New York Health Benefit Exchange

Detailed Design Review Summary for Section 3.0 Enrollment and Eligibility October 9-10, 2012

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Section 3.1 Single Streamlined Application(s) for Exchange and SHOP

New York anticipates using the single streamlined HHS developed individual Exchange application, and standard SHOP application developed by HHS for employer and employee, subject to review once they are released. New York has reviewed draft data elements for both applications, and is attempting to conform to process flows developed by the FFE to the extent possible, as they reflect anticipated required data elements. (See slide 3.1)

Section 3.2 Coordination Strategy between Exchange and Other Agencies administering Insurance Affordability Programs and the SHOP that Enables Exchange to carry out eligibility and enrollment functions

The New York Health Benefit Exchange (Exchange) was established in the New York State Department of Health (DOH) pursuant to Governor Cuomo's Executive Order (EO) issued on April 12, 2012 (see prior submission on Exchange Legal Authority and Governance, Section 1). DOH is a co-regulator of commercial insurance/HMOs with the New York State Department of Financial Services (DFS, formerly the Department of Insurance). The Exchange will coordinate closely with DFS in terms of Exchange oversight of QHPs (individual and SHOP) and SHOP eligibility and enrollment activities, including broker

assistance. DOH is also the single state agency administering the Medicaid program, as well as the Child Health Plus (CHP) program, through the Office of Health Insurance Programs (OHIP).

DOH is in the process of developing and/or amending several intra-agency memoranda of understanding (MOUs) with state agencies that will be supporting Exchange eligibility and enrollment activities through data sharing agreements (e.g. Tax and Finance, Department of Labor, etc). (See slide 3.2).

DOH intra-agency organization under Commissioner of Health Dr. Nirav Shah, will help ensure close coordination of all Exchange eligibility and enrollment activities and functions, including those under the Division of Health Insurance Reform and Health Insurance Exchange Integration, and those that help support plan selection by individual consumers, employers and employees such as plan quality data collection by DOH Office of Patient Safety. OHIP will be responsible for administering the Insurance Affordability programs, including Medicaid, CHP, APTC/CSRs and any Basic Health Program (BHP) that New York may determine to offer, as well as for the development and implementation of the integrated system platform that will support Exchange eligibility and enrollment determinations for QHPs and IA programs, for the individual and SHOP Exchanges.

There will additionally be coordination between the Exchange and SHOP, in terms of appropriately leveraging system and back end operational capabilities, as well as at a program level. For example, employees who lose their coverage through SHOP will also informed of individual coverage options available through the exchange. And the Exchange will seek to utilize SHOP employer information as a potential electronic data source of minimum essential coverage (MEC) to support Exchange eligibility determinations.

The SHOP Exchange will provide employees with information on affordability programs available under the Individual Exchange, and with the ability to access consumer support and application assistance for such programs as required.

Section 3.3 Applications, Updates, Redeterminations

3.3a Acceptance and processing of applications, updates, and responses to redeterminations from applicants and enrollees in-person

Applications, updates, and redeterminations can be accepted in person at Navigators, Brokers, and a wide range of third-party assistors such as local departments of social services and providers who currently assist applicants in person. While applicants/enrollees may provide information in person, we expect the assistor to electronically enter the information into the online eligibility system.

3.3b Acceptance and processing of applications, updates, and responses to redeterminations from applicants and enrollees online

The NY-HX eligibility and enrollment system will accept applications, updates, and responses to redeterminations online. It will also perform administrative renewal prior to the end of coverage and send requests for redeterminations to enrollees, if needed. A back-end eligibility operation will handle the manual work associated with applicants/enrollees who cannot complete the process of enrolling, updating, or renewing online. New York will build upon technology currently in place for the existing New York Health

Options Enrollment Center (EC) to identify the age of various applications, updates, redeterminations and, missing information; and determine work priorities.

3.3c Acceptance and processing of applications, updates, and responses to redeterminations from applicants and enrollees via mail

New York intends to minimize the amount of applications, updates, and determinations it receives by mail, but mail is always an option for a consumer. All mail will be delivered to a centralized processing unit. The centralized processing unit will be public/private partnership of state staff and vendor staff. The mail will be scanned and, if a verification source or renewal, will be linked to the appropriate individual. The information will be uploaded into NY-HX using an efficient worker interface. Technology and operational procedures that incorporate document management and workflow processing allow for acceptance and processing of applications, updates, and responses from applicants and enrollees via mail (3.3c) and phone (3.3d) and applications that were started online by an applicant, but transferred to the call center when assistance is needed (3.3b). A system workflow manager component, being leveraged in our current operation, is responsible for moving an application from initiation to completion.

3.3d Acceptance and processing of applications, updates, and responses to redeterminations from applicants and enrollees via phone

Consumers will be able to apply, update information, and renew by phone. We intend to employ a separate user interface for workers accepting phone applications to efficiently gather the information to complete an eligibility determination. Currently, New York EC offers telephone renewals in 16 counties. About half of the renewals in those counties are completed by phone. The experience of telephone renewal offers lessons for the Exchange. Phone renewal is popular with consumers. It takes more time for an eligibility worker to complete than a mail renewal, but they generate a higher renewal rate because discrepancies can be resolved over the phone. Telephone renewals also have a much higher response rate to missing documents than mail renewals. The eligibility processing center will employ the same technology for workflow management as with mail and online applications.

3.3e Conducting all aforementioned activities for applicants and enrollees who have disabilities or limited English proficiency

The current New York Health Options Call Center (Call Center) includes staff that are proficient in both English and Spanish, and provides materials to the public in many languages. Additional service details include:

- Oral Translation Services: When an applicant or an enrollee speaks a language other than those spoken by the Customer Service Representatives (CSR), the Call Center assists them through Language Line translation services. This service is available during all call center operating hours and all callers are provided this service free of charge. The process for using Language Line services is simple: the CSR stays on the line with the caller and conferences in the Language Line interpreter, so the caller never has to hang up and call another number for translation assistance. Language Line currently interprets more than 170 languages.
- TDD Capability: Individuals with special communication needs must be provided an equal opportunity to interact with our CSRs. The NY Health Options Center Call Center provides accessibility for hearing- and speech-impaired callers through the use of a software-based Teletype (TTY) system. A separate, dedicated toll-free number is

maintained for TTY calls, which transfers these calls directly to the TTY system. Incoming TTY calls are announced with a screen-pop and audible ring alert to the CSR. Designated CSRs communicate with TTY callers through an intuitive, user-friendly on-screen "chat window" interface facilitating effective response to callers. CSRs are trained to follow appropriate TTY etiquette and use industry-standard abbreviations, such as *SK* for "stop keying" used by both parties to end the call. With the exception of this and other abbreviations commonly used and accepted by the TTY community, all other conversational content is spelled out fully by the CSR to avoid introducing any confusion.

- Other Translation Services: The NY Health Options Call Center responds to requests for materials by mailing out program brochures and other materials in English, Spanish, and other languages required for New York population groups, such as Chinese, French Creole, and Russian. As requested, materials are also distributed in the appropriate languages in audio format or Braille. The Call Center vendor offers the services of the Center for Health Literacy to provide culturally and linguistically appropriate translations of written materials as well as call center scripts.

The Exchange Call Center will incorporate all the translation functions currently provided by the NY Health Options Center Call Center, at no cost to the caller.

The user interface of the online portal will take into account usability and accessibility by individuals living with disabilities as well as individuals with limited English proficiency. The online portal will be available in English and Spanish and will contain taglines in other languages informing consumers that language assistance is available at no cost.

The Exchange system solution incorporates usability recommendations from ACA Section 1561 and will comply with the US Rehabilitation Act Section 508 requirements. It will guide the user through the selection process with easy to follow, simple language format (4th grade reading level), and contemplates conditional questions to elicit the minimum information necessary to make eligibility determination. The screens are being designed using elements including aspects of “look and feel” from the UX-2014 project (a multi-state/federal/foundation collaborative design project utilizing human subject research to improve the Exchange customer experience), further adapted for Section 508 compliance. The base application and the underlying Content Management System are both designed to support multiple languages (English and Spanish are planned for deployment for October 2013 open enrollment).

The SHOP Exchange will develop standard procedures for applications, updates, and redeterminations. When employers enter the SHOP Exchange and are approved for participation in the SHOP, they will be able to select plans for Employee choice or have a Broker complete this process for them. After employees are entered into the system, either manually or via roster upload, they will be able to begin selecting their insurance option and completing the application process. Notice will be provided to employees, either in writing or via email (or both) that their employer has selected health insurance options for them within the Exchange, and they will be provide with instructions on how to proceed. The timing associated with the applications has not yet been determined, but is likely to reflect current industry standard of at least 30 days for employer selection, then 30 days for employee selection of plans.

Upon receipt of an application, the employer will receive notification that applications have been received. If minimum participation rates are met (if the State decides to require minimum participation rates), the applications will be processed, appropriate 834 enrollment transactions for approved applicants will be transmitted by the Exchange to issuers, along with aggregated premiums from employers. The SHOP

Exchange will ensure that a QHP issuer notifies a qualified employee enrolled in a QHP of the effective date of coverage consistent with §156.260(b). Electronic submission of applications will be encouraged, but applications will be accepted in-person at designated locations, over the phone, and by mail, as required by the ACA. The handling of paper applications will mirror the procedures utilized in the individual Exchange.

Redeterminations will be done on an annual basis in the SHOP Exchange, upon the anniversary or renewal date of the employer. Notification will be provided to employers, and employees, prior to the anniversary date, and option given to change selections from the previous year.

3.4 Notices and Data Matching, Annual Redeterminations and Response Processing (see slide)

3.4 b Periodic Data Matching

As per 45 CFR 155.330 (d)(2), the Exchange plans to implement data matching processes with the Social Security Death Index and the Public Assistance Reporting Information System to identify changes in circumstance related to death or eligibility for public programs. If the data match results in a change in eligibility, the consumer will be informed of the change and the date of enrollment/disenrollment and will given an opportunity to respond to the finding from the data match.

3.4 c Annual Redeterminations

The Exchange plans to conduct annual redeterminations, including the ability to process redeterminations on-line, via mail, phone and in person (see 3.3). The Exchange also plans to implement an automated administrative renewal process for individuals that agree that their tax information may be accessed for this purpose. Initial development focus is on application functionality, but discussions are underway regarding renewals.

3.5 Verifications

New York generally plans to align with the draft FFE process flows and draft business service definitions (BSDs) provided to date, in terms of its approach to data sources for verifications for residency, citizenship and immigration status, incarceration, household income, tax household size, whether an individual is an American Indian, enrollment in an eligible employer-sponsored plan (if applicable), and eligibility for qualifying coverage in an eligible employer-sponsored minimum essential coverage. New York plans to accept attestation as required for family/household composition. More detail is provided below.

New York plans to use all required federal data hub services made available to states for Exchange eligibility determinations and verifications. Examples of federal data hub services New York plans to use include, but are not limited to, SSN validation through SSA, citizenship/immigration status through SSA/DHS, incarceration status from the Prisoner Update Processing System (PUPS), tax household size, MAGI total household income, or any other federal tax information through the IRS , and any federal hub source available to verify eligibility for public minimum essential coverage (e.g. Medicare, TRICARE, Peace Corps MEC, Veterans health MEC). New York plans to check its own administrative data sources for enrollment in public MEC for Medicaid, CHP and any BHP offered. Additionally, if PUPS is not required, New York will use data from the NYS Department of Corrections to verify incarceration status.

As provided in the ACA and final rules, and in anticipated conformity with the Federally Facilitated Exchange (FFE), New York generally anticipates relying on attestation, and verifying, where possible,

against trusted electronic data sources before requiring, with the exception of specific circumstances, production of a paper document by electronic/upload or other means.

To the extent that, in the future, the federal hub develops/offers a reliable, more "real time" source for income verification (e.g. offers access to state wage reporting or other source of current income through the federal hub, or offers a third party service like WORK/TALX), New York remains interested in accessing a shared solution with the potential for shared/reduced costs among states and the FFE. New York also continues to be interested in accessing a current/reliable federal electronic trusted data source to verify: residency, employer sponsored coverage (ESI) and/or minimum essential employer sponsored coverage (ESI/MEC), and American Indian/Alaska Native status.

New York has not identified a trusted data source for these factors of eligibility, and has not yet seen a draft FFE business services definition (BSD) for ESI or ESI/MEC. New York has reviewed the Verification of Access to Employer Sponsored Coverage Bulletin dated April 26, 2012, and anticipates using a combination of methods outlined in that bulletin to verify ESI/MEC for all IA programs in 2014 and 2015. New York anticipates continuing to work with the FFE and other states to identify and agree on a shared, trusted source for ESI/ESI MEC that could more readily/easily facilitate employer reporting and where the costs could be lowered across multiple users.

New York is working to establish access to additional state data sources to enable more "real time" electronic verification against trusted data sources (to "ping" against data in real time, even where data may be for a past quarter or prior period), particularly with respect to sources of income. New York has begun discussions and is working on establishing/amending existing MOUs and data sharing agreements with several state agencies (E.g. Tax and Finance, Department of Labor) to facilitate this process. The near term priorities are on automating access to wage reporting data, unemployment income, Title II income data currently available through Bendex, new hire registry information, and state income tax data.

New York is preparing its verification plan to identify its hierarchy of data sources, with the goal of establishing an authoritative data source for each element/sub component of eligibility factors. New York would prefer to check only one trusted data source, and thereby avoid generating "discrepancies" irrelevant to eligibility that would nonetheless required Exchange administrative resources to resolve (e.g. where data from different sources is for different time periods).

For example, New York wants to query a database to check for incarceration status, rather than ask a direct question as incarceration will likely only apply to a small subset of individuals who might be seeking coverage for themselves through an Exchange. The State finds that its DOCCS (Department of Corrections) data source generally has the most updated, current information on the New York State prison population, and uses this data source today to support the Medicaid suspension process for inmates. New York would prefer to continue to use DOCCS as it does now, and depending on feedback received during its upcoming design review, plans to include use of DOCCS as the sole/authoritative data source for incarceration status in its verification plan. However, if use of the federal PUPS data source is required to verify incarceration status through the Federal Hub, New York would plan to use PUPS as the authoritative/best data source for federal prison incarceration verification, and DOCCS as the authoritative source for state prison verification.

The State wants to be able to display and return a trusted source for particular components of income (e.g. wages- wage reporting, UIB- unemployment income) to assist a consumer in constructing and validating their MAGI income. New York's approach envisions helping a consumer construct his/her household MAGI income only when the consumer attests that the IRS data for the household is not reflective of their

current/projected annual MAGI income, or when relevant IRS data is not available. New York is working on conforming language to align current Medicaid and CHP eligibility requirements to comply with the ACA and final Medicaid, Exchange and IRS guidance.

New York envisions one aligned annual income definition for all IA programs. New York's approach will define current/reasonably anticipated future income on an annual basis, and align that definition with the definition for projected annual income. New York additionally contemplates applying an aligned, end- to-end "reasonable compatibility" process to income eligibility determinations for all IA program.

New York's "reasonable compatibility" approach will enable application of rules (automated to the extent possible) to determine when an eligibility determination will be based on an attestation confirmed by a trusted data source, when the determination will be based on a data source with appropriate notice to a consumer, or when a further explanation or documentation may be required. This approach to annual income and reasonable compatibility is part of an overall effort to simplify and streamline the Exchange eligibility process for consumers, and to better support and enable New York's envisioned integrated Exchange eligibility determination by the Exchange for APTC/CSR, Medicaid, CHP and any BHP program. An aligned approach is particularly critical for a state like New York where the Exchange will conduct integrated eligibility determinations for enrollment in the appropriate IA program.

Finally, New York plans to leverage the federal identity proofing service offered by Experian, subject to confirmation of test results for low income populations. Experian provides questions for a consumer and verifies against data available for a consumer, enabling the Exchange to confirm the individual's identity. New York is additionally interested in the potential to leverage this service as a verification source for residency, to the extent that this process can be automated, is reliable, and is not cost prohibitive. We understand that residence address within the state/service area of the Exchange is an element of the identity proofing process contributing to the confidence score for establishing identity. The Exchange plans to utilize a business service to validate addresses as being correct addresses within the state/service area of the Exchange.

Section 3.7 & 3.8 Individual Eligibility Determinations + Capacity to Determine Eligibility for APTC and CSR

New Yorkers seeking health care coverage in 2014 will be able to apply for or buy health insurance, learn more about their options, and get assistance online, by phone, by mail, or in person. An individual will be allowed to "anonymously browse" for available health plans, utilizing a simple screener to give an approximate level of eligibility to inform their review of plan options (QHPs, Medicaid, CHP, BHP).

An individual who wants to purchase a QHP without subsidy through the Exchange will be required to qualify based on their citizenship/lawfully residing status, not being incarcerated (this will be verified by check "behind the scenes" per 3.7 b1 and 2), and residency in the state/service area of the Exchange.

Sections 3.7 b1 and b2 and 3.8 Integrated Eligibility Determinations

New York is taking an integrated approach to determining eligibility for all insurance affordability programs by developing an IT systems solution to process applications and determine eligibility for Medicaid (MA) for the MAGI population, Child Health Plus (CHP), the Advanced Premium Tax Credit (APTC), and any Basic Health Program (BHP) option that the state may offer. The NYS Health Benefit Exchange (Exchange) will provide a streamlined, consumer-centric application process that results in near real-time eligibility

determinations and automates processes to the maximum extent possible. This section first describes the online ("self-service") application process for an individual requesting financial assistance to obtain health care coverage, followed by a discussion of the envisioned "back end" eligibility determination support process for both on-line consumers and those submitting applications by mail or in person.

The first step in the application process, after creating an account with language preference and logging in, will involve a consumer building a profile of their household. Questions will be conditional and will elicit basic demographic information about the primary applicant (usually, but not necessarily, the account holder) and all individuals in his/her household, including name, date of birth, social security number, gender, and whether or not they are applying for health coverage. Questions will gather information about pregnancy and student status. Consumers will also provide information about familial relationships to the primary applicant and to other household members as well as anticipated tax filing status and relationships (filer, dependent) of all individuals in the household. Lastly, the application will collect information about the citizenship or immigration status for those household members applying for coverage. A question will be included regarding whether any member of the household has a disability or special health care need (e.g. long term care).

At this point in the application process, the NYS Health Benefit Exchange will have the data elements needed in order to validate social security number and verify citizenship or immigration status from the Federal Data Hub. While the information is being validated and verified by the Hub[1], the application will continue to collect residency information as well as information about race/ethnicity and American Indian/Alaskan Native status from the consumer. It will also do some verification checks in the "background"- for incarceration status, and for enrollment in other public minimum essential coverage (e.g. Medicaid, CHP, Medicare, Veterans).

The consumer will then continue through the application process by attesting to or constructing his/her current projected annual household income. The Exchange will first query the Federal Data Hub for the consumer's federal income tax information and display that information to the consumer. The consumer will either attest that the IRS amount represents his/her projected current annual income, including reasonably anticipated future income ("income"), or will indicate that it does not. If the consumer attests to this income, he/she skips to the third step (ESI MEC, below).

If the consumer states that the IRS data is not reflective of his/her income, then the consumer is given the opportunity to construct the household's income by individual and by income type (i.e. wages/earnings, unearned income, "other"). New York is planning to use state and other federal data sources, such as NYS Department of Labor (UIB), NYS Department of Tax and Finance (wage reporting, state tax), SSA (Title II retirement income), both to display to a consumer to help them construct their MAGI income, as well as to electronically verify income sources identified by the consumer.

The third step in the application process is to collect information about other minimum essential coverage (MEC) or available third party health insurance, including employer-sponsored coverage. Information will be collected to determine availability/affordability of MEC or whether coverage is cost-effective in terms of potential Medicaid program coverage/premium assistance payments. For those individuals who indicate they have access to or are enrolled in employer sponsored health insurance, questions will additionally be included regarding the contact information and employer identification number(s) for his or her (or related individual's) employer(s), whether the applicant or related individual is employed on a full-time basis,

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[1] Decisions regarding whether/to what extent and at what points in the flow the Exchange will employ individual vs composite calls to the federal data hub are pending/evolving as system development proceeds.

whether the applicant's or related individual's employer provides minimum essential coverage, and if so, the required employee contribution for the second lowest cost plan offered by the employer.

At any point in the application process, information provided by consumers that is not/cannot be verified through the Federal or State Data Hub or that does not meet the reasonable compatibility guidelines set forth by the NYS Health Benefit Exchange will be given the opportunity to provide documentation to satisfy the eligibility criteria for IAPs. Notices will be provided and appropriate clocks (e.g. 90 days from receipt of notice for citizenship/immigration status) will be set for consumers to provide documentation.

At this point in the application process, the Exchange will have collected all of the information needed in order to perform an eligibility calculation. Eligibility will first be determined for Medicaid and Child Health Plus based on Modified Adjusted Gross Income. If the individual is not eligible for Medicaid or Child Health Plus, then eligibility will be determined for Advanced Premium Tax Credit. Based on the results of the eligibility determination, individuals will move forward to select and enroll into a health plan. If the individual is eligible for APTC, the maximum advance premium tax credit will also be calculated and displayed to the consumer. (see 3.12 b)

The Exchange will provide integrated application assistance for consumers applying online as well as those applying by mail or by phone. New York intends to centralize the back end operations for eligibility determinations for all individuals receiving an APTC and for new enrollments in Medicaid and Child Health Plus for the MAGI population. The centralized eligibility and enrollment processing unit will be staffed by a combination of state and vendor staff and will perform eligibility and enrollment operations for both the Individual and SHOP portals, using the new IT systems solution, in a manner designed to ensure consistency of outcomes based on self-service and other channels/forms of assistance. In addition, the State will operate a Call Center staffed with customer service representatives that will assist consumers over the phone and via co-browsing sessions, to help ensure high quality customer service and consistent outcomes. The call center representatives will also assist consumers in understanding what health plans are available and selecting a health plan based on their program eligibility and their personal preferences. Call center representatives will also educate consumers on the requirements associated with enrolling in a QHP with/without subsidy.

This centralized approach to providing application assistance and renewal processing seeks to simplify the process for a consumer and minimizes the transfer of applications among agencies. The Exchange will utilize a hybrid vendor/state staff model to renewing coverage for IAPs determined through the Exchange. Most renewals will be processed by a centralized processing unit which will handle renewals automated for consumers renewing online and provide back end support to those renewing by phone or by mail. In addition, some local departments of social services will continue to handle MAGI mail in renewals, utilizing the new Exchange system.

New York is continuing its progress towards centralizing and automating Medicaid eligibility and enrollment functions, but it is anticipated that local districts will continue to accept and process applications for non-MAGI Medicaid, for the next several years, and potentially continuing thereafter, subject to ongoing discussions and contracting arrangements. New York continues to work through the communications and coordination requirements for processing mixed MAGI/non-MAGI Medicaid households, as it transitions from existing legacy eligibility systems to an integrated Exchange system of record for all health coverage programs, including MAGI and non-MAGI Medicaid.

Section 3.7c SHOP eligibility

For a business to be determined eligible to participate in the SHOP exchange, it must be a valid business, attesting to employing 50 or fewer employees and to offering health insurance to all full time employees. New York State plans to retain the 50 employee limit at least through 2014. The business must have its primary office or a work site in New York State. The Exchange is examining several state data sources to verify small employers, with a decision anticipated soon.

An eligible employee is anyone to whom a qualified employer makes the offer of insurance as indicated on the roster of employees submitted by the employer. An employee will be able to purchase health insurance through the exchange from the plans preselected by their employer.

Section 3.7 d Applications from other agencies

New York does not envision MAGI applications being transferred to the Exchange from other agencies. Rather, all MAGI applications would be centralized through the integrated system, submitted through the on-line portal, or if mailed or submitted by phone or in person, input into the new system, as outlined in 3.3.

Section 3.9 Applicant and Employer Notices

The Exchange is developing the capacity to independently send notices, as necessary, to applicants and employers pursuant to 45 CFR 155 Subpart D that are in plain language, address the appropriate audience and meet content requirements.

The Exchange will generate notices, to the maximum extent practicable, through an automated process in regards to eligibility and enrollment determinations, appeals, and other required communications pertaining to Medicaid for the MAGI population, Child Health Plus, the Advanced Premium Tax Credit, and any Basic Health Program (BHP) the state may determine to offer. Notices will be created dynamically and will be stored in the Exchange content management system. New York will be working with a health literacy consultant to develop the content of required notices for applicants and employers in plain language, and plans to contribute to and leverage anticipated work by Manatt Health Solutions (Manatt) on model notices through participation in the federal/state Coverage Learning Collaborative. As New York develops and runs iterations of various “end to end” scenarios/use cases through its Eligibility and Enrollment sprints, and as the Exchange architecture team concurrently develops a notice service for the Exchange across all sprint tracks, New York is building on initial work by Oregon to identify all the junctures along the application and enrollment process where notices are either legally required or desired from a user experience perspective. This work is being done and will be shared with other states under the auspices of the bi-weekly federal/state Income Verification Workgroup, as well as through the Exchange Innovator Collaborative (formerly the Early Innovator Collaborative). New York is developing the capacity to store and make notices available on an individual’s online account, and plans to mail any legally required eligibility notices to an individual/household only in those cases where the application filer has not opted to receive electronic notices in lieu of mail.

Section 3.10 Individual Responsibility Determinations and Payment Exemptions

The Exchange is developing an automated approach, to the maximum extent possible, to elicit information from a consumer seeking an exception determination from the individual responsibility mandate or payment exemption, and to provide an opportunity for appeal. The consumer will be provided with the option to make such a request, and drop down menus will provide available options (e.g. religious

objection), with appropriate options to verify via attestation or documentation, if unable to verify against a trusted data source electronically. Work continues on defining the requirements and processes for the mandate/payment exemption process.

Section 3.12 Individual QHP Plan Selection

The Exchange plans to rely heavily on leveraging plan comparison and selection functionality from Hcentive (a COTS system purchased by CSC) including elements from the UX 2014 that are being reflected in an updated version of the application. Depending on a consumer's eligibility, appropriate health plan options (Medicaid, CHP, Qualified health plans) will be presented to the consumer. Plan selection will be customized to the individual's eligibility and personal preferences. Consumers will be able to view plans based on filtering criteria, such as metal level, cost, quality, and provider network. This section will also include functionality for a consumer to change the amount of their advanced premium tax credit and recalculate their premium costs. Once a consumer selects a plan for each person applying for coverage an enrollment transaction (834) will be generated and sent either to the plan (e.g. QHP) or the state MMIS system (e.g. Medicaid). The consumer will receive a confirmation message indicating that their information has been sent to the plan they selected for enrollment, and directing them to any "next steps" needed (e.g. payment of premium to the health plan)

3.12a Individual QHP Plan Processing

Hcentive has the capacity to generate an 834 enrollment transaction and receive a confirmation. The functionality to receive and reconcile information from an issuer 834 is being developed. New York will be working with health plans and other experts to discuss standards, required data elements and implement the new ACA 834 transactions (5010).

3.12b Capacity to Compute APTC

The Exchange plans to assist a consumer is constructing their MAGI household and income as outlined in 3.7/3.8 and 3.5, in order to be able to compute and determine eligibility for APTC and relevant cost sharing. The Exchange will provide the estimated applicable maximum advance premium tax credit to a consumer for a determination as to how much of the APTC the consumer seeks to have applied, and will calculate appropriate estimated cost sharing reduction based on the applicable second lowest cost silver plan for that individual/household to the consumer. This information will be provided to the consumer to enable them to utilize it as part of plan selection, including a tool to assess the impact of electing receipt of various levels of APTC

3.12c Capacity to Reconcile APTC and QHP plan selection

The Exchange plans to reconcile and report, as appropriate, APTCs based on reported changes in household circumstance or income that affect eligibility or plan selection.

3.12 d SHOP QHP Plan Selection

The Exchange plans to rely heavily on leveraging plan comparison and selection functionality from Hcentive. An employer will be able to select a level of coverage and offer all plans within that level to employees as well as other options in plan choice for employees, with decision support tools including a premium calculator. Employers will have the ability to filter plans based on many factors including but not limited to region, cost, and metal levels. HCentive also has a broker module, and based on current

practices, it is anticipated that brokers will provide assistance to many of the SHOP employers. An employee will be able to access plans selected by the employer and further filter according to factors such as cost and provider. The display and sorting of insurance plans for employees will parallel the display in the Exchange for individual consumers.

3.12 e SHOP QHP Plan Processing

hCentive has the capacity to generate an 834 enrollment transaction and receive a confirmation. The functionality to receive and reconcile information from an issuer 834 is being developed. New York will be working with health plans and other experts to discuss standards, required data elements for the new ACA 834 transactions (5010).

Section 3.13 Reporting

The Exchange will have the capacity to generate electronic reporting of results of eligibility assessments and determinations, and provide associated information to HHS, IRS as required for reconciliation of enrollment information that affects APTC calculations, and with respect to individual mandate exemptions and determinations regarding affordability of ESI minimum essential coverage (MEC), with respect to employers with an employee qualifying for an APTC on the basis that such insurance was not MEC.

Section 3.14 Pre-Existing Conditions Insurance (PCIP) Transition Plan (New York Bridge Plan)

New York plans to transition its PCIP **(Bridge Plan)** enrollees to appropriate Exchange or other coverage options through a process that, at a minimum, will include in person assistance and customer service available by phone by October 2013, in advance of the December 31, 2013 anticipated transition date. New York will provide at least three (3) mailings to Bridge enrollees with information about the end date of coverage, enrollee rights, and providing information for assistance or questions, as well as information about potential Exchange QHP and other options. New York will additionally work to ensure that all required coverage transition/ care coordination requirements are met, along with any other applicable provisions of state insurance law.