultants & suppliers
37	Hire IT project manager for implementation oversight
38	Identify vendors/suppliers for adminstrative needs
39	**Key administrative tasks**
40	Locate physical space for exchange (temporary or permanent)
41	Acquire computers, software, email capability, data storage, communications equipment
42	Ensure physical facility is properly wired and configured for IT needs of staff
43	Develop a procurement strategy for IT purchase in coordination with Medicaid, including order of priority for systems
44	Develop technical specifications in accordance with key policy decisions
45	Assess IT requirements for Exchange data needs
46	Working with IT consultants, develop IT budget
47	Assign staff ownership for completion of rpts & recommendations required by statute
48	Set up recurring interagency meetings and/or ensure exchange representation in exisitng mtgs
49	Acquire Tax ID for exchange
50	Register exchange as public authority with Secretary of State, IRS, etc.
51	Develop Level 2 grant application
52	**Financial Management**
53	**Key Federal Milestones**
54	Adhere to HHS financial monitoring activities carried out for the Planning Grant and under the Establishment Cooperative Agreement



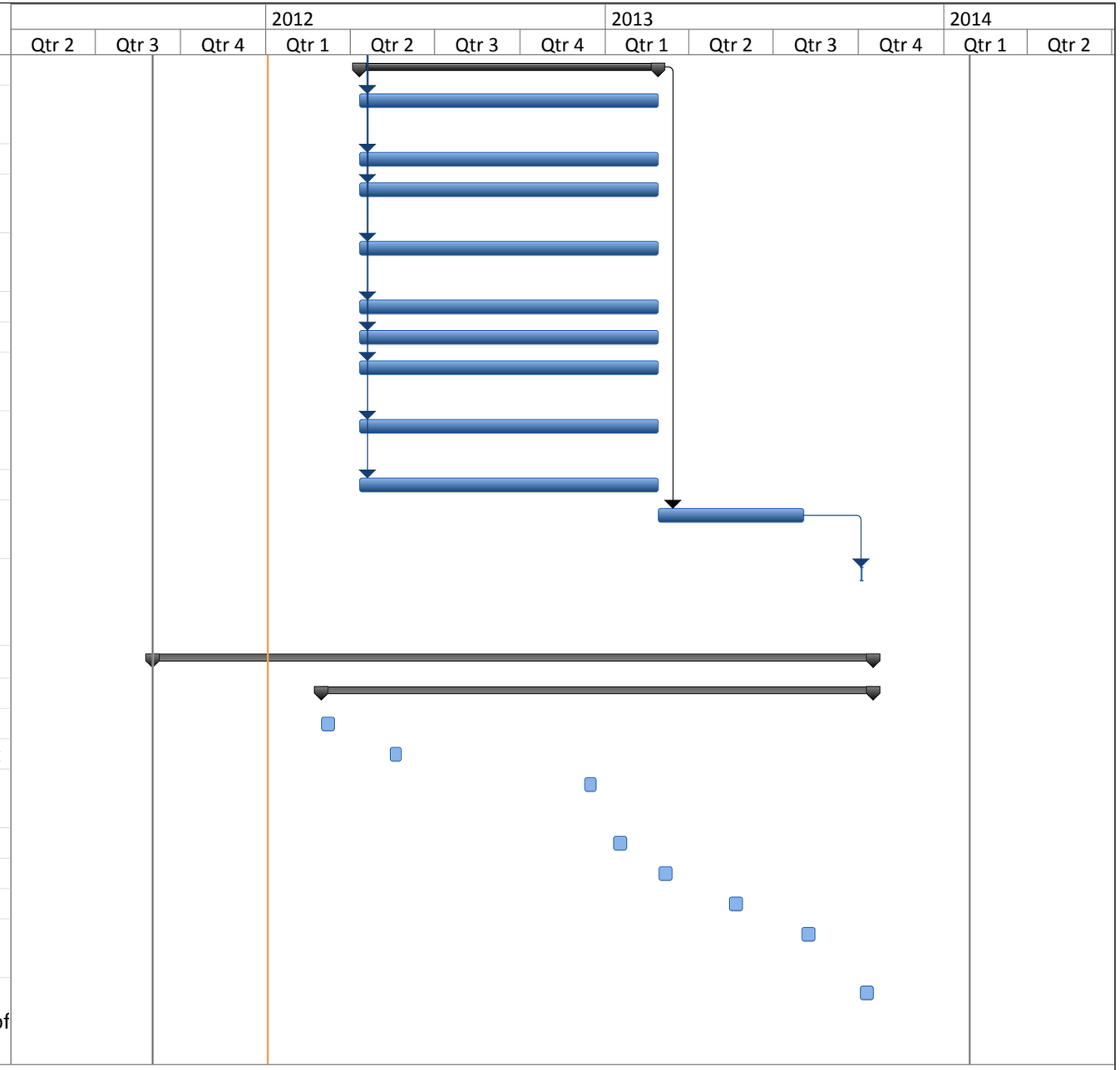
ID	Task Name
55	Begin defining financial management structure and the scope of activities required to comply with requirements
56	Establish a financial management structure and commit to hiring experienced accountants to support financial management activities
57	Develop a plan to ensure sufficient resources to support ongoing operations and determine if legislation is necessary to assess user fees
58	Assess adequacy of accounting and financial reporting systems and finalize financial systems IT plan
59	Develop guidance for premium processing requirements
60	Conduct a third party objective review of all systems of internal control
61	Demonstrate capability to manage the finances of the Exchange soundly, including the ability to publish all expenses, receivables, and expenditures consistent with Federal requirements
62	Post information related to Exchange financial management on its website and has identified other means to make financial activities associated with the management of the Exchange transparent
63	Submit the required annual accounting report to HHS
64	**Staffing**
65	Hire accounting and budgeting staff
66	Hire payroll vendor
67	Hire audit firm (operational and financial)
68	**Requirements Definition**
69	Begin to develop administrative budget model
70	Research short term accounting system to record basic exchange rec/pay transactions
71	Develop exchange chart of accounts
72	Identify accounting structure for recording of transactions -- GAAP/STAT, etc.
73	Identify and scope out basic financial reports for CMS/BOD during start up
74	Set up banking structure in coordinaton with State Comptroller
75	Working with HCA, begin to develop IT operational financing strategy
76	Develop a contracting process for acquiring computers and office equipment



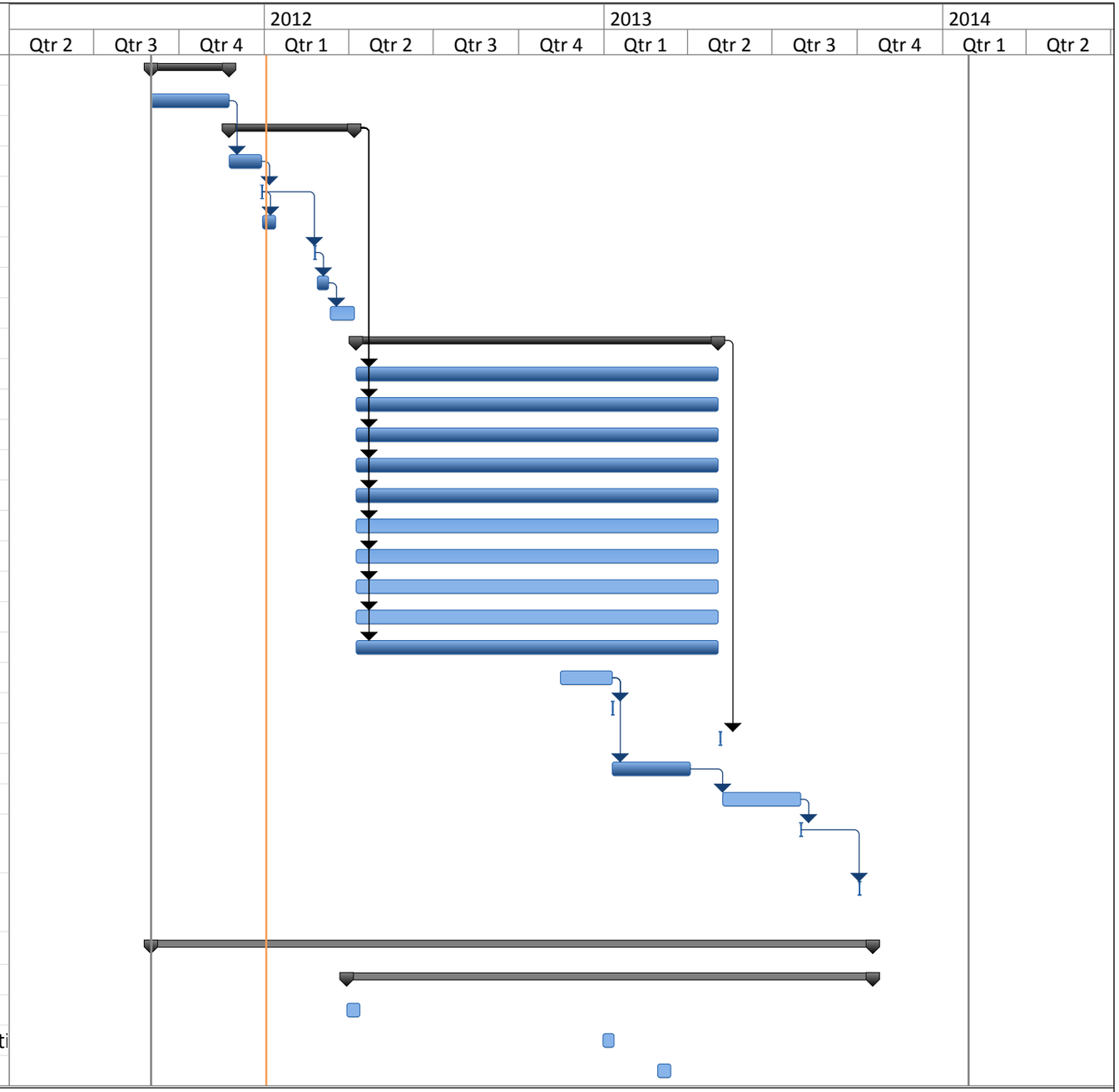
ID	Task Name
77	Begin to develop system of internal control for exchange finance operations
78	Refine five year budget and self sustainability model
79	Prepare financial & budget components of level 2 grant application
80	Begin to assess longer term exchange finance systems -- PB; Accting; QHP Coordination
81	**Core Systems & SHOP-specific processes**
82	**Eligibility Verification**
83	**Key Federal Milestones**
84	2012 Q1 -Begin system development including any systems development needed by OASHSPs (and other programs as appropriate)
85	2012 Q4 - Complete system development and prepare for final user testing, including testing of any systems with OASHSPs
86	2013 Q1 -Begin final user testing, including testing of all interfaces
87	2013 Q3 or before open enrollment - complete user testing, including full end-to-end integration testing with all other components
88	As early as mid-2013 -begin conducting eligibility determinations for Other Publicly Subsidized Programs, coordinating all relevant business functions, and receiving referrals from OASHSPs for eligibility determinations
89	**Analysis Phase**
90	Ensure close coordinaton with Office of Medicaid/CHIP
91	Assign Exchange IT staff to work groups / committees to ensure exchange representation
92	Develop cost allocation methodology as part of operational financing strategy
93	Conduct IT gap analysis and develop business/technical requirements
94	**Procurement Process**
95	Develop RFPs
96	Publish RFP's
97	RFP Bidders conference
98	Receive RFP responses
99	Assess and score RFP's
100	Select vendor(s), negotiate terms, finalize contracts



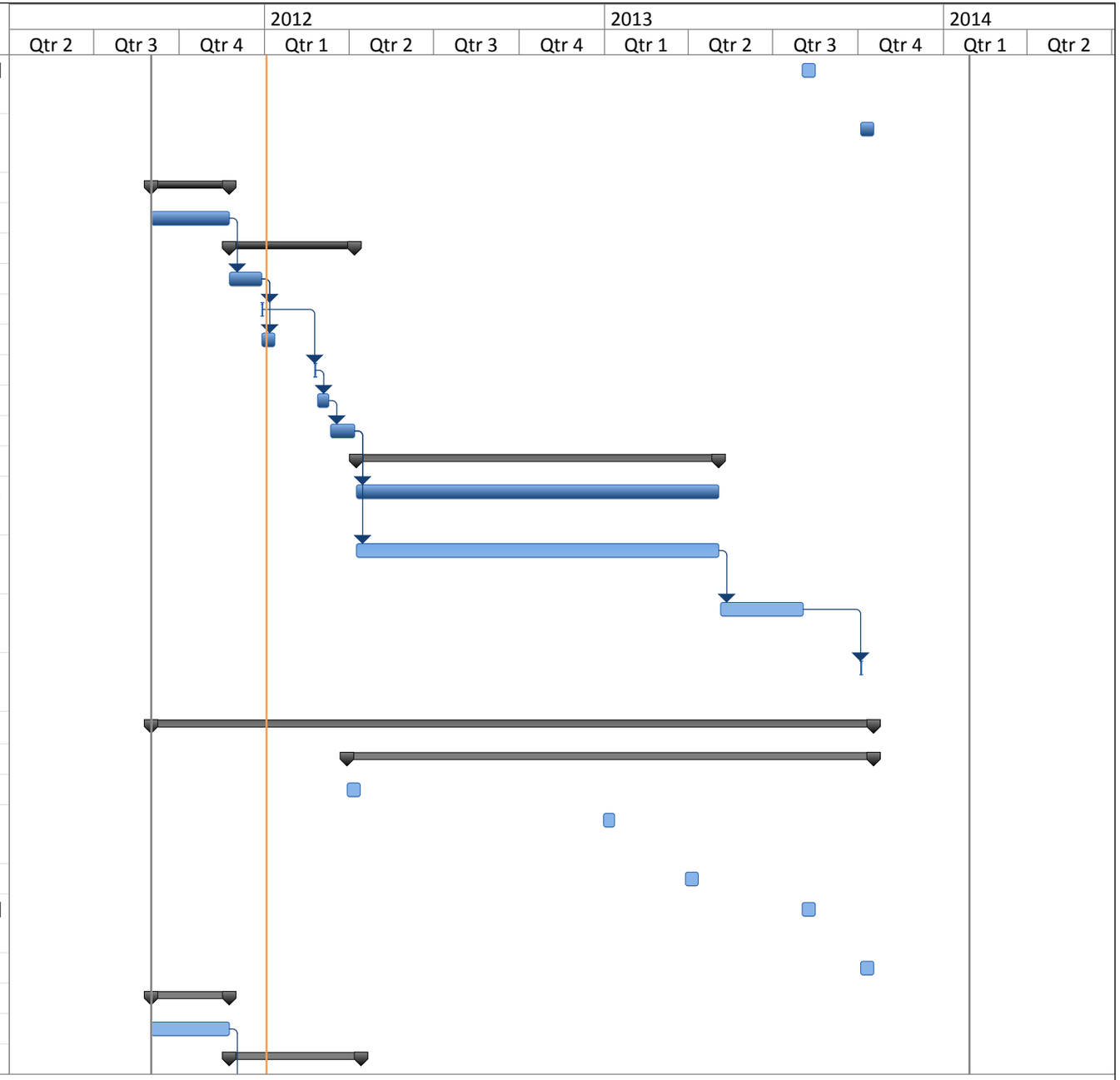
ID	Task Name
101	**System Development**
102	Design, build, test interfaces with federal hub, state and other verification sources
103	Integrate new eligibility rules into decision trees
104	Identify customer service requirements and technology to support applicants
105	Determine exception processing (ie. Non-MAGI populations) consistent with federal regulations
106	Document and develop reporting requirements
107	Document and develop noticing requirements
108	Develop process for determination of newly eligible and existing Medicaid
109	Integration of eligibility determination and process for administration of tax credits
110	Develop policies and procedures for redetermination
111	Final user testing (including interfaces and full end to end integration testing with all other components)
112	Begin conducting eligibility determinations for OASHSPs, coordinating all relevent business funtions, and receiving referrals from OASHSPs for eligibility determinations
113	**Website**
114	**Key Federal Milestones**
115	2012 Q1 -Begin systems development
116	2012 Q3 -Submit content for informational website to HHS for comment
117	2012 Q4-Complete systems development and final user testing of informational website
118	2013 Q1 -Launch information website
119	2013 Q1-Collect and verify plan data for comparison tool
120	2013 Q3 -Test comparison tool with consumers and stakeholders
121	Prior to Open Enrollment -launch comparison tool with pricing information but without online enrollment function
122	As early as mid-2013 -launch fully functioning comparison tool with pricing information and online enrollment functionality on the first day of open enrollment



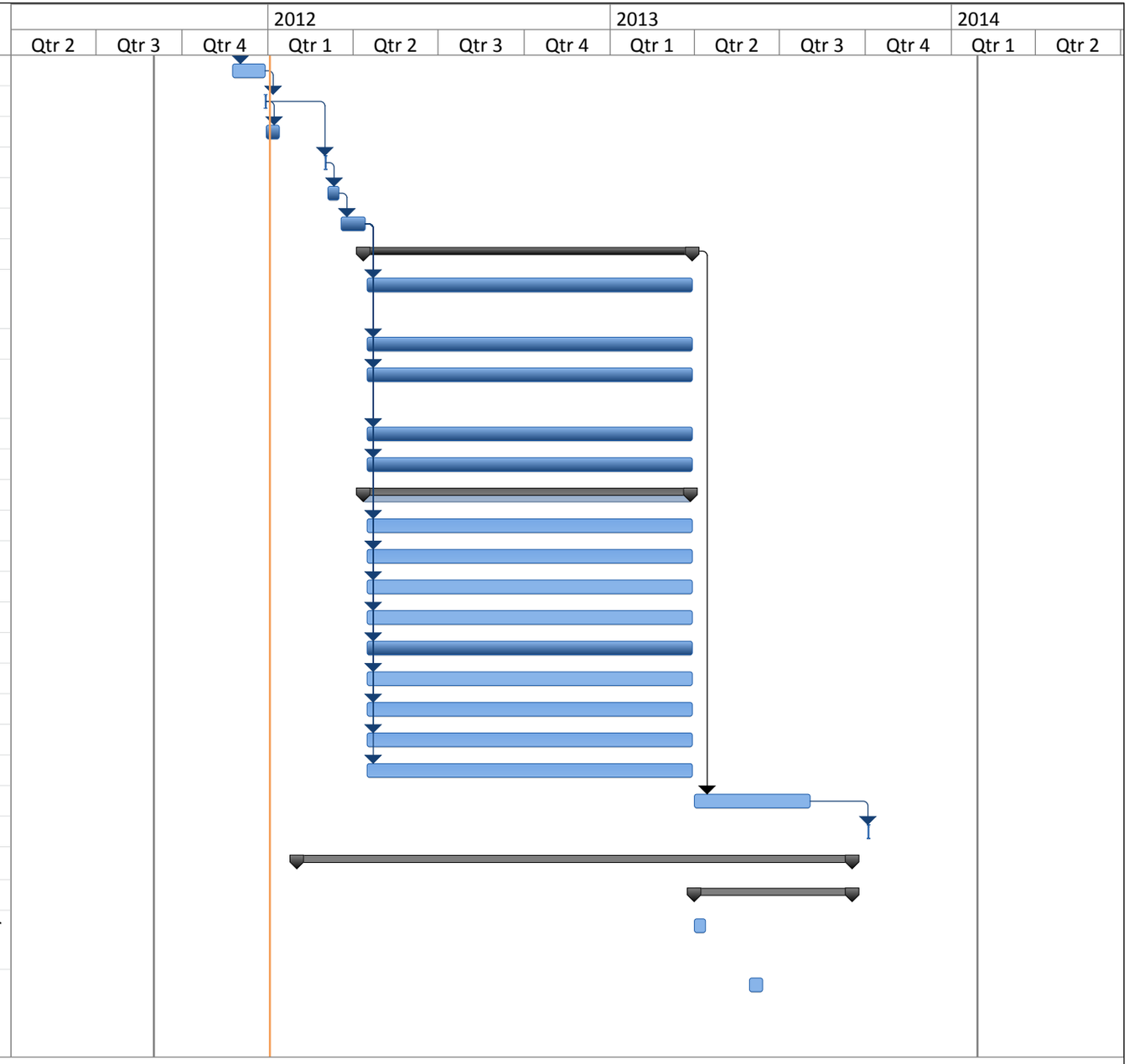
ID	Task Name
123	**Analysis Phase**
124	Requirements Definition for all exchange website functionality
125	**Procurement Process**
126	Develop RFPs
127	Publish RFP's
128	RFP Bidders conference
129	Receive RFP responses
130	Assess and score RFP's
131	Select vendor(s), negotiate terms, finalize contracts
132	**System Development**
133	Online comparison of qualified health plans
134	Online application and selection of qualified health plans
135	Premium tax Credit and Cost Sharing Subsidy Calculator
136	Quality rating functionality system requirements
137	Requests for assistance
138	Links to OSHSP
139	Integration with Eligibility system
140	Integration with SHOP
141	Integration with QHP
142	Integration with Medicaid
143	Final user testing of informational website
144	Launch information website
145	User testing of all component functionality
146	Collect and verify plan data for comparison tool
147	Test Comparison tool with consumers and stakeholders.
148	Launch tool with comparison shopping and pricing but without online enrollment functionality
149	Launch fully functioning comparison tool with pricing information and online enrollment functionality on the first day of open enrollment
150	**Premium Tax Credit and Cost Sharing Subsidy Calculator**
151	**Key Federal Milestones**
152	2012 Q1 - Begin system development
153	2012 Q4 - Complete systems development and prepare for final user testi
154	2013 Q1 - Begin final user testing, including testing of all interfaces



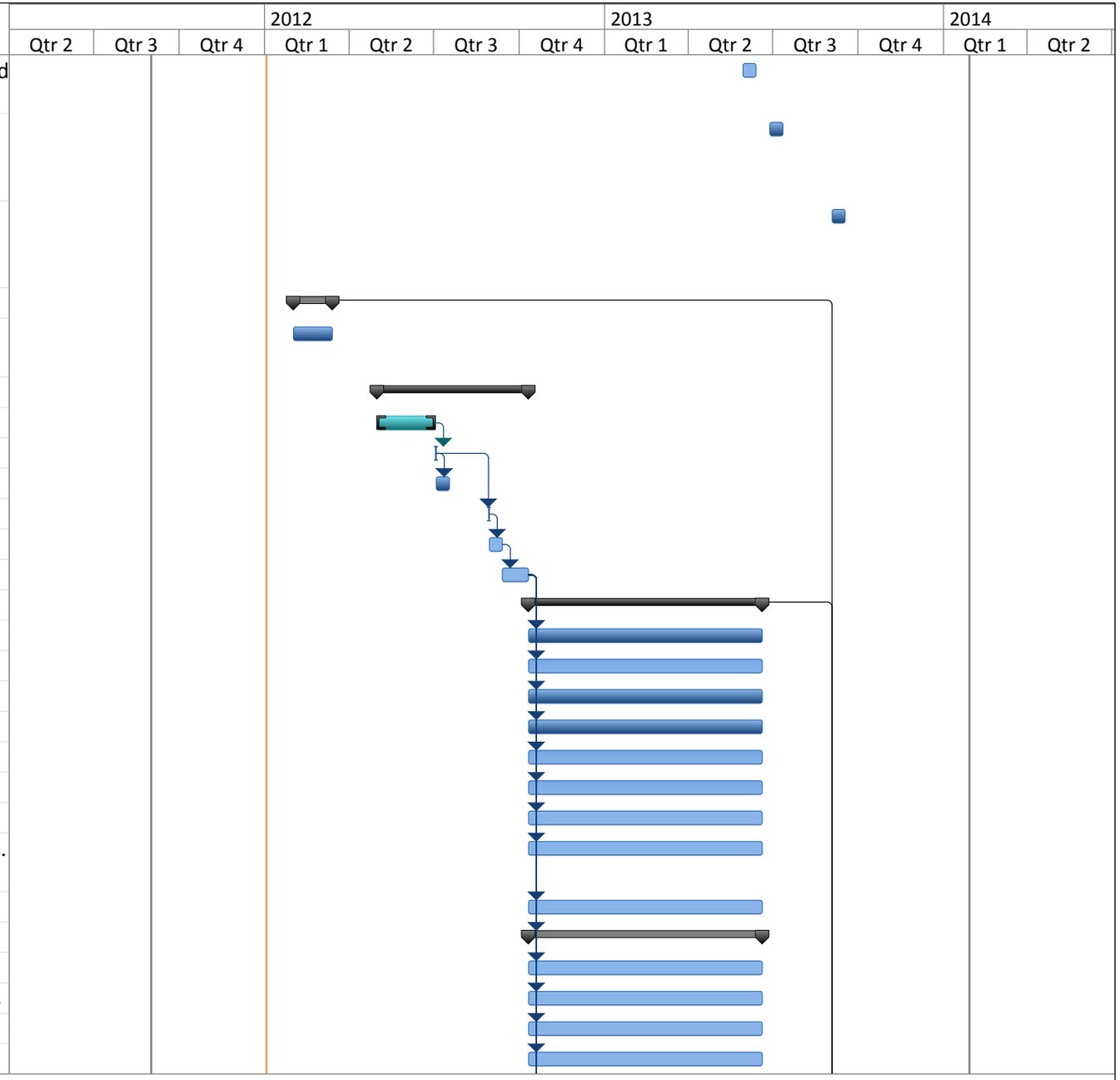
ID	Task Name
155	2013 Q3 or before open enrollment -complete user testing, including full end-to-end integration testing with all other components
156	As early as mid-2013 -begin submitting tax credit and cost-sharing reduction information to QHP issuers and HHS
157	**Analysis Phase**
158	Develop and finalize business and technical requirements
159	**Procurement Process**
160	Develop RFPs
161	Publish RFP's
162	RFP Bidders conference
163	Receive RFP responses
164	Assess and score RFP's
165	Select vendor(s), negotiate terms, finalize contracts
166	**System Development**
167	Build to utilize eligibility solution information obtained from federal data hub and other verification sources with QHP premium data
168	Build to provide relevant information to QHP issuers and HHS to start, stop or change level of tax credit and cost sharing
169	Final user testing (including interfaces and final end to end integration testing with other components)
170	Begin submitting tax credit and cost sharing reduction information to QHP issuers and HHS
171	**Enrollment, Billing & Collections**
172	**Key Federal Milestones**
173	2012 Q1 -Begin system development
174	2012 Q4 -Complete systems development and prepare for final user testing
175	2013 Q1 -Begin final user testing, including testing of all interfaces
176	2013 Q3 or before open enrollment -complete user testing, including full end-to-end integration testing with all other components
177	As early as mid-2013 -begin enrollment into qualified health plans
178	**Analysis Phase**
179	Develop and finalize business and technical requirements
180	**Procurement Process**



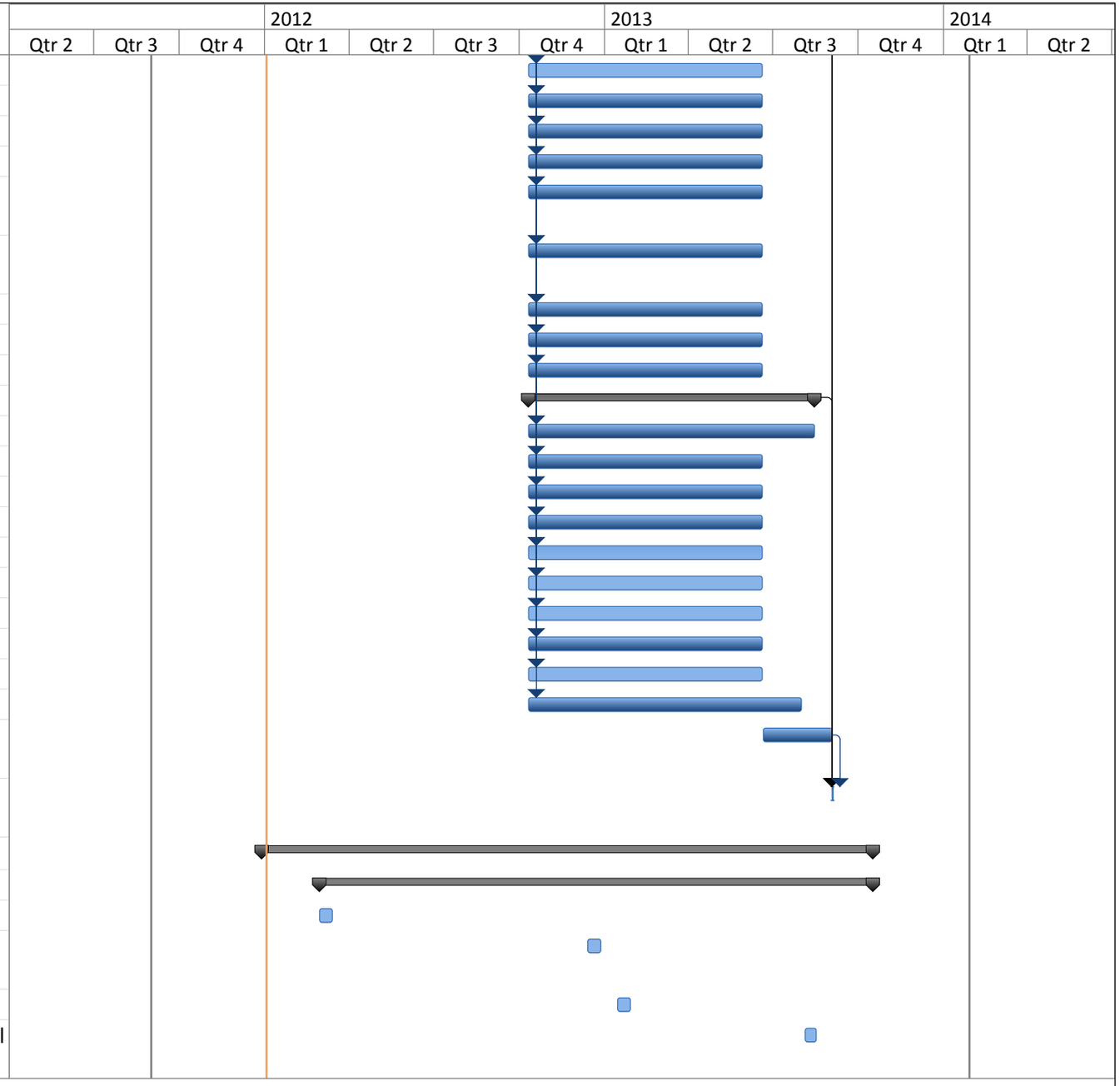
ID	Task Name
181	Develop RFPs
182	Publish RFP's
183	RFP Bidders conference
184	Receive RFP responses
185	Assess and score RFP's
186	Select vendor(s), negotiate terms, finalize contracts
187	**System Development**
188	Providing customized plan information to individuals based on eligibility and QHP data
189	Submitting enrollment transactions to QHP issuers
190	Receiving acknowledgements of enrollment transactions from QHP issuers
191	Submitting relevant data to HHS
192	Integration with Call Center Services solution
193	**Premium Billing Functionality**
194	Account set up
195	Invoice generation
196	Interface with lockbox
197	Payment receipt process
198	Financial Management
199	Refunds
200	Member Support (Epay functionality, online account view, etc)
201	Noticing
202	Reporting
203	Final user testing including testing all interfaces with partners
204	Begin enrollment into qualified health plans
205	**Customer Service Call Center**
206	**Key Federal Milestones**
207	2013 Q2 -Complete call center procurement process and select a vendor to operate the call center
208	2013 Q2-Develop call center customer service representative protocols and scripts to respond to likely requests from health care consumers in the State



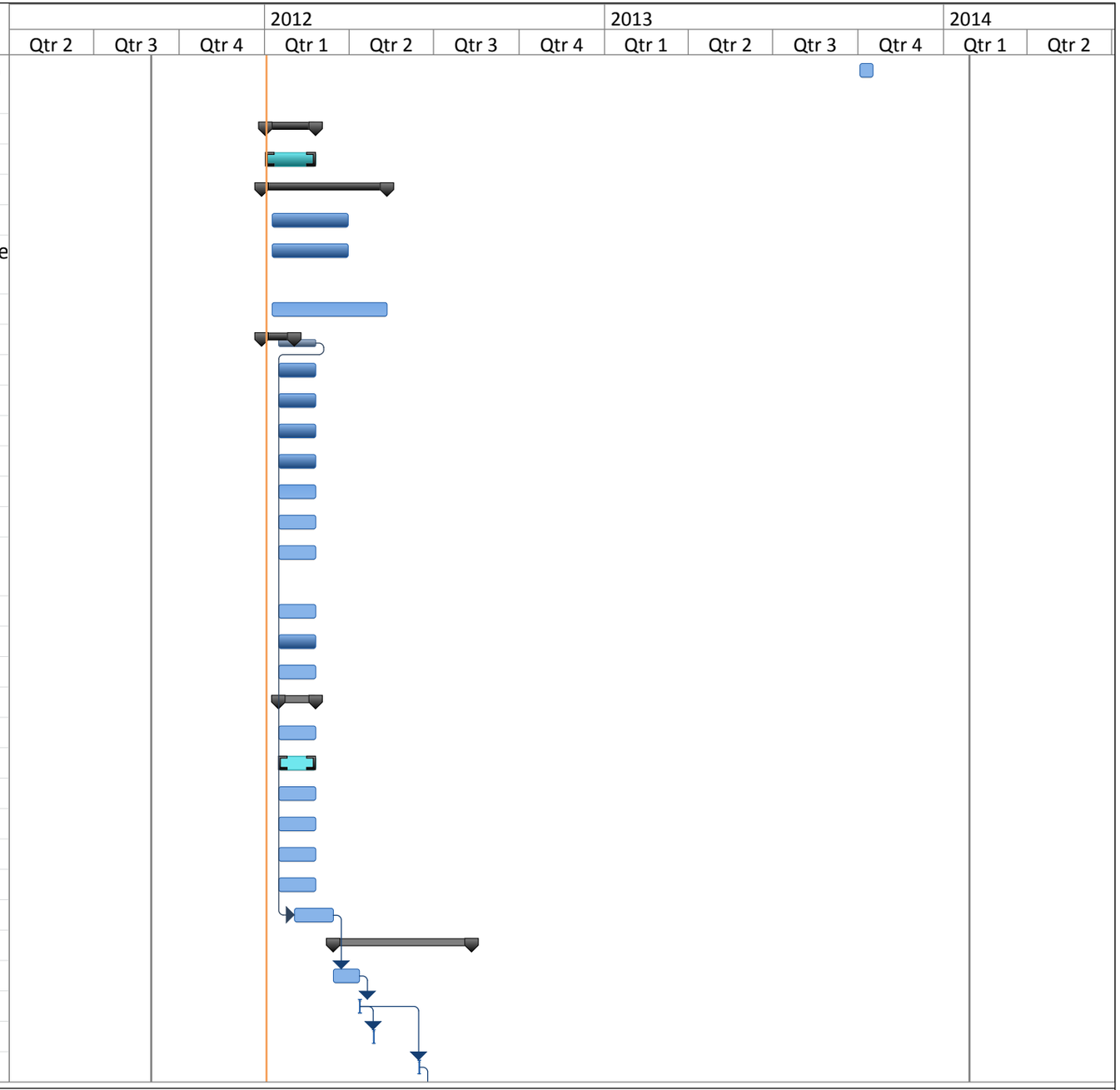
ID	Task Name
209	2013 Q2-Develop protocols for accommodating the hearing impaired and those with other disabilities and foreign language translation services
210	2013 Q2-Train call center representatives on eligibility verification and enrollment process, and other applicable areas, so they can facilitate enrollment of individuals over the phone
211	2013 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
212	**Analysis Phase**
213	Determine to enhance existing Call Center Operations or Procure/build call center services and define requirements
214	**Procurement Process**
215	Develop RFPs
216	Publish RFP's
217	RFP Bidders conference
218	Receive RFP responses
219	Assess and score RFP's
220	Select vendor(s), negotiate terms, finalize contracts
221	**Administrative/Start up Activities**
222	Establish/modify facility for Customer Services Center
223	Set up organizational structure for Customer Services Center
224	Create Job Descriptions
225	Staff Customer Services Center
226	Develop/confirm workplace principles
227	Identify/Develop training program for staff
228	Identify/develop standard reports.
229	Identify/Develop proposal for Customer Service related communications.
230	Identify/Develop production schedule for Premium Billing.
231	**Policy and Procedures for all Customer Services functions**
232	Establish policy and procedure for member encounter support
233	Establish policy and procedure for member complaints and grievances
234	Establish policy and procedure for member Self Service
235	Establish policy and procedure for member Outreach



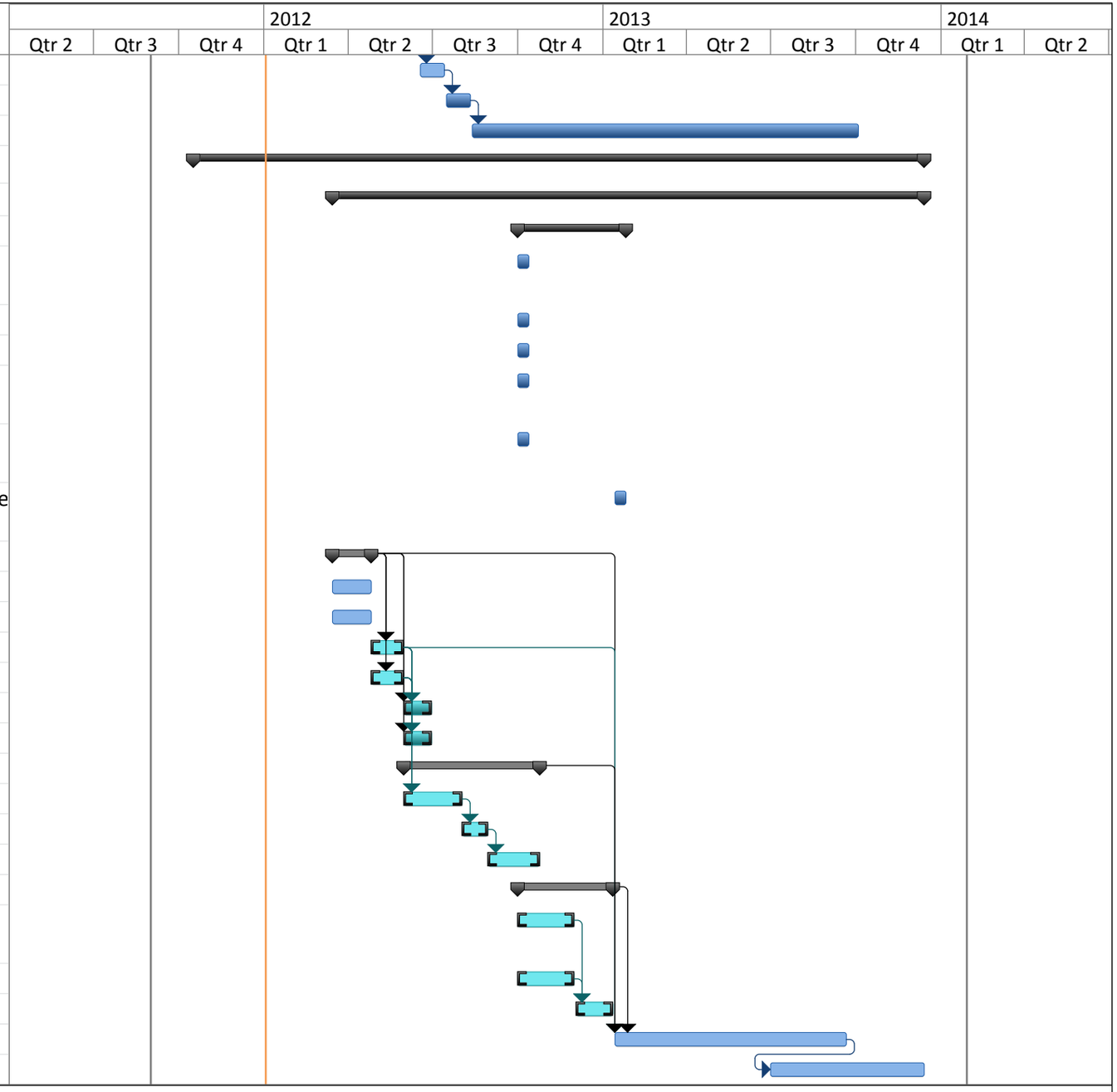
ID	Task Name
236	Establish policy and procedure for member Enrollment
237	Establish policy and procedure for member Appeals
238	Establish policy and procedure for member Premium Billing
239	Establish policy and procedure for member Hardship Requests
240	Establish policy and procedure for member Permission to Share Information
241	Establish policy and procedure for Document Management and Mailings
242	Establish policy and procedure for Certificate of Exemption
243	Negotiate sub-contracts (as needed)
244	Develop continuity of operations plan.
245	**Infrastructure/Technology**
246	Order hardware & software as needed
247	Install or update/test Contract Management Portal
248	Install or update/test Telephone System
249	Install or update/test Customer Relationship Management System
250	Install or update/test Premium Billing System
251	Install or update/test Member Web Portal
252	Install or update/test Knowledge Management System
253	Install or update/test Workflow Management System
254	Install or update/test Document Management System
255	Develop and test interfaces to the required Systems and Partners
256	Train CSRs on eligibility verification, enrollment process and other applicable areas
257	Launch call center functionality and publicized 1-800 number. Post information on website related to contacting the call center for assistance
258	**SHOP-specific processes**
259	**Key Federal Milestones**
260	2012 Q1 -Begin system development
261	2012 Q4 -Complete systems development and prepare for final user testing
262	2013 Q1 -Begin final user testing, including testing of all interfaces
263	2013 Q3 or before open enrollment -Complete user testing, including full end-to-end integration testing with all other components



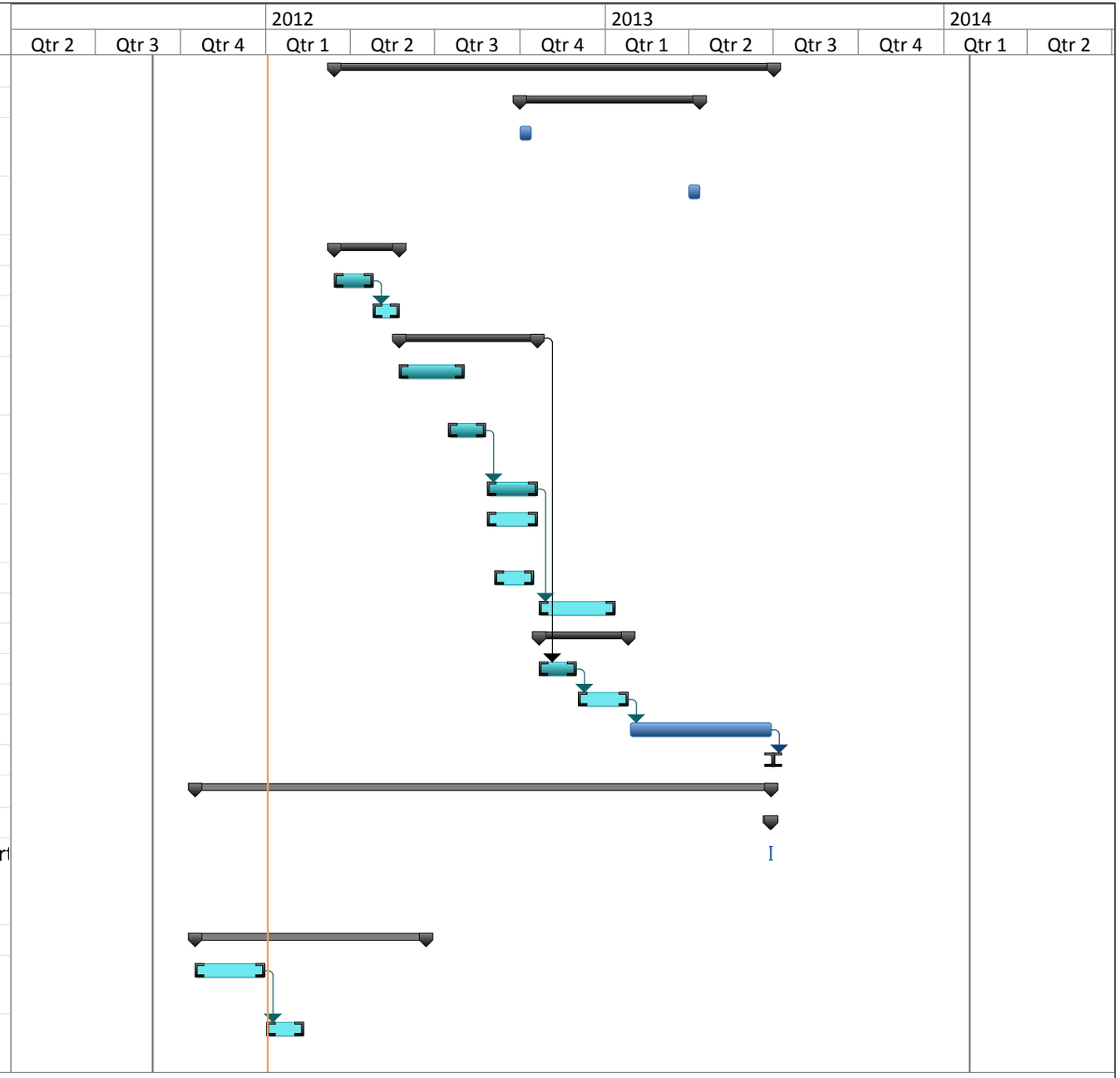
ID	Task Name
264	As early as mid-2013 -Begin enrolling employees of small employers into qualified health plans
265	**Staffing**
266	Hire SHOP specific staff
267	**Administrative and Operational Considerations**
268	Coordination with individual and Medicaid call centers
269	Determine website functionality and integration with individual exchange
270	Determine operational implications of federal regulations/guidance
271	**Develop policy and procedures**
272	Customer Service
273	Employer set up: self service, through call center or broker
274	Broker setup and maintenance
275	QHP setup and maintenance
276	Employee shopping experience
277	Triage between individual and SHOP exchange scenarios
278	Enrollment, Renewal and disenrollment of employees, employers, brokers, QHPs
279	Outreach and open enrollment (continuous)
280	Financial Management
281	Reporting
282	**Billing and Collections**
283	List Bill versus Composite Rating
284	Online Payment options
285	Reconcile payments (lockbox, nonpayment, reporting)
286	Payment to QHP
287	Payment to Brokers
288	Premium rate updates from QHPs
289	Develop technical specifications in accordance with key policy decisions
290	**Procurement (website, call center, print/fulfilment, marketing, other)**
291	Develop RFP's
292	Publish RFP's
293	RFP Bidders conference
294	Receive bids



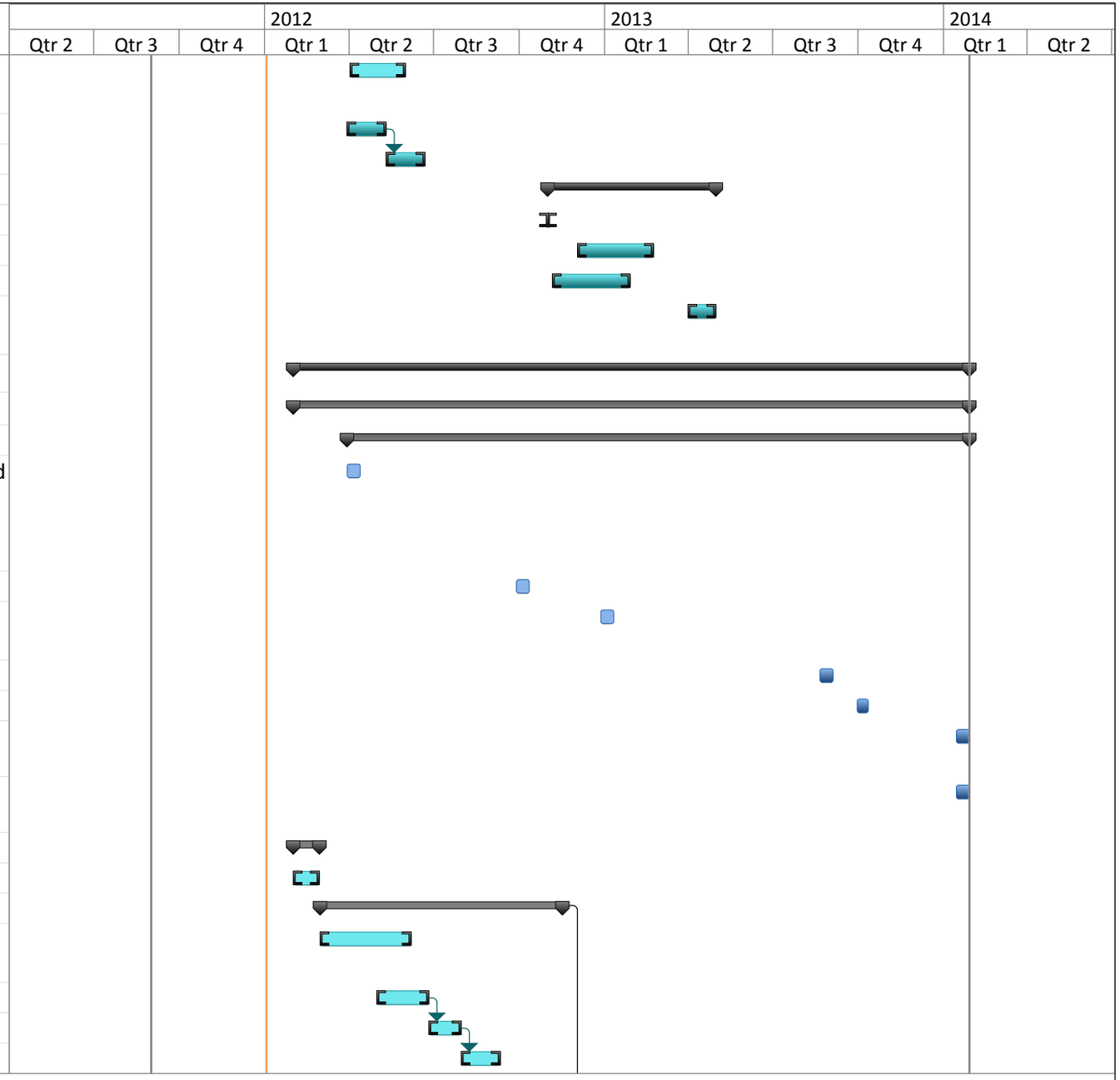
ID	Task Name
295	Assess and score RFP's
296	Select vendor(s), negotiate terms, finalize contracts
297	Implement, test, validate, go live
298	**Communication & Outreach**
299	**Outreach & Marketing Plan**
300	**Key Federal Milestones**
301	"Develop a ""toolkit"" for outreach to include educational materials and information"
302	Develop performance metrics and evaluation plan
303	Design a media strategy and other information dissemination tools
304	Submit final outreach and education plan (to include performance metrics and evaluation plan) to HHS
305	Focus test materials with key stakeholders and consumers and make refinements based on input
306	2013 Q1 - Launch outreach and education strategy and continue to refine messaging based on response and feedback from consumers
307	**Staffing**
308	Hire Chief Communications Officer
309	Hire Chief Sales & Marketing Officer
310	Develop a high level communication & outreach strategy for exchange
311	Solict input from key stakeholders in state
312	Develop an outreach and marketing budget
313	Develop return on investment (ROI) metrics
314	**Procure Marketing Services**
315	Develop & Publish RFP for Marketing & Advertising Vendor
316	Finalize RFP process and select vendor
317	Working with vendor, begin market research and planning activities
318	**Select outreach and marketing partners**
319	Identify outreach partners (other state agencies and existing health care advocacy grps)
320	Identify potential marketing partners and alliances for exchange
321	Select outreach and marketing partners
322	Execute outreach and communication plan
323	Collect data and calculate ROI



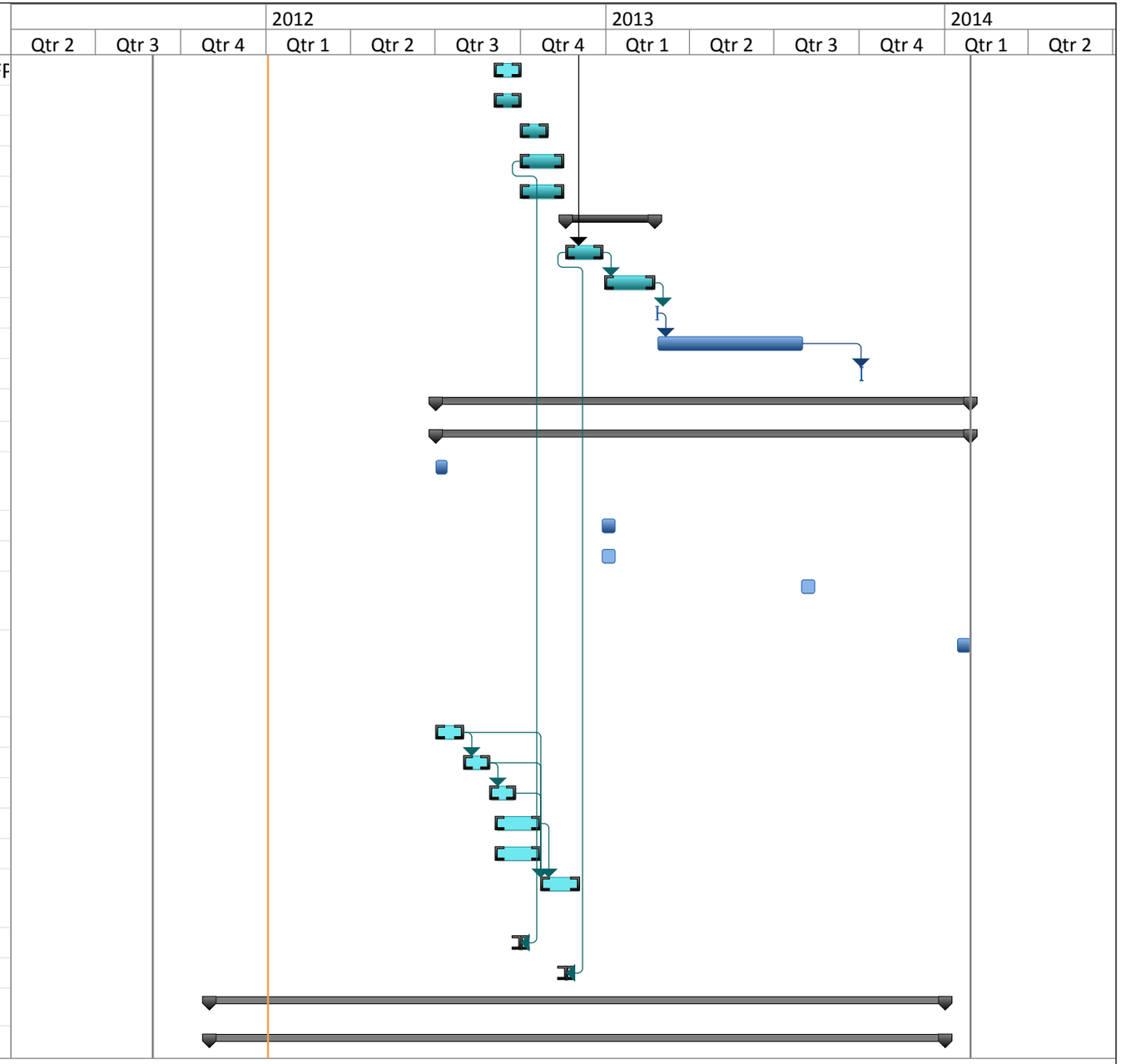
ID	Task Name
324	**Navigator Program**
325	**Key Federal Milestones**
326	Determine targeted organizations in the State who would qualify to function as Navigators
327	2013 Q2 - Determine Navigator grantee organizations and award contracts or grants (funded from the organizational funds for the
328	**Staffing**
329	Hire exchange staff to oversee Navigator program
330	Determine level of consulting services required, if any
331	**Analysis and Policy Development**
332	Schedule Navigator stakeholder meetings to solicit input from key stakeholders
333	Determine level of training and certification required of Navigators by Exchange
334	Develop Navigator training program
335	Determine level of compensation to be paid to Navigators -- per enrollee/fixed grants, etc
336	Develop funding stream for Navigators -- pre 2014 / post 2013
337	Develop Navigator Management Tool
338	**Procurement**
339	Develop RFP for Navigators
340	Select Navigators
341	Train Navigators
342	Begin operations of Navigators
343	**Broker Program**
344	**Key Federal Milestones**
345	Broker functionality, training, and oversight must be in place prior to start of open enrollment, if brokers will be a sales channel utilized by the Exchange.
346	**Analysis**
347	Perform market study to determine broker compensation, services provided, markets serviced
348	Schedule broker stakeholder meetings to solicit input from broker community



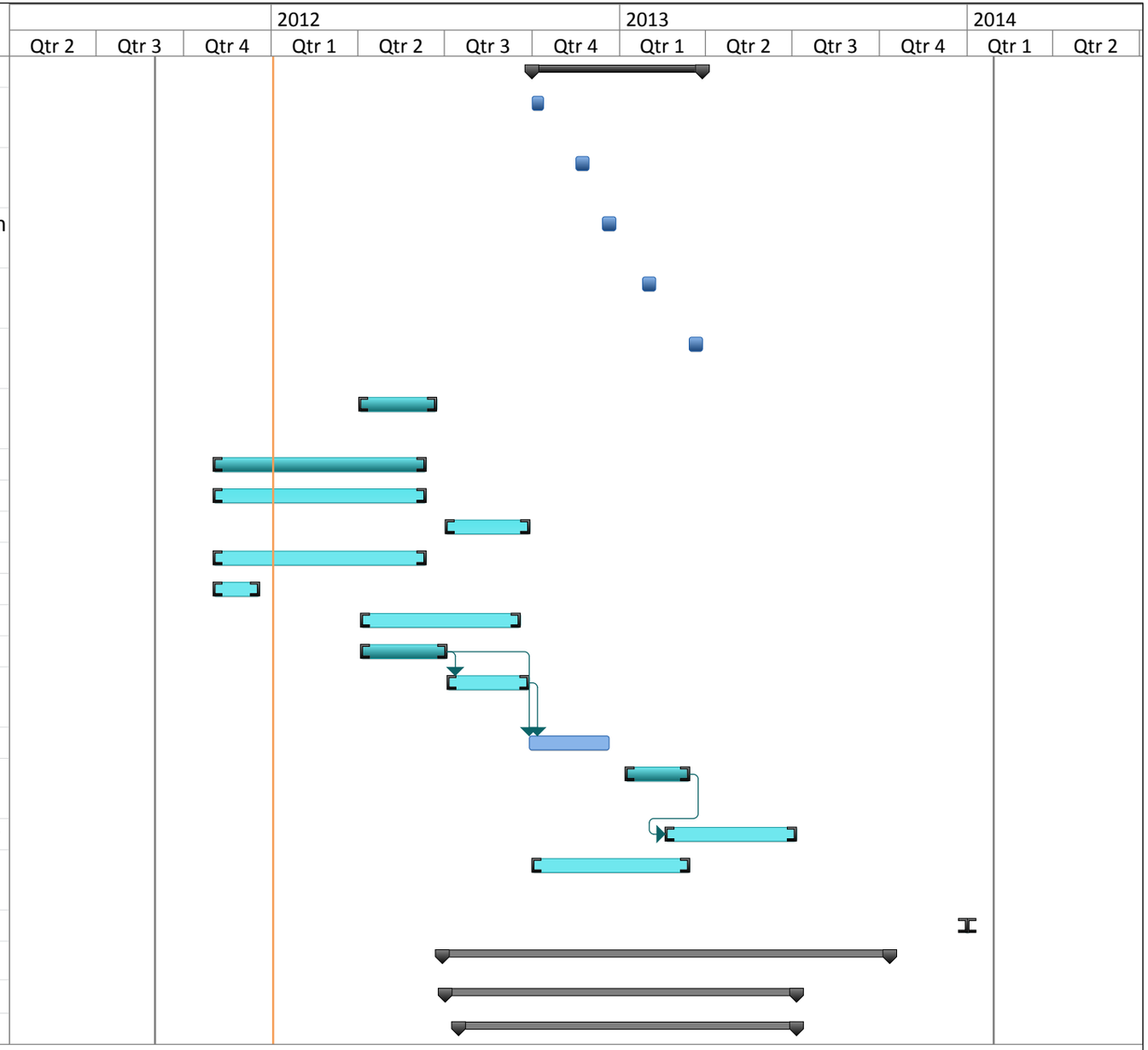
ID	Task Name
349	Using data from market study and stakeholder mtgs, develop exchange broker strategy
350	Determine level of broker compensation for writing exchange business
351	Determine funds flow of broker payments
352	**Implementation**
353	Reflect broker-specific policies in QHP procurement
354	Develop a broker training program for exchange products
355	Develop broker management tool to track key broker metrics
356	Develop a broker-advisory council for ongoing feedback from brokers once operational
357	**QHP Plan Management**
358	**Qualified Health Plan (QHP) Certification**
359	**Key Federal Milestones**
360	2012 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
361	2012 Q3 – Release RFP
362	2012 Q4 - Begin training health plan issuers to become qualified health plans
363	2013 Q3 – Conduct readiness reviews
364	2013 Complete QHP Certification Process: September 30, 2013
365	2014 Q1- Begin collecting user fees if the exchange is using this funding mechanism
366	2014 Q1- Demonstrate capability to monitor the practices and conduct as well as pricing and benefits of QHPs
367	**Staffing**
368	Determine exchange staff to oversee QHP procurement
369	**Analysis**
370	Develop with IT, operational specifications for QHP's -- enrollment/premium rates/billings
371	Compile data necessary to analyze and develop procurement goals
372	Analyze data and develop state procurement goals
373	Communicate goals of procurement with BOD



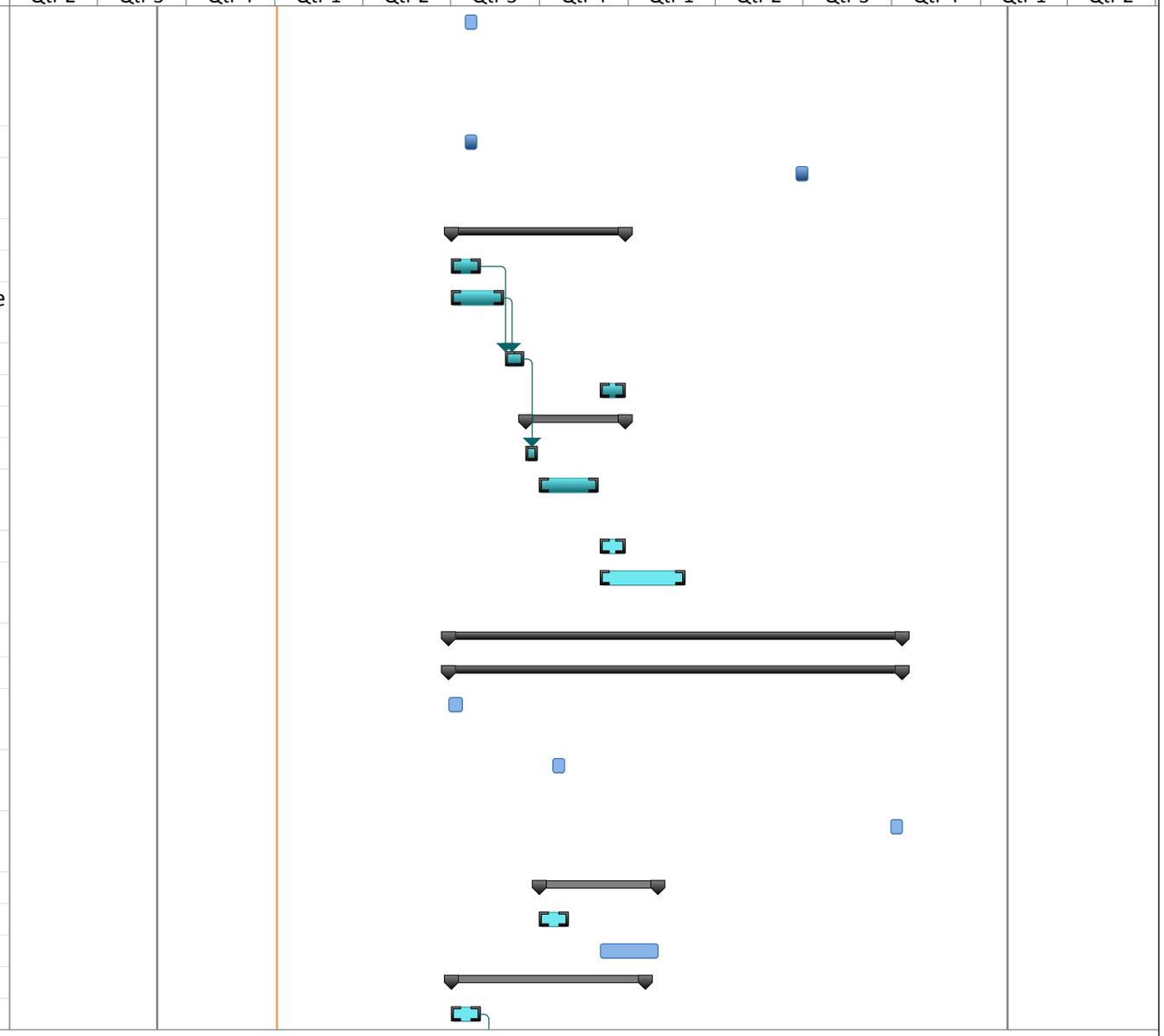
ID	Task Name
374	Develop communication plan to meet with carriers prior to release of RFP
375	Incorporate into QHP procurement strategy OPM offerings
376	Organize cross-functional QHP procurement team
377	Incorporate Plan Rating System in procurement
378	Incorporate Risk Adjustment methodology in procurement
379	**Procurement**
380	Develop and publish RFP
381	Select & Contract with QHP's
382	Begin implementation of QHP's
383	Implement, test systems, interfaces, website design
384	Begin open enrollment
385	**Plan Rating System**
386	**Key Federal Milestones**
387	Include quality rating functionality in system business requirements for the Exchange website
388	Complete system development of quality rating functionality
389	Complete testing and validation of quality rating functionality
390	Before Open Enrollment - Post quality rating system information on the Exchange website
391	Continually update quality rating information on the Exchange website and for call center representatives so they have the most up to date information on QHPs
392	Review federal guidance for Plan Rating System
393	Determine goals of state in rating QHP's
394	Select type of quality/cost metrics to rank QHP's
395	Determine availability of plan rating data
396	Integrate with exchange website
397	Develop implementation plan for ongoing data maintenance and updating of ratings
398	Integrate with QHP procurement strategy
399	Include plan rating specifications into QHP procurement document
400	**Reinsurance & Risk Adjustment**
401	**Reinsurance, Risk Corridors and Risk Adjustment**



ID	Task Name
402	**Key Federal Milestones**
403	Release of Federal risk adjustment model and reinsurance parameters – Oct. 2012
404	State deadline to propose alternate model and parameters for HHS approval – Nov. 2012
405	State deadline to file exception to minimum standards for data collection (if APCD in place) – Dec. 2012
406	HHS informs states if alternate model and parameters are approved – Jan. 2013
407	State deadline to provide notice to local stakeholders that alternate model and parameters will be used – Mar. 2013
408	Determine level of interaction necessary with HHS regarding federal implem of risk corridors
409	Determine availability of enrollment and claims data for analysis
410	Compile necessary data to begin analytical assessment
411	Determine where will program be managed within the state
412	Decide where will data be held and managed for start up and operations
413	Contract with subject matter experts
414	Develop risk adjustment methodology for program implementation
415	Develop schedule of meetings with carriers in market
416	Discuss proposed risk adjustment methodology with carriers and solicit input
417	Communicate with BOD program specifics after meeting with carriers
418	Develop " dry runs " of agreed upon methodology to determine impact on market
419	Share results of " dry runs " with carriers; modify methodology if necessary
420	Develop implementation plan -- data mgmt; communications; funds flow; reconciliation
421	Implement program
422	**Regulatory Compliance & Reporting**
423	**External Reporting**
424	**Key Federal Milestones**



ID	Task Name
425	Develop requirements for systems and program operations including capturing data used in enrollment process; submitting relevant data to HHS for later use in information reporting: capacity to generate information reports to enrollees
426	Q1-Q3 Systems development
427	Q1-Q3 Final user testing including testing all interfaces including full end-to-end integration testing with all other components
428	**Analysis Phase**
429	Identify reporting requirements per ACA and CMS/HHS guidelines
430	Solicit BOD and key stakeholder input as to type of information exchange should report
431	Develop list of reports mandatory and optional
432	Depending on level of reporting, hire exchange staff to support initiative
433	**Development**
434	Create report template for content of each report
435	Develop or acquire necessary databases to support mandatory and optional reporting
436	Create schedule of report publication dates: monthly; quarterly; annual
437	Develop IT requirements: reporting tools; interfaces; CMS/HHS requirements
438	**Exemption Certificates & Appeals of Eligibility**
439	**Key Federal Milestones**
440	2012 Q2 Begin developing business processes and operational plan for appeals functions
441	2012 Q4 Establish resources to handle appeals of eligibility determinations including training on eligibility requirements
442	2013 Q3 or before open enrollment - Initiate communication with HHS on process for referring appeals to the Federal appeals process
443	**Staffing**
444	Determine amount of exisitng resources which could be leveraged
445	Hire necessary staff
446	**Analysis Phase**
447	Identify obligations and requirements per ACA and CMS/HHS guidelines



ID	Task Name
448	Document appeals processes currently in operation in other state agencies
449	Document a process flow of how certificates and appeals would be administered
450	Identify as part of process flow: data needs; type of support staff required; est. # of appeals
451	Develop specifications for IT needs
452	Develop implementation plan for appeals dept in exchange: budget; physical space; staff
453	**System Development**
454	Build or modify solution to manage exemption requests and appeals
455	Final user testing (including all interfaces and integration with other components)
456	Begin processing exemptions from individual responsibility
457