

**Maine Health Benefit Exchange**  
**Steering Committee – Introductory Meeting May 20, 2011**

**Federal Vision**

*An Exchange is a mechanism for organizing the health insurance marketplace to help consumers and small businesses shop for coverage in a way that permits easy comparison of available plan options based on price, benefits and services, and quality. By pooling people together, reducing transaction costs, and increasing transparency, Exchanges create more efficient and competitive markets for individuals and small employers.*

**Key Principle – Consumer Experience**

*State Health Benefit Exchanges are meant to provide an online consumer experience for buying health insurance that is comparable to best of class commercial shopping websites such as Amazon, Expedia, and Zappos.com. The basic goal of the Exchange is to allow someone shopping for health insurance to sit down, compare plans, figure out if they are eligible for a subsidy (including Medicaid), pick a plan, and enroll - **all within 15 minutes**.*

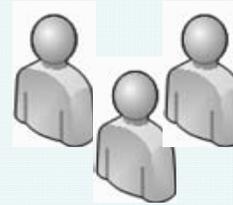
**Key Principle – Eleven Core Areas (see Establishment Grant Appendix A).**

# Example of a Use Case for Searching or Enrolling for Medical Insurance Using a One Stop Portal - 2014

1 Consumers, family members, small businesses, and others use the Exchange to search for health insurance options available in their geographic area



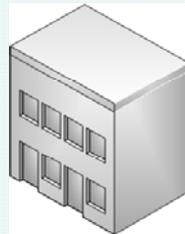
2 Using an interactive rules engine based model the Exchange server collect basic information from the consumer



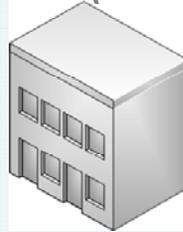
5 State-of-the-art Call center on standby to support consumer through the transaction

4 Consumer mediated workflow supported by ability to handle electronic document submissions results in enrollment and subscription to appropriate insurance which may include ability to print temporary insurance card for the consumer. All in real time!

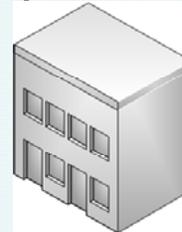
3 In real time Exchange use standards based web services to interact with state, federal and commercial systems to collect, verify and submit information



State Systems  
(Eligibility, Enrollment)



Federal Systems  
(Tax, Vitals, Hires)



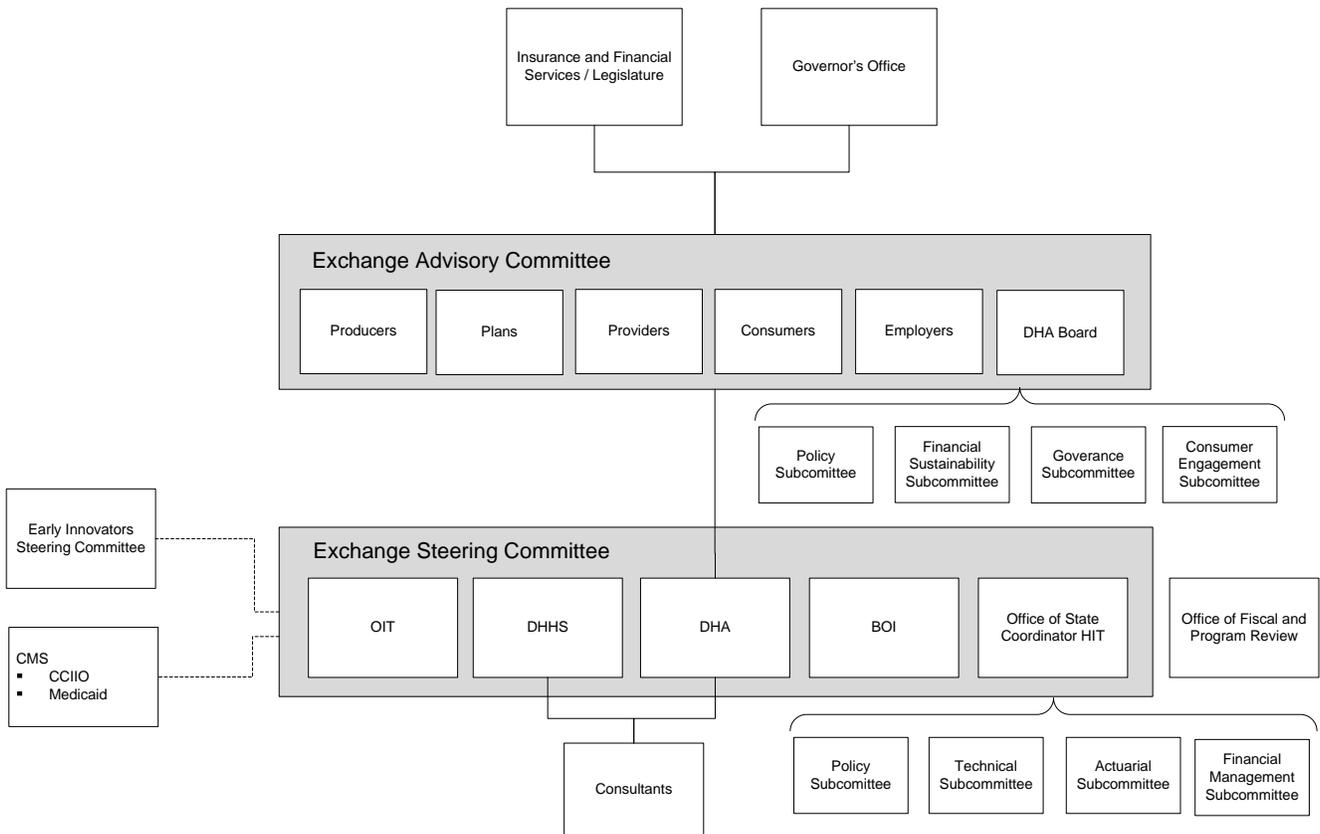
Commercial  
Insurance  
(Rates, Subscription)

## Process and Organization

DHA and DHHS are in the process of selecting a vendor to assist the Steering Committee with needs assessment, environment scan, and planning activities. The vendor is responsible for producing a **business plan** and an **implementation plan** (see below) for the Exchange.

The Steering Committee, made up of representatives from the appropriate State Agencies and Departments will support the Advisory Committee, coordinate with the New England Collaborative Early Innovator project and CMS (Medicaid and CCIIO).

The Advisory Committee, made up of stakeholders, will produce a final report including draft legislation for the Insurance and Financial Services Committee and the Governor's Office.



## Current Defined Deliverables

- Business Operations Plan - The business operations plan will describe those systems and operational capacities that Maine will require in running an Exchange
- Implementation Plan - The implementation plan must describe how Maine will build upon, reallocate, and/or streamline its existing resources to efficiently reach the capacities described in the business operations plan.

The Business Operations and Implementation Plans must include:

- an actuarial analysis of the impact of the Affordable Care Act (ACA) on the health market in Maine
- a full technical and operational review of the State's existing capabilities and systems that will be affected in the deployment of the Exchange
- the identification and description of the technical systems required for the operation of the Exchange
- the identification and description of the business processes / workflows required for the operation of the Exchange
- the identification and description of those resources required to deploy the implementation plan

September 1, 2011

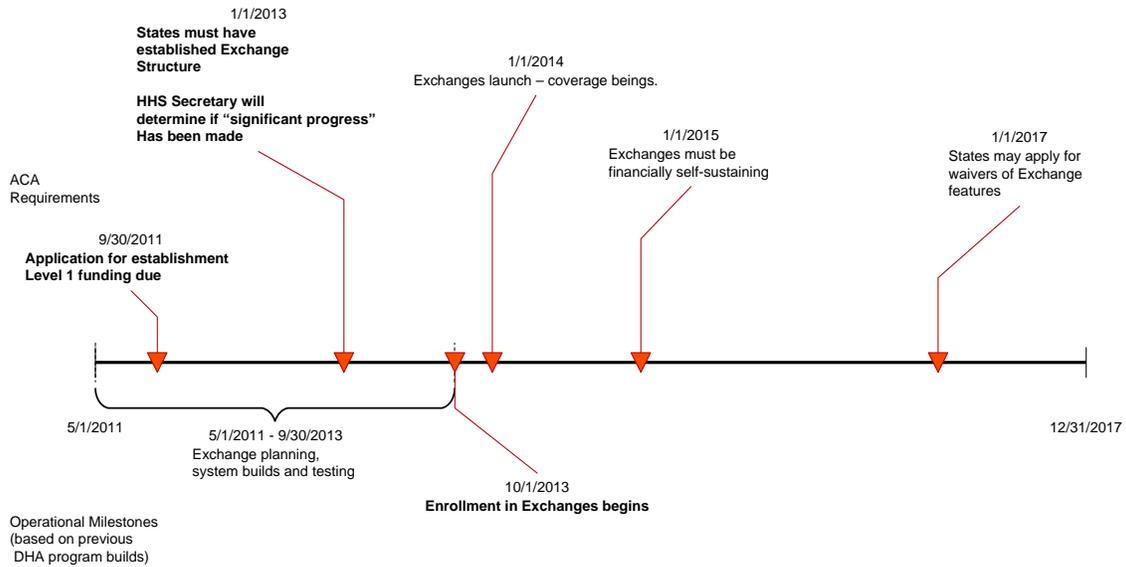
- Report & Draft Legislation – The Advisory Committee is tasked with producing recommendations on the governance and operational structure of the State's Health Insurance Exchange, including draft legislation for the Legislature to consider in the Second Regular Session of the 125<sup>th</sup>.

September 30, 2011

- Exchange Establishment Grant Application – Level 1 funding

# Health Insurance Exchange Timeline

## Key Milestones



The first Notice of Proposed Rulemaking (NPRM), which will address many of the basic federal requirements, is scheduled for publication in the spring of 2011. Additional regulations are scheduled for publication later in 2011 and in 2012.

## VIII. APPENDICES

### A. Appendix A: Description of the Eleven Exchange Establishment Core Areas

Although it is emphasized in program integrity and financial management, one of the key principles that will inform federal funding and technical support for State establishment of Exchanges is public accountability and transparency. Accountability requires transparency. Section 1311(d)(7) requires public reports on Exchange activities, and Section 1311(e)(3) requires additional reporting, which should include standardized data reporting on price, quality, benefits, consumer choice and other factors that will help measure and evaluate performance. Successful Exchanges must ensure public accountability in areas such as objective information on the performance of plans; availability of automated comparison functions to inform consumer choice; fair and impartial treatment of consumers, plans and other partners; and prohibitions on conflict of interest.

For more information on the initial guidance provided to States on the Principles and priorities of Exchanges, please go to:

[http://www.healthcare.gov/center/regulations/guidance\\_to\\_states\\_on\\_exchanges.html](http://www.healthcare.gov/center/regulations/guidance_to_states_on_exchanges.html)

Further information on each of these Exchange Establishment Core Areas will be provided in future guidance and regulations.

#### 1. Background Research

As part of their planning activities, many States are currently undertaking studies and other research to determine the best approach for supporting an Exchange. In some States, this research includes evaluating whether or not the State should establish an Exchange, and if so, where it should be housed, how it should be governed, and what approach it will take. For *Level One Establishment* and *Level Two Establishment* applicants, background research will only be considered as a Core Area under previous Exchange grants and will not need to be carried forward under the Establishment Cooperative Agreement except to the extent that the State determines more research is needed.

#### 2. Stakeholder Consultation

Section 1311(d)(6) of the Affordable Care Act requires that each Exchange consult with a variety of key stakeholders in the planning, establishment and ongoing operation of Exchanges. For example, Stakeholder input should be considered in the development of legislative options and drafts of enabling legislation, Exchange design and approach, and Exchange operational issues, among numerous other topics, including coordination with State health information exchanges. Successful Exchanges will undertake multi-faceted outreach to inform the public of their services and coverage options and will work closely with a variety of stakeholders including, but not limited to advocates for consumers, patients, employees, unemployed individuals, self employed individuals, and other consumers likely to be Exchange enrollees as well as consumers likely to be eligible for premium tax credits and cost-sharing reductions, representatives of small

businesses, health insurance issuers, State HIT Coordinators, State Medicaid offices, State human services agency, and health care providers.

In the spirit of Executive Order 13175 the Secretary is anticipating requiring each State that has one or more federally recognized Tribe(s) located within its borders to provide documentation that it has (1) established a process of consultation with such Tribe(s) regarding the start up and ongoing operation of the Exchanges; (2) implemented that process; and (3) assurance that it will continue to conduct and document such Tribal consultations for Exchange matters. Further guidance will be provided on this and other Indian specific issues. States are encouraged to review and adapt to procedures for State Medicaid consultation. States have the option to subcontract with Tribes for activities related to their grant. Please clearly identify funding set aside for such consultation in the budget narrative.

### 3. Legislative and Regulatory Action

Section 1321(b)(1) of the Affordable Care Act requires that by January 1, 2014, a State that elects to establish an Exchange must adopt and have in effect the Federal standards for Exchanges that will be issued by HHS or that the State have in effect a State law, regulation, or other legal mechanism, that implements these standards. Each State should ensure that it provides its Exchange with the authority necessary to meet all the Exchange requirements of the Affordable Care Act. The State must determine all the necessary steps it must take to have the necessary legal authority to establish and operate an Exchange that complies with Federal requirements. Each State will have its own milestones under this Core Area that correspond to its legislative calendar and the political environment of the State. We provide examples of basic milestones to guide the timeline for this process.

### 4. Governance

Each Exchange must have in place a governance structure that conforms to the requirements of the Affordable Care Act and the regulations to be issued by HHS. Section 1311(d)(1) provides States with the option of establishing an Exchange within an existing State agency, within a new or existing quasi-governmental entity, or as a separate non-profit. In addition, a State could choose to partner with one or more other States to establish a regional Exchange or to create more than one subsidiary Exchange within the State. Regardless of its organizational form, the Exchange must be publicly accountable, transparent, and have technically competent leadership, adhering to States' conflict of interest requirements, with the capacity and authority to take all actions necessary to meet Federal standards, including the discretion to determine whether health plans offered through the Exchange are in the interests of qualified individuals and qualified employers.

### 5. Program Integration

As required by Section 1413 of the Affordable Care Act, the Exchange will need to work closely with Medicaid, CHIP, and other Health and Human Services Programs in order to ensure seamless eligibility verification and enrollment processes. To reach this goal, the Exchange and the State Medicaid agency will need to closely partner on systems development and operational

procedures. States are encouraged to consider how the Exchange system can be integrated with other health and human services systems in the State since the eligibility function the Exchange will perform has significant similarities to eligibility determinations in other programs. States are encouraged to consider steps necessary to achieve interoperability with other specific health and human services programs for purposes of coordinating eligibility determinations, referrals, verification, or other functions.

Each Exchange will also need to work closely with the State Department of Insurance in order to successfully carry out the activities of the Exchange. The State Department of Insurance will oversee the regulation and licensure of health insurance issuers, including those that offer qualified health plan coverage through the Exchange. In addition, the State Department of Insurance may be the State entity that processes consumer coverage appeals and complaints. Working with the State Department of Insurance will be essential in ensuring the financial stability of insurance companies, certification of plans, rate review, State licensure, solvency, and market conduct. Key issues, such as adverse selection, related to the functioning of the individual and small group markets inside and outside the Exchange will be important to Exchange success. To the extent Exchanges are not one of these entities, they should get started early in working with these other departments as well as legislators to determine the best approach to mitigating these issues.

#### 6. Exchange IT Systems

Information technology will be a component of many business functions of the Exchange, including those set forth in Section 1311(d)(4) as well as the requirements in Sections 1411, 1412 and 1413 related to eligibility and enrollment. This Core Area encompasses the performance of the Exchange in planning for and establishing these systems in these various functional areas. When planning or developing Exchange IT systems, the State should take steps to ensure a modular, flexible approach to systems development, including use of open interfaces and exposed application programming interfaces; the separation of business rules from core programming; and the availability of business rules in both human and machine readable formats. Milestones related to information technology for establishment of an Exchange will be located under each of the Exchange business functions. Exchanges will be required to follow all applicable Federal IT guidance. In addition, States are encouraged to leverage the expertise of the State health information exchange program (HIE). HIE is defined as the mobilization of healthcare information electronically across organizations within a region, community or hospital system. HIE provides the capability to electronically move clinical information among disparate health care information systems while maintaining the meaning of the information being exchanged. The goal of HIE is to facilitate access to and retrieval of clinical data to provide safer, more timely, efficient, effective, equitable, patient-centered care. HIE is also useful to Public Health authorities to assist in analyses of the health of the population.

#### 7. Financial Management

As required by Section 1313, each Exchange will establish a financial management structure and accounting system that adheres to applicable provisions of generally accepted accounting

requirements and ensures sound financial management of Exchange funds. We have provided some milestones that should be included in the Exchange Work Plan related to establishing these functions. Applicants should create additional milestones that are tailored to their Exchanges' particular management structure and that will ensure the Exchanges are in compliance with State and Federal regulations.

#### 8. Oversight and Program Integrity

Also required by Section 1313, each Exchange will need to ensure program integrity related to Federal and State funds utilized to start-up and operate the Exchange. Exchanges will need to ensure that they take steps to prevent waste, fraud, and abuse. The Financial Management core area includes the infrastructure the Exchange must establish for financial management while this core area includes the oversight and program integrity activities the Exchange undertakes to ensure compliance with Federal and State requirements, including annual audits.

#### 9. Health Insurance Market Reforms

In Sections 1311(a)(4)(A)(ii) and 1321(c)(1)(B)(ii)(II), the Affordable Care Act requires each State to show progress implementing the health insurance market reforms that are set forth in Subtitles A and C of the Affordable Care Act as a condition of receiving establishment grants and for certification of the State's Exchange. Making progress on implementation would include passing State legislation or issuing appropriate regulations implementing these reforms as well as other activities, including stakeholder consultation on these issues and development of a plan to implement these reforms. These activities will be carried out by the State. HHS will release guidance on how States demonstrate progress in implementing these reforms. States must also demonstrate they are enforcing Affordable Care Act consumer protections to be certified as eligible to operate an Exchange.

#### 10. Providing Assistance to Individuals and Small Businesses, Coverage Appeals, and Complaints

Exchanges are required to provide certain services for State residents, including responding to requests for informational assistance, providing a toll free telephone hotline, and helping individuals learn whether they are eligible for Medicaid, CHIP and applicable State health subsidy programs and facilitate the enrollment process, where applicable. Exchanges also must offer assistance to individuals and provide for coverage appeals. These requirements are set forth in Sections 1311(d)(4) and 1413 as well as other Sections. Exchanges also must offer assistance through navigators, as required by Section 1311(i) of the Affordable Care Act (funded from the operational funds of the Exchange), to individuals and provide for coverage appeals.

An Exchange may provide these services directly, or through contracts or by referral arrangements to entities or other state agencies that provide such assistance services. Many States already have assistance programs that help residents resolve problems, answer questions, file complaints and appeals, enroll in. When an Exchange provides this assistance through contracting entities or interagency agreements, it must ensure the outside entity has capacity to provide assistance that consumers need. Building sufficient capacity for providing assistance to State residents is a core activity of Exchange planning and establishment. For these reasons, a

State must ensure robust capacity for providing such assistance for all of its residents and must ensure that the Exchange reinforces and strengthens this assistance capacity. The Exchange should collaborate closely with other entities within the State who are carrying out these activities and develop a plan to facilitate this ongoing collaboration.

#### 11. Business Operations of the Exchange

Exchanges must carry out several functions required by the Affordable Care Act. More detailed information will be provided on the requirements for each function in future guidance. Each of the minimum functions of an Exchange are listed below and explained in greater detail below. These requirements are mainly set forth in Sections 1311(d)(4), 1341, 1343, and 1411-1413.

#### **Minimum functions of an Exchange:**

- Certification, recertification, and decertification of qualified health plans
- Call center
- Exchange website
- Premium tax credit and cost-sharing reduction calculator
- Quality rating system
- Navigator program
- Eligibility determinations for Exchange participation, advance payment of premium tax credits, cost-sharing reductions, and Medicaid
- Seamless eligibility and enrollment process with Medicaid and other State health subsidy programs
- Enrollment process
- Applications and notices
- Individual responsibility determinations
- Administration of premium tax credits and cost-sharing reductions
- Adjudication of appeals of eligibility determinations
- Notification and appeals of employer liability
- Information reporting to IRS and enrollees
- Outreach and education
- Free Choice Vouchers
- Risk adjustment and transitional reinsurance
- SHOP Exchange-specific functions

#### Certification, Recertification, and Decertification of Qualified Health Plans

Each Exchange, whether for the small group or individual market, must have a process in place to certify, recertify, and decertify qualified health plans. States must begin defining their process and approach to these activities with health plans in the early planning and establishment phases of an Exchange. There are many steps in this process, and we have provided milestones as a framework for carrying out these activities. However, States may be on slightly different timelines and we encourage States to develop timeframes for these activities that are achievable yet ensure they can be ready for open enrollment in mid to late

2013. In order to meet this deadline, Exchanges must begin the process of selection and certification of qualified health plans in 2012.

#### Call Center

As part of its plan to provide meaningful assistance to individuals and small businesses, each Exchange must operate a toll-free hotline to respond to requests for assistance from consumers. HHS will provide future guidance containing more specific information about the requirements for Exchange call centers. Each Exchange should aim to have a call center ready before open enrollment, but States may set up these services earlier to facilitate outreach to consumers and to answer consumer questions about how the Affordable Care Act may affect individual access to health insurance. In addition, a State could explore partnering with its State Consumer Assistance Program or Health Ombudsman program to jointly contract for or to operate a call center as these activities will be very closely related.

#### Exchange Website and Premium Tax Credit and Cost-sharing Reduction Calculator

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

#### Quality Rating System

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

#### Navigator Program

Each Exchange will establish a Navigator program, as required by Section 1311(i) of the Affordable Care Act, under which it awards grants (funded from the operational funds of the Exchange) to entities that will assist consumers in navigating their choices in the health insurance marketplace. This includes facilitating enrollment in qualified health plans.

#### Eligibility determinations for Exchange participation, advance payment of premium tax credits, cost-sharing reductions, and Medicaid

Key operations of the Exchange will be verification and determination of eligibility for qualified health plans. The Affordable Care Act includes requirements for these functions that will be spelled out in greater detail in future HHS guidance. Key functions within this functional area include:

- Eligibility determinations for:
  - Advance payment of premium tax credits
  - Cost-sharing reductions

- Other applicable State health subsidy programs, including Medicaid and CHIP, and
- Free Choice Vouchers
- Appeals of eligibility determinations for enrollment in a qualified health plan and premium tax credits and cost-sharing reductions

Seamless eligibility and enrollment process with Medicaid and applicable State health subsidy programs

There are numerous milestones that Exchanges will need to accomplish between now and 2014 to create seamless eligibility and enrollment between the Exchange and other State health subsidy programs. The Exchange must determine an individual’s eligibility for Medicaid, CHIP, and other applicable State health subsidy programs and the State must ensure that such individuals are seamlessly enrolled in the program for which they are eligible without need for further determination by the other program. States are encouraged to consider how the Exchange eligibility system can be integrated – in the short or longer term - with other health and human services systems in the State since the eligibility function the Exchange will perform has significant similarities to eligibility determinations in other programs. States are encouraged to consider steps necessary to achieve interoperability with other specific health and human services programs for purposes of coordinating eligibility determinations, referrals, verification, or other functions.

Each State’s situation will be different and milestones will need to be tailored to the specific scenarios. In addition, many of the steps needed to achieve streamlined eligibility and enrollment in Exchanges and other applicable State health subsidy programs will be carried out through the development of information technology systems in close partnership with State Medicaid programs. We will work closely to help States with the process. States should refer to *Guidance for Exchange and Medicaid Information Technology (IT) Systems*, Version 1.0 or the most current version, the standards adopted by the Secretary pursuant to the Affordable Care Act, and future guidance for additional guidance related to the effort to bring together eligibility and enrollment processes across these programs.

Enrollment process

The Exchange will need to facilitate plan selection for an individual who is eligible to enroll in a qualified health plan. This includes providing information about available qualified health plans that is customized according to an individual’s preferences, receiving an individual’s choice of plan, and providing enrollment transactions to qualified health plan issuers using applicable standards that will be set forth in future HHS guidance..

Applications and notices

The Exchange must implement all requirements for applications and notices consistent with Federal requirements, including facilitating the use of a single, streamlined application. Applications and notices include mechanisms for consumers to carry out enrollment steps (screening, enrollment forms, verifications) both in person or online. Applications and notices will facilitate the application, eligibility determination process, and enrollment of

individuals into qualified health plans as well as notices that the Exchange will issue to facilitate program operations and communication with enrollees. For example, the Exchange will have to notify individuals upon determination of eligibility for enrollment in a qualified health plan through the Exchange.

#### Individual responsibility determinations

The Exchange must have in place a process to receive and adjudicate requests from individuals for exemptions from the individual responsibility requirements of the Affordable Care Act, and to communicate information on such requests to HHS for transmission to IRS. This is a required function of Exchanges under the Affordable Care Act.

#### Administration of advance premium tax credits and cost-sharing reductions

The Exchange must perform administrative activities related to premium tax credits and cost-sharing reductions. For example, an Exchange will need to communicate with HHS in situations when a person would like to report a change in income level, which will trigger redetermination of eligibility for advance payment of the credits. Exchanges are the first point of contact for prospective enrollees who will be interested in learning more about premium tax credits and for seeking assistance when needed.

#### Adjudication of appeals of eligibility determinations

Individuals may seek to contest the eligibility determinations made by the Exchange for premium subsidies and Exchange participation, and therefore the Exchange will need to implement a process for processing appeals, and this process will coordinate with Medicaid and CHIP.

#### Notification and appeals of employer liability

The Exchange must notify employers when one or more of their employees is determined to be eligible for advance payment of a premium tax credit because the employer does not offer minimum essential coverage or the coverage is not affordable or does not meet the minimum value requirement. Further, the Exchange must offer the employer an opportunity to appeal.

#### Information reporting to IRS and enrollees

The Exchange must report to the IRS and enrollees each year certain information regarding the enrollee's coverage provided through the Exchange.

#### Outreach and education

Each State will need to have in place a robust education and outreach program to inform health care consumers about the Exchange and the new coverage options available to them. The Exchanges must also educate consumers about the benefits of purchasing health insurance coverage through the Exchange, including access to health plans that meet State and Federal certification standards and access to assistance with paying their premiums and cost-sharing. Each Exchange may determine a unique strategy for conducting outreach and education activities and timelines may vary depending on the investment Exchanges choose

to make in these activities as well as the size and diversity of the populations each Exchange serves.

#### Free Choice Vouchers

Individuals who have access to employer sponsored coverage that is not affordable according to the affordability standards set forth in the Affordable Care Act, may be eligible to receive Free Choice Vouchers from their employers. These vouchers will be used to offset the cost of health insurance premiums for these individuals. The Exchange will need to conduct eligibility determinations for Free Choice Vouchers and will need to implement a process to notify an employer regarding an individual's eligibility for a Free Choice Voucher, collect funds from an employer, apply funds to an individual's purchase of a qualified health plan, and refund excess funds to an individual, consistent with Federal standards.

#### Risk adjustment and Transitional Reinsurance

Pursuant to the Affordable Care Act, each State must implement a risk adjustment program and a transitional reinsurance program in accordance with Federal standards. Funding under the Establishment grants may be used to support risk adjustment and transitional reinsurance. States will need to plan for necessary data collection to support risk adjustment, including demographic, diagnostic, and prescription drug data. Qualified health plans may be required to submit encounter data, and therefore, States need to develop data and other systems to support risk adjustment. HHS is working with insurance plans and experts so that each State does not have to develop a risk adjustment model independently. We will release more guidance in the future, including information on a risk adjustment model that States may use and the Federal standards for data collection and operations.

#### SHOP Exchange-specific functions

The Affordable Care Act requires each State that elects to operate an Exchange to establish a Small Business Health Options Program (SHOP) Exchange. States may choose to merge the operations of their SHOP Exchange with their individual market Exchange. The SHOP Exchange will facilitate the purchase of coverage in qualified health plans for the employees of small businesses that choose to purchase coverage through the Exchange. Starting on January 1, 2014, small employers can only qualify for Small Business Health Care Tax Credits if they purchase coverage for their employees inside the Exchange or SHOP Exchange. For purposes of this funding opportunity, we have identified SHOP Exchange-specific functions to aid States in their operational planning efforts related to the SHOP Exchange.