Application for Approval of an American Health Benefit Exchange

On March 23, 2010, the President signed into law the Patient Protection and Affordable Care Act (P.L. 111-148). On March 30, 2010, the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) was signed into law. The two laws are collectively referred to as the Affordable Care Act. The Affordable Care Act creates new competitive private health insurance markets called American Health Benefits Exchanges (Exchanges).

The law gives States the opportunity to establish State-based Exchanges, subject to certification that the State-based Exchange meets federal standards and will be ready to offer health care coverage on January 1, 2014. The deadline for certification is January 1, 2013. In a State that does not achieve certification by the deadline, the law directs the Secretary of Health and Human Services to facilitate the establishment of an Exchange in that State.

The submission of this application indicates your State's formal application for certification as a State-based Exchange.

PART 1: ENABLING AUTHORITY AND GOVERNANCE

I. **Enabling Authority:** Section 1311(b) of the Affordable Care Act requires every State to establish a health insurance Exchange. Please explain your State's authority to establish an Exchange by one of the following:
   - **a.** A copy of current law and/or current regulation that clearly indicates that the State has the necessary legal authority to establish an Exchange or that clearly establishes the Exchange; OR
   - **b.** Other legislation related to health reform implementation or another general authority (such as an Executive Order) that the State determines provides the necessary legal authority to establish an Exchange AND a written legal opinion (correspondence or a formal legal opinion) from the legal counsel of the office of the applicant or the State's Attorney General's Office certifying that the State is authorized to establish an Exchange under State law.

   Please note that proposed or pending legislation will not be sufficient to establish that a State has the necessary authority to establish an Exchange. To the extent that any law or regulation is not clear on its face that either an Exchange has been established or the State (through an identified agency or official) has the authority to establish an Exchange consistent with the requirements of the Affordable Care Act, the written legal opinion described in (b) above should be provided.

II. **Governance** Section 1311(d) of the Affordable Care Act requires that an Exchange be a governmental agency or non-profit entity established by the State. The State may

decide to establish an Exchange in an existing State agency or establish a new agency or non-profit organization to serve as the Exchange

a. Governing Body

- **i.** To demonstrate that the governance structure for the Exchange has been established, the State should submit one or more of the following, if not provided in documentation submitted to demonstrate the State's legal authority to establish an Exchange:
  - **1.** A copy of current legislation or regulation establishing the governance structure of the Exchange; OR
  - **2.** Other legislation related to health reform implementation or another general authority (such as an Executive Order) that establishes the governance structure of the Exchange AND a written legal opinion (either correspondence or a formal opinion) from the legal counsel of the office of the applicant or the State's Attorney General's Office certifying that the provided authority establishes the governance structure of the Exchange under State law.
- ii. Provide a description of the entity that will be running the Exchange and overseeing governing body, including rationale for selecting this governance model (i.e. State agency, non-profit organization, quasi-agency, etc.)
- iii. Describe the organizational structure of the Exchange, including providing an organizational chart and resumes on executive leadership
- iv. Provide bylaws and standard operating procedures if available.

b. Board Membership

- i. Describe the overall board composition, rationale for this structure, and how members are selected
- ii. Provide a list of all current members and a resume for each member
- iii. Provide conflict of interest policy and procedure for preventing or mitigating conflicts of interest- include explanation if any conflicts of interest exist
- iv. Provide conflict of interest disclosure statements for Exchange board members

c. **Contracted Entities** Section 1311(f)(3)(B) of the Affordable Care Act authorizes an Exchange to enter into agreements with eligible entities to carry out one or more responsibilities of the Exchange.

i. Describe current and future agreements with eligible entities that will carry out responsibilities of the Exchange, including relationships with IT vendors.
ii. Describe procedures in place to ensure program integrity and prevention of fraud, waste, and abuse related to contracted entities.
iii. Describe how the Exchange will ensure that entities carrying out responsibilities of the Exchange do so in compliance with all Exchange requirements.
iv. Provide conflict of interest policies and procedures related to contracted entities
v. Provide copies of contracting materials including: RFP and contract agreement.

III. Regional or Subsidiary Exchanges

a. Regional Exchange Section 1311(f)(1) of the Affordable Care Act provides the option for States to establish Regional Exchanges that operate in more than one State if this operation is permitted by each State and if the Regional Exchange is approved by the Secretary of Health and Human Services.

i. If the State is establishing a regional Exchange, please provide the following materials:
1. Memorandum of Understanding among all States participating in the Exchange related to the utilization of grant funding.
2. Agreement between the Regional Exchange and State Medicaid agencies related to eligibility coordination.
3. Memorandum of Understanding with any participating State's department of insurance and the regional Exchange involving matters related to health insurance issuers' solvency, licensure, and benefits.
4. Procedures to ensure that to the maximum extent possible the operation of the Regional Exchange is seamless to the consumer.
5. The process and period for transition in the event that a State elects to withdraw from participation in the regional Exchange.

b. Subsidiary Exchange Section 1311(f)(2) of the Affordable Care Act provides States with the option to establish one or more subsidiary Exchanges if each such Exchange serves a geographically distinct area and the area served by each such Exchange is at least as large as a rating area described in section 2701(1) of the Public Health Service Act.

i. If the State will establish one or more subsidiary Exchanges, please provide the following materials:

1. A description of how each subsidiary Exchange will ensure that all Exchange functions are performed.
2. A description of the relationship among the subsidiary Exchanges and the State.
3. A description of the governance model for subsidiary Exchanges.
4. A description of the allocation of grant funding across subsidiary Exchanges.
5. A description of the process for ensuring that the entire State is served by an Exchange.

c. **Presumption for Certain State-Operated Exchanges**: In compliance with Section 1321(e)(2) of the Affordable Care Act if your State has been operating an Exchange prior to January 1, 2010, please indicate completion of the process to show compliance with all Exchange standards.

IV. Non-interference with Federal Standards Section 1311(k) of the Affordable Care Act specifies that an Exchange may not establish rules that conflict with or prevent the application of regulations promulgated by the Secretary related to the Exchange.

a. **Attestation**

i. Provide an attestation that the Exchange will not establish standards that conflict with those promulgated by the Secretary of Health and Human Services related to the Exchange.

PART 2: EXCHANGE FUNCTIONS

I. Consumer Functions

a. **Outreach and Education:** Section 1311(d)(6) of the Affordable Care Act requires an Exchange to consult with relevant stakeholders, including: consumers, individuals and entities with experience in facilitating enrollment in health plans, representatives of small businesses and self-employed individuals, Sate Medicaid offices, and advocates for enrolling hard to reach populations. In addition, Section 1311(d)(4) lays out the functions of an Exchange, many of which will entail conducting of outreach and education for consumers as well as other stakeholders

i. Provide a description of the approach to providing outreach and educational materials to the public about the Exchange
ii. Provide a description of the approach for establishing relationships and working with partners to connect with hard-to-reach populations
iii. Provide a brief summary, evidence of consultation to date, and plans for future engagement with stakeholders (e.g. health care consumers, individuals and entities with experience in facilitating enrollment, state

Medicaid offices, representatives from small businesses and self-employed individuals, advocates for hard-to-reach populations)

iv. Provide an implementation plan, including key milestones, high-level timeline, and detailed progress reports showing acceptable achievement of milestones

v. Provide a description of how the Exchange considered the comments and recommendations submitted by stakeholders

vi. *If contracting out any outreach and education operations - please provide name of contractor, point of contact, address, evidence of contractor qualifications, and conflict of interest assessment*

b. **Call Center** Section 1311(d)(4)(B) of the Affordable Care Act requires an Exchange to provide for the operation of a toll-free telephone hotline to respond to requests for assistance.

i. Provide a description of the approach to develop call-center operations (e.g., leveraging existing organizations, contracts)

ii. Provide a description of the approach to ensure sufficient consumer outreach, interpretation services, and overall consumer experience

iii. Provide a description of call center functionality

iv. Provide an implementation plan, including key milestones, high-level timeline, and detailed progress reports showing acceptable achievement of milestones

v. *If contracting out any call center operations – please provide name of contractor, contact point, address, evidence of contractor qualifications, and conflict of interest assessment*

c. **Insurance Portal:** Section 1311(d)(4)(C) of the Affordable Care Act requires an Exchange to maintain an Exchange website through which enrollees and prospective enrollees of Qualified Health Plans may obtain standardized comparative information on such plans

i. Provide a description of the implementation plan, including key milestones and high-level timeline, for establishment of the Exchange insurance portal, including:

1. How the insurance portal will support the consumer experience – this includes how the portal will interface with the call center and with Navigators and agents/brokers.

2. How the insurance portal will display QHPs and provide prospective enrollees with accurate pricing information for QHPs– including how the Exchange will (1) provide standardized comparative information and transparency on plan coverage (i.e.

benefits, providers, etc.), (2) establish a rating engine to calculate premiums and second lowest cost silver plan, (3) and facilitate consumers accessing information on providers and whether a specific doctor is in network, and (4) display health plan quality rating information and enrollee satisfaction information

3. How the insurance portal will support a seamless eligibility and enrollment process for consumers

ii. Provide a description of the electronic calculator and method to determine actual cost of coverage after premium tax credit and cost-sharing reductions in compliance with Section 1311(d)(4)(G)

iii. *If contracting out any insurance portal operations -provide name of contractor, contact point, address, evidence of contractor qualifications, and conflict of interest assessment.*

d. **Navigators** Section 1311(d)(4)(K) of the Affordable Care Act requires an Exchange to establish a Navigator program.

i. Provide a description of the Navigator program, including the types of entities serving as Navigators and avoidance of conflict of interest.

ii. Provide an implementation plan, including key milestones, high-level timeline, and detailed progress reports showing acceptable achievement of milestones.

iii. Provide a description of the State strategy for funding Navigator grants

iv. *If contracting out navigator program - please provide name of contractor, contact point, address, evidence of contractor qualifications, and conflict of interest assessment.*

e. **Agents/Brokers** Section 1312(e) of the Affordable Care Act allows States to use agents or brokers to enroll individuals and employers.

i. Provide a brief summary of approach for engagement of agents/brokers.

II. **Eligibility** Section 1411 of the Affordable Care Act defines eligibility criteria for Exchange participation.

a. Provide a description of the eligibility determination and redetermination process, including business process models.

b. Provide evidence of capacity, including adequate staffing, to accept and process applications through channels including in-person, online, mail, and phone, and to conduct verifications.

c. Provide an implementation plan, including key milestones, high-level timeline, and detailed progress reports showing acceptable achievement of milestones

d. If not using the single, streamlined application provided by CMS, provide a copy of State-developed application.

e. Provide a description of relevant notices.
f. Provide Internal Revenue Service Safeguards Procedures Report letter of acceptance verifying adequate safeguards are in place to receive federal tax information which is required for eligibility determinations and renewals for Premium Tax Credit and cost-sharing reductions.
g. *If contracting out any eligibility operations - provide name of contractor, contact point, address, evidence of contractor qualifications, and conflict of interest assessment*

III. **Exemptions from the Individual Responsibility Requirement** Section 1411(b)(5) of the Affordable Care Act specifies the information required in the case of an individual who is seeking an exemption certificate under section 1311(d)(4)(H).

a. Provide a description of the exemption process, along with business process models.
b. Provide evidence of capacity, including adequate staffing, to accept and process applications through channels including in-person, online, mail, and phone, and to conduct verifications.
c. Provide an implementation plan, including key milestones, high-level timeline, and detailed progress reports showing acceptable achievement of milestones.
d. *If contracting out any eligibility operations - provide name of contractor, contact point, address, evidence of contractor qualifications, and conflict of interest assessment.*

IV. Certification of Qualified Health Plans (QHPs) & Plan Management

Section 1311(d)(4)(A) of the Affordable Care Act requires that an Exchange must implement procedures for the certification, recertification, and decertification of QHPs. In addition, section 1301(a) provides a definition of a QHP, including that each QHP must have in effect a certification that such plan meets the criteria for certification set forth in section 1311(c), provides the essential health benefits package described in section 1302(a) and is offered by a health insurance issuer that is licensed and in good standing in the State and meets additional requirements.

a. Provide a description of State policies and procedures (to date) for the following:
- **i.** The Exchange approach to certification, recertification, and decertification of QHPs, including:
  - **1.** Meeting minimum QHP certification standards specified by HHS under section 1311(c) of the Affordable Care Act
  - **2.** The QHP certification approach (use of best interest test)
  - **3.** Roles and responsibilities of the State Department of Insurance and the Exchange

4. **4.** Additional certification standards above the Federal minimum standards required by section 1311(c) of the Affordable Care Act
5. **5.** Approach, if any, to creating plan alignment between Medicaid and the Exchange
6. **6.** The frequency of recertification and the approach to annual plan renewal

ii. Ongoing oversight and monitoring of QHPS, including the Exchange approach to monitoring QHP performance, tracking and resolving complaints, and ensuring that QHPs continue to meet certification requirements,

iii. The Exchange approach to rate analysis and benefit package review, and population of the rating engine for the Exchange website and calculation of the second lowest cost silver plan,

iv. Collection and analysis of quality data from issuers.

b. Provide description of implementation plan, including key milestones and high-level timeline, for establishment of the QHP certification and plan management operations.

c. Provide a description of approach for engagement with issuers, including

i. Issuer outreach and education,

ii. Issuer call center, help tools, and technical assistance and training,

d. *If contracting out any plan management and qualified health plan operations - provide name of contractor, contact point, address, evidence of contractor qualifications, and conflict of interest assessment.*

V. Financial Management

a. Provide a description of the policies and procedures (to date) for the following:

i. **Risk Adjustment Program** Section 1343 of the Affordable Care Act defines requirements for adequate risk adjustment within the Exchanges.

1. Please indicate whether you expect to administer risk adjustment or elect to have HHS operate risk adjustment on your behalf. If you expect to run risk adjustment, please provide an answer to question 2
2. Do you seek to use an alternate risk adjustment methodology?

ii. Reinsurance Program: Section 1341(a)(2) of the Affordable Care requires that each state establish (or enter into a contract with) 1 or more applicable reinsurance entities to carry out the reinsurance program.

1. **1.** Please indicate if you will be establishing a not-for-profit reinsurance entity or contracting with one.
2. **2.** Please provide a work plan for implementing reinsurance, including the timeline for contracting with or establishing a not-

for-profit reinsurance entity and any functions of the reinsurance program that you plan on subcontracting

iii. **Financial Management** Section 1313(a)(1) of the Affordable Care Act requires that an Exchange shall keep an accurate accounting of all activities, receipts, and expenditures and shall annually submit to the Secretary a report concerning such accountings.

1. Describe State's plan for financial management of exchanges and the premium stabilization programs including premium processing for the individual (optional) and/or small group Exchange markets, and a funding vehicle for Exchange operations post-2014.
2. Evaluation of existing state financial systems for compliance with Federal requirements and an evaluation of system needs, such as book-keeping, accounting, data, and electronic funds transfer capability to/from employers, individuals (if applicable), and issuers. Please share your financial systems IT plan.
3. Strategy for oversight and monitoring, including procedures to prevent fraud, waste, and abuse in compliance with Section 1313 of the Affordable Care Act.

b. Provide a description of implementation plan, including key milestones and high-level timeline, for establishment of the Exchange financial management operations.

c. *If contracting out any financial management operations - provide name of contractor, contact point, address, evidence of contractor qualifications, and conflict of interest assessment.*

VI. **Enrollment**: Section 1312(a)(1) of the Affordable Care Act specifies that a qualified individual may enroll in any qualified health plan available to such individual. Please provide:

a. Description of the process for enrollment in a QHP, along with business process models.

b. Evidence of capacity to accept and process QHP selections.

c. Evidence of plan comparison functionality that integrates eligibility information and ability to select and enroll in a plan, post positive eligibility determination.

d. Description of relevant notices.

e. Implementation plan, including key milestones, high-level timeline, and detailed progress reports showing acceptable achievement of milestones, including readiness for initial open enrollment.

f. *If contracting out any enrollment operations - please provide name of contractor, contact point, address, evidence of contractor qualifications, and conflict of interest assessment.*

VII. **Small Business Health Options Program (SHOP)** Section 1311(b)(1) of the Affordable Care Act provides for the establishment of a SHOP Exchange that is designed to

assist qualified employers in facilitating the enrollment of their employees in qualified health plans offered in the small group market in the State

a. **Authorization:** If the SHOP was separately authorized from the Exchange, under section 1311(b)(2) of the Affordable Care Act, please provide the information in Part 1, Section I, above for the SHOP.
b. **Governance:** If the SHOP has a separate governance body from the Exchange, provide the information in Part 1, Section II above for the SHOP.
c. **Consumer Facing Functions: Outreach and Education:** Describe outreach and education efforts aimed specifically at small employers and employees, following the outline in Part 2, I. a.
d. **Consumer Facing Functions: Call Center.** If the call center described in Part 2, I. a. will serve the SHOP, please describe any specific adaptations to the needs of employers and employees. If inquiries from consumers will be handled through a different mechanism unique to the SHOP, describe how different types of inquiries (such as pre-enrollment questions, enrollment issues, changes after enrollment, claims issues, and billing issues) will be handled and by whom.
e. **Consumer Facing Functions: Insurance Portal.** If the insurance portal described in Part 2, I. c. will serve the SHOP, describe any differences in implementation or functionality needed to serve employers and employees. If the SHOP uses a separate portal, provide the information in Part 2, I. c. i and iii for the SHOP. In either case, please describe:
    i. Whether the portal serves both brokers and consumers,
    ii. What employer, employee and broker account management tools are built into the portal,
    iii. Employer options with regard to offering health plans,
    iv. Employer options with regard to how employer and employee contributions are calculated,
    v. When presenting any choices an employee may have among plans and family tiers, whether the portal calculates and displays the employee's contribution.
f. **Brokers, Agents, Navigators:**
    i. Describe who can assist and act on behalf of employers and employees in registering the employer, assisting in any employer and employee eligibility determinations, assisting employers in making available employer choices, and enrolling in health plans,
    ii. Describe the method by which brokers, agents, or Navigators are compensated for their services in the SHOP,

iii. Describe any ongoing responsibilities of brokers, agents, or Navigators after enrollment or re-enrollment.

g. **Eligibility**

i. Section 1304(a) of the Affordable Care Act defines small business compliance

1. Describe the State's election with regard to whether the small group market includes employers with 51 to 100 employees in 2014 and 2015.
2. Describe how the size of a small business is determined in the exchange.

ii. Describe the process used for determination and redetermination of employer and employee eligibility, including whether attestation or documentation is required.

iii. Describe the process for employers and employees appealing their eligibility decisions.

h. Enrollment

i. Describe the enrollment process for the SHOP with respect to:

1. Rolling enrollment,
2. Special Enrollment periods,
3. The criteria described in Section VI.

i. **Plan Management & Qualified Health Plans.**

i. If the SHOP uses the same plan management process described in Section IV, describe any adaptations needed to serve the SHOP,

ii. If the SHOP has a different plan management process for health plans offered through the SHOP, provide the information required in Section IV for the SHOP plan management process,

iii. Describe your strategy for assuring that multiple issuers offer a variety of qualified health plans in the SHOP.

j. **Premium Aggregation.**

i. Please describe the role of the SHOP in billing employers, receiving employer and employee contributions toward premium, making aggregated premium payments to issuers, and reconciling accounts.

ii. Describe how non-payment of premiums is addressed, including how and when notices are sent to employers and employees.

iii. *If contracting out any premium aggregation operations - provide name of contractor, contact point, address, evidence of contractor qualifications, and conflict of interest assessment.*

- ***k.*** **Reporting, Funding, Oversight and Monitoring.** If the SHOP is governed separately from the Exchange, provide the information in Sections VIII (including reporting of the information required in Section 36B(f)(3) of the IRC), IX, and XI with regard to the SHOP.

VIII. Reporting

- **a.** In compliance with Section 1311(d)(4)(I) of the Affordable Care Act provide a description of the process for the following, along with business process models.
  - **i.** Process for reporting to Secretary of the Treasury:
    - **1.** List of individuals (name and taxpayer ID) who received an exemption from the individual responsibility requirement.
    - **2.** List of individuals (name and taxpayer ID) determined eligible for advance payments of the premium tax credit or cost-sharing reductions based in part on a finding that an individual's employer does not provide minimum essential coverage (MEC), or provides MEC that is unaffordable or does not meet the minimum value requirement.
    - **3.** List of individuals (name and taxpayer ID) for whom advance payments of the premium tax credit are made or who are receiving cost-sharing reductions, and who have notified the Exchange that they have changed employers or who have ceased coverage under a QHP during the benefit year.
  - **ii.** Process for reporting to the employer regarding any employees for whom advance payments of the premium tax credit are made or who is receiving cost-sharing reductions cease coverage
  - **iii.** Process for publication of
    - **1.** Cost of licensing, regulatory fees and any other payments required by the Exchange.
    - **2.** Administrative cost of an Exchange, and monies lost to waste, fraud and abuse.
- ***b.*** *If contracting out any reporting operation - provide name of contractor, contact point, address, evidence of contractor qualifications, and conflict of interest assessment.*

IX. Funding: Section 1311(d)(5)(A) of the Affordable Care Act requires that the State shall ensure that such Exchange is self-sustaining beginning on January 1, 2015, including allowing the Exchange to charge assessments or user fees to participating health insurance issuers, or to otherwise generate funding, to support its operations.

a. Provide a description of approach, including key milestones and high-level timeline, for Exchange to become self-sustaining by Jan 1, 2015 (e.g. any use of user fees, appropriations, etc.)

X. **Program Integration / Pre-existing Condition Insurance Plan (PCIP) Transition:** Section 1331(c)(4) of the Affordable Care Act requires that a State shall seek to coordinate the administration of, and provision of benefits under, its program under this section with the State Medicaid program under title XIX of the Social Security Act, the State child health plan under title XXI of such Act, and other State-administered health programs to maximize the efficiency of such programs and to improve the continuity of care. Please provide:

a. Description of strategy for coordination between Exchange, Medicaid, CHIP, and BHP (where applicable), along with business process models.

b. Evidence of collaboration with agencies administering Medicaid, CHIP, and BHP, if applicable, including:

   i. Any MOUs or contracts developed with each agency;

   ii. Descriptions of roles and responsibilities of Exchange and the State DOI, related to qualified health plans;

   iii. Description of roles and responsibilities of Exchange and agencies administering Medicaid, CHIP and BHP, if applicable, related to eligibility determinations, verifications, and enrollment processes.

c. Description of the plan for PCIP transition.

d. Implementation plan, including key milestones, high-level timeline, and detailed progress reports showing acceptable achievement of milestones.

XI. **Oversight and Monitoring:** Section 1313(b) of the Affordable Care Act requires that the Comptroller General shall conduct an ongoing study of Exchange activities and the enrollees in qualified health plans offered through Exchanges not later than 5 years after the first date on which Exchanges are required to be operational. Please provide:

a. Description of the policies and procedures (to date) for Oversight and monitoring, including procedures to prevent fraud, waste, and abuse in compliance with Section 1313(b) of the Affordable Care Act.

b. *If contracting out any oversight operation - provide name of contractor, contact point, address, evidence of contractor qualifications, and conflict of interest assessment.*

XII. **Adjudication of Appeals Eligibility Determinations:** Section 1411(f)(1)(A) of the Affordable Care Act shall establish procedures by which the Secretary or one of such other Federal officers hears and makes decisions with respect to appeals of any determination. Please provide:

a. Description of process for adjudication of eligibility appeals, including timelines and notice requirements and process for coordination with State Medicaid agency.
b. Evidence of capacity, including adequate staffing, to accept and process eligibility appeals.
c. Evidence of a firewall or absence of a conflict of interest between the entity performing appeals and the entity providing eligibility determinations.

Part 3: Operational Readiness

Please demonstrate operational ability to meet the requirements outlined in Parts 1 & 2 by:

1. Successfully completing the Establishment Grant Gate Review process or
2. Demonstrating to CMS the ability to meet the requirements of the Gate Review process.