Wakely
Consulting Group

Business Plan of Operations

New York Health Benefit Exchange

Support for this resource was provided by New York's Exchange Planning Grant and a grant from the Robert Wood Johnson Foundation's State Health Reform Assistance Network program.

June 2012

Wakely
Consulting Group

Impact of Executive Order to Establish New York's Health Benefit Exchange (Supplement to Business Plan of Operations)

June 2012

INTRODUCTION

On April 12, 2012, Governor Andrew Cuomo signed Executive Order 42[1] to establish the New York Health Benefit Exchange. In doing so, New York joins fourteen other states as of April 30, 2012 who have established health benefit exchanges in accordance with the Affordable Care Act (ACA) of 2010. Thirteen states established their exchanges through legislation while New York and Rhode Island utilized an executive order to do so.[2]

Exchange establishment is a critical step in positioning the State of New York to achieve Exchange certification status by demonstrating to the federal government by January 1, 2013 that its' Exchange will be able to begin accepting applications by October 1, 2013, and be fully operational by January 1, 2014. Failure to adequately demonstrate operational readiness would require New Yorkers to participate in a federally-facilitated Exchange, which is not well-suited to accommodating the very diverse needs of the country's third most populous state. Even within New York there are many regional differences in the insurance market for individuals that are best addressed by a state-based Exchange that understands the health insurance needs of different ethnic, cultural and language-based constituencies. A state-designed Exchange can better optimize the development of health plans to be offered, as well as select insurance carriers with a strong presence in and commitment to New York State. The intersecting business and health care interests of small employers are also better served by a Small Business Health Option Program ("SHOP") that is tailored to the needs of New York business owners and their employees.

Further, the establishment of the Exchange by executive order will impose no cost on the State as both the development and operational costs will be funded entirely with federal funds until January 1, 2015, at which time the Exchange will be wholly self-funded, utilizing no state or county taxpayer dollars.

In 2011 Wakely developed for New York a Business Plan of Operations Report to provide a high level overview of the Exchange business functions that must be established, the type of work that must be undertaken by Exchange staff and a relative timeline and chronological order for standing up its Exchange. This document, finalized in early 2012, is centered on the assumption that the Exchange would be established through legislation as a public corporation. Now that the Exchange has been created through an executive order, certain assumptions and operational considerations have changed and it is the intent of this supplemental document to only identify and discuss those business operations impacted by this change (see Table #1).

Overview of Business Requirements and Core Work Processes

The work to establish an exchange and achieve certification can be divided into 5 Business Requirements and 17 Core Work Processes. The business requirements most impacted by establishing the Exchange through an executive order are identified below. We take each of these core work processes in turn and comment on how each is impacted by the establishment of New York's Exchange by executive order.

[1] See Appendix A

[2] http://www.statehealthfacts.org/comparemaptable.jsp?ind=962&cat=17#notes-1

Table #1

Business Requirements	Core Work Process	Impacted by Establishment of Exchange by Executive Order
I. Exchange Set Up	1. Governance and Oversight	Yes
	2. Internal Administration	Yes
	3. Financial Management	Yes
II. Core Systems	4. Eligibility Verification	No
	5. Premium Tax Credit and Cost Sharing Subsidy Calculator	No
	6. Website (and Decision-Support Tools)	No
	7. Enrollment & Billing	No
	8. Customer Service Operations (Call Center)	No
	9. SHOP-specific Processes	No
III. Communication & Outreach	10. Outreach & Marketing Plan	No
	11. Navigator Program	No
	12. Broker Program	No
IV. QHP Certification	13. QHP Certification	No
	14. Plan Rating System	No
	15. Risk Adjustment	No
V. Regulatory Compliance & Reporting	16. External Reporting	No
	17. Mandate Determination & Appeals	No

Exchange Set Up

During exchange set up, the focus is on establishing the legal and physical entity that is the exchange, including the governance structure. The ACA gives states several options for how exchanges can be structured, one of which is to establish the exchange within an existing state agency. Governor Cuomo's executive order complies with the ACA by establishing the NY State Health Benefit Exchange within the Department of Health (DOH). The order further stipulates that the DOH, in conjunction with the Department of Financial Services (DFS) and other state agencies, will take all necessary steps to effectuate the Exchange and expedite its ability to perform all necessary functional requirements. From a business operations perspective, the establishment of the Exchange by executive order (EO), rather than as a public corporation, most significantly impacts the core work processes within the exchange set up business requirement.

Governance & Oversight

The EO both establishes the Exchange within the DOH and requires the Exchange to "convene regional advisory committees, consisting of consumer advocates, small business consumer representatives, health care providers, agents, brokers, insurers, labor organizations, and any other appropriate stakeholders, to provide advice and make recommendations about relevant regional factors."[3] The EO further obliges the Exchange to provide opportunities for public input on such matters.

The exchange will need to move quickly in order to continue to solicit public comment and meet the aggressive deadlines established by the ACA. Activities of the new Exchange will include: (i) the evaluation of policy issues

[3] Executive Order No. 42: Establishing the New York Health Benefit Exchange. New York Governor Andrew Cuomo. April 12, 2012

and ongoing federal guidance and rulemaking; (ii) assessing and developing exchange design elements; and (iii) implementation of the myriad of systems, processes and functions required of the exchange. By placing the exchange within the Department of Health (DOH), New York will be able to move quickly in developing the governance and oversight over what is planned to be a fast-growing organization.

As an existing state agency, the DOH will not need to spend the time or resources to appoint a Board of Directors (BOD) and related BOD policies and procedures such as conflict of interest rules, organizational bylaws, legal support, and development and appointment of BOD Subcommittees. Rather, the DOH can leverage the existing exchange interagency planning team, regional advisory committees as called for in the EO, and its existing processes and protocols for decision-making to address promptly the multi-faceted needs of the exchange. The DOH has years of experience managing the State's public health insurance programs and has strong working relationships with DFS which is the State's regulator of the commercial insurance market and other important state agencies impacted by the implementation of an exchange. In operating the exchange through the DOH, the institutional experience, competency, and knowledge base of health insurance inherent in the DOH, along with the experience of the DFS will allow the state to maintain all the positive attributes of organizing the exchange as if it were a public corporation, but on a much faster timeline. The EO should cut months from the implementation timeline relative to governance and oversight activities, without compromising any of the necessary public input, or decision-making processes contemplated as a public corporation.

Internal Administration

Basing the Exchange within an existing state agency enables the entity to efficiently leverage established administrative systems and procedures. At least four other states (Vermont, Rhode Island, West Virginia and Utah) have also chosen to house their exchanges within state government.[4]

New York will now not be required to address the many administrative-type decisions common to start-up organizations that would have been confronting the exchange as a public corporation. Acquiring a tax identification number, purchasing liability and property insurance, or developing and procuring an employee benefits package is not necessary. Locating a physical location, including the time consuming process of negotiating rent can be averted. Additionally, the development of human resource policies and procedures, as well as designing and implementing a system of internal control is now a matter of customizing existing DOH infrastructure rather than developing new processes and procedures. This will allow for an efficient set up of exchange internal administration, and mitigate the business risk inherent in building such systems from the ground up.

While there is great efficiency to be gained from the administrative processes and systems, the lack of excess capacity within the DOH, as well as other state agencies will require the hiring of a number of new personnel for the exchange. It is highly probable that the number of senior executives contemplated under the public corporation model will not be needed, however, due to the need for additional subject matter expertise and state resource constraints, most of the positions below senior executive will most likely be necessary. We also contemplate that the average salary levels of the exchange will be slightly less as part of a state agency than a public corporation.

[4] "Establishing Health Insurance Exchanges: An Update on State Efforts." Focus on Health Reform. The Henry J. Kaiser Family Foundation. July 2011. http://www.kff.org/healthreform/upload/8213.pdf

Financial Management

Managing revenue and expenses will be one of the most critical functions performed by the Exchange, regardless of how the Exchange is established, structured or governed. As a public corporation, many of the financial systems would have been developed by the exchange creating yet another significant implementation and resulting business risk for the state. However, as part of the DOH, the exchange can now take advantage of a number of financial management functions already being performed. For example, establishing a banking relationship, including the development of the critical purchasing and accounts payable system, along with appropriate cash management processes and protocol is now being delegated to the DOH. This will allow the exchange to utilize existing systems and best practices of a well-established state agency for business areas that present a high degree of business risk and can often times not perform at a high level for startup organizations balancing many time-sensitive initiatives.

Other areas in which the DOH will be helpful to the exchange is the development of an accounting and financial reporting structure. While there may need to be some level of customization to the chart of accounts and management reports for certain unique business functions of the exchange, many of the transactions to be processed by the exchange should be easily handled by the DOH systems.

While the accounting system currently in use by the DOH may be able to handle exchange transactions, the state should continue to assess, as part of its larger IT exchange platform procurement, the need for an accounting system purchased for the unique aspects of the exchange. Additionally, the DOH will not likely have the requisite system for premium billing, especially for the SHOP exchange. Therefore, the state should continue to explore market options in both of these areas despite the establishment of the exchange in an existing state agency.

SUMMARY

The EO establishing the Exchange within the DOH will have a significant positive impact on the administrative set up of the exchange. In fact, the advantages of establishing the New York Health Benefit Exchange on April 12, 2012 by Executive Order No. 42 will allow New York to more quickly transition the exchange to operational status from an administrative perspective, and allow for the exchange staff to operate efficiently more quickly and to focus more specifically on the many other core work processes requiring significant resources and effort in order to meet the ACA timelines.

State of New York

APR 12 2012

Department of State
Secretary of State

State of New York

Executive Chamber

No. 42

EXECUTIVE ORDER

ESTABLISHING THE NEW YORK HEALTH BENEFIT EXCHANGE

WHEREAS, the implementation of a Health Benefit Exchange and other reforms in New York will: (1) result in lower premiums for individuals and small businesses; (2) allow individuals and small businesses purchasing coverage through such Exchange to receive $2.6 billion in federal tax credits and cost sharing subsidies; and (3) provide one million additional New Yorkers access to affordable, comprehensive health insurance, reducing the percentage of New Yorkers who are without health insurance;

WHEREAS, a state that chooses to operate its own Exchange must demonstrate to the federal government, by January 1, 2013, that its Exchange will be able to begin accepting applications by October 1, 2013, and will be operational by January 1, 2014, and if the state does not demonstrate operational readiness of its own Exchange, its residents will be required to participate in a federal Exchange;

WHEREAS, the State of New York is best positioned to: (1) understand the ramifications of operating an Exchange within New York's commercial insurance market; (2) consider the unique regional and economic needs of the State's individual and small business health insurance markets; (3) account for the diversity of its population, with its ethnic, cultural and language differences; and (4) decide what benefits will be provided to enrollees in the Exchange, which health plans can participate in the Exchange, what rules should apply to the marketing of products by health plans, and how to operate the Small Business Health Option Program ("SHOP") for small businesses;

WHEREAS, the Affordable Care Act requires an Exchange to evaluate the eligibility of individuals for Medicaid and other public health coverage and enroll them if eligible, meaning that it will be essential to coordinate the operations of the Exchange with the State's administration of these programs;

WHEREAS, the taxpayers of this State subsidize the costs associated with care for the 2.7 million New Yorkers without health insurance, who frequently forego preventive care and other needed treatment, putting them at risk of being sicker throughout their lives and dying sooner than those who have health insurance, which diverts funds from other public uses and costs state and county taxpayers more than $600 million annually just to pay for a portion of the services rendered by hospitals to people without insurance;

WHEREAS, New York's uninsured working families often earn too much to qualify for public health insurance, but not enough to purchase coverage that costs, on average, over $1,200 per month for an individual and $3,450 per month for a family of four;

WHEREAS, small businesses, without assistance, cannot afford to purchase health insurance coverage for their workers, nearly 800,000 of whom have lost employer-sponsored coverage over the last decade, and thus face a major competitive disadvantage that inhibits their ability to grow, create jobs and otherwise support the State's economic development;

WHEREAS, the costs associated with care for the uninsured are shifted through increased premiums to those individuals and groups that purchase health insurance coverage, causing working families with health insurance to pay $800 more in premiums on average each year;

WHEREAS, the development and operation of an Exchange in New York will impose no cost on the State, but will be funded entirely with federal funds until January 1, 2015, at which time the Exchange will be wholly self-funded, meaning that no State or county taxpayer dollars will be used for such purposes; and

WHEREAS, it is therefore critical that the State of New York establish and operate its own Exchange, and that it do so expeditiously;

NOW, THEREFORE, I, Andrew M. Cuomo, Governor of the State of New York, by virtue of the authority vested in me by the Constitution and the Laws of the State of New York, do hereby order as follows:

1. There is hereby established within the Department of Health, in conformity with the Affordable Care Act, the New York Health Benefit Exchange (the "Exchange"). The Department of Health, in conjunction with the Department of Financial Services and other state agencies, shall take all necessary steps to effectuate the Exchange, and expedite its ability to perform those functions necessary to carry out the requirements and serve the goals of the Affordable Care Act.

2. The Exchange shall, among other things, facilitate enrollment in health coverage and the purchase and sale of qualified health plans in the individual market in this state, and enroll individuals in health coverage for which they are eligible in accordance with federal law.

3. The Exchange shall, among other things, take such actions necessary to enable eligible individuals to receive premium tax credits and cost-sharing reductions and to enable eligible small businesses to receive tax credits, in compliance with all applicable federal and state laws and regulations.

4. The Exchange shall, among other things, enter into agreements with appropriate entities, including but not limited to federal, state and local agencies, to the extent necessary to carry out its duties and responsibilities, provided that such agreements incorporate adequate protections with respect to the confidentiality of any information to be shared.

5. The Exchange shall, among other things, convene regional advisory committees, consisting of consumer advocates, small business consumer representatives, health care providers, agents, brokers, insurers, labor organizations, and any other appropriate stakeholders, to provide advice and make recommendations on the establishment and operation of the Exchange, including recommendations about relevant regional factors, and shall provide opportunities for public input on such matters.

6. The Exchange shall, among other things, become financially self-sustaining by January 1, 2015, as required by the Affordable Care Act.

7. Nothing in this Order shall be construed to duplicate, preempt, supersede, limit or otherwise restrict the statutory authority, duties and functions of the Department of Health, the Department of Financial Services or any other agency of this State.

GIVEN under my hand and the Privy Seal of the State in the City of Albany this twelfth day of April in the year two thousand twelve.

BY THE GOVERNOR

Secretary to the Governor

Wakely
Consulting Group

Business Plan of Operations

New York Health Benefit Exchange

February 2012

Table of Contents

PREFACE

At the time this paper was finalized, exchange establishment legislation had not been enacted. As several activities within this document are predicated on the passage of establishment legislation and subsequent appointment of a Board of Directors, the hiring of an Executive Director and other senior leadership to run the exchange, an assumption needed to be made as to when such legislation might be likely to pass. A date of April 1, 2012 was utilized for purposes of this report. Should passage occur before or after this date, or if the governance model is different than that used to develop this report, dates and certain activities need to be re-evaluated. The use of timeline dates prior to April 1, 2012 suggest that the work can be initiated by current and to be hired exchange staff (including part-time assistance of state employees) operating under the multi-agency exchange planning team structure. These suggestions were based on reasonable assumptions given the current operating environment and the impending dates established by HHS to establish an exchange. New York is encouraged to consider these assumptions accordingly.

INTRODUCTION

This paper is intended to provide New York State with a high level overview of the business functions that must be established, the type of work that must be undertaken by exchange staff, and a relative timeline and chronological order for standing up its Health Benefit Exchange. Drawing on its experience in establishing the Massachusetts Health Connector, knowledge and interpretation of the ACA and pending state exchange legislation (A-8514/S-5652 and New York's 2012-13 Executive Budget), and exchange planning and implementation in other states, Wakely has identified 5 business requirements and 17 core work processes necessary for exchange implementation. This does not represent the entire list of tasks and responsibilities that the exchange will need to complete prior to 2014, but it does provide sufficient detail to allow key stakeholders, interim exchange staff and eventual permanent exchange staff with a "blueprint" of the major business operation functions critical to successful implementation.

In addition to assisting state leaders with a baseline understanding of the business operation functions an exchange must develop, including start up activities required of a newly created public authority, future uses of this report include:

1. A starting point for the development of more detailed project plans for each core work process,
2. Identification of potential resource "bottlenecks" that may require project prioritization or resource augmentation for timely completion of all tasks,
3. Identification of key dependencies, and
4. An order of priority for the type of expertise and skill sets of for the early hiring of exchange personnel.

Overview of Exchange Elements and Core Work Processes

New York's Progress to Date

New York has taken significant steps in implementing the Affordable Care Act (ACA) and establishing a state-based health insurance exchange. A few of the more noteworthy accomplishments are:

1. Requesting and receiving an exchange planning grant to perform initial analyses and hiring of exchange-focused state personnel and consultants.
2. The state's selection as an Early Innovator grant recipient.
3. New York is one of ten states awarded technical assistance through the State Health Reform Assistance Network, a RWJF funded initiative.
4. The creation of an interagency exchange planning team consisting of part-time staff from the Governor's Office and State Departments of Health and Financial Services working with staff funded through federal exchange planning grants.
5. The successful launch of a statewide consumer assistance program.
6. Receiving a Level One Establishment grant to continue to build on the exchange planning process and to further study key exchange design elements, market analysis, and the hiring of necessary resources to begin in earnest the implementation phase of the New York Health Benefit Exchange.

In addition, New York has commissioned through key funders a number of consultant led studies on exchange development, policy considerations and strategic choices. The exchange establishment legislation passed by the Assembly in June 2011 and subsequently included in the 2012-13 Executive Budget, requires the completion of a number of additional studies which will further inform the design, development and implementation of an exchange that fully embraces New York State's longstanding commitment to the availability of affordable, quality care to all residents. In November, New York released an RFP for six such consultant-led studies on the following topics: essential benefits, benchmark benefits, insurance market issues, purchasing role of the exchange (i.e., active/passive), role of Healthy New York/Family Health Plus Employer Partnership, and role of Health Savings Accounts (HSAs) in the exchange.

This business plan of operations is intended to help the state transition from planning the exchange to building it by outlining the systems and processes needed to realize the type of exchange New York intends to build, and then discussing in detail the core work processes required to put these elements in place. Due to the complex nature of the exchange, there is significant overlap and/or interdependency between these systems and processes, and, where appropriate, this document will highlight these interdependencies.

HHS/CCIIO identified, in its Funding Opportunity Announcement (FOA) dated January 20, 2011, a number of business operations of the exchange. The areas identified were addressed in the state's application for establishment grant funding. Although there is significant overlap between the FOA identified exchange business operations and this business plan of operations, we have not oriented our business plan of operations around this FOA. However for informational purposes, we have provided a table which identifies where in the attached timeline the exchange business operation functions identified in the FOA would be addressed.

Principles for New York's Health Benefit Exchange and Business Plan Implications

As outlined in stakeholder presentations made in the spring of 2011, New York's principles for a health benefit exchange focus on a model of providing affordable, comprehensive coverage options with a strong consumer-orientation, transparency and accountability, and perhaps most important of all, a requirement that "it must work."

Achieving the components of this vision will require the development or acquisition of robust IT systems and/or processes over the next twenty months, as well as the hiring of knowledgeable staff, and coordination with other government agencies on the state and federal level. For example, providing clear, easy-to-use consumer information on participating plans that compete on price and quality will require expertise on carrier procurement and negotiation as well as the development and maintenance of a high-performing, state-of-the-art web portal. Achieving a consumer oriented experience for New York's highly diverse population will require, among other things, communications and outreach, a strategically executed navigator program and a well-structured, flexible, and culturally sensitive appeals process to adjudicate individual responsibility certificate of exemptions and eligibility determination appeals. The table below provides additional detail on the implications for realizing New York's vision in terms of specific exchange components that need to be developed. It also links these elements to the Core Work Processes the state will need to undertake to put these components in place. Clearly, achieving the four abiding principles for New York's Health Benefit Exchange will require the successful and timely execution of each core work plan process.

Principles for New York Health Benefit Exchange	Core Work Processes
1. Promote affordable, comprehensive health insurance options • Access to federal subsidies • Plans compete on price and quality, not risk selection • Opportunity to pool purchasing power	▪ **Premium Tax Credits** ▪ **QHP Certification** ▪ **Plan Rating System** ▪ **Risk Adjustment**
2. It must be consumer-oriented • First class consumer experience • Easy to navigate • Assistance for questions and problems • No wrong door • Attracts small business	• **Website** • **Customer Service Operations** • **SHOP-specific Processes** • **Eligibility Verification** • **Outreach & Marketing Plan** • **Navigator Program** • **Broker Program** • **Enrollment, Billing & Collections**
3. It must be transparent and accountable • Information publicly accessible • Opportunity for stakeholder input • Subject to reporting, audits and review • Ethics considerations (e.g., conflicts, gifts, post- employment)	• **Governance & Oversight** • **Internal Administration** • **Financial Management** • **Outreach & Marketing Plan** • **External Reporting** • **Mandate Determination & Appeals**
4. It must work • Short timeframe: operating by late 2013 • Needs to be flexible	• **All of the above**

The balance of this document will discuss in greater detail the elements of the exchange necessary to meet federal requirements as well as to achieve New York's vision for the exchange and the core work processes and timeline required to develop these elements.

Overview of Exchange Elements and Core Work Processes

The work to establish an exchange and move towards full implementation by 2014 can be divided into 5 Business Requirements and 17 Core Work Processes. While there is a considerable amount of overlap and interdependency between these processes, for ease of discussion and sequencing, they can be grouped into five categories which occur in rough chronological order: Exchange Set Up, Core Systems, Communication & Outreach, QHP Plan Management, and Regulatory Compliance & Reporting.

BUSINESS REQUIREMENTS	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 15. Risk Adjustment
V. Regulatory Compliance & Reporting	16. External Reporting 17. Mandate Determinations & Appeals

A multitude of activities, many concurrent, will need to be performed to establish the exchange. While formal establishment of the exchange and its governance structure through legislative action is the most desirable path to operationalizing many of these business planning requirements, New York is utilizing an interagency planning team established to oversee the Early Innovator and Establishment grants to actively proceed with building out the exchange. This work is being led by the Governor's office with part-time assistance from either agency staff at the Departments of Health and Financial Services or staff hired with the exchange planning grants. Additionally, an IT Project Office has led exchange IT planning, design and development activities, and directed the RFP to procure a

Systems Integrator who will be responsible for development of the exchange's core systems, including its eligibility verification, website, enrollment & billing and premium tax credit platforms. The System Integrator must also ensure that SHOP-specific processes are considered for all core systems. These "first order" vendor procurements must be completed as soon as possible to meet the tight timeframes associated with the Early Innovator grant requirements and the end of year 2012 operational "ready" date established by HHS. In November, HHS released a draft certification application and New York must submit this application during the fall of 2012 and demonstrate operational readiness through both virtual and on-site readiness reviews. The application process requires substantive demonstration of NY's expected ability to stand up the exchange in time for open enrollment which begins on October 1, 2013 for a January 1, 2014 effective date of coverage.

During exchange set up, the state will also be focused on establishing the legal and physical entity that is the health benefit exchange, including finalizing the formal governing structure through the pending legislative action, locating office space, and establishing the financial and administrative infrastructure and oversight processes needed to administratively run the exchange. "Second order" procurements will follow, including those for a marketing vendor and for the selection of navigator grantees, which will parallel efforts needed to select QHPs, including the development of a risk adjustment methodology and the procurement of the QHPs themselves. Finally, as full implementation draws closer, the Exchange will need to focus on the establishment of an external reporting package, including metrics relevant to the operations of the exchange, regulatory compliance reporting, certificates of exemption from the individual responsibility requirement and eligibility determination appeals functions required to meets its consumer protection and regulatory responsibilities.

Business Requirement I: Exchange Set Up

Overview

In order for the exchange to meet the aggressive deadlines established by the ACA, evaluate policy issues and ongoing federal guidance and rulemaking, assess and develop exchange design elements, and implement the myriad of systems, processes and functions required of the exchange, exchange management will need to move quickly in developing the administrative infrastructure necessary to accommodate what is planned to be a fast-growing organization.

To do this, it is important for New York to secure passage of the exchange enabling legislation at the earliest possible opportunity. The proposed legislation would establish the New York Health Benefit Exchange as a public benefit corporation, managed by a Board of nine directors, including two ex officio members (Superintendent of the Department of Financial Services and the Commissioner of Health). Recommendations on the appointed board members will occur within thirty days of passage of the legislation and the first meeting of the board will take place within fourteen days of the final appointment. Only after the Board is in place can the important first step of hiring an Executive Director and other senior leadership take place, and full time permanent leadership is critical to operationalizing the business plan. Given the aggressive timelines of the major tasks in the business plan associated with standing up an exchange that is capable of accepting the first application for health insurance coverage as early as October 1, 2013, it is imperative that the State secure passage of the enabling legislation and begin the Board appointment and staff hiring process as quickly as possible. Additionally, the state might consider a preliminary search process for Executive Director that begins to recruit and vet candidates before the Board is being appointed, and current exchange staff should initiate as many of the internal administration set-up tasks marked with early dates as is feasible. Even in the scenario of April 2012 passage, the first board meeting might not be until June or July. At that point, the Exchange Certification Application process, as described in HHS' November 10, 2011 proposed application, begins one or two months later and the need for a fully tested and operational exchange is only 15 months away. While awaiting passage of the formal governance structure, New York, through the interagency planning team, must continue to move forward with exchange planning and development for both business and IT components. Once the formal governance structure is established, the ongoing work can be transitioned over to the newly established governance framework.

Once an Executive Director is appointed, it is important to begin to focus immediately on the development of the organizational infrastructure necessary to complete the numerous tasks ahead. Based on the expected size of the New York exchange and the inherent complexity of starting a new insurance "store" from the ground up, it is not unreasonable to assume that a very fast ramp up of personnel in a short time span is required. This will necessitate that exchange leadership consider the long term implications of initial, early decision-making in areas such as physical office space, employee benefits, company policies and procedures, and financial management and reporting systems.

Bringing on the necessary permanent staff to begin to develop critical internal administration functions will be the first priority for the Executive Director and existing senior staff currently working on exchange implementation. The initial hires, using establishment grant funding, should be in the finance area. It would be prudent to expect that initial hiring plans include a Chief Financial Officer, Budget Manager, an Accounting Manager, one accountant, and an office manager to be brought on board in the June to August 2012 timeframe (most likely using funds requested in the December 2011 Level 1 Establishment grant). The focus for both current exchange staff and the permanent staff to be hired once the Executive Director is in place should be as follows:

1. As soon as possible, existing staff or the newly hired financial staff should begin the process of acquiring physical space for the exchange. Although less than ideal, should the expected timeframe for finding permanent office space take longer than three to five months, temporary space should be considered. In looking for physical space the key considerations include: (i) where should the exchange be located – Albany, New York City or somewhere else? Will the exchange data center be co-located with the exchange office or will the two entities be housed in separate locations? (ii) the square footage of the space should be adequate to house the personnel expected to be hired over the next 24-30 months, or allow for expansion as staff numbers ramp up; (iii) the office space should include the appropriate number of conference rooms for meeting with key business partners such as health insurance carriers, brokers and navigators, and vendors; (iv) the office space should be reflective in decorum and furnishings of the type of facilities expected of public corporations, with an emphasis on accessibility; and (v) the space should include adequate security for staff and visitors.

   In deciding whether to locate in Albany, New York City, or another location, the exchange will need to assess how closely aligned they will need to be with state government. The location of the exchange data center should be considered separately as it need not be located within the exchange office space. The issue of location(s) is one of practicality in the sense that there will need to be a high level of coordination requiring frequent meetings with Medicaid, the Department of Financial Services, the Department of Health and other state agencies. Such meetings are generally easier to coordinate and more productive if work teams are in close physical proximity to each other which facilitates direct meetings. On the other hand, the exchange, as an organization with a unique blend of public and private characteristics, may desire to develop a separate identity from state government. Locating the exchange away from sister agencies may create the distance necessary from state government to allow the exchange to develop more of a private-market identity that is very different from existing state agencies, i.e. a start-up, sales-driven, cost-conscious enterprise. A third element to consider regarding the location(s) of the exchange and the data center is the ability to recruit personnel. With the fast ramp-up of staff that is anticipated, the ability to recruit staff and the depth of the available talent pool is an extremely important aspect to be assessed. Should the ability to recruit appropriate staff be compromised due to the location of the exchange, the ability to meet the aggressive timelines will be challenged and higher administrative cost in the form of higher salaries and benefits to recruit staff may result. Finally, the location of exchange board meetings is an important consideration in selecting the location of the exchange. If meetings will take place at the offices of the exchange, this should bear on both the location of the exchange as well as on the physical size and meeting space incorporated into the exchanges office space.

   In determining an appropriate physical footprint for the exchange, a standard metric for required square footage, which includes conference areas, kitchen, restrooms, file areas, and space for copiers and other office equipment, is generally 424 square feet per person. For New York, expected staffing levels based on

exchange enrollment estimates will likely require a fairly good size physical facility, and depending on lease terms, may require additional staff to maintain the facility. Should the exchange data center be located separately, the exchange footprint will be smaller and footage will need to be assessed for data center equipment and personnel.

2. Establishing the exchange as a new business. This will require the exchange to:
    a. Establish a Tax ID number
    b. Establish the corporation with the IRS, and depending on state laws, various state agencies
    c. File the organization with the Secretary of State (depending on state law)
    d. Obtain a mailing address (if need to use temporary office space, all of the filings noted will need to be updated.)

3. Develop the necessary banking relationships to operate the exchange. The exchange will need to develop check-writing and electronic fund transfer (EFT) capabilities, as well as the development of a process to allow exchange finance staff access to the fund on a regular and ongoing basis. There may need to be a strong cash management process instituted between the exchange and the State Comptroller, as pending exchange legislation requires grant funds to be transferred to the exchange.

4. Secure computers, supplies, furniture and fixtures, and other office equipment. In order for new staff to be as effective and efficient as possible soon after hiring, it will be important to establish an internal process that readily provides for such amenities for and new hires. This function will require a dedicated resource to anticipate the lead time necessary to order computer equipment and software for new staff, a preferred office supply vendor, and the build-out of offices and workstations. A process to receive and safely store the supplies will also need to be instituted to safeguard against theft. It would also be beneficial for the exchange to develop a standard computer and software configuration to allow for ease in ordering, consistency in updating software and begin to develop an inventory of equipment by tagging, labeling, and securing. Although leasing is generally more cost effective for computers and office equipment, the exchange should formally assess and document the pros and cons of leasing versus buying.

5. Employee benefits and civil service requirements (excluding management personnel) will be important factors in the recruitment effort of personnel and will have administrative cost implications that need to be understood before committing. The proposed legislation, establishes (non-management) employees of the exchange as state employees with respect to civil service requirements, collective bargaining, state employee benefits and the public employees' retirement system. Although this may be very beneficial in recruiting state personnel to work for the exchange, and would presumably be much easier than going to the market to procure, the level and type of benefits offered state employees may be less than what is expected of private-market employees. For example, while state employees generally have lower average salaries, but a greater number of personal and vacation days as well as a richer retirement plan, private market employees may simply value higher salaries with a bonus opportunity, and be willing to accept fewer personal and vacation days, as well as a less rich retirement plan. It will be important for the exchange to attract personnel with a mix of public and private experience. Corporate Policies and Procedures (P&P's) need to be developed prior to the heavy ramp up of full time staff. For many start up organizations, this is an area that can often times be neglected and not fully developed until an external

event precipitates the need. As a new entity that will be highly transparent and subject to freedom-of-information (FOIA) requests, it will be important to have as much of this area completed prior to the heavy ramp up of staff in 2012. For example, the employee handbook should reflect the organization's mission and purpose, but also include rules in areas such as employee dress code, office hours, attendance expectations, training and hiring, annual reviews and a process for requesting time-off. Other P&P's that should be developed include Purchasing and Contracting Policies, Corporate Planning, Ensuring Regulatory Compliance, Federal Regulation Review, Procedures for Disaster Response, as well as a formal process and review for regular updates and revisions.

Leveraging the same core financial leadership and staff that will be responsible for establishing the internal administration of the exchange, the financial management infrastructure of the exchange will need to be assessed, developed and implemented on a parallel track to internal administration. Although more weighted towards the accounting and financial skill set of early exchange hires, many of the decisions regarding internal administration will impact the financial management area and will require close coordination among all of the staff of the exchange. Examples where integration will be especially important include: (i) the securing of computers, supplies and office equipment; (ii) the exchange banking relationship and resulting process and controls; and (iii) development of corporate policies and procedures.

An immediate task for financial management is the assessment and implementation of an accounting system. To meet the short-term needs of the exchange, a simple off-the-shelf software program such as QuickBooks Pro will suffice. These programs are easy to install and learn, and will provide the necessary functionality to allow the exchange to reflect basic cash, receivable, and payable transactions. Longer-term, the exchange should perform a more comprehensive study of its needs relative to accounting software. For example, to what extent will the exchange be involved in premium processing? With enrollment estimates from the Urban Institute pegged as high as 817,500 by CY 2015 (assuming no BHP) and corresponding staffing needs targeted at almost 80 employees, as well as the potential need to manage multiple revenue streams such as federal grants and member premiums, the exchange will quickly outgrow a basic accounting package. Some of this analysis has already been initiated through NY's Early Innovator Joint Application Design ("JAD") sessions and more work will be advanced once the State's System Integrator (SI) is in place.

The core functions of a business accounting software includes a general ledger, accounts receivable, accounts payable, payroll and a reporting module. One of the key decision points in this area for the exchange (and the System Integrator) will be whether to purchase and implement an expensive enterprise resource planning (ERP) system that generally has a large collection of extra features and functionality, and corresponding complexity in installation and use, or a more modest software package commonly in use by small businesses. Software packages in this segment include Sage Simply Accounting, NetSuite, Sage Peachtree, and CMS Professional (Cougar Mountain). QuickBooks also has more powerful software called Premier as well as an ERP solution.

After selection of the accounting software, accounting staff will need to develop a chart of accounts for the exchange. This task should not be taken lightly or performed in haste. The chart of accounts 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. The challenge in developing a chart of accounts is to capture a level of transaction detail that is necessary to manage the company, but not overwhelming to the point where it becomes a data management or transaction recording burden, or slows the production of financial statements and monthly management reports. The chart of accounts should be developed with an eye towards a hierarchal structure that represents various levels of detail, budget development, and is flexible enough to anticipate longer term transaction detail and reporting needs.

In developing a financial and management reporting package, the basic reports should include 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 which compares actual expenses to a fixed budget, a monthly trial balance, significant payments to vendors, as well as periodic reports on anticipated cash flow needs; current and projected. 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.

Another important and early implementation task in the financial management area is the selection of a payroll system. As a public authority, the exchange should consider the ability and usefulness of leveraging the state payroll system if permissible under state law. Similar to the earlier discussion regarding banking, although utilizing the state payroll system may be easier from a startup perspective, it may come at a cost of less functionality and features necessary for the exchange. 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; and direct deposit. Other features to consider are the administration of an HSA/FSA, payroll deduction of public transportation costs if the exchange is located in an urban area, and ease of retroactive transactions. It will also be important for the exchange, from an internal control perspective, to have the ability to review and approve the payroll register prior to disbursement.

As key financial management decisions are being made early in the exchange life-cycle, a team with the expertise to begin to develop a system of internal control will be a critical core competency. The exchange is required to be audited by the Secretary of HHS, and will certainly be subject to state-level audits and operational reviews. Enabling legislation calls for the State Comptroller to examine the accounts and book of the authority. The exchange is also responsible for a broad range of obligations and responsibilities, and will interact with a number of market partners and affiliations such as carriers, brokers and navigators, state agencies and consumers. As a new entity responsible for implementing a complex law affecting nearly all New Yorkers, there will need to be a high degree of transparency, competency, and program integrity displayed by the exchange. The result is a need to design and implement a system of internal control and program integrity measures that reflect the best practices of the public and private market segments.

A strong system of internal controls is the underpinning of a system designed to detect fraud, waste and abuse (FWA) which is an especially important issue to HHS/CMS. As a hybrid public and private organization, the exchange should look to existing government agencies for internal control models to evaluate. However, with the level of public scrutiny, transparency, and the number of federal and state audits the exchange is likely to be subject to, looking to the private market for additional examples and models of best practices will be required. Regulations such as the U.S. Federal Sentencing Guidelines of 2005, and the U.S. Sarbanes-Oxley Act of 2002, as well as professional organizations such as the Institute of Certified Public Accountants (AICPA), and the Association of Certified Fraud Examiners (ACFE) are good resources for information and guidance.

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 as follows: (1) Control Environment; (2) Fraud Risk Assessment; (3) Anti-fraud Control Activities; (4) Information and Communication; and (5) Monitor. A grid identifying the five components and associated fraud risk activities can be found at Appendix IV.

Due to the complexity and required ongoing updating and refinement of developing a system of internal control in a start-up environment, it will be important for the exchange to augment internal staff with outside expertise in this area. Designing a system correctly from the outset should be an early goal of the exchange, as retrofitting systems and processes to correct gaps in a system generally leads to greater administrative costs, potential for liability, financial and political risk, and a greater likelihood of an audit finding.

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 to ensure the financial security and sustainability of the organization. Under the ACA, the exchange must become financially self-sufficient by January 1, 2015. Although funding will initially be provided by the federal government, key operational and financial decisions made early in the implementation process will affect the long-term viability of the exchange when it must become self-funding. Exchange finance staff, working with senior managers, 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. The degree to which budget management is delegated to functional program leaders versus held within the finance group will be an important decision. In any case, establishing regular meetings between finance staff and functional leaders, paired with ongoing budget variance reporting, will create appropriate tension between operational and financial constraints.

Because the financial sustainability of the exchange will be highly dependent on the scale of enrollment and the speed with which membership ramps up, the exchange will need to develop a financial plan that provides for appropriate management, oversight, and resources at various take up levels, and that also incorporates the flexibility to incorporate regular updates as critical factors change or become more clear. To manage short term cash issues that can be particularly prevalent during start-up, as noted previously; the exchange should weigh the option of leveraging state banking relationships to procure a line of credit.

Governance & Oversight, Internal Administration & Financial Management

During exchange set up, the state needs to establish the physical and legal infrastructure upon which to base exchange operations. These include establishing a governing entity and legal identity; providing for physical office space, administrative support, and IT infrastructure; and developing the financial management infrastructure and policies to accept, safeguard and disburse establishment grant and other funding. During this critical phase, the exchange will hire its first staff and lay the groundwork needed for the rapid escalation of activity that will take place as it begins to build out its core systems.

Major Activities:	Appoint and convene the BOD; Appoint and convene five regional advisory committees; Establish governing structure; Hire senior leadership; Obtain office space; Establish administrative and financial infrastructure; Develop financial and operational policies and procedures
Staff:	Board of Directors, Executive Director, Office Manager, Director of Policy, Grants Administrator, Chief Financial Officer, Director of Accounting, Senior Accountant, Budget Manager, Director of Communications/Outreach
Consultants:	Legal Counsel, Project Managers, Internal Audit Firm, Temporary Administrative Support
Major Milestones:	Appoint governing board and approve by-laws; Appoint and convene five regional advisory committees; Hire Executive Director; Establish financial infrastructure, including a basic accounting system; Develop plan of operations, including administrative budget; Establish financial management, system of internal control, and corporate policies and procedures.

1. Governance & Oversight

While awaiting legislative passage of a formal exchange governing authority, state agencies will administer and manage exchange grant funding, resource needs and procurements. In addition to finalizing a governance model and structure to guide exchange policy and decision making, the state will need to establish policies and procedures that define the board's role, the relationship between the board and management, and the role of the board in the larger state policy and market environment. For example, public board meetings are likely to attract a significant amount of public and media attention. 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.

While the proposed rules released in July 2011 acknowledge the option to create a separate governance structure for the individual and SHOP exchanges, the preamble expresses a preference for a single structure, and the proposed rules require coordination between the two if elected.

Staff:	Board of Directors, Executive Director, Director of Policy
Consultants:	Legal Counsel
IT/System Needs:	None
Key Tasks:	Develop conflict of interest policy (as part of the Code of Ethics as required under NY Public Authorities Law section 2824), meeting protocol, transparency practices, executive sessions ability, and press and media relations

1. Governance & Oversight (assumes BOD appointed in Spring 2012)	Begin	End
Interim exchange staff initiates search process for Exec Director and other senior leadership	Mar-12	Apr-12
BOD assumes responsibility for ED search process and selects ED	Apr-12	Jun-12
BOD begins process to hire legal counsel	Apr-12	Jun-12
BOD develops board calendar & location of meetings	Apr-12	Jun-12
Exchange ED identifies issues requiring Board vote	Jun-12	Jul-12
BOD develops Board Subcommittees	Apr-12	Jun-12
BOD develops Board Policies and Procedures	Aprl-12	Jul-12
BOD begins process to adopt Organizational Bylaws	Jun-12	Aug-12
BOD adopts conflict-of-interest rules for Directors & Exchange Staff	Jun-12	Jul-12
Develop and submit (second) Level 1 grant application	Oct-11	Dec-11
Develop and submit Level 2 grant application	Apr-12	Jun-12
Develop schedule for reviewing studies/reports and recommendations as required by statute	May-12	Jul-12
Create advisory committee schedules and select meeting places for 5 regional advisory committees	Apr-12	Jun-12
Develop process for incorporating recommendations of Regional Advisory Committees	Jun-12	Jul-12

2. Internal Administration

Once the exchange exists on paper, it must have a physical location to support operations and the means to pay staff and manage funds. Critical steps include the procurement of office space, furniture, and fixtures; acquisition of computer equipment, data servers, telephone and conference lines, and copier/fax machines; the acquisition of bank accounts, accounting structure, and payroll capabilities; and the development of human resources policies and employee benefits. While some or all of these functions may be temporarily contributed by other state agencies, the faster these administrative structures are developed, the more quickly the exchange will be able to attract and retain staff in order to move on to the development of core systems.

Staff:	Office Manager, Chief Financial Officer, Chief Operating Officer, Chief Technology Officer, Accounting and Budgeting staff
Consultants:	Payroll system, IT infrastructure/support vendor, Telephone system vendor, Copy machine lease vendor (if leasing), Employee liability and property liability insurance, Employee benefits (e.g. health and life insurance, employee pension/401(k), dependent care deductions, etc.)
IT/System Needs:	Telephone and internet service, Computers and business software for internal staff, Data storage equipment and firewall capabilities, accounting software
Key Tasks:	Obtain employer tax ID; Acquire accounting software; Hire financial staff, Locate physical office space including furniture & fixtures, computers, software, phone system; Develop preliminary plan of operations and administrative budget

2. Internal Administration (assumes Board of Directors appointed in Spring 2012)	Begin	End
Interim exchange staff initiates search process for Exec Director and other senior leadership	Mar-12	Apr-12
BOD assumes responsibility for ED search process and selects ED	Apr-12	Jun-12
ED hires key Senior Mgmt., including CFO/COO/CIO	Jun-12	Aug-12
Develop exchange organizational chart	Jul-12	Aug-12
Develop staffing plan	Jul-12	Aug-12
Interim staff locates physical space options for exchange (temporary or permanent)	Jan-12	Mar-12
ED/Sr. Mgmt. begin to hire exchange staff, especially in key areas of IT, Finance, and Ops	Jun-12	Sep-12
ED finalizes physical space decision	Jun-12	Jul-12
Begin to hire consultants for subject matter expertise in key areas	Jun-12	Oct-12
Assign staff ownership for completion of studies/reports & recommendations required by exchange statute	Jan-12	Aug-12

Start analytical work on list of studies and reports required by exchange statute	June-11	Jan-12
Develop Exchange IT Strategy in coordination with Medicaid	Mar-11	Feb-12
Set up interagency meetings and/or ensure exchange representation in existing mtgs	Feb-11	Dec-13
Identify vendors/suppliers for administrative needs	Apr-12	Jun-12
Acquire Tax ID for exchange	Apr-12	Dec-12
Register exchange as public authority with Secretary of State, IRS, etc.	Apr-12	Jun-12
Develop proposal for salary structure and benefits for exchange personnel	Jan-12	Mar-12
Develop organizational policies & procedures	May-12	Aug-12
Develop contracting mechanism to easily bring on consultants & suppliers	May-12	Jul-12
Develop and submit (second) Level 1 grant application	Oct-11	Dec-11
Develop and submit Level 2 grant application	Apr-12	Jun-12

3. Financial Management

Managing funds is one of the most critical functions performed by the exchange and a robust management structure must be put in place at the outset to ensure the exchange is fully meeting its fiduciary obligations. The financial management of the exchange is two-fold; it must meet the administrative and financial needs of the entity 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 federal funds. Taking the time to establish strong policies and procedures with respect to the management of funds at the outset will be critical to managing the rapid growth of funds under the custody of the exchange. An important element to financial control will be ensuring that the exchange has sufficient analytical and reporting capabilities to track and report on the funds under its control.

Staff:	Chief Financial Officer, Director of Accounting, Grants Administrator, Budget Manager, Compliance Officer, Financial Analyst(s)
Consultants:	Internal audit firm, Bank and/or investment firm (for accounts), Bank and/or lender (for line of credit), Financial and data security and/or compliance firm
IT/System Needs:	Accounting software, Management and financial analysis and reporting software
Key Tasks:	Establish banking and wire transfer functions; Establish accounting protocols, policies, and procedures; Establish cash management policies related to payment authorization; Develop procurement policies and procedures; Develop administrative budget and actual/variance reporting protocols; Retain audit firm to establish and/or review internal financial controls; and Establish financial reporting mechanism to meet state/federal reporting requirements

3. Financial Management (assumes Board of Directors appointed in Spring 2012)	Begin	End
Hire CFO	Jun-12	Aug-12
Set up banking structure in coordination with State Comptroller	Jun-12	Aug-12
Begin to develop administrative budget model	Jun-12	Aug-12
Hire accounting and budgeting staff	Jun-12	Aug-12
Hire payroll vendor or establish internal payroll department	Apr-12	Jun-12
Research short term accounting system to record basic exchange rec/pay transactions, TBD**	May-12	Jul-12
Develop exchange chart of accounts	Jun-12	Aug-12
Identify accounting structure for recording of transactions -- GAAP/STAT, etc.	Jun-12	Sep-12
Identify and scope out basic financial reports for CMS/BOD during start up	Jun-12	Sep-12
Working with DOH, begin to develop IT operational financing strategy	Mar-11	Feb-12
Develop a contracting process for acquiring computers and office equipment	Jun-12	Jul-12
Begin to develop system of internal control for exchange finance operations	Jun-12	Sep-12
Hire audit firm (operational and financial)	Sep-12	Sep-12
Refine five year budget and self-sustainability model	Jun-12	Dec-13
Prepare financial & budget components of Level 2 grant application	Apr-12	Jun-12
Begin to assess longer term exchange finance systems -- PB; Accounting; QHP Coordination	Jun-12	Oct-12

**Systems design, development and implementation of core business functions of exchange expected to be within Systems Integrator contract (e.g. financial management, plan management, customer service, communications, eligibility and enrollment, oversight).

Business Requirement II: Core Systems and SHOP-specific Processes

Overview

Even before permanent exchange leadership is in place, significant time and attention must be focused on procuring the core systems the exchange needs to commence the basic operations: Eligibility Verification, Premium Tax Credits, Website, Enrollment, Billing and Collections, and Customer Service - Call Center Operations. Additionally, the unique functionalities of the SHOP exchange need to be considered when evaluating the functionalities of the Individual exchange in order to capture any differences that must be accounted for within each of the core systems. Addressing each one of these areas should commence as soon as possible under the inter-agency exchange planning team, especially once the Systems Integrator (SI) is in place in early 2012, and then be transitioned over to the formal governance structure as required.

New York's selection of the Systems Integrator (SI) in early 2012 will determine the system solution(s) and a buy vs. build approach. To a large extent, it may be reasonable to assume that New York State will opt to buy core system functionality for all or some of the following reasons: (1) it may be faster and less expensive in both the short and long run to buy rather than build; (2) multiple state exchanges with similar needs have created simultaneous marketplace demand and vendors are anxious to respond quickly with both "off the shelf" and customized solutions; (3) cobbling together existing system resources, which will generally reflect dated technology in much of the budget challenged public sector, may not be possible in the time allowed, or more likely, would not result in an efficient or acceptable response to the ACA's sophisticated technology requirements for exchanges; and (4) federal grants are readily available for purchasing the core systems necessary for standing up an exchange within a very aggressive timeframe.

If operational and IT system functionalities are purchased, then, however different the core system specifications may be, the exchange will want to contract with or employ several individuals with skillsets consisting of procurement experience, development of business process specifications, contract negotiation, time and performance monitoring, negotiation of service level agreements, project management and vendor oversight. Preliminary Cost Benefit Analysis (CBA) consideration should be given to initial system cost at purchase and ongoing maintenance expense. 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 fully enhanced federal support after 2014 (ongoing system operations may be supported at 75% post- 2014). While it is difficult to predict enrollment gains in the out years, exchange management should nonetheless factor in growth expectations. For example, while New York may initially define small group size as 1-50, the law requires that employers with 51-100 employees be accommodated as of 2016. Additionally, large employers may be eligible for exchange participation on or after 1/1/2017 as well. A third possibility might include one day inviting state and/or municipal employee groups to join the exchange to expand the purchasing power of the exchange and to build scale, a critical success factor for the exchange's financial model. All of these possibilities represent policy decisions that may be made in the future but which have practical implications today and therefore need to be considered sooner rather than later. In this respect, few decisions made in the early days of the exchange build-out can be made quickly and easily, or in department silos. Cross communication among all areas is critical.

Eligibility verification is at the heart of the exchange and represents one of the most complex and challenging aspects of standing up the exchange. The ACA requires states to have an eligibility process that can determine an individual's eligibility for Medicaid, CHIP, the Basic Health Plan if offered, and exchange premium tax credits and cost sharing subsidies. Additionally, the exchange must determine eligibility for qualified health plans (QHPs) when an applicant is not subsidy eligible. The exchange will need to collect information needed for eligibility determinations, transmit it to the appropriate agencies for verification and then return eligibility decisions in real-time in most cases. Core system development must accommodate eligibility verification requests made online, in person, over the phone and by mail. In short, the requirements of the ACA for a simple and seamless eligibility system apply regardless of entry point; whether an individual is seeking subsidized or unsubsidized coverage; and whether the subsidy is for a qualified health plans (QHP) or Medicaid.

In New York, consideration is being given to an integrated approach that allows the exchange to determine eligibility for exchange and insurance affordability programs using the Medicaid validated system and rules engine. The proposed eligibility rules released in August of 2011 outline the interdependency of state exchanges and Medicaid agencies in determining eligibility for QHP and Insurance Affordability Programs, and to ensure that such coordination occurs, the guidance allows the states three broad options: the state can utilize a fully integrated system that allows one entity (the exchange, Medicaid or CHIP agencies) to perform the responsibilities of all parties; each entity can perform their responsibilities separately but with strong communication and coordination to ensure the seamless exchange of necessary information and data; or, one or more of the parties can participate in an agreement whereby some or all of the responsibilities of each are performed by another. Regardless of which option is ultimately put in place, the ACA has envisioned an online marketplace where data is exchanged electronically, and where the mantra is to minimize the burden of the application process to the individual as much as possible. New York's Department of Health endorses this vision and expects Medicaid enrollees to benefit from streamlined processing.

The proposed eligibility rules provide planners with significant operational detail (although much remains unknown, a particularly vexing challenge for planners given both the time constraints and complexities involved). The proposed rules stress the importance of aligning exchange eligibility rules with those of the Medicaid and CHIP programs to ensure that an applicant applies once and is automatically routed to the appropriate plan based on their qualifications for the different programs. The eligibility rules are now remarkably consistent from program to program but a few differences remain. For example, 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 among programs. The proposed regulations do permit a Medicaid program to align with advance premium tax credits to develop a projected annual income figure, an option which NY has under consideration.

Where differences exist, the Medicaid requirement will generally take precedence as Medicaid eligibility must be determined first. If the applicant does not qualify for Medicaid, the eligibility system must support the exchange specific requirements. As such, this means that the system must be able to accommodate eligibility for Medicaid, CHP and advanced premium tax credits.

Eligibility redeterminations continue the theme of minimizing the burden to the enrollee. The proposed regulations require that the exchange provide the QHP enrollee with an annual redetermination notice and any applicable updated information. The enrollee should sign and return the notice (making any corrections as needed) but if he does not, the exchange is expected to re-determine eligibility based on available information. For Medicaid enrollees, the process will be slightly different. If Medicaid has sufficient information available from electronic data bases to determine continued eligibility, they must do so. If such an administrative renewal is not feasible, the Medicaid agency will need to send a pre-populated renewal form to the enrollee, who will have a certain number of days to complete and return the needed information. Depending on New York's current Medicaid renewal process, this guidance may not reflect a new process, but regardless, the party performing eligibility redeterminations will need to accommodate the different processes for Medicaid and QHP enrollees.

The proposed regulations address several data sources that will be available to exchanges, including Social Security, the Department of Homeland Security, the Internal Revenue Service and whatever state-based data sources that might be available. The regulations require that the exchange utilize these sources (or other data sources if approved by HHS) before requesting documentation from the applicant. That said, the importance of the federal "data hub" to the eligibility process and the number (and magnitude) of unknowns even today only serves to complicate the policy making process and build. For example, in November HHS stated that it may provide verification of "employer-sponsored insurance" (ESI) as part of the federal "data hub". Planners don't yet have specifics but must nonetheless continue working on the systems build. Furthermore, the regulations impose a "reasonably compatible" standard upon the exchange when verifying applicant supplied data against any available electronic sources. This means that information need not match exactly. The State (not the federal government) will have a fair amount of discretion in determining what is "reasonably compatible." There are many policy issues embedded in this determination process and all will need to be reflected in the systems build. This point demonstrates why eligibility and enrollment requirements have implications well beyond a straightforward systems build.

The August guidance addresses the enhanced federal matching dollars for individuals "newly eligible" for Medicaid under the ACA's expanded Medicaid program. Consistent with the ACA's simplification goals for eligibility determination processes, exchanges may be able to evaluate several different population-based methodologies for claiming the appropriate federal match for their newly eligible population that enrolls in Medicaid.

One final note regarding the eligibility and Medicaid regulations released in August: throughout both proposed rules, HHS asks repeatedly for State comments on specific provisions of the rules. There is a fair amount of speculation that this suggests the final rules may depart from the proposed regulations in either small or meaningful ways. For this reason, it is not the intent of this paper to comment extensively or in any greater detail on specific eligibility and Medicaid rules.

For SHOP exchanges, an employer verification process will need to be established, as well as a simple and streamlined employer application system that will expedite the collection of necessary data from employers. Employers must be able to select a tier (or multiple tiers) of coverage and indicate their contribution to coverage. Small group employees will need to be able to select from among plans within the specified tier (employee choice model). Exchanges will need to transmit enrollment information to health plans. In the proposed regulations released in July 2011, it appears that employers will also have the option to select one QHP for all employees (single source model). HHS specifically seeks comment on this latter provision, which in statute appears to apply to large employers, but in the proposed rule has been extended to small employers as well. The proposed eligibility rules released in August provide that a qualified employer may continue to participate in the SHOP exchange if it ceases to be a small employer. The regulations further state that new employees hired outside of the annual open enrollment period must be given the opportunity to enroll in a QHP on the first day of their employment.

Premium tax credits and cost sharing subsidies are expected to be available to the majority of individual exchange enrollees and will be a key driver of exchange enrollment since eligible individuals will not be able to benefit from them if they elect to purchase coverage outside of the exchange. Prospective enrollees contacting the exchange will need access to an automated calculator tool that will quickly inform the prospective enrollee of their cost of coverage after the application of any available tax credit or subsidy.

In August, the Internal Revenue Service (IRS) released a proposed rule that addresses eligibility requirements for premium tax credits and provides very detailed regulations on the calculation of the tax credit. This guidance also addresses how to reconcile advance payments with actual credits at the end of the year. The specifics of much of this guidance are outside the purview of this paper. What may be helpful here, however, is a brief discussion on the new insights that all three regulations provide on the interaction between employers and exchanges with respect to the availability of premium tax credits based on employer-sponsored insurance.

Premium tax credits (and cost sharing subsidies) are available to individuals who do not have access to affordable, minimum essential coverage through their employer. During the initial eligibility process, the exchange will need to determine if the applicant's employer offers coverage that meets the minimum value (i.e., covers 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). First, the NPRM clarifies that employees who are offered individual-only coverage for less than 9.5% of their household income are ineligible for the tax credit even if they have dependents and their share of the cost for family coverage exceeds 9.5% of their household income. As such, the eligibility determination process for tax credits should evaluate only the cost of individual coverage. Second, the preamble notes that the employer penalty regulations will offer a safe harbor to employers such that employers will not be held to the standard of determining the household income of an employee. Rather, provided the cost of coverage is less than 9.5% of an employee's income, the employer will not be penalized if the cost of coverage ends up costing more than 9.5% of the employee's entire household income.

The exchange will need to evaluate the best way to verify employer data for employed applicants applying for premium tax credits. In guidance released on November 29, 2011, HHS suggested that a federal data base on employer-sponsored insurance might be made available, thereby simplifying the task for the exchange. In the absence of access to a federal hub, access to state-based data bases are one alternative 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. In New York, both New Hire and quarterly wage reporting requirements were revised this year to collect data on the availability of employer-sponsored insurance for dependents for the purposes of child support enforcement. New York might wish to consider a further revision to these reporting requirements that would allow the exchange to collect all necessary employer information for premium tax credit (and employer penalty) determination purposes. One challenge in doing so involves the approval of making wage information available to a state entity (i.e., the exchange) which is not currently statutorily entitled to such access. An option to a state data base might entail a template document on employer-sponsored insurance that employers are required to submit to the exchange either upon request or annually. Last, HHS could offer exchanges the option of tapping into a federal data base on employer-sponsored insurance. This last option is only a possibility and the regulations do not suggest that it is likely.

In the SHOP exchange, a tax credit is available to eligible small businesses purchasing coverage through the exchange. In this respect, both the individual and SHOP exchange rules are the same – coverage must be purchased within the exchange in order to obtain the benefit of tax credits or subsidies. The ACA does not specify, however, that the exchange must provide small employers with information concerning the tax credit. Despite the absence of a requirement to do so, the exchange should nonetheless seize the opportunity to do so since it is an effective "sales and marketing" tool for expanding small business enrollment at the exchange's disposal. And, as a scale entity, the exchange should always welcome any opportunity to grow enrollment, both in the individual and SHOP exchanges. Employers may initially need to be incented to consider participating in the exchange and providing this "extra" service is one good way to do so. The exchange must remember, however, that it is important to offer this service only as an estimate since actual determination of employer tax credits is a function of the employer's income tax filing as processed by the IRS.

Exchanges are required to establish a website that provides standardized comparative information on QHPs. While other systems are equally important to the overall operations of the exchange, it must be remembered that the enrollee "sees" only the website. This is where the shopping experience begins and the design must successfully engage the prospective buyer within the first few clicks or the sale may be lost for good. Many retailers, the industry most familiar with online buying practices, subscribe to a "3 clicks or gone" theory that suggests if a buyer can't find what they are looking for with 3 clicks of their mouse, they exit the site and/or spend their money elsewhere. This will be true with the purchase of health insurance. Even with tax credits and subsidies, health insurance is a very expensive annual purchase and many people may be reluctant to buy something they hope not to need or use. Younger, healthier people and males in particular, are especially reluctant to buy health insurance. While women tend to equate the purchase with buying access to care, men approach the buy with "value" in mind and are looking to get the most for their money. Website design needs to be responsive to the buying impulses of targeted demographics and simplify a complex and resented purchase.

To this end, New York is one of eleven states participating as a design partner in the Enroll UX 2014 project, which will provide state and federal governments with a human centered user experience (UX) design specifically for health insurance exchanges to help people better understand and connect with coverage. IDEO, a global design and innovation consultancy is leading the engagement. The project will ultimately deliver a detailed design implementation manual, including: information architecture; design principles; detailed design specifications; description of proposed behavior of key interactions; wireframe illustrations; and typography, iconography, graphics and color schemes. These deliverables and design guidance are intended to allow a skilled software development team to implement the user experience into a functional web-based system. The final design package will support all insurance affordability programs, including Medicaid, Children's Health Insurance Program (CHIP), tax credits, cost sharing reductions, and a Basic Health Plan. Enroll UX 2014 will be ready in April 2012 and recognizing that every state faces a distinct set of circumstances and challenges, each state may opt for a slightly different configuration. The user experience design will be system agnostic.

When New York contemplates how they might personalize the design, the following catalog of website reflections might be helpful. While this list is by no means complete, it does illuminates several possible considerations for New York's early planning process.

The most successful websites today are engaging, easy to navigate and responsive to visitor needs. They offer a persuasive buying proposition and utilize several common online marketing tools based on understanding aspects of human nature that are often automatic and work at a subconscious level. The exchange can benefit from modifying several of these tools to fit a healthcare purchase. For example, people look to others and will often do what they are doing, especially when uncertain about something. This human tendency results in the online use of such terms as: 'Most popular items', 'Customers who bought this also bought,' 'Top sellers', and 'Testimonials'. This is not to suggest that the website should attempt to hawk the sale of health insurance like a retail product but understanding the psychology of these marketing tools is important, particularly in designing decision support tools. For example, the website might ask the buyer a series of questions and then prompt a decision by concluding something like, "80% of buyers who strongly value network choice the way you do purchased one of the following three plans."

Decision-support tools might also be utilized to allow the exchange to offer more QHPs without the accompanying confusion that "too many" choices might otherwise bring to the market. For example, if the website builds a decision tree process for the potential buyer, only those plans that match the purchaser's narrowed down needs can be displayed. This allows the exchange to have a fully stocked "backroom" or warehouse of healthcare products, with the ability to stock the virtual shelves for the individual consumer with only the most relevant and meaningful choices. In this scenario, an exchange can encourage more choice and innovation in the market as a whole, without burdening the individual purchaser (or small employer) with the need to sort through every option.

User-generated reviews can have a significant influence on peoples' buying decisions. Fuelled by the rapid growth of social media, they are becoming an essential part of website design for the simple reason that people trust what people like themselves say more than what the marketers want to tell them. And while formal satisfaction survey results are required by the ACA to be available on the website, the exchange might also want to consider allowing users to write reviews and express overall ratings for both their buying experience on the exchange and the QHP they ultimately purchase. If the prospect of negative input is unsettling, the exchange may want to consider how helpful both good and bad feedback can be in improving service to the exchange client. Online feedback can also be used with QHP issuers to improve carrier performance and product design. Best of all, it's free – something that cannot be said for consumer focus groups, the 'go to' marketing tool for many.

Imagery is a very persuasive tool and the exchange should maximize the use of pictures and videos. Videos might be a particularly effective decision support tool for prospective buyers with limited literacy skills or buyers who speak a language other than English. Many people either don't like to read or struggle in doing so. Watching videos requires less effort than reading and offers a richer experience. A video with simple story telling and culturally sympathetic presenters may appeal to many exchange visitors. Videos should be an option for the interested and not mandated for all. The length needs to be short and it is important to let the user start and stop the video.

Use of video can also be adapted to smart phone usage, technology that the exchange needs to give serious thought to accommodating. Many people who cannot afford a computer will buy a smart phone, and even people

with a computer are increasingly turning to their smartphones and tablets for information and web surfing. Nielson projects smartphones will overtake feature phones in the U.S., and that one in two Americans will have a smartphone by the end of 2011. Contrast this forecast with Neilson data that suggests smartphone usage in the summer of 2008 was in place for one in ten Americans and the dramatic growth curve is undeniable. "There's an app for that" is a ubiquitous catchphrase for a reason as there are literally hundreds of thousands of apps to choose from today and the number may very well double by 2014. According to Ask.com and Harris Interactive, 69% of smartphone users have downloaded an app, with slightly more males than females having done so. In another recent survey, this one by American Express, 60% of smartphone users who download apps only do so if they are free. An innovative exchange establishment grant request might include several states banding together to obtain funding for a pilot project with a company like Apple or any number of their competitors.

The exchange also needs to consider persons with disabilities when designing the website and other media. Although the content is the same regardless of the media, users with disabilities draw upon different assistive technologies to access needed information. For example, sight impaired individuals navigate web pages using a screen reader, such as JAWS. As blind users navigate a web page with their keyboard, the screen reader tells them what is on the screen. They hit "Tab" to move to different parts of the webpage. What a web page reads like to someone who is blind is often very different than how a web page reads to a sighted user. The exchange may want to take these types of issues into consideration when designing the website. While a state may not be required to adhere to the strictest standards of Section 508 of the US Rehabilitation Act, the exchange may want to consider voluntary compliance (note: private companies building online tools and applications often speak of Section 504 compliance which represents a lesser standard).

Exchanges will need to consider the best way to develop websites and related decision-support tools for individual versus SHOP exchange visitors. As New York's thinking on websites has been largely influenced by the IDEO-developed web interface for exchanges, it is likely that the state will adopt IDEO's recommendation to create one website with separate portals for the individual and SHOP exchanges. As both the needs and demographics of the two exchange populations are largely different, separate gateways will accommodate customizable access to data and functionality for the two groups. Certain underlying functionality needed in the SHOP exchange will be different from the functionalities needed for the individual exchange, and some functionality and decision-support tools will be based on shared needs. Both exchanges groups will need access to provider directories as part of their decision-making process and both groups are fundamentally shopping for coverage. Both groups need access to calculators but the calculations will be different. SHOP exchanges may include broker contact information for employers on the website, and individual exchanges may focus on navigator resources. The exchange will need to catalog and contrast the needs of the two groups in order to capture all required elements.

To the extent the website needs to intersect with and transmit information from every part of the exchange, website architecture and design must be flexible and responsive to both exchange audiences. A final point to consider on website development is this: while building a website might be considered a technical project, virtually every design decision will be based on a policy decision, regulation requirement, functional need, marketing preference, legal decision, carrier need or stakeholder consideration. As such, website design impacts literally every business leader in the exchange and their ability to do their jobs. Elements of website design are therefore in everyone's job description and will be an integral part of the earliest staff discussions on building out

the exchange. The build versus buy choice on website development must be made early, and the state will benefit from rich choices on either front. 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. As with all core systems, exchange management needs to consider current and future costs associated with both options given the requirement that the exchange be financially on its own after 2014. Can an outside vendor support and maintain website functionality after 2014 more cost effectively than staff assigned to a home grown solution? Is a mixed decision in order – perhaps the exchange builds part of the solution and buys other pre-packaged solutions? For a health benefit exchange, website design is not simply a marketing tool. It reflects - and connects - virtually every aspect of exchange operations.

We also note here that in the proposed regulations released in July 2011, HHS contemplates requiring functionality that would permit consumers to store and access information on the website. Functionality would include allowing both applicants and enrollees to store, access and update personal account information. Similarly, enrollment assisters, such as case workers, navigators, agents and brokers, would be allowed to maintain records of individuals they have assisted in the enrollment process. If included in the final regulations, this functionality might have significant bearing on core system designs, particularly given security needs.

Enrollment, Billing and Collection core work processes will need to accommodate both individual and small groups, and there are significant differences in the workflows for the two exchange memberships. For enrollments in the individual exchange, the exchange will most likely enroll directly into Medicaid for automated MAGI when sufficient information is provided through the web application. If the exchange needs additional information or other follow up on a Medicaid enrollee, a referral process will be needed. Such a process might entail a Medicaid unit within the exchange, use of a contractor, or the involvement of local district or state staff. For carrier products (including managed Medicaid programs), the exchange may need to have additional involvement in the enrollment process. ID card issuance and distribution of member enrollment materials such as benefit plan descriptions can reasonably be expected to be done by the carrier. Minimally, the exchange should expect to build a process that captures plan selection, premium subsidy level, monthly enrollee premium (subsidized or unsubsidized, effective date of coverage (or termination), and member data such as name, address, SSN, electronic medical record number (if applicable), email address, telephone, date of birth and dependent data when applicable. Once issued, the exchange may want to add the member's carrier Identification number to its own databases.

While specifics continue to be evaluated, New York is nonetheless committed to leveraging continued support by existing agencies wherever feasible for certain functions impacting outside constituencies. For example, carriers might continue to interface with DFS and the exchange would certify QHPs based on information from DFS and DOH in order to minimize the burden on carriers. Similarly, the exchange and the Department of Health will discuss ways to share information so as to avoid parallel processes for plan selection (for QHPs and managed Medicaid plans respectively). Undoubtedly, there are other synergies that will be identified in similar efforts to avoid unnecessary duplication of work, parallel processes or added regulations.

In the proposed rules released in July 2011, HHS articulates three options for individual premium collection by the exchange. First, the exchange can elect to take no part in the process and the individual would pay the QHP issuer directly. Second, the exchange can create an electronic "pass-through" without retaining any of the payment. Third, the exchange can collect premiums from enrollees and pay an aggregated sum to the QHP issuer. Regardless of the preferred approach of the exchange, the individual retains the right to pay the QHP issuer directly if s/he so chooses and the exchange cannot object. This means that if the exchange does get involved in the premium collection process, they must also build in "exception-processing" for those individuals who choose to pay the carrier directly, thus creating a major administrative challenge to the exchange given that it is also the authoritative source of information to the IRS and carriers on premium flows to QHPs and tax credits.

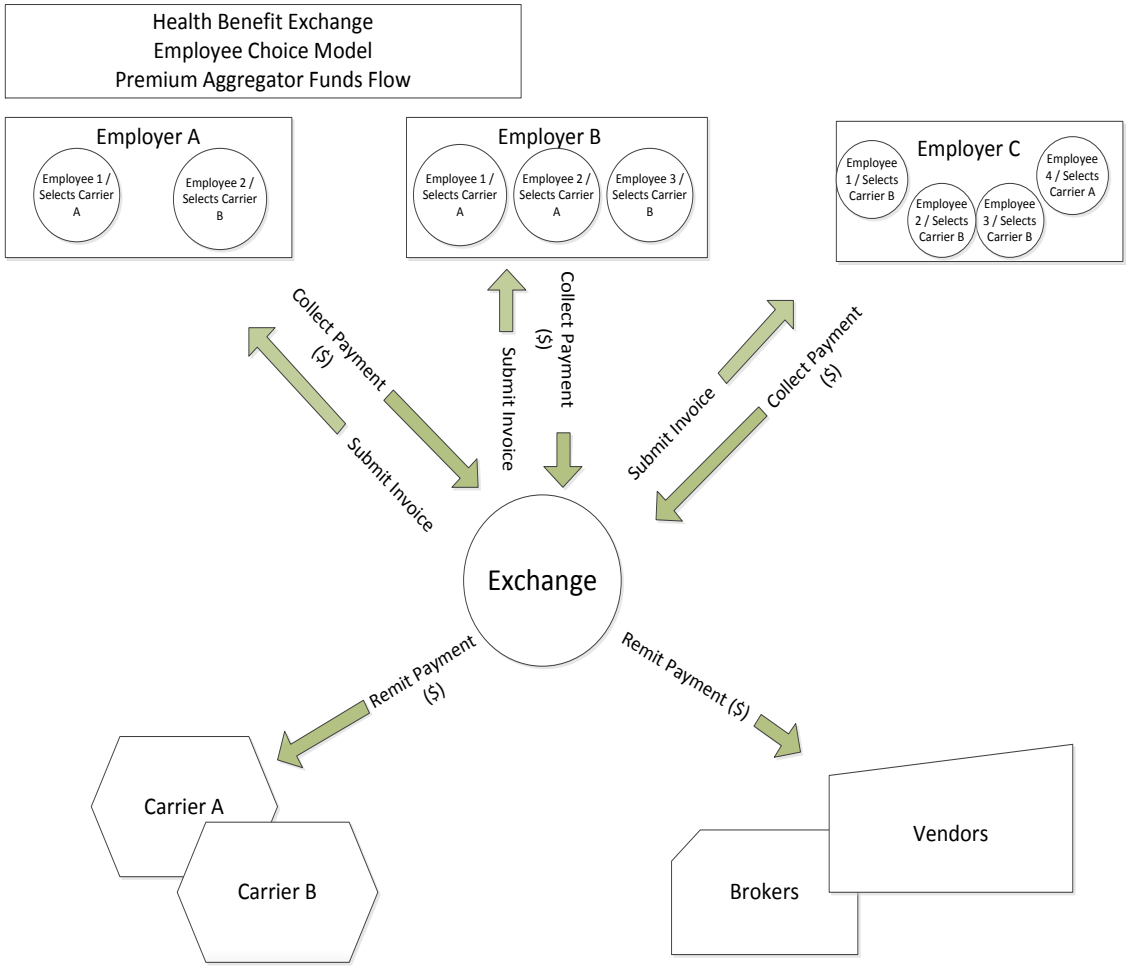
The exchange should develop automated data exchange protocols between the eligibility, enrollment, and billing systems so that enrollees only need to enter information once and data in each system is consistent. The exchange has already begun to explore using the existing System for Electronic Rate and Form Filing (SERFF) for use in the QHP certification and renewal process (SERFF is currently used by carriers when submitting rate and form filings to DOH and DFS). System development of these functionalities needs to include interfaces all with QHP issuers, a task that will be complicated by both the number of QHP issuers and their legacy system constraints. This is a good example of why the exchange needs to be talking with potential QHP issuers as soon as the second quarter of 2012. Both groups need to understand operational interfaces with each other, any system constraints that may exist, and allow time for all parties to build out necessary systems. While exchanges may enjoy federal funding for exchange development processes, private carriers will not. The new Medical Loss Ratio (MLR) requirements have carriers looking for ways to cut administrative costs, not add to them. That said, they will undoubtedly spend administrative dollars when they anticipate enrollment gains for doing so. The key for successful exchange-carrier partnerships will be "early and often" communication strategies to avoid surprises to either party.

For the SHOP exchange, the enrollment process has two layers as both the employer and their eligible employees need to be enrolled in exchange systems. 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.

In contrast to the payment choices available in the individual exchange, the SHOP exchange is required to perform premium payment administration duties. This requirement is largely thought to reflect a policy of administrative simplification for small employers. While employers will certainly benefit from the ability to write one check each

month for several QHP issuers managing the healthcare needs of their employees, the exchange needs to prepare for a very complex flow of funds as shown below:



Source: Wakely Consulting Group

Customer Service operations, focused mainly in the Call Center, will be fundamental to the success of both the individual and SHOP exchanges, particularly in the early days of both exchanges when operational glitches are to be expected and will make themselves known through a call to Customer Service. The ACA requires that the exchange provide a toll free telephone number for all prospective buyers, enrollees, and employers, and federal guidelines suggest that the exchange extend the hours of call center operation outside of normal business hours. Brokers will also use the Call Center. As with all front line customer service centers, virtually all questions, complaints and the occasional compliment are fair game. Customer Service representatives will need training in QHP benefits, consumer protections, individual and SHOP eligibility, carrier administrative policies, enrollment rules, subsidy and tax credit allowances, provider networks, broker needs, employer support services, website navigation, exchange policies, and eligibility, enrollment and premium interfaces with carriers and public agencies such as Medicaid and CHIP.

Customer Service staff needs to work with a wide range of people who will represent all walks of life, income levels, ages, multiple languages, cultural differences, physical and mental challenges, and different experience levels with insurance and so on. The exchange needs to plan how incoming calls will be routed, and how peak calling times will be handled. Will representatives take any incoming calls or will they specialize? How will callers who do not speak English be routed to representatives who are fluent in their language? How will the Call Center identify and measure trends? How will complaints be tracked? A customer control contact management system will be needed to track incoming calls, assign reason codes and maintain records of calls at the individual level. Will call center staff also respond to "live chat" requests from website visitors? To what extent can a well thought out Interactive Voice Response or IVR system reduce the need for "live" assistance?

The exchange may choose to hire and train customer service representatives that will be employees of the exchange, or the exchange may decide to outsource the Call Center. The exchange should also investigate early on if there are any existing call centers within state government that can be expanded and which may be a good candidate to partner with the exchange for Call Center resources. There are private vendors who offer Call Center staffing and technology as well as website vendors who will package website and Call Center services together. As with other core systems, the exchange will need to evaluate the cost of in-house staff versus the cost of an outsourced model. Either option will require the development of specific training programs and documentation. Fluctuations in enrollment levels will also need to be considered and the exchange will need to consider which model can be more responsive to both expected and unexpected enrollment trends over time.

In the SHOP exchange, many of these same considerations will apply, as will a host of additional needs that are more relevant to the small business community. Small employers will have more of a choice in using the exchange or not, and the SHOP exchange will need to actively compete for their business. Employer calls are likely to take on a greater sense of urgency or represent escalated issues. The SHOP exchange might also decide to use service as a market differentiator in trying to bring more small business to the exchange. A user-friendly, highly intuitive self-service web portal for employers is a likely requirement. One innovation that the SHOP exchange might want to consider is the availability of a virtual HR department at the exchange for the exclusive use of enrolled small businesses. For example, one national carrier now offers their small groups and brokers access to an online human resource and benefits library. The service provides comprehensive information and interactive guides that walk a small employer step by step through such processes as how do a performance review, hiring and terminations.

The service also provides a job description builder, salary benchmarking tools and access to laws and regulations. While the exchange must always consider the need to be financially self-sustaining as of 1/1/2015, offering this type of tool might be a particularly cost effective service differentiator for the SHOP exchange.

The SHOP exchange may want to consider outsourcing some or all of the SHOP-specific functionalities to one or more General Agencies (GA) or other intermediaries who already have strong, flexible technological capabilities, robust website architecture, current working relationships with New York brokers, and existing interfaces with many of the commercial carriers in the state. Many commercial carriers already use General Agencies to support their small group market and broker distribution channel; essentially, the carriers are outsourcing many of the administrative requirements and needs of the small group market to the General Agency. These General Agencies are effectively the face of the carrier for the broker and virtually all sales, support and service activities for the small group employer are managed through the GA channel. Carriers, who frequently contract with more than one General Agency for these services, pay a commission to the GA in addition to the commission of the individual broker. An advantage of outsourcing is the immediately acquired expertise and access to existing system capabilities (which nonetheless still need to interface with exchange systems but which may already interface with carriers). A disadvantage might entail foregoing federal dollars now to otherwise build SHOP related functionality into core systems before 2015 and a subsequent reliance on outsourcing in later years because federal funding won't be available for a later build out. As with much of the work impacting core system development, the exchange will need to perform a cost benefit analysis to determine the best approach given both short and long term needs and funding availability.

Finally, the business planning process should take into account a number of SHOP-specific considerations impacting QHP issuers selected for the small business market. For example, there is compelling evidence that standardizing carrier underwriting and other administrative practices in the SHOP exchange is advisable for the employee-choice model. There are several important differences between individual and small group insurance that suggest the need for greater uniformity across carriers when they are serving a single employer group. First, as a regulated entity, 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. Second, the employer is paying premiums and sponsoring coverage on behalf of the group, so must be able to understand and handle related functions with administrative ease. While differences in the way that carriers perform certain functions are inconsequential if the employer offers only one carrier, with multiple carriers in the group, these variations become intolerable. Third, the exchange is performing certain functions normally handled by a carrier serving the entire group, such as billing and collection, so the exchange needs some degree of uniformity in order to be able to administer those functions across carriers. Fourth, risk selection dynamics may dictate some standardization across plans to minimize the potential for adverse selection, relative to the conventional small group market.

Areas of potential uniformity or carrier standardization include the following:

1. Application of Adjusted Community Rating

While New York plans to keep pure community rating (i.e., no age-based variations) in place for the individual and small group markets, differences in how the carriers apply geographic factors in their rating practices for individuals and small employers can lead to different pricing of the same group among the carriers and can also generate a difference between the rates that a carrier might generate under a single-source versus an employee-choice model for exactly the same enrollees. Such differences can lead to unintended selection dynamics and premium increases.

2. Rating-basis type

While less than optimal, issuers can use different family size buckets (1-person, 2-adults, 1 adult + 1 child, 3 or more, etc.) for the non-group market, whereas an employer will expect all his/her carriers to use the same set of rating-basis categories. Employer contributions would be impossibly more complicated if, when choosing among plans, employees were also (unknowingly) selecting different rating basis types.

3. Participation Requirements

In the proposed regulations released in July 2011, HHS contemplates issuers' minimum participation rules, a typical rating tool in small group rating, and invites comment on whether QHPs offered in the SHOP exchange should be required to waive application of these rules on an issuer or plan basis or whether application of minimum participation rules should be permitted, and how that rate should be calculated. It is worth noting that Massachusetts has not prohibited its use, and that carriers and Insurance Commissioners are likely to see it as a legitimate group underwriting factor, even with community rating. If carriers are allowed to turn down a group or increase its rates because of low participation, then all carriers in the SHOP exchange must use the same standard for any group in the exchange.

4. Effective dates

In order to communicate enrollment processes to employers and to enroll his/her employees in multiple plans, employers, employees and issuers will need to abide by a uniform schedule for the entire enrollment process. This begins with the window for employers to make a "buy" decision – e.g. between 30 and 60 days prior to the effective date – and continues through a series of steps that culminates in the last day of employee enrollment. At the conclusion of the process, the employee participation rate – if allowed -- can be calculated, to see whether the group can be effective and whether rates need adjusting because of low participation. The July 2011 proposed rules delegate responsibility to the SHOP exchange to establish a uniform schedule. HHS notes in the preamble discussion that due to the rolling enrollment process for employers, the timeline will be standardized to the plan year as opposed to the calendar year timeline applicable to individuals.

5. Premium billing, collections & termination for non-collection

To minimize employer hassles, all carriers must bill employers through the exchange, which will consolidate billing and collection for any employer. Because different carriers will serve a single group, carriers must use the same standards for continuing/terminating service under conditions of late- or non-payment.

6. Broker commissions

These are normally set and paid by each carrier, but when carriers are splitting groups, the SHOP exchange will probably need to consolidate tracking and payment of broker commissions for the carriers, and use one standardized commission rate.

7. Employer audits

Like participation as an underwriting factor, false enrollment of non-employees in a group can raise costs because of selection dynamics, and carriers typically use different audit standards and practices to ensure that enrollees truly are employees and dependents of the group that offers to cover them. The exchange will need to perform this function on behalf of its issuers, which should be consistently applied across carriers by the SHOP exchange.

8. Late Adds & Terms, Qualifying Events, COBRA

The requirements of carriers regarding the timing, form and process for employers to notify them of mid-year adds and terms, their interpretation of legitimate qualifying events, the "run-out" coverage when employees switch plans, the extension of COBRA coverage, and other "administrivia" handled for employers by carriers all should be standardized to the extent feasible, to avoid gaps in coverage, misunderstandings by employers, and inequities between handling of one employee versus another.

9. Out-of-State Coverage

Unlike the households who buy through the individual market, employers may have out-of-state employees, so the SHOP exchange will want to offer such coverage. Moreover, rating employees residing out of state will be especially tricky under an employee-choice model because the different plans will be subject to different selection dynamics out of state, depending on product type in other states (e.g., HMO vs. PPO), breadth of network, and other factors. So, policies will need to be developed by the SHOP exchange to satisfy out of state employees that do not discriminate against some carriers in underwriting this risk.

In addition to these areas of uniformity for consideration, there are also many decisions that policymakers will need to make in the design of the SHOP exchange. Any of these decisions will impact the business planning process so we quickly mention them here as possible placeholders for the business plan.

1. To what extent should the state limit the insurance market outside of the exchange?
2. How aggressive should the state be in selectively contracting with carriers?
3. To what extent does the state want to standardize benefit designs within each tier? To what extent does the state want to standardize designs across multiple programs (individual and SHOP exchanges, Medicaid, CHIP, state employee health plan)?
4. Are there specific features in benefit design that the state wishes to promote, such as value-based insurance design or tiered or limited networks?
5. Does the state want to limit the SHOP exchange initially to employers with 50 or fewer employees?

Eligibility Verification, Premium Tax Credit and Cost Sharing Subsidy Calculator, Website, Enrollment, Billing & Collections, Customer Service (Call Center), Shop-Specific Processes

Once the Systems Integrator is in place, staff will need to transition quickly to the core systems that the exchange will operate: Eligibility Verification, Premium Tax Credits, Website, Enrollment & Billing, and Customer Service – Call Center Operations. Although the internal technical specifications for each will be different, the arch of development for these components will require a set of key competencies. The System Integrator will likely be responsible for procurement, contract negotiation, project management, and vendor oversight, while the State will need to oversee the performance of the System Integrator. As these core systems will constitute the bulk of exchange spending, both during start up and following implementation, it is critical to ensure that contracts are structured and negotiated in an efficient manner, and that both vendor and SI oversight is tightly managed. For example, while start-up costs may be paid on a fixed cost or time and materials basis, once operational, systems should be funded on a scalable basis (e.g., PMPM) to ensure the exchange can efficiently manage costs. Further, the exchange is in a unique position to leverage vendor competition and the SI should maximize this position to garner as competitive contracts as possible.

Major Activities:	Continue to develop specifications for and procure core operational and IT systems; Hire operational and IT project staff; Initiate Systems Integrator (SI) work with DOH oversight
Staff:	Chief Technology Officer, Chief Operating Officer, Director of Operations, Project Manager, Operations Analyst, IT Implementation Analyst, Financial Analysts (Support Procurements, Budget Management), Legal Counsel (contract oversight), Compliance Officer (procurement oversight)
Consultants:	RFP Support; Project Management; Eligibility Systems Vendor; Website Vendor; Enrollment & Billing Vendor; Customer Service Vendor; Legal Counsel
Major Milestones:	Select Systems Integrator; Select Quality Assurance Overseer; Decide on approaches to core systems; Complete specifications for eligibility verification, website, enrollment & billing, and customer service vendors; Select vendors; Negotiate and sign major vendor contracts; Begin system development and testing; System go-live

As the timelines for the core systems are largely redundant, we offer one aggregated timeline for Business Requirement II:

4-7;9: Eligibility Verification; Premium Tax Credit; Website; Enrollment, Billing & Collections and SHOP Specific Processes – Responsibilities of System Integrator(SI)**:	Begin	End
Assign interim exchange IT staff to work groups/committees to ensure exchange representation	Apr-11	Jul-11
Gather and define preliminary exchange business and technical requirements	Apr-11	Mar-12
Develop exchange Systems Integrator (SI) RFP	Jun-11	Aug-11
Publish exchange Systems Integrator (SI) RFP	Sep-11	Sep-11
Develop exchange Quality Assurance RFP	Sep-11	Dec-11
Publish exchange Quality Assurance RFP	Nov-11	Dec-11
Assess and score exchange Systems Integrator RFP responses	Feb-12	Mar-12
Assess and score exchange Quality Assurance RFP responses	Feb-12	Mar-12
Select exchange Systems Integrator vendor; negotiate terms , finalize contract	Feb-12	Mar-12
Select exchange Quality Assurance vendor; negotiate terms, finalize contract	Mar-12	Apr-12
Finalize design, implement, test, validate, go live	Feb-12	Oct-13
Ensure close coordination with DOH on all Eligibility-Related Matters	Mar-11	Dec-13
Develop cost allocation methodology as part of operational financing strategy	Feb-12	Apr-12
Hire CIO	Jun-12	Aug-12
Hire permanent exchange IT staff (Mgr., Analysts, Project Managers)	Jun-12	Sep-12
Work with CFO/COO once hired to implement exchange administrative IT infrastructure	Jun-12	Sep-12
Acquire computers, software, email capability, data storage, communications equipment (perm staff)	Jun-12	Sep-12
Ensure physical facility is properly wired and configured for IT needs of new staff	Apr-12	Jun-12
Help locate physical space for influx of short term IT implementation (SI and QA vendors)	Jan-12	Mar-12

8. Customer Service Call Center – Expected to be outside of SI contract	Begin	End
Gather and define business and technical requirements for call center	Apr-12	Jul-12
Hire exchange IT staff for call center	Apr-12	May-12
Determine buy/build approach for call center	Aug-12	Sep-12
Implement, test, validate, go live	Sep-12	Oct-13

**Systems design, development and implementation of core business functions of exchange expected to be within Systems Integrator contract (e.g. financial management, plan management, customer service, communications, eligibility and enrollment, oversight).

4. Eligibility Verification

Because it is the gateway to consumer shopping and subsidy-determination, establishing a real-time eligibility engine will be a gating issue for the development of other systems. The ACA requires an eligibility system to determine an individual's eligibility for Medicaid, CHIP, and exchange premium and cost-sharing subsidies. In November guidance, HHS offered that a state-based exchange could be approved if it uses Federally-managed services to make determinations for advance payments of the premium tax credit, cost-sharing reductions and exemptions from the individual responsibility requirement. The exchange will need to collect the information needed for eligibility determinations, transmit it to the appropriate agencies for verification, and then return eligibility decisions in real-time (for most customers). Federal guidelines indicate that customers should have the same, high-quality shopping experience regardless of which door (Medicaid, CHIP, or exchange) they utilize. The system should accommodate robust performance evaluation and management functions. The guidelines state that the federal government will establish an approach to verification from its agencies so that states will not have to independently establish their own interfaces and connections.

The key interfaces for the eligibility system will be with the existing public programs in the state, as well as to the federal government for subsidy eligibility determination. Managing the change in individual eligibility over time, properly communicating these changes, and reflecting them in the enrollment and billing system, will also be a critical portion of eligibility functionality. Like all systems, developing a structure to accommodate flexibility and appropriate reporting capabilities, in addition to scalability to support increased membership, will also be critical.

Staff:	Director of Operations, Project Manager(s), Operations Analyst(s)
Consultants:	RFP Support, Project Management, Eligibility System Vendor
IT/System Needs:	Eligibility verification system, Public program integration, Interface to secondary systems (enrollment & billing, website, reporting)
Key Tasks:	Develop RFP's; Coordinate development with state Medicaid office; Conduct gap analysis; Develop systems for collecting enrollment verification data; Determine exception processing consistent with federal regulations and guidance; Develop process for determination of newly eligible and existing Medicaid; Process for administration of tax credits

5. Premium Tax Credit and Cost Sharing Subsidy Calculator

The determination of premium tax credits and cost sharing subsidies is a critical business function of the exchange. The exchange is the only place where subsidy eligible individuals and small businesses can purchase health insurance in order to access their subsidies. Therefore, developing the necessary infrastructure that allows enrollees to readily determine the amount of the subsidy while engaged in the plan comparison shopping feature is not only a core business function, but an extremely important customer service feature.

The development and implementation of the premium tax credit calculator will require coordination with a number of different stakeholders. The calculation itself is dependent on the cost of the second lowest priced silver plan, so coordination with the QHP procurement process is very important. Submitting information to Treasury and HHS will be necessary, especially for those individuals who request and receive an advance tax credit. Coordination and reconciliation with QHP's will also be necessary, as 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.

The premium tax credit calculator will be an important source of information for exchange enrollees, key partners such as the federal government and QHP's, and will need to be performed in real-time during the initial eligibility process.

Staff:	Chief Financial Officer, Chief Information Officer, Finance Analysts, IT Analysts. Project Managers
Consultants:	RFP Support, Project Management, IT System Vendor (Eligibility Verification, Website)
IT/System Needs:	Premium tax credit system, interface to Treasury and HHS, interface to eligibility system and website
Key Tasks:	Develop RFP's; Coordinate with IT development; Develop cost calculator; Test accuracy of cost calculator; Develop and test data interfaces with HHS and US Treasury

6. Website

Exchanges are required to establish a website that provides standardized comparative information on QHPs and inform consumers about the eligibility criteria for Medicaid, the Children's Health Insurance Program (CHIP), and other applicable state and local programs. The exchange must provide a cost calculator that calculates the cost of coverage after the application of a premium or cost-sharing tax credit. This means that the exchange must have a mechanism for "grabbing" rates each month from carriers, assuming that carriers are allowed to adjust premium rates in the individual market based on enrollment dates during the year, as is currently the case. The internet portal must also provide information about enrollee satisfaction. In addition, the exchange should provide decision support tools, such as searchable provider directories, to help consumers choose a plan and additional functionality to support employees selecting coverage through the SHOP exchange.

The website is the public face of the exchange, and for many that interact with it, the website will be their only interaction with or perception of the exchange. The fact that the website must intersect with and transmit information from every part of the exchange means that having a solid and flexible website architecture and design in place will be necessary before other work processes can complete. New York's participation as a design partner in the IDEO Enroll UX 2014 project places the state on very firm footing to successfully meet these challenges. As the Enroll UX 2014 design deliverables are system agnostic, the state will need to assess available vendor options. In any event, managing the development of the site, while largely an IT exercise, will require collaboration from all areas of the exchange – including marketing, outreach, sales, IT and operations.

Staff:	Chief Technology Officer, IT Project Managers, IT implementation analysts, Outreach Manager
Consultants:	RFP Support, Project Management, Website development vendor, Website hosting vendor, marketing/design vendor
IT System Needs:	State-of-the-art website design, Interfaces with QHP's, Consumer decision support tools, Plan comparison tool
Key Tasks:	Develop vendor RFP; Select vendor; Determine and select content for website; Development of data interfaces with key business partners such as QHP's, state Medicaid, HHS and Treasury

7. Enrollment, Billing & Collections

The exchange will need to be able to enroll both individuals and small groups into health plans. This should include a process for confirming and communicating about plan selection, enrollment date, premium subsidy level, monthly enrollee premium (subsidized or unsubsidized), dollar flows, effective date of coverage, and fulfillment of enrollment process and materials by carrier. The exchange will need 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.

There should be automated data exchange between the eligibility, enrollment, and billing systems, so that consumers do not need to re-enter or re-transmit basic information at each step. Because of the likelihood of enrollee eligibility status changes with respect to eligibility, integration between the enrollment and eligibility systems is especially critical to ensure these changes are accurately reflected within the billing and account management system. Another critical interface will be with participating QHPs, both because the exchange will need to provide timely and accurate service and information to consumers, and also because the exchange's ability to efficiently perform the billing and enrollment function is one of the primary opportunities for the exchange to demonstrate value to participating carriers.

HHS has proposed an initial open enrollment period of October 1, 2013 through February 28, 2014 for the individual exchange, noting that it extends beyond January 1, 2014 to allow for sufficient outreach and education. The proposed rule also specifies that the initial open enrollment period for the SHOP exchange begin on October 1, 2013, with a rolling enrollment process established so that small employers are able to enter the SHOP exchange at any point during the year. These are red letter dates for exchange leadership to manage to within the business plan.

Staff:	Chief Operating Officer, Chief Financial Officer, Director of Accounting, Senior Accountant, Operations Project Manager, Operations Analyst
Consultants:	RFP Support, Project Management, Enrollment & Billing Vendor, Internal Audit Firm.
IT System Needs:	Enrollment & Billing System; Interfaces with secondary systems such as call center, eligibility; and accounting system
Key Tasks:	Develop RFP; Select vendor; Assess process for billing, collection, and account management; Establish IT interface between billing and other systems (eligibility, carriers, accounting, and website); Developing financial controls; Testing system performance and interface

8. Customer Service (Call Center)

Exchanges are required to provide a toll-free telephone hotline to provide for consumer assistance in addition to the website described. Exchanges need customer service to respond to individual, employer, and broker queries, any difficulties with website functionality or navigation, as well as problems in transmission of enrollment and premium information to plans.

Along with the website, the customer service center will provide a public face for the exchange in dealing with individual and small business consumers. Unlike the other systems, which are primarily or exclusively technology based, the customer service center involves a significant amount of staff that will need to be hired, trained, and managed. Experience running and/or managing call center operations are vital to the project staff tasked with procuring and/or managing this function. Of the core operational systems, the customer service center is also the most sensitive to changes in membership using the exchange, so, in addition to service quality, flexibility and scalability will be critical elements of the approach to developing a call center.

Staffing call centers may or may not be an exchange function, depending on whether the exchange builds or buys this service. As call centers are readily available in the private sector and most exchange website vendors will probably offer customer service as well, hiring and training staff for the call center may be a matter of vendor oversight, rather than a state responsibility.

Staff:	Director of Operations, Call Center Reps, Business Analysts, IT Analysts
Consultants:	RFP Support, Project Management, Customer Service Vendor
IT System Needs:	Flexible IVR System, Web Portal Self-Service, B2B Gateway
Key Tasks:	Develop RFP; Select Vendor(s); Integration plan for key system components; Determine unique needs of SHOP exchange

9. SHOP-Specific Processes

The SHOP exchange serving small businesses will need to provide a number of functions specific to the small group market. In contrast to the individual exchange where there will be a great deal of connectivity to Medicaid/CHIP and other New York based public assistance programs, the SHOP exchange will need to create an efficient and administratively simple process for small employers similar to the standards currently found in the commercial health insurance market in New York. In fact, in order to become a destination for the purchase of health insurance by small employers, the SHOP exchange will need to be able to serve the needs of small employers at least as effectively as the current market options, and as a new market entrant, will most likely need to improve upon standards.

Moreover, based on the NPRM of July 11th, state exchanges may be given the flexibility to decide whether to offer small employers various different models of purchasing coverage for their employees, ranging from employee choice across all QHPs, to employee choice of QHPs across one actuarial tier, to no employee choice of plans. If so, making such decisions will represent critical strategy and marketing determinations for the SHOP exchange, and will enhance the need for a separate strategic focus on the business of selling insurance to small employers in NYS. While not shown below as a separate task, the strategy of successfully "competing" in the small-group market is the greatest challenge with SHOP, and deserves careful consideration and specialized expertise. The SHOP exchange might consider outsourcing some or all SHOP specific functions to one or more General Agencies (GA) or other intermediaries with strong technology capabilities and existing relationships (and interfaces) with major carriers.

SHOP functionality will need to address online premium quote generation, employer account set up, employer verification process to confirm eligibility of employees, plan selection options, contribution levels, employee cost calculator, employer invoicing and payment receptacles, aggregated payments to carriers, customer service protocols for employers, employees and brokers, tax credit determination, broker training and sales tools, broker compensation, broker reporting and analytics, and uniformity requirements among carriers.

Staff:	Chief Sales & Marketing Officer, Business Analysts, IT Analysts
Consultants:	Project Management, Broker(s), General Agent
IT System Needs:	All core systems are impacted by SHOP requirements; Customer Relationship Management (CRM) tool
Key Tasks:	Determine required modifications and enhancements for SHOP-specific processes for each of the following core systems: eligibility verification; premium tax credit administration; website; enrollment, billing & collections; and customer service/call center operations; Build or buy CRM tool/functionality for managing employer business accounts

Business Requirement III: Communication & Outreach

Overview

Communication and Outreach requirements for the exchange can be separated into three critical paths: Outreach & Marketing, Navigators and Brokers. The Outreach & Marketing Plan will include the traditional tools of the trade including advertising, public relations, media relations, partnerships with other public or private entities, and most importantly, a carefully crafted marketing plan based on solid research that "connects the dots" for numerous stakeholders of a groundbreaking entity that will debut on a very public stage in a politically sensitive environment.

For New York's exchange to succeed and grow, the marketing plan must successfully communicate the value proposition of the exchange to both the public at large and to each of the many constituencies that will comprise the enrollment base: the uninsured, individuals (and families) eligible for tax credits and cost sharing subsidies, non-subsidized individuals, and small group employers and their employees. The target demographics represent an unusual marketing challenge as the exchange needs to appeal to both ends of the spectrum for: low income individuals and highly compensated entrepreneurs; "uninsurables" with pre-existing conditions who want coverage and young, healthy "invincibles" who don't; and people who value low cost above all else versus people who value provider choice at any price.

The exchange will need to approach the marketing plan with analytical discipline and a commitment to process. The plan should outline the key marketing challenges (brief description of the products to be marketed and associated goals, such as enrollment targets and strategic initiatives); conduct a situation analysis (outline goals, focus, culture, strengths, and weaknesses of the exchange); customer analysis (identify market segments, size, value drivers, decision and buying process); existing market analysis (strengths, weaknesses and market shares of carriers in the individual and small group space outside the exchange); partners (distributors, e.g., brokers, navigators, public agencies like Medicaid, QHP issuers, providers, etc.); climate (political, legal, economic, social, cultural, technological, and environmental factors); SWOT analysis (internal attributes of the exchange weighed as strengths and weaknesses while opportunities and threats are identified in the external environment); market segmentation (by segment: description, percent of desired enrollment, what they want, support requirements, how to reach them, price sensitivity); marketing strategies; and short and long term enrollment forecasts. Each marketing strategies should include the marketing mix decisions (4 P's) of product, price, place (distribution, e.g., navigators, brokers, direct sales) and promotion.

The product decisions should consider the QHP features and advantages and how they will be leveraged. Product decisions might include factors tied to either the QHP issuer or the QHP plan, such as: benefit offering, metal tier, quality indicators, value-based design, network breadth and depth, wellness features; adoption of electronic health records, outcome standards, enrollment of at-risk members and underserved populations, accreditation status, management of chronic conditions, reporting, and adherence to transparency guidelines. The QHP pricing strategy might include use of such variables as: geography, and tobacco usage. Place or distribution variables include direct sales, navigator assisted sales and broker directed sales. Finally, promotion includes: advertising (including type of media, how much and when); public relations, promotional programs or outreach partnership, marketing budget, and expected ROI for each of the various promotional programs.

In developing the promotional campaign, the exchange will want to hire external consultants or firms with expertise in advertising, PR, public/private partnerships and media relations. For example, in Massachusetts, the Connector partnered with the Red Sox organization to promote the exchange and universal access to health care. The campaign was extremely successful and helped the state to promote awareness of universal care across all socio-economic segments. New York may want to consider similar "partnership" opportunities in the Empire State as such partnerships generally have relatively small price tags and broad reach. Expertise in working with the media will also be a required skill set given the public nature of board meetings and the politics of healthcare. Finally, the exchange will need to be sensitive to how (and how much) money is spent on advertising to avoid criticism of a highly charged line item in all public budgets.

There are two sections to the marketing plan which should be attended to with considerable detail: the Navigator Program and Broker Plan.

Brokers often act as a trusted advisor for small business, and often assume the additional role of a human resource function for small business owners. Brokers will assist the small business owner in explaining insurance options to employees, provide information on cost sharing provisions and availability of certain health care providers, assist in completing the required health plan paperwork for employer and employees, explain insurance laws and generally ensure that the entire purchasing process beginning with plan comparisons to paying the first months premium is performed smoothly and efficiently. Although the ACA and exchanges are expected to radically change how health insurance is purchased by individuals and small businesses, by streamlining and simplifying the research and purchase function through the use of state-of-the-art technology, benefit standardization, and transparency, it is still important for New York to analyze and assess the future role of brokers in an exchange environment.

Navigators, which are different than brokers but perform similar functions, and are specifically referenced in the ACA legislation, are expected to play an important role in the new health insurance market post-2013. The ACA defines Navigators as "Community and consumer-focused nonprofit groups; trade, industry, professional associations; commercial fishing industry organizations; ranching and farming organizations; chambers of commerce; unions; partners of the Small Business Administration; licensed insurance agents and brokers."

The role of the Navigator, as specified under ACA, is not too dissimilar to the role played by facilitated enrollers for the Medicaid and Child Health Plus programs. More specifically, the duties of Navigators are expected to include activities such as:

- Conduct public education activities to raise awareness of the availability of qualified health plans;
- Distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits and cost-sharing reductions;
- Facilitate enrollment in qualified health plans;
- Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or determination under such plan or coverage; and
- Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the exchange.

Naturally there is a lot of interest on the part of brokers about how the Navigator program will affect their role, and are Navigators being afforded an unfair competitive advantage in assisting prospective exchange enrollees. New York has already recognized this debate and has commissioned a "Third Party Assistor" study to review the role of the broker and other third parties in more depth. Notwithstanding this analysis, there are some relevant planning questions that can be cataloged here: (i) How should each of these roles be defined; (ii) What are fair and reasonable compensation levels for each; (iii) Should there be licensure or certification criteria for navigators, and if so, what are they; (iv) How will brokers and navigators be measured or evaluated in terms of their effectiveness to the exchange; and (v) Should roles and compensation for navigators and brokers be different for the individual market and small group markets. The answers to these questions will add further substance to the business planning document.

Outreach & Marketing Plan, Navigator Program, & Broker Program

Communicating effectively to individuals, employers, community-based organizations, brokers, and the public at large about the value and potential of the exchange, quality and value of health plan options, as well as health care reform in the whole, will be critical to the success of the exchange both from the standpoint of fulfilling its mission as well as its ability to become financially self-sustaining soon after start-up. Because the business of the exchange is complex and multi-functional, the communications strategy employed by the exchange will by necessity be multi-faceted as well. In fact, there are numerous functions, each uniquely distinct under this umbrella heading, demanding their own expertise and core competencies:

- Marketing – developing the formal marketing plan
- Public relations – managing communications with the press and inquiries from 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. The Sales function will be carried out in the field by navigators and brokers.

Establishing these marketing and outreach functions of the exchange will require an internal sales management staff as well as staff with broad communications capabilities and experience working and building relationships with the many different constituencies with whom the exchange must do business. This will probably entail a combination of internal staffing, work with one (or more) outside PR/advertising agencies, a navigator program and a broker plan.

Major Activities:	Hiring key communications staff; Building relationships with the media, key partner organizations, and broker/producer community; Developing Navigator grant program and selecting Navigator grantees; Selecting advertising vendor; Designing and implementing advertising campaign, development of a plan rating system
Staff:	Chief Sales & Marketing Officer, Public Affairs Associate, Manager of Outreach, Outreach Associate, Sales Manager; Manager of Navigator Program and Manager of Broker Management.
Vendors/Partners:	Navigator grantee organizations; Insurance brokers; General Agencies; PR agency, and Advertising vendor
Major Milestones:	Develop Marketing Plan; Develop funding model and goals for Navigator program; Develop RFP and select Navigator organizations; Develop RFP and select advertising vendor; Develop and implement outreach and advertising campaigns; Develop details and algorithms for ranking health plans; Develop broker relationships and management capabilities

10. Outreach & Marketing Plan

As mentioned above, marketing and outreach is a broad category under which several different types of activities will fall: marketing, public relations, community-based outreach, advertising, and sales. The relative weight given to these different activities will change as the exchange moves from start up to full operations. At the outset, the focus will need to be on managing the media and public inquiries, as well as developing relationships with partner organizations and other constituents. As the date for full implementation draws closer, increased focus will be placed on outreach and marketing activities to publicize the exchange and cultivate membership. Finally, when the exchange becomes operational, explicit sales and broker management functions will become critical to increase and sustain membership coming through the exchange.

Staff:	Chief Sales & Marketing Officer, Chief Communication Officer, Sales Manager, Outreach Manager, Marketing/PR or Outreach Specialist
Vendors/Partners:	Marketing/Advertising Vendor, Printing Vendor, Mail House Vendor, Digital Marketing Vendor, Design Vendor
IT/System Needs:	Design/publishing software; Market research and survey design tools
Key Tasks:	Determine marketing plan; Develop marketing RFP; Select market & advertising vendor; Place media buy; Develop tools to evaluate effectiveness of marketing campaign and return on investment (ROI)

10. Outreach & Marketing Plan	Begin	End
Begin search and hire Chief Sales & Marketing Officer	Aug-12	Sept-12
Begin search and hire Chief Communications Officer	Aug-12	Sept 12
Develop a high level communication & outreach strategy for exchange; initiate research	Jul-12	Aug-12
Solicit input from key stakeholders in state	Jul-12	Aug-12
Develop an outreach and marketing budget	Aug-12	Sep-12
Develop return on investment (ROI) metrics	Aug-12	Sep-12
Develop & Publish RFP for Marketing & Advertising Vendor	Oct-12	Nov-12
Finalize RFP process and select vendor	Nov-12	Jan-13
Working with vendor, complete market research and begin planning activities	Jan-13	Jan-13
Identify outreach partners (other state agencies and existing health care advocacy groups)	Oct-12	Jan-13
Identify potential marketing partners and alliances for exchange	Oct-12	Jan-13
Select outreach and marketing partners	Jan-13	Feb-13
Execute outreach and communication plan	Jan-13	Dec-13
Collect data and calculate ROI	Jul-13	Dec-13

11. Navigator Program

In addition to the outreach efforts outlined above, the exchange will need to establish and fund a Navigator grant program. Navigators will perform outreach, especially to hard-to-reach populations, and help clients through the plan selection and eligibility determination process. The start-up and management of this program will require the state to identify, contract with, train, oversee, and support organizations and/or individuals to act as Navigators. Prior to performing these functions, however, the exchange must determine the size and shape of the navigator program, including the scale and source of funding, which will need to be provided by the state. The exchange will then 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.

Staff:	Manager of Navigator Program
Vendors/Partners:	Participating Navigator Grantees
IT/System Needs:	Analysis and reporting software; training and support tools
Key Tasks:	Develop RFP for selection of Navigator; Select Navigators; Develop Navigator Management tool; Determine funding needs

11. Navigator Program	Begin	End
Conduct Third Party Assistor study and review results	Oct-11	Apr-12
Hire exchange staffer to oversee Navigator program	Jul-12	Aug12
Determine level of consulting services required, if any	Aug-12	Sep-12
Develop Navigator stakeholder meetings to solicit input from key stakeholders	Jul-12	Aug-12
Determine level of training and certification required of Navigators by Exchange	Sep-12	Oct-12
Develop Navigator training program	Oct-12	Dec-12
Determine level of compensation to be paid to Navigators -- per enrollee/fixed grants, etc.	Aug-12	Oct-12
Develop funding stream for Navigators -- pre 2014 / post 2013	Sep-12	Oct-12
Develop RFP for Navigators	Oct-12	Nov-12
Select Navigators	Dec-12	Jan-13
Train Navigators	Apr-13	Jul-13
Develop Navigator Management Tool, TBD**	Nov-12	Jan-13

**Systems design, development and implementation of core business functions of exchange expected to be within Systems Integrator contract (e.g. financial management, plan management, customer service, communications, eligibility and enrollment, oversight).

12. Broker Program

While brokers in New York are thought to have very little presence in the individual market, they are believed to be playing a significant role with small groups. Small group employers often do not have a formal Human Resource function and brokers frequently assist the employer with plan comparisons, claim problems and administrative issues with the carrier. Once the exchange determines how brokers will be used to market the exchange, the exchange will need to identify, select, train, manage and support brokers; determine compensation and tools needed to execute compensation agreement; develop a broker specific web portal; provide access to a CRM tool for brokers to access exchange information on employer customers and maintain a sales pipeline both for forecasting enrollment and assessing broker effectiveness. The exchange might also want to consider outsourcing broker management (or other SHOP functions) to a General Agency.

Staff:	Manager of Broker Relations
Vendors/Partners:	Brokers, General Agencies
IT/System Needs:	Customer Relationship Management (CRM) tool; training and support tools (web portal)
Key Tasks:	Develop RFP for selection of General Agency; Select Brokers; Develop CRM tool; Determine commissions

12. Broker Program	Begin	End
Conduct Third Party Assistor study to determine broker comp, services provided, markets serviced	Oct-11	Feb-12
Conduct broker stakeholder interviews to solicit input from broker community	Oct-11	Jan-12
Using data from market study and stakeholder interviews, develop exchange broker strategy	Apr-12	May-12
Determine level of broker compensation for writing exchange business	Jun-12	Aug-12
Hire exchange staffer to oversee broker program	Jul-12	Aug-12
Determine funds flow of broker payments	Aug-12	Sep-12
Develop broker management tool to track key broker metrics, TBD**	Nov-12	Jan-13
Develop a broker training program for exchange products	Sep-12	Nov-12
Train brokers	Jan-13	Jul-13
Develop a broker-advisory council for ongoing feedback from brokers once operational	Apr-13	Apr-13
Reflect broker-specific policies in QHP procurement	Nov-12	Nov-12

**Systems design, development and implementation of core business functions of exchange expected to be within Systems Integrator contract (e.g. financial management, plan management, customer service, communications, eligibility and enrollment, oversight).

Business Requirement IV: QHP Plan Management

Overview

QHP Plan Management is at the heart of the exchange and represents a critical core competency that cannot be outsourced or bought. The exchange will want to hire staff with considerable expertise in healthcare, health insurance, provider contracting, product development/management, healthcare economics, quality assessment, and pricing. Procurement expertise and RFP development and proposal evaluation experience will be needed as well. The staff will need to know the New York individual and small group insurance market inside and out, and what sells and what doesn't. QHP Plan Management is responsible for stocking the virtual shelves of the exchange with the right products for the target markets and the product selection process will include both strategic and tactical considerations.

As a key first step, the state must decide how to define the essential health benefits (EHB) package. HHS released initial guidance on EHBs in December and issued a Frequently Asked Questions (FAQ) document in February of 2012. In the FAQ document, HHS confirmed that a state may select only one of the benchmark options outlined in the December bulletin as the applicable EHB benchmark plan across its individual and small group markets, both inside and outside of the exchange. The specific set of benchmark benefits selected in 2012 would apply for plan years 2014 and 2015. For 2014 and 2015, the EHB benchmark plan selection must take place in the third quarter of 2012.

NY has the flexibility to select a benchmark plan that reflects the scope of services offered by a "typical employer plan," as long as it provides coverage in ten statutory benefit categories. To this end, HHS will allow a state to choose one benchmark plan from: (1) One of the three largest small group plans in the state by enrollment; (2) One of the three largest state employee health plans by enrollment; (3) One of the three largest federal employee health plan options by enrollment; or (4) The largest HMO plan offered in the state's commercial market by enrollment. The benefits and services included in the benchmark plan would constitute the state's essential health benefits package.

As New York's selection of one benchmark plan will define benefit offerings in both its individual and small group markets, both inside and outside of the exchange, the selection process must be carefully considered. Additionally, if New York were to choose a benchmark plan that does not include all NY-mandated benefits, the ACA requires the State to defray the cost of those mandated benefits in excess of EHB as defined by the selected benchmark. In addition to these considerations, the selection of the benchmark plan will be certain to capture the close interest of virtually all of the State's stakeholders in the exchange planning process.

The exchange needs to determine their purchasing strategy in the very early days: does the exchange intend to take on an active purchasing role or a passive contracting strategy or something in between the two? How can the purchasing strategy be leveraged to achieve additional value and quality objectives? Does the exchange want to use the purchasing strategy to help reform the larger health care market? Does the strategy ensure that safety net providers are adequately protected? Will the purchasing strategy be the same for the individual and small group markets? Will plan designs be standardized or will innovation among QHPs be encouraged? How will the provider network(s) be structured to influence price? How much plan choice will be offered?

The ACA gives the exchange considerable latitude in determining what's best for New York and New Yorkers. At a minimum, the certification process must ensure that plans meet two basic requirements to be certified as a QHP: the plan must meet minimum certification requirements in the ACA and the exchange determines that the plan is in the best interests of qualified individuals and employers. There are very few plan design decisions the exchange cannot make (e.g., it cannot exclude a plan because it is fee-for-service, by imposing premium price controls or because a plan provides treatments necessary to prevent a patient's death under circumstances the exchange determines are costly or inappropriate).

Additional plan management considerations include: a process to establish or evaluate the service area of a QHP to ensure that it is nondiscriminatory; certification of QHPs must be completed prior to open enrollment periods; QHP issuers must be monitored for evidence of ongoing compliance with certification requirements; a process to ensure price increases are reviewed and justified in a timely manner (with the objective that the review process will not unnecessarily duplicate the state's rate review program); and QHP issuers must comply with exchange processes, procedures, requirements, interfaces and risk adjustment program.

Some of these plan management considerations may be addressed through the State's contemplated use of NAIC's System for Electronic Rate and Form Filing (SERFF), which is already being utilized by carriers in rate and form filings with DOH and DFS in NY (as well as many other states). Exchange planners continue to look for any opportunity to re-purpose or re-use existing systems and processes that work well and that are already understood by carriers.

A further component of the QHP procurement strategy includes the development of a plan rating system which will allow both the exchange and consumers to evaluate QHPs on the dimensions of quality and value. The rating system should be established before the RFP process is initiated as it will be important for prospective carriers to understand what metrics are important to the selection process. Metrics should reflect the goals of the exchange and perhaps the larger health care reform goals of the state. New York can utilize the HHS developed model or customize it to reflect these goals and to establish the relative importance of various dimensions of quality and value. 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. As such, the plan rating system should be accurate, comprehensive, current, and relevant.

The RFP plan selection process can be initiated once the exchange has finalized their QHP strategy and plan rating system, and linked each component to its operational requirements. Throughout this process, it behooves the exchange to be communicating with stakeholders and insurers in particular on the expected timeline, process and goals of the solicitation process. Once the RFP selection 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. Clearly, certifying, recertifying and decertifying health plans touches almost every operation of the exchange and effort will involve the time and talents of nearly every employee of the exchange.

The last core work processes associated with the business requirements of QHP Plan Management involve the establishment of two temporary programs designed to minimize adverse selection in the first three years of exchange operations as well as a permanent risk adjustment program. All three programs are designed to provide stability and some financial protections for issuers in the individual and small group markets. The three programs include: reinsurance, risk corridor protection and risk adjustment. As the risk corridor program is administered by HHS, it has the least impact on the business plan. As long as the state elects to build an exchange, it is required to administer a reinsurance program as HHS will not do so. The administration of the risk adjustment program can either be deferred to HHS or the state can elect to administer the program. As managing either risk program requires highly specialized knowledge, the exchange will need to determine whether they want to outsource these functions or hire the necessary skillsets and manage the processes internally. Secondly, for both risk adjustment and reinsurance, the exchange will need to develop a plan for which agency or entity will administer the necessary functions.

The state of New York has engaged Wakely Consulting to assist in their planning for the risk adjustment and reinsurance provisions of the ACA. As part of this work, Wakely has largely completed a review of the current risk adjustment programs in NY, and is now developing a work plan that New York (and other states) can utilize to implement the reinsurance and risk adjustment provisions of the ACA. This work is funded by the Robert Wood Johnson Foundation through the State Health Reform Assistance Network, of which New York is one of 10 states selected to receive technical assistance. Additionally, the NYS Health Foundation is providing support for a stakeholder engagement process that will ultimately inform the development of the New York specific work plan.

As provided under the ACA, assessments of the entire insurance market will pay for the reinsurance program. Under the proposed rules released in July 2011, a uniform percentage of premiums will be applied to all fully insured plans and all states (self-funded employers will contribute based on a percentage of claims). New York will have the option of increasing the assessment but may not decrease it. The reinsurance provision will follow typical stop loss provisions based on actual expenditures, but the attachment point will be relatively low compared to commercial reinsurance and allowable amounts will be capped at a commercial stop loss reinsurance amount. As a result, reinsurance will not protect against the highest cost individuals but rather will protect against a disproportionate share of higher cost enrollees. New York will have the option to change the attachment point, coinsurance rate and cap amount (including eliminating the cap). The state will want to develop a plan to model the funds available under various assessment rates and attachment point, coinsurance and cap options given those various assessment rates. Modeling should ensure that assessments are sufficient to avoid any shortfalls. Given the uncertainties of insuring previously uninsured individuals, the risks associated with the modeling process are high and the exchange should hire the best talent it can find to perform these tasks in-house or outsource the program to a firm with appropriate expertise and experience.

The risk adjustment program under the ACA is a permanent program that will begin in 2014. It is intended to protect health plans operating in the individual and small group markets, both inside and outside of the exchange, from attracting a disproportionate share of higher risks after factoring out the allowable rating variables (e.g., , family size/composition, tobacco use and geography), as may be applicable in New York. If New York decides not to outsource this program to HHS, it must first decide whether the exchange will perform the risk adjustment functions or if this work will be performed by another entity, which can include the state Medicaid agency or a private entity that meets HHS eligibility requirements (e.g., incorporation in at least one state; experience in the individual and small group markets, and is not or does not act as a health insurance issuer). HHS will develop a federal model that states can use, or alternatively, New York can develop its own model or use any state model that has been filed with HHS and approved. If New York 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.

A key component of risk adjustment involves data collection and to this point, the authority for New York's creation of an All Payer Claims Database (APCD) in April of 2011 is a very positive development for the exchange. The advantage of developing an APCD includes relatively lower administrative costs as the state will not have to collect and conform to certain data standards that are not necessary for the purposes of risk adjustment or reinsurance, providing that the APCD is operational on or before January 1, 2013.

The risk adjustment planning process must also include an audit function (e.g., who will perform the audits and what will the schedule and level of adjustments for payment transfers should be). New York might consider creating a stakeholder work plan to identify necessary steps, stakeholder feedback checkpoints and timelines. Potential members could include exchange representatives, Department of Insurance, Department of Health, health plans and providers.

Qualified Health Plan Certification, Plan Rating System, & Risk Adjustment

Procuring Qualified Health Plans (QHPs) will be one of the most important tasks performed by the New York Health Benefit Exchange and the exchange will need to focus a great deal of energy and resources on this critical core competency. To develop this function successfully, New York will draw upon a number of different exchange areas; legal to assist in structuring the RFPs; finance to develop sufficient QHP assessment, broker commissions, and other financial elements; operations to ensure the requirements and necessary detail is contained in the RFP and subsequent QHP contracts; and of course IT will play a critical role in ensuring information such as enrollment and premium rates can be shared timely and accurately. A key first step will be selecting the EHB benchmark plan.

In addition to drawing on a number of different internal staffing areas, expertise unique to QHP procurement will be necessary. Financial and data analyses to help develop a procurement strategy will be important, as well as access to data such as medical and enrollment trends, popular benefit designs, and provider access.

There are three types of risk adjustment programs created by the ACA. The state will have the option of administering the risk adjustment program or outsourcing the function to HHS. Unlike risk adjustment, states that establish a state-based exchange must administer the temporary reinsurance program, which operates from 2014 – 2016. While temporary risk adjustment cannot be outsourced to HHS, the state can contract with or establish a reinsurance administrator subject to certain standards. If New York elects to administer their risk adjustment program, the exchange (or other eligible entity) will need to develop a model and/or weights and file with HHS by November 2012. The third program, risk corridor protection, will be administered by HHS for all states.

In September, Wakely (through the State Reform Network) began to develop a proposed work plan for the reinsurance and risk adjustment provisions. As part of this project, Wakely has begun to engage stakeholders for the purpose of developing a New York-specific methodology approach.

The exchange will work with HHS to develop a plan rating system that provides consumers with clear, concise information regarding the quality and value of plan options on the exchange. Plan ratings will be displayed on the website for consumers to consider in their decision-making process.

Main Activities:	Decision on EHB benchmark plan selection; Decisions on risk adjustment programs; if applicable, development of risk adjustment methodology and analytic infrastructure; development of reinsurance program; develop QHP procurement; select QHPs; negotiate contracts; conduct open enrollment
Staff:	Chief Financial Officer; Chief Operating Officer; Financial Analysts; Chief Information Technology Officer
Vendors/Partners:	Actuaries, Legal Counsel, RFP Development, Vendor specializing in ranking of health plan quality
Major Milestones:	Selection of EHB benchmark plan; Develop risk adjustment methodology; Develop reinsurance program; Develop IT and analytical infrastructure to accept and analyze carrier claims data; Develop RFP for QHPs; Select QHPs; Development of IT interfaces with health plans; Website go live and start of shopping

13. Qualified Health Plan (QHP) Certification

Certifying and offering QHPs for sale 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. The exchange must first establish standards for QHPs, which will be informed by federal guidelines, and then develop its requirements for benefit designs to be offered through the exchange. It will then need to develop the procurement 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). The ability to support these functions will depend, of course, on the successful development of the work processes outlined above (e.g., eligibility, enrollment, website, and risk adjustment).

Staff:	Chief Financial Officer; Financial Analyst; Project Manager; Legal Counsel; Director of Policy; IT Manager
Consultants:	RFP Development; Consulting Actuary; Legal Counsel
IT/System Needs:	Enrollment & Billing interface to health plans; Website for shopping and open enrollment; possible leveraging of SERFF for plan management activities
Key Tasks:	Design procurement strategy; Develop RFP and review responses; Negotiate with health plans; develop IT interface to carriers for enrollment & billing; assess SERFF capabilities; develop member materials and outreach campaign; prepare systems for open enrollment and online shopping

13. Qualified Health Plan (QHP) Certification	Begin	End
Select Essential Health Benefits (EHB) Benchmark plan	Apr-12	Sept-12
Determine exchange staff to oversee QHP procurement	Jul-12	Aug-12
Compile data necessary to analyze and develop procurement goals	May-12	Aug-12
Analyze data and develop state procurement goals	Jul-12	Aug-12
Communicate goals of procurement with BOD	Aug-12	Sep-12
Develop communication plan to meet with carriers prior to release of RFP	Sep-12	Sep-12
Assess NAIC SERFF for use in plan management	Aug-11	July- 12
Incorporate into QHP procurement strategy OPM offerings	Sep-12	Sep-12
Organize cross-functional QHP procurement team	Oct-12	Oct-12
Incorporate Plan Rating System in procurement	Oct-12	Nov-12
Incorporate Risk Adjustment methodology in procurement	Oct-12	Nov-12
Develop with IT, operational specifications for QHP's -- enrollment/premium rates/billings, TBD**	Mar-12	Aug-12
Develop and publish RFP	Nov-12	Dec-12
Select & Contract with QHP's	Jan-13	Feb-13
Begin implementation of QHP's	Feb-13	Feb-13
Test systems, interfaces, website design	Jun-13	Sep-13
OPEN ENROLLMENT	**Oct-13**	**Feb-14**

**Systems design, development and implementation of core business functions of exchange expected to be within Systems Integrator contract (e.g. financial management, plan management, customer service, communications, eligibility and enrollment, oversight).

14. Plan Rating System

As required in the ACA and in coordination with HHS, New York's exchange will be implementing a plan rating system for Qualified Health Plans (QHPs). This rating system is expected to evaluate QHPs on the dimensions of quality and value, and will be an important consumer decision support tool. In addition to allowing consumers the opportunity to evaluate the QHPs offered across the exchange, it could also provide critical information that allows consumers the ability to evaluate plans on the exchange to plans not offered on the exchange. This plan rating system could be a competitive differentiator for the exchange, help drive consumer traffic to its website, and provide meaningful data to the consumer market. As a result, it will be important that any plan rating system be as thorough, empirically accurate, and current as possible, while providing the level of clarity and conciseness necessary for easy interpretation by consumers.

Depending on the level of detail provided by HHS regarding the plan rating system, it may be necessary for New York to develop state-specific metrics in which to compare plans. Or even if the HHS developed model is very detailed and requires little state customization, New York may decide to develop a rating system that is reflective of the goals of its exchange and the implementation of any health care reforms specific to the state. Therefore, it will be necessary for New York to develop a policy perspective on the plan rating calculated by state personnel. To date, consideration has been given toward building upon NY's existing Quality Assurance Reporting Requirements (QARR) system, which consists of measures from the national Committee for Quality Assurance's (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) and NY State-specific measures.

The plan rating system can also be utilized during the QHP procurement process to advance an active purchaser exchange model, if desired, by providing differential value to QHPs that rank high on the plan rating system. In order to integrate the plan rating system to the QHP procurement, the plan rating system will need to be significantly complete prior to releasing the QHP RFP.

Staff:	Chief Marketing Officer, Chief Financial Officer, Public Relations Manager, Outreach Manager, Public Relations Associate, Sales Manager
Vendors/Partners:	Health Plan Quality Ranking Vendors, Marketing Vendor, Website Designer
IT/System Needs:	Plan Ranking Tool; Website; Call Center
Key Tasks:	Assess and determine quality and value metrics; Determine algorithm for plan ranking; Communicate with prospective QHP's; Develop/purchase plan ranking tool, integrate into website and call center system

14. Plan Rating System	Begin	End
Review federal guidance for Plan Rating System	Jul-12	Jul-12
Determine goals of state in rating QHP's	Aug-12	Aug-12
Select type of quality/cost metrics to rank QHP's	Sep-12	Sep-12
Determine availability of plan rating data	Sep-12	Oct-12
Integrate with exchange website, TBD**	Jul-13	Jul-13
Develop implementation plan for ongoing data maintenance and updating of ratings	Nov-12	Dec-12
Integrate with QHP procurement strategy	Oct-12	Oct-12
Include plan rating specifications into QHP procurement document	Oct-12	Nov-12

**Systems design, development and implementation of core business functions of exchange expected to be within Systems Integrator contract (e.g. financial management, plan management, customer service, communications, eligibility and enrollment, oversight).

15. Risk Adjustment

The ACA creates three kinds of risk adjustment programs: a temporary reinsurance program that assesses fees on all carriers and makes payments to individual plans enrolling high-risk individuals; a temporary risk corridor program for qualified health plans in the individual and small group markets; and a risk adjustment program for issuers offering plans in the 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 any state that builds their own exchange; and HHS will administer the risk corridor program for all states.

Development of a risk adjustment program will require multiple steps and competencies: actuarial, technological, and financial. Developing a program that appropriately adjusts risk will require first a conceptual and strategic perspective on how the exchange will operate and how risk adjustment will support the goals of the exchange. Then it will require sufficient empirical data to assess and model the risk of membership anticipated inside and outside the exchange and between carriers. Analyzing this data will first require that the exchange acquire the capability to store and analyze claims data. Once the exchange becomes operational, the exchange will need the ability to accept, store, and analyze large volumes of claims data from participating QHPs. New York's April 2011 passage of the authority to create an All Payer Claims Database (APCD) that builds on the state's existing SPARCS law (PHL 2816) will certainly help facilitate this process. Finally, the exchange will need to develop a system of financial controls and public reporting to ensure payment adjustments are being made accurately and that the system has sufficient levels of transparency to sustain trust and support.

Staff:	Chief Financial Officer, Financial Analysts, IT Manager, Compliance Officer (data storage, control)
Consultants:	Consulting Actuary, Data Analytics, Internal Audit
IT/System Needs:	Data Warehouse; Claims Acceptance and Storage Capability; Claims Analytics and Reporting Tools; Financial Payment and Reporting System
Key Tasks:	Develop claims data and analytics infrastructure; Assess market and claims information to determine risk adjustment methodology requirements; Develop consulting actuary RFP; Develop risk adjustment methodology; Communicate with health plans; Develop payment and financial reporting functions

15. Reinsurance & Risk Adjustment Program	Begin	End
Conduct study on reinsurance and risk adjustment needs and options	Sep-11	Mar-12
Determine level of interaction necessary with HHS regarding federal implem of risk corridors	Apr-12	Jun-12
Determine availability of enrollment and claims data for analysis	Nov-11	Jun-12
Compile necessary data to begin analytical assessment	Nov-11	Jun-12
Determine where will program be managed within the state	Jul-12	Sep-12
Decide on where will data be held and managed for start-up and operations	Nov-11	Jul-12
Contract with subject matter experts	May-12	Aug-12
Develop risk adjustment methodology for program implementation	Apr-12	Sep-12
Develop schedule of meetings with carriers in market	Apr-12	Jun-12
Discuss proposed risk adjustment methodology with carriers and solicit input	Jul-12	Sep-12
Communicate with BOD program specifics after meeting with carriers	Oct-12	Dec-12
Develop "dry runs" of agreed upon methodology to determine impact on market	Jan-13	Mar-13
Share results of "dry runs" with carriers; modify methodology if necessary	Feb-13	Jul-13
Develop implementation plan -- data mgmt.; communications; funds flow; reconciliation	Oct-12	Mar-13
Implement program	Jan-14	Dec-14

Business Requirement V: Regulatory Compliance & Reporting

Overview

The exchange has several regulatory compliance and reporting functions under the ACA that are typical for governmental entities. These functions include: processing and adjudicating grievances and appeals of eligibility determinations of individuals or employers, decertification of QHPs, as well as for the individual mandate provision of the ACA; notifying employers who may be subject to penalties and notifying HHS of same; supporting federally required applications and notices related to the eligibility and enrollment processes; providing relevant information to QHP issuers and HHS to start, stop, or change the level of premium tax credits and cost-sharing reductions; reporting requirements to the IRS and enrollee; reporting on consumer experiences and satisfaction levels with the exchange; reporting on QHP metrics; audits, financial reports and performance updates on the operations of the exchange to HHS and state government; and ad hoc reporting requests of the Board of Directors, the public and the media. Generally a function not seriously evaluated until well beyond the start-up of an organization, regulatory compliance and reporting needs 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 legislature, the public, and market participants, as any other function it will perform.

Regulatory compliance and reporting will impact virtually every core system and work process.

External Reporting, Mandate Determination & Appeals

In addition to its operational role, the Exchange has important regulatory and reporting functions that will put it into contact with the public in a form that is more classically governmental. These functions include processing and adjudicating appeals of the individual mandate and eligibility determination, notifying employers who may be subject to penalties, reporting on consumer experiences with the exchange, and reporting on QHP quality metrics. Carrying out these politically sensitive tasks efficiently, effectively and with considerable flexibility will be necessary to maintain public support for the health reform, and are vital to meeting New York's vision for an accessible, transparent, and consumer-oriented organization.

Major Activities:	Developing infrastructure to collect and report information; creating metrics, methodology and technical capabilities to rate health plan quality; establishing appeals process rules, policies, and procedures; managing and adjudicating appeals
Staff:	Compliance Officer, Policy Manager, Policy Analyst, IT Project Manager, IT Implementation Analyst, Chief Legal Counsel, Assistant Legal Counsel, Appeals Manager, Appeals Associate
Consultants:	Quality Rating System Development; Data Analytics; Website/Online Tool Development; Document Management Support, Legal Counsel, Hearing Officers, Hearing Location Providers, Mail house for employer notifications

Major Milestones:	Develop requirements for systems and program operations, including capturing appropriate data and submission of information to HHS; Conduct user testing for data reporting system; Establish protocols for appeal review and adjudication process; Draft policies and procedures for appeals process; Develop internal capacity and workflows to manage review of appeals

16. External Reporting

The ACA requires exchanges to carry out a number of consumer protection and public reporting functions. While some of these requirements relate to addressing consumer complaints, the bulk of the requirements relate to collecting and then distributing information. The exchange must collect a wide variety of information from health plans, including enrollment, claim denials, and financial disclosures; they must collect and distribute information on enrollee satisfaction; rate participating health plans on quality; and provide information to the public on consumer experience in the exchange. In addition, the exchange will need to provide updates and information to both the state and federal governments around spending and performance management, and will likely face significant additional requests for information from stakeholders and members of the public and media. Meeting these requirements will require the development of adequate data collection, storage, and reporting capabilities; document management policies and procedures; and the dedicated attention of a compliance officer or reporting manager.

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.

Staff:	Compliance Officer, Policy Manager, Policy Analyst, IT Project Manager, IT Implementation Analyst
Consultants:	Quality Rating System Development; Data Analytics; Website/Online Tool Development; Document Management Support
IT/System Needs:	Data warehouse; Data aggregation and reporting solution; Website/Online reporting tool; Interface to health plans, treasury, and HHS;
Key Tasks:	Determine reporting needs and specifications; Develop internal data and reporting systems necessary to capture and communicate information; Collect and store required information; Develop quality control system to test and verify reporting outputs

16. External Reporting	Begin	End
Identify reporting requirements per ACA and CMS/HHS guidelines	Jul-12	Aug-12
Solicit BOD and key stakeholder input as to type of information exchange should report	Jul-12	Sep-12
Develop list of reports mandatory and optional	Sep-12	Oct-12
Create report template for content of each report	Oct-12	Nov-12
Develop or acquire necessary databases to support mandatory and optional reporting, TBD**	Nov-12	Dec-12
Create schedule of report publication dates: monthly; quarterly; annual	Dec-12	Dec-12
Depending on level of reporting, hire exchange staff to support initiative	Dec-12	Dec-12
Develop IT requirements: reporting tools; interfaces; CMS/HHS requirements, TBD**	Dec-12	Feb-13

**Systems design, development and implementation of core business functions of exchange expected to be within Systems Integrator contract (e.g. financial management, plan management, customer service, communications, eligibility and enrollment, oversight).

17. Mandate Determination & Appeals

The exchange will need to build the capacity to accept, review and adjudicate appeals for exemption to the individual mandate, as well as informing employers when their employees become eligible for subsidized coverage, which may result in employer penalties. The exchange will also likely need to be able to implement the eligibility appeals process that is provided by the federal government.

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.

Staff:	Chief Legal Counsel, Assistant Legal Counsel, Appeals Manager, Appeals Associate
Consultants:	Legal Counsel, Hearing Officers, Hearing Location Providers, Mail house for employer notifications
IT/System Needs:	Data integration to eligibility, enrollment, and employer data systems; Document management solution

17. Exemption Certificates & Appeals of Eligibility	Begin	End
Identify obligations and requirements per ACA and CMS/HHS guidelines	Jul-12	Aug-12
Document appeals processes currently in operation in other state agencies	Aug-12	Aug-12
Document a process flow of how certificates and appeals would be administered	Sep-12	Sep-12
Identify as part of process flow: data needs; type of support staff required; est. # of appeals	Oct-12	Oct-12
Determine amount of existing resources which could be leveraged	Oct-12	Oct-12
Develop specifications for IT needs, TBD**	Nov-12	Jan-13
Develop implementation plan for appeals department in exchange: budget; physical space; staff	Dec-12	Dec-12
Begin to hire necessary staff	Dec-12	Jan-13
Implement plan	Sep-13	Sep-13

**Systems design, development and implementation of core business functions of exchange expected to be within Systems Integrator contract (e.g. financial management, plan management, customer service, communications, eligibility and enrollment, oversight).

APPENDIX I: Business Requirements, Core Work Processes, and FOA Business Activities

Business Requirement	Core Work Process	FOA Grant Exchange Operations Area
I. Exchange Set Up	1. Governance and Oversight	*Governance (Establishment Activity)*
	2. Internal Administration	*N/A*
	3. Financial Management	*Financial Management (Establishment Activity)*
II. Core Systems	4. Eligibility Verification	Eligibility Determinations Applications & Notices
	5. Premium Tax Credit Administration	Administration of premium tax credit & cost-sharing reductions
	6. IT/Website Infrastructure	Exchange Website Premium tax credit & cost-sharing calculator Seamless Eligibility & Enrollment Process SHOP Exchange-specific functions
	7. Enrollment, Billing & Collections	Enrollment Process
	8. Customer Service Operations	Call Center
	9. SHOP-specific Processes	SHOP Exchange-specific functions
III. Communication & Outreach	10. Communications & Outreach	Outreach & Education
	11. Navigator Program	Navigator Program
	12. Broker Program	
IV. QHP Plan Management	13. Qualified Health Plan Certification	Certifications of QHPs
	14. Plan Rating System	Quality Rating System
	15. Risk Adjustment	Risk adjustment & transitional reinsurance
V. Regulatory Compliance and Reporting	16. External Reporting & Consumer Protection	Information reporting to IRS and enrollees
	17. Mandate Determinations & Appeals	Individual Responsibility Determinations Adjudication of Appeals of Eligibility Determinations Notification and appeals of employer liability

APPENDIX II-A: Start-up Staffing Chart Plan

(In addition to staff reflected in this table, start-up personnel expense includes Exchange-allocated portion of salary, fringe, and indirect costs for 12 IT program analysts engaged in system design and development)

	FTEs by Calendar Year		
	CY 2011	CY 2012	CY 2013
Leadership			
Sr. Executives :	**0**	**5**	**8**
Executive Director	0	1	1
General Counsel	0	0	1
Chief Financial Officer	0	1	1
Chief Technologist	0	1	1
Chief Operating Officer	0	1	1
Chief Marketing Officer	0	0	1
Chief Communications Officer	0	0	1
Deputy Director	0	1	1
Staff by Functional Area			
Administration	**2**	**3**	**4**
Manager	0	1	1
Assistant	2	2	3
Appeals	**0**	**0**	**1**
Director	0	0	0
Manager	0	0	1
Specialist	0	0	0

Finance	**2**	**5**	**8**
Director	0	1	1
Manager	0	2	3
Analyst/Accountant	2	2	4
HR	**0**	**1**	**1**
Director	0	0	0
Manager	0	1	1
Specialist	0	0	0
IT	**3**	**5**	**5**
Director	1	1	1
Manager	0	2	2
Specialist/Analyst	2	2	2
Legal	**3**	**3**	**3**
Asst Gen Counsel	0	0	0
Attorney	3	3	3
Paralegal	0	0	0
Operations	**1**	**5**	**10**
Director	0	1	1
Manager	1	2	3
Specialist/Analyst	0	2	6
Communications/Outreach	**2**	**2**	**3**
Director	0	0	0
Manager	2	2	2
Specialist	0	0	1

	Policy	**7**	**7**	**4**
	Director	1	1	1
	Actuary	1	1	1
	Manager	4	4	1
	Analyst	1	1	1
	Sales	**0**	**1**	**2**
	Director	0	0	0
	Manager	0	1	2
	Specialist	0	0	0
	Grant Administrator	**0**	**0**	**0**
	Director	0	0	0
	Manager	0	0	0
	Specialist	0	0	0
Total		**20**	**37**	**49**

Note: Chart above suggest that Chief Marketing and Communication Officer positions can be staffed in 2013; alternatively, these positions can be filled earlier with support staff hired at a later date to achieve budget neutral costs.

APPENDIX II-B: Operational Staffing Load Projections: FTEs by Functional Area for High, Low, and Moderate Enrollment Scenarios, 2014 and 2015

Estimated Operational Staffing Load (No BHP)

	CY 2014 Estimated FTEs			CY 2015 Estimated FTEs		
Scenario	Low	Moderate	High	Low	Moderate	High
Membership	258,650	361,600	464,550	405,700	611,600	817,500
Functional Areas:						
Administrative	2	2	2	2	3	3
Appeals	4	5	6	5	6	6
Sr. Executive	7	9	9	9	9	9
Finance	8	11	12	12	13	15
HR	1	1	1	1	2	2
IT	4	5	6	5	6	6
Legal	3	4	4	4	4	4
Operations	11	16	16	16	17	18
Outreach	4	5	6	5	6	6
Policy	2	3	3	3	4	4
Sales	1	3	4	3	4	6
Grant Administrator	1	1	1	1	2	2
Total	**48**	**65**	**70**	**66**	**76**	**81**

Estimated Operational Staffing Load (With BHP)

	CY 2014 Estimated FTEs			CY 2015 Estimated FTEs		
Scenario	Low	Moderate	High	Low	Moderate	High
Membership	142,550	217,600	292,650	264,700	414,800	564,900
Functional Areas:						
Administrative	1	2	2	2	2	3
Appeals	3	4	4	5	5	6
Sr. Executive	5	7	8	9	9	9
Finance	5	7	8	9	12	13
HR	0	1	1	1	1	2
IT	4	4	5	5	5	6
Legal	2	3	3	4	4	4
Operations	7	10	12	14	16	17
Outreach	2	3	4	5	5	6
Policy	2	2	3	3	3	4
Sales	1	1	2	2	3	4
Grant Administrator	0	1	1	1	1	2
Total	**32**	**45**	**53**	**60**	**66**	**76**

APPENDIX III: Timeline by Core Work Process

1. Governance & Oversight (assumes BOD appointed in Spring 2012)	Begin	End
Interim exchange staff initiates search process for Exec Director and other senior leadership	Mar-12	Apr-12
BOD assumes responsibility for ED search process and selects ED	Apr-12	Jun-12
BOD begins process to hire legal counsel	Apr-12	Jun-12
BOD develops board calendar & location of meetings	Apr-12	Jun-12
Exchange ED identifies issues requiring Board vote	Jun-12	Jul-12
BOD develops Board Subcommittees	Apr-12	Jun-12
BOD develops Board Policies and Procedures	Aprl-12	Jul-12
BOD begins process to adopt Organizational Bylaws	Jun-12	Aug-12
BOD adopts conflict-of-interest rules for Directors & Exchange Staff	Jun-12	Jul-12
Develop and submit (second) Level 1 grant application	Oct-11	Dec-11
Develop and submit Level 2 grant application	Apr-12	Jun-12
Develop schedule for reviewing studies/reports and recommendations as required by statute	May-12	Jul-12
Create advisory committee schedules and select meeting places for 5 regional advisory committees	Apr-12	Jun-12
Develop process for incorporating recommendations of Regional Advisory Committees	Jun-12	Jul-12

2. Internal Administration (assumes Board of Directors appointed in Spring 2012)	Begin	End
Interim exchange staff initiates search process for Exec Director and other senior leadership	Mar-12	Apr-12
BOD assumes responsibility for ED search process and selects ED	Apr-12	Jun-12
ED hires key Senior Mgmt., including CFO/COO/CIO	Jun-12	Aug-12
Develop exchange organizational chart	Jul-12	Aug-12
Develop staffing plan	Jul-12	Aug-12
Interim staff locates physical space options for exchange (temporary or permanent)	Jan-12	Mar-12
ED/Sr. Mgmt. begin to hire exchange staff, especially in key areas of IT, Finance, and Ops	Jun-12	Sep-12
ED finalizes physical space decision	Jun-12	Jul-12
Begin to hire consultants for subject matter expertise in key areas	Jun-12	Oct-12
Assign staff ownership for completion of studies/reports & recommendations required by exchange statute	Jan-12	Aug-12
Start analytical work on list of studies and reports required by exchange statute	June-11	Jan-12
Develop Exchange IT Strategy in coordination with Medicaid	Mar-11	Feb-12
Set up interagency meetings and/or ensure exchange representation in existing mtgs	Feb-11	Dec-13
Identify vendors/suppliers for administrative needs	Apr-12	Jun-12
Acquire Tax ID for exchange	Apr-12	Dec-12
Register exchange as public authority with Secretary of State, IRS, etc.	Apr-12	Jun-12
Develop proposal for salary structure and benefits for exchange personnel	Jan-12	Mar-12
Develop organizational policies & procedures	May-12	Aug-12
Develop contracting mechanism to easily bring on consultants & suppliers	May-12	Jul-12
Develop and submit (second) Level 1 grant application	Oct-11	Dec-11
Develop and submit Level 2 grant application	Apr-12	Jun-12

**System design, development and implementation of core business functions of Exchange expected to be within Systems Integrator contract (e.g. financial management, plan management, customer service, communications, eligibility and enrollment, oversight).

3. Financial Management (assumes Board of Directors appointed in Spring 2012)	Begin	End
Hire CFO	Jun-12	Aug-12
Set up banking structure in coordination with State Comptroller	Jun-12	Aug-12
Begin to develop administrative budget model	Jun-12	Aug-12
Hire accounting and budgeting staff	Jun-12	Aug-12
Hire payroll vendor or establish internal payroll department	Apr-12	Jun-12
Research short term accounting system to record basic exchange rec/pay transactions, TBD**	May-12	Jul-12
Develop exchange chart of accounts	Jun-12	Aug-12
Identify accounting structure for recording of transactions -- GAAP/STAT, etc.	Jun-12	Sep-12
Identify and scope out basic financial reports for CMS/BOD during start up	Jun-12	Sep-12
Working with DOH, begin to develop IT operational financing strategy	Mar-11	Feb-12
Develop a contracting process for acquiring computers and office equipment	Jun-12	Jul-12
Begin to develop system of internal control for exchange finance operations	Jun-12	Sep-12
Hire audit firm (operational and financial)	Sep-12	Sep-12
Refine five year budget and self-sustainability model	Jun-12	Dec-13
Prepare financial & budget components of Level 2 grant application	Apr-12	Jun-12
Begin to assess longer term exchange finance systems -- PB; Accounting; QHP Coordination	Jun-12	Oct-12

**System design, development and implementation of core business functions of Exchange expected to be within Systems Integrator contract (e.g. financial management, plan management, customer service, communications, eligibility and enrollment, oversight).

4-7;9: Eligibility Verification; Premium Tax Credit; Website; Enrollment, Billing & Collections and SHOP Specific Processes – Responsibilities of System Integrator(SI):	Begin	End
Assign interim exchange IT staff to work groups/committees to ensure exchange representation	Apr-11	Jul-11
Gather and define preliminary exchange business and technical requirements	Apr-11	Mar-12
Develop exchange Systems Integrator (SI) RFP	Jun-11	Aug-11
Publish exchange Systems Integrator (SI) RFP	Sep-11	Sep-11
Develop exchange Quality Assurance RFP	Sep-11	Dec-11
Publish exchange Quality Assurance RFP	Nov-11	Dec-11
Assess and score exchange Systems Integrator RFP responses	Feb-12	Mar-12
Assess and score exchange Quality Assurance RFP responses	Feb-12	Mar-12
Select exchange Systems Integrator vendor; negotiate terms , finalize contract	Feb-12	Mar-12
Select exchange Quality Assurance vendor; negotiate terms, finalize contract	Mar-12	Apr-12
Finalize design, implement, test, validate, go live	Feb-12	Oct-13
Ensure close coordination with DOH on all Eligibility-Related Matters	Mar-11	Dec-13
Develop cost allocation methodology as part of operational financing strategy	Feb-12	Apr-12
Hire CIO	Jun-12	Aug-12
Hire permanent exchange IT staff (Mgr., Analysts, Project Managers)	Jun-12	Sep-12
Work with CFO/COO once hired to implement exchange administrative IT infrastructure	Jun-12	Sep-12
Acquire computers, software, email capability, data storage, communications equipment (perm staff)	Jun-12	Sep-12
Ensure physical facility is properly wired and configured for IT needs of new staff	Apr-12	Jun-12
Help locate physical space for influx of short term IT implementation (SI and QA vendors)	Jan-12	Mar-12
8. Customer Service Call Center – Expected to be outside of SI contract	Begin	End
Gather and define business and technical requirements for call center	Apr-12	Jul-12
Hire exchange IT staff for call center	Apr-12	May-12
Determine buy/build approach for call center	Aug-12	Sep-12
Implement, test, validate, go live	Sep-12	Oct-13

10. Outreach & Marketing Plan	Begin	End
Begin search and hire Chief Sales & Marketing Officer	Aug-12	Sept-12
Begin search and hire Chief Communications Officer	Aug-12	Sept 12
Develop a high level communication & outreach strategy for exchange; initiate research	Jul-12	Aug-12
Solicit input from key stakeholders in state	Jul-12	Aug-12
Develop an outreach and marketing budget	Aug-12	Sep-12
Develop return on investment (ROI) metrics	Aug-12	Sep-12
Develop & Publish RFP for Marketing & Advertising Vendor	Oct-12	Nov-12
Finalize RFP process and select vendor	Nov-12	Jan-13
Working with vendor, complete market research and begin planning activities	Jan-13	Jan-13
Identify outreach partners (other state agencies and existing health care advocacy groups)	Oct-12	Jan-13
Identify potential marketing partners and alliances for exchange	Oct-12	Jan-13
Select outreach and marketing partners	Jan-13	Feb-13
Execute outreach and communication plan	Jan-13	Dec-13
Collect data and calculate ROI	Jul-13	Dec-13

11. Navigator Program	Begin	End
Conduct Third Party Assistor study and review results	Oct-11	Apr-12
Hire exchange staffer to oversee Navigator program	Jul-12	Aug12
Determine level of consulting services required, if any	Aug-12	Sep-12
Develop Navigator stakeholder meetings to solicit input from key stakeholders	Jul-12	Aug-12
Determine level of training and certification required of Navigators by Exchange	Sep-12	Oct-12
Develop Navigator training program	Oct-12	Dec-12
Determine level of compensation to be paid to Navigators -- per enrollee/fixed grants, etc.	Aug-12	Oct-12
Develop funding stream for Navigators -- pre 2014 / post 2013	Sep-12	Oct-12
Develop RFP for Navigators	Oct-12	Nov-12
Select Navigators	Dec-12	Jan-13
Train Navigators	Apr-13	Jul-13
Develop Navigator Management Tool, TBD**	Nov-12	Jan-13

12. Broker Program	Begin	End
Conduct Third Party Assistor study to determine broker comp, services provided, markets serviced	Oct-11	Feb-12
Conduct broker stakeholder interviews to solicit input from broker community	Oct-11	Jan-12
Using data from market study and stakeholder interviews, develop exchange broker strategy	Apr-12	May-12
Determine level of broker compensation for writing exchange business	Jun-12	Aug-12
Hire exchange staffer to oversee broker program	Jul-12	Aug-12
Determine funds flow of broker payments	Aug-12	Sep-12
Develop broker management tool to track key broker metrics, TBD**	Nov-12	Jan-13
Develop a broker training program for exchange products	Sep-12	Nov-12
Train brokers	Jan-13	Jul-13
Develop a broker-advisory council for ongoing feedback from brokers once operational	Apr-13	Apr-13
Reflect broker-specific policies in QHP procurement	Nov-12	Nov-12

**System design, development and implementation of core business functions of Exchange expected to be within Systems Integrator contract (e.g. financial management, plan management, customer service, communications, eligibility and enrollment, oversight).

13. Qualified Health Plan (QHP) Certification	Begin	End
Select Essential Health Benefits (EHB) Benchmark plan	Apr-12	Sept-12
Determine exchange staff to oversee QHP procurement	Jul-12	Aug-12
Compile data necessary to analyze and develop procurement goals	May-12	Aug-12
Analyze data and develop state procurement goals	Jul-12	Aug-12
Communicate goals of procurement with BOD	Aug-12	Sep-12
Develop communication plan to meet with carriers prior to release of RFP	Sep-12	Sep-12
Assess NAIC SERFF for use in plan management	Aug-11	July- 12
Incorporate into QHP procurement strategy OPM offerings	Sep-12	Sep-12
Organize cross-functional QHP procurement team	Oct-12	Oct-12
Incorporate Plan Rating System in procurement	Oct-12	Nov-12
Incorporate Risk Adjustment methodology in procurement	Oct-12	Nov-12
Develop with IT, operational specifications for QHP's -- enrollment/premium rates/billings, TBD**	Mar-12	Aug-12
Develop and publish RFP	Nov-12	Dec-12
Select & Contract with QHP's	Jan-13	Feb-13
Begin implementation of QHP's	Feb-13	Feb-13
Test systems, interfaces, website design	Jun-13	Sep-13
OPEN ENROLLMENT	**Oct-13**	**Feb-14**

14. Plan Rating System	Begin	End
Review federal guidance for Plan Rating System	Jul-12	Jul-12
Determine goals of state in rating QHP's	Aug-12	Aug-12
Select type of quality/cost metrics to rank QHP's	Sep-12	Sep-12
Determine availability of plan rating data	Sep-12	Oct-12
Integrate with exchange website, TBD**	Jul-13	Jul-13
Develop implementation plan for ongoing data maintenance and updating of ratings	Nov-12	Dec-12
Integrate with QHP procurement strategy	Oct-12	Oct-12
Include plan rating specifications into QHP procurement document	Oct-12	Nov-12

15. Reinsurance & Risk Adjustment Program	Begin	End
Conduct study on reinsurance and risk adjustment needs and options	Sep-11	Mar-12
Determine level of interaction necessary with HHS regarding federal implementation of risk corridors	Apr-12	Jun-12
Determine availability of enrollment and claims data for analysis	Nov-11	Jun-12
Compile necessary data to begin analytical assessment	Nov-11	Jun-12
Determine where will program be managed within the state	Jul-12	Sep-12
Decide on where will data be held and managed for start-up and operations	Nov-11	Jul-12
Contract with subject matter experts	May-12	Aug-12
Develop risk adjustment methodology for program implementation	Apr-12	Sep-12
Develop schedule of meetings with carriers in market	Apr-12	Jun-12
Discuss proposed risk adjustment methodology with carriers and solicit input	Jul-12	Sep-12
Communicate with BOD program specifics after meeting with carriers	Oct-12	Dec-12
Develop "dry runs" of agreed upon methodology to determine impact on market	Jan-13	Mar-13
Share results of "dry runs" with carriers; modify methodology if necessary	Feb-13	Jul-13
Develop implementation plan -- data mgmt.; communications; funds flow; reconciliation	Oct-12	Mar-13
Implement program	Jan-14	Dec-14

**System design, development and implementation of core business functions of Exchange expected to be within Systems Integrator contract (e.g. financial management, plan management, customer service, communications, eligibility and enrollment, oversight).

16. External Reporting	Begin	End
Identify reporting requirements per ACA and CMS/HHS guidelines	Jul-12	Aug-12
Solicit BOD and key stakeholder input as to type of information exchange should report	Jul-12	Sep-12
Develop list of reports mandatory and optional	Sep-12	Oct-12
Create report template for content of each report	Oct-12	Nov-12
Develop or acquire necessary databases to support mandatory and optional reporting, TBD**	Nov-12	Dec-12
Create schedule of report publication dates: monthly; quarterly; annual	Dec-12	Dec-12
Depending on level of reporting, hire exchange staff to support initiative	Dec-12	Dec-12
Develop IT requirements: reporting tools; interfaces; CMS/HHS requirements, TBD**	Dec-12	Feb-13

17. Exemption Certificates & Appeals of Eligibility	Begin	End
Identify obligations and requirements per ACA and CMS/HHS guidelines	Jul-12	Aug-12
Document appeals processes currently in operation in other state agencies	Aug-12	Aug-12
Document a process flow of how certificates and appeals would be administered	Sep-12	Sep-12
Identify as part of process flow: data needs; type of support staff required; est. # of appeals	Oct-12	Oct-12
Determine amount of existing resources which could be leveraged	Oct-12	Oct-12
Develop specifications for IT needs, TBD**	Nov-12	Jan-13
Develop implementation plan for appeals department in exchange: budget; physical space; staff	Dec-12	Dec-12
Begin to hire necessary staff	Dec-12	Jan-13
Implement plan	Sep-13	Sep-13

**System design, development and implementation of core business functions of Exchange expected to be within Systems Integrator contract (e.g. financial management, plan management, customer service, communications, eligibility and enrollment, oversight).

APPENDIX IV: Five Components of Internal Control & Associated Fraud/Risk Activities

Twenty Basic Principles Representing the Fundamental Concepts Associated with and Drawn Directly From the Five Components of the Framework (COSO)	
Control Environment	• Integrity and Ethical Values – Sound integrity and ethical values, particularly of top management, are developed and understood and set the standard of conduct for financial reporting
	• Board of Directors – the board of directors understands and exercises oversight responsibility related to financial reporting and related internal control.
	• Management's Philosophy and Operating Style – Management's philosophy and operating style support achieving effective internal control over financial reporting
	• Organizational Structure – The company's organizational structure supports effective internal control over financial reporting
	• Financial Reporting Competencies – The company retains individuals competent in financial reporting and related oversight roles.
	• Authority and Responsibility – Management and employees are assigned appropriate levels of authority and responsibility to facilitate effective internal control over financial reporting
	• Human Resources – Human Resource policies and practices are designed and implemented to facilitate effective internal control over financial reporting.
Fraud Risk Assessment	• Financial Reporting Objectives – Management specifies financial reporting objectives with sufficient clarity and criteria to enable the identification of risks to reliable financial reporting.
	• Financial Reporting Risks – The company identifies and analyzes risks to the achievement of financial reporting objectives as a basis for determining how the risks should be managed.
	• Fraud Risk – The potential for material misstatement due to fraud is explicitly considered in assessing risks to the achievement of financial reporting objectives.
Anti-Fraud Control Activities	• Integration with Risk Assessment – Actins are taken to address risks to the achievement of financial reporting objectives.
	• Selection and Development of Control Activities – Control activities are selected and developed considering their cost and their potential effectiveness in mitigating risks to the achievement of financial reporting objectives.
	• Policies and Procedures – Policies related to reliable financial reporting are established and communicated throughout the company, with corresponding procedures resulting in management directives being carried out.
	• Information Technology – Information technology controls, where applicable, are designed and implemented to support the achievement of financial reporting objectives.

Information and Communication	• Financial Reporting Information – Pertinent information is identified, captured, used at all levels of the company, and distributed in a form and timeframe that supports the achievement of financial reporting objectives.
	• Internal Control Information – Information used to execute other control components is identified, captured, and distributed in a form and timeframe that enables personnel to carry out their internal control responsibilities.
	• Internal Communication – Information used to execute other control components is identified, captured, and distributed in a form and timeframe that enables personnel to carry out their internal control responsibilities.
	• External Communication – matters affecting the achievement of financial reporting objectives are communicated with outside parties.
Monitoring	• Ongoing and Separate Evaluations – ongoing and/or separate evaluations enable management to determine whether internal control over financial reporting is present and functioning.
	• Reporting Deficiencies – Internal control deficiencies are identified and communicated in a timely manner to those parties responsible for taking corrective action, and to management and the board as appropriate.